MEDICARE A Bulletin

A NEWSLETTER FOR FLORIDA MEDICARE PART A PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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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- ☐ _____
- ☐ _____

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

Questions concerning this publication or its contents may be faxed to:

Medicare Publications
1-904-361-0723

A MESSAGE TO PROVIDERS

FCSO UNVEILS "NEWS & BULLETINS" PAGE

FCSO is pleased to announce the latest enhancement to our Web site: the "News & Bulletins" page. By bringing together Medicare articles and FCSO publications in one convenient location, this section is your one-stop for the latest Medicare news.

SAME LOCATION, NEW TITLE

With this launch, publications are now found by selecting the "News & Bulletins" link in the **Quick Find** menu on the Medicare Part A and Part B main pages. To view or download publications, select the "Archives" link in the **Topics Menu Bar** at the top of the page.

All articles released during the month will be posted to this "News & Bulletins" page. Similar to an electronic magazine, this page builds chronologically with each new article released so that providers can stay up-to-date on the latest Medicare news.

At the end of the month, many of these articles will then be archived into our *Medicare A Bulletin* and/or *Medicare B Update!* publications. Those articles not included in our publications will remain on the appropriate Web site pages.

IMPROVED LAYOUT

Another change is the addition of a **Topics Menu Bar**, located at the top of the page, which organizes all articles by topic or specialty. Gone are the days of scrolling down a long list of articles! By clicking directly on your area of interest, this menu allows visitors to easily locate the articles most relevant to them.

These topic headings are modeled after the subject categories found in our *Medicare A Bulletin* and *Medicare B Update!* publications. If there are no articles yet released for a particular topic, you will see the message, "There are no updates in this section at this time."

As a reminder, you can still locate many of these articles on the topic and specialty pages throughout our Web site.

We need your feedback! Please let us know what you think about this latest enhancement by completing our Web Site Feedback. You can access this form in the "Contact" link located in the upper right corner of our Web site. ❖

2008 MEDIFEST SYMPOSIUM—REGISTER TODAY

Registration is now open for FCSO's 2008 Medifest Symposium occurring on May 6 & 7 in Orlando, FL. This popular education seminar brings together Medicare experts, clinicians, billing staff, coders and suppliers throughout Florida to learn the latest on the Medicare program and to network with their peers. This year's Medifest is located at:

Marriott Orlando Downtown

400 West Livingston Street

Orlando, FL 32801

1-407- 843-6664 or 1-800- 574-3160

FCSO is working hard to make this the most rewarding Medifest ever. Take a look at the changes coming this year…

- **Two 1-Day Sessions**. We will conduct Medifest as two 1-day sessions to accommodate providers' busy schedules. The cost to attend is $136 per person, per day.
- **Advanced Courses**. With our new training Web site, the LMS, FCSO now offers providers convenient and free access to its introductory-level Medicare courses. This allows us to devote this year's Medifest to more advanced courses targeted at experienced Medicare providers.
- **Mandatory Prerequisite Courses**. To ensure all participants benefit from the new advanced curriculum, some classes require completion of mandatory prerequisite Web-based Training (WBT) courses. All prerequisite courses are free and available through the LMS or CMS' Web site. Participants cannot register for classes with mandatory prerequisite WBTs until participants successfully complete them through the LMS.

In addition to the required prerequisites, we also suggest complementary WBT courses available through CMS' Web site. While these WBTs are not mandatory for registration, we encourage you to complete them.

To view the list of mandatory and recommended prerequisite WBT courses, as well as complete instructions on registering for this year's Medifest, visit our Web site at *www.fcso.com*. Click on "Florida Part A and B" under Medicare Providers, and select the "Provider Outreach & Education" tab.

This is the only Medifest event in Florida for 2008, and space is limited, so register early through the FCSO Medicare Training Web site, the Learning Management System (LMS), at *www.fcsomedicaretraining.com*. First-time users to LMS can set up an account using our user guide at *www.floridamedicare.com/Education/108651.asp*. ❖

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

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

NEW VALUE CODE TO REPORT PATIENT PRIOR PAYMENTS

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

PROVIDER TYPES AFFECTED

Hospitals, home health agencies, and other providers who bill Medicare contractors (fiscal intermediaries [FI] regional home health intermediaries [RHHI], or Medicare administrative contractors [A/B MAC]) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change request 5882, from which this article is taken, announces the creation of a new value code for the Medicare Form UB-04 (CMS-1450). This new code, value code FC – Patient prior payment, will enable you to continue to report patient prior payments (the amount you received from the beneficiary toward payment of the submitted claim prior to the billing date).

Make sure that your billing staffs are aware of the creation of this new value code, and that they know to implement it effective July 1, 2008.

BACKGROUND

Previous Medicare Form CMS-1450 billing instructions for form locator (FL) 54 allowed providers to report the total amount of payments toward deductibles and/or coinsurance that they had collected from a patient for all services other than inpatient hospitals or skilled nursing facilities (SNF). However, with the implementation of the UB-04, the National Uniform Billing Committee (NUBC) eliminated "Patient" from FL 54; which is now used to report prior payer payments.

To enable Medicare providers to continue to report patient prior payments, the Centers for Medicare & Medicaid Services (CMS) asked the NUBC to create a value code for this purpose. NUBC approved this request on 11/14/2007; and CR 5882, from which this article is taken, announces the creation of this new value code: value code FC – Patient prior payment.

Effective July 1, 2008, you may use this value code to report patient prior payments.

ADDITIONAL INFORMATION

You may find CR 5882 on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1427CP.pdf.*

There is also information in the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the Form CMS-1450 Data Set), on completing the UB-04. This manual is available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

If you have any questions, please contact your FI, RHHI, or A/B MAC at their toll-free number, which may be found on the CMS 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: MM5882
Related Change Request (CR) Number: 5882
Related CR Release Date: February 1, 2008
Related CR Transmittal Number: R1427CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1427, CR 5882

SUMMARY OF POLICIES IN THE 2008 MEDICARE PHYSICIAN FEE SCHEDULE AND THE TELEHEALTH ORIGINATING SITE FACILITY FEE PAYMENT AMOUNT

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

PROVIDER TYPES AFFECTED

Physicians, other practitioners, providers, and suppliers 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 and paid under the Medicare physician fee schedule (MPFS).

PROVIDER ACTION NEEDED

This article is based on change request (CR) 5895, which contains summaries of the policy changes in the 2008 Medicare physician fee schedule and the telehealth originating site facility fee for 2008. (Note: this CR does not include any changes that would be affected by recent legislation (i.e., 0.5 percent update to the conversion factor, changes to the geographic practice cost indices floor, etc. Information regarding these changes may be found in CR 5944, Legislative Change Affecting the 2008 Medicare Physician Fee Schedule (MPFS) and Extension of the 2008 Participation Open Enrollment Period).

Summary of Policies in the 2008 MPFS and the Telehealth Originating Site Facility Fee Payment Amount (continued)

BACKGROUND

The Social Security Act (Section 1848(b)(1) at *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* on the Internet) requires the Centers for Medicare & Medicaid Services (CMS) to provide (by regulation before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year. CMS published a document that will affect payments to physicians effective January 1, 2008.

The Social Security Act (Section 1834(m) at *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm* on the Internet) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 21, 2002 at $20.

For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare economic index (MEI) as defined in the Social Security Act (Section 1842(i)(3) at *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm* on the Internet). The MEI increase for 2008 is 1.8 percent.

For calendar year 2008, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is either 80 percent of the lesser of the actual charge or $23.35.

Note: The beneficiary is responsible for any unmet deductible amount or coinsurance.

In summary, CR 5895 instructs your Medicare contractor to:

- Pay for the Medicare telehealth originating site facility fee as described by HCPCS code Q3014 at 80 percent of the lesser of the actual charge or $23.35.
- Consider payment for the following HCPCS codes only when appropriate, reasonable and necessary (i.e., when the service is provided to evaluate patients with signs/symptoms of illness or injury) as per of the Social Security Act (Section 1862(a)(1)(A) at *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the Internet):

HCPCS Code	Descriptor
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and brief intervention, 15 to 30 minutes.
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and intervention greater than 30 minutes.

See the attachment to CR 5895, on the CMS Web site available at *http://www.cms.hhs.gov/Transmittals/downloads/R1423CP.pdf*, for:

- A summary of significant issues discussed in CMS-1325-FC, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions.

ADDITIONAL INFORMATION

The official instruction, CR 5895, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1423CP.pdf*.

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

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

MLN Matters Number: MM5895
Related Change Request (CR) Number: 5895
Related CR Release Date: February 1, 2008
Related CR Transmittal Number: R1423CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1423, CR5895

NEW MEDICARE LEARNING NETWORK PRODUCTS NOW AVAILABLE ON THE TOPIC OF IACS-PC

As previously mentioned, the Centers for Medicare & Medicaid Services (CMS) will soon be offering the Provider Enrollment, Chain and Ownership System (PECOS) and Provider Statistical and Reimbursement Report (PS&R) online. These new online enterprise applications will allow Medicare fee-for-service (FFS) providers to access, update, and submit enrollment and cost report information over the Internet. Providers and/or appropriate staff must register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider Community (IACS-PC). CMS urges FFS providers to read the series of *MLN Matters* articles on this subject and act now. They may be accessed at the following URLs:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf

Source: CMS Provider Education Resource 200802-05

IMPLEMENTATION OF THE MEDICARE CLINICAL LABORATORY SERVICES COMPETITIVE BIDDING DEMONSTRATION

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

PROVIDER TYPES AFFECTED

Providers or suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [A/B MAC]) and/or order laboratory services for Medicare fee-for-service (FFS) beneficiaries under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration project.

WHAT YOU NEED TO KNOW

Change request (CR) 5772, from which this article is taken, implements the Centers for Medicare & Medicaid Services (CMS) Medicare Clinical Laboratory Services Competitive Bidding Demonstration in the first Competitive Bidding Area (San Diego-Carlsbad-San Marcos, California metropolitan statistical area, or CBA1); and changes some of the demonstration's requirements that were stated in CR 5205, issued August 1, 2006, (see the MLN Matters article on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5205.pdf*) and superseded by CR 5359, issued November 1, 2006, (see the MLN Matters article on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5359.pdf*).

Specifically, CR 5772 requires that:

- The demonstration covers tests provided to beneficiaries enrolled in the traditional) Medicare FFS program who reside in the competitive bidding area (CBA1) during the three-year demonstration period required bidders that do not bid, or bid and do not win, may serve as a reference laboratory to laboratories participating in the demonstration. However, they would not be allowed to bill Medicare directly for demonstration tests performed for Medicare FFS beneficiaries residing in the CBA.
- *Laboratories not required to bid*: These laboratories will be paid under the competitively set demonstration fee schedule for the duration of the demonstration.
  - CMS will exempt laboratories that supply less than $100,000 annually in demonstration tests to Medicare FFS beneficiaries residing in the CBA from submitting bids.
  - CMS will exempt laboratories providing services exclusively to beneficiaries entitled to Medicare by reason of end-stage renal disease (ESRD) from submitting bids. (Tests that are paid as part of the ESRD payment bundle are excluded from the demonstration.)
  - CMS will exempt laboratories providing services exclusively to beneficiaries in nursing facilities or receiving home health services from submitting bids.

CR 5772 further announces that the demonstration in CBA1 is scheduled to begin on July 1, 2008; and provides Medicare contractors detailed record layouts for the quarterly report and for listing laboratories in the CBA.

CMS will issue a later CR that implements the demonstration in the second CBA (CBA2), which is tentatively scheduled to start on July 1, 2009.

BACKGROUND

Section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires CMS to conduct a project to demonstrate the application of competitive acquisition for the payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

In this project, each of two demonstration sites (competitive bidding areas – CBA1 and CBA2) will run for three years with a staggered start of one year. It will cover certain "demonstration tests" furnished under Medicare Part B to any beneficiary enrolled in FFS Medicare who lives in the CBAs.

Competitively bid fees will be set for all tests paid under the Medicare Part B clinical laboratory fee schedule in these demonstration sites, with the exception of Pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. In each CBA, the payment basis determined by the bidding will substitute for present payment under the existing clinical laboratory fee schedule.

CBAs will be defined geographically by ZIP codes, and will roughly correspond to a metropolitan statistical area (MSA). Beneficiary residence status will be determined by information in the Medicare system as of the date the claim is processed, and review of a beneficiary's ZIP code of residence must reveal that it is included in the same listed CBA. CMS will provide Medicare contractors with a list of ZIP codes included in each MSA, which they will use to determine whether a beneficiary's residence is included in one of the CBAs.

Two previous CR, 5205 and 5359, (issued August 1, 2006 and November 1, 2006, respectively), implemented the necessary system requirements to accomplish this project. CR 5772, from which this article is taken, establishes the project implementation dates; changes the requirements for referring and reference laboratory services, skilled nursing facility (SNF) and home health services; and provides Medicare contractors a detailed record layout for the quarterly report, for listing laboratories in the CBA with their CB status.

The demonstration in CBA1 is scheduled to begin on July 1, 2008. CMS will issue a later CR that implements the demonstration in the second CBA (CBA2), which is tentatively scheduled to start on July 1, 2009. You should note that multiple winners are expected in each CBA.

Note: Only CLIA-certified laboratories will be allowed to participate in the demonstration.

LABORATORY CATEGORIES

Under the demonstration, laboratories will be classified as either: 1) "Required bidders" (laboratories that are required to bid in the demonstration because (regardless of where they are located) they provide FFS beneficiaries

Implementation of the Medicare Clinical Laboratory Services Competitive Bidding Demonstration (continued)

residing in the CBAs "demonstration tests" that yield $100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2006); or 2) "Non-required bidders" (laboratories whose payments for Medicare Part B (fee-for-service) payments for demonstration tests are below this $100,000 threshold.

"Non-required bidders" may choose to bid or not bid. Those that do not bid will be considered "passive" laboratories. Such passive laboratories, as well as "non-required bidders" who choose to bid (and win) and "required bidders" who win, (both labeled "winners") will be allowed to provide laboratory services to Medicare beneficiaries in the CBA and will be paid at the competitive bid rate for the demonstration tests paid under the Part B clinical laboratory fee schedule (CLFS), regardless of where the laboratory firm is located.

Conversely, "required bidders" and "non-required bidders" who bid and do not win (along with "required bidders" who do not bid) will be labeled "non-winners" under the demonstration. Medicare will not directly pay these "non-winner" laboratories (under either the Part B clinical laboratory fee schedule or the competitively bid price) for demonstration tests that they provide to beneficiaries residing in the CBAs for the duration of the demonstration (regardless of where the laboratory firm is located). Therefore, a passive laboratory that chooses to bid but does not "win" cannot participate in the demonstration in its "passive" status.

There are three types of passive laboratories: 1) "Passive-small business" (those with less than $100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBA); 2) "Passive-ESRD" – those that provide clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBAs); and 3) "Passive SNF/Home Health" – those that provide laboratory services exclusively to beneficiaries residing in nursing homes or are receiving home health services.

The "passive-small business" category of passive laboratories is subject to an annual payment ceiling of $100,000, however this payment-ceiling threshold does not apply to the "passive ESRD" or "passive SNF/Home Health" laboratories. Further, you should note that the $100,000 threshold for "passive" laboratories does not include Medicare payment for tests excluded from the demonstration test list, services for beneficiaries residing in areas outside the CBA, or revenues from sources other than Medicare fee-for-service.

You should also note that the $100,000 threshold does not apply to either the "passive ESRD" or passive SNF/Home Health laboratory categories.

In addition, in order to make it easier for nursing facilities to continue to provide continuity of care, CMS is exempting "passive SNF/Home Health" laboratories from being required bidders. Laboratories providing both Part A and Part B laboratory services to nursing facilities will be able to continue existing business relationships because they will not be at risk of losing Medicare Part A business as a result of the demonstration. They will be paid at the competitively set rate for demonstration tests otherwise paid under the Part B CLFS, and will also continue to receive payment for mileage, phlebotomy, and the existing payment under any schedule other than the Part B CLFS for those tests included in the demonstration.

You should also be aware that during the demonstration period, CMS will require that Medicare contractors monitor (and report to CMS quarterly):

- "Passive-small business" laboratories to ensure that their Medicare Part B annual payments for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the dollar threshold (so that they do not unfairly gain market share within the CBA). Passive laboratory firms exceeding their threshold limitations during the demonstration period will be converted to a "non-winner" status, and will be terminated from the demonstration project, and not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

  Note: All changes from a "passive" to a "non-winner" will be prospective to the next quarter.

- "Passive-ESRD" laboratories to ensure that payments under Medicare Part B for demonstration tests are provided only to beneficiaries with ESRD residing in the demonstration sites.

- Passive SNF/Home Health" laboratories to ensure that payments under Medicare Part B for demonstration tests are provided only to beneficiaries residing in nursing homes or are receiving home health in the demonstration sites.

PROJECT IMPLEMENTATION

The project is being implemented in multiple phases. The first phase (analysis and design) was implemented in January 2007. The second phase (finalization of the requirements, coding development, testing and documentation) was implemented in April 2007.

CR 5772, from which this article is taken, announces that the demonstration in CBA1 is scheduled to begin on July 1, 2008, and that the tentative start date for the demonstration in the second CBA is July 1, 2009.

During the second quarter of calendar year (CY) 2008, CMS will provide Medicare contractors with:

- Information that specifies (along with a few other required fields) the laboratories' names and Medicare provider numbers, address and ZIP code, demonstration status (winning, passive (SB, SNF/Home Health, ESRD), or non-winner) and each laboratory's payment history for services provided to beneficiaries' living within the first CBA1 as of CY 2006. This information will identify the laboratories eligible to participate in the demonstration ("winning" laboratories), the passive laboratories that are exempt from bidding in the demonstration due to their relatively small size as measured by annual Medicare payments or due to their status as an ESRD or SNF/home health laboratory, and those not selected to participate in the demonstration after unsuccessfully bidding ("non-winner" laboratories). The list will specify the name of the laboratory, address, ZIP code, Medicare provider number, and the laboratory's demonstration status. Any changes to a laboratory's status in this report will be handled on an ad hoc basis.

Implementation of the Medicare Clinical Laboratory Services Competitive Bidding Demonstration (continued)

- A test version of the laboratory competitive bidding demonstration fee schedule file containing the demonstration fee amounts for the preliminary list of services that the demonstration covers. (This test file will be populated only with the data pertaining to CBA1.)
- Modifications to the existing five-position national ZIP code pricing file for the laboratory competitive bidding demonstration. Also during the second quarter of CY 2008, CMS will provide the final version of the laboratory competitive bidding demonstration fee schedule file containing the *Current Procedural Terminology (CPT*) codes of the services covered by the demonstration and fees for CBA1.

To determine the correct laboratory competitive bidding fee schedule amount, contractors will use the July 2008 version of the five-position national ZIP code pricing file to locate the ZIP code of the beneficiary's residence and map the beneficiary locality designation (i.e., CBA1 or CBA2) to the matching locality on the laboratory competitive bidding demonstration fee schedule file.

Notes:

1) This mapping is for demonstration pricing purposes only, and will not be used to report the laboratory state locality information.

2) For claims within a local carrier's jurisdiction, carriers will continue to report the state locality of the billing laboratory as they do now for clinical laboratory services.

CR 5772 also contains the following details about the demonstration:

- Physician office laboratory (POL) testing and hospital-based laboratories that function as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital are included in the demonstration. A POL enrolled as an independent laboratory or a hospital-based laboratory furnishing laboratory services to non-patients are subject to the demonstration rules. Services provided by a POL and/or a hospital-based laboratory for their own patients are not included in the demonstration and will continue to be paid under the existing CLFS.

  Note: For hospital-based laboratories, only 14x type of bills submitted for non-patient laboratory services are covered under this demonstration.

- Hospital inpatient testing is covered by Medicare Part A, it is, therefore, exempt from the demonstration.
- Pap smears and colorectal cancer screening tests are excluded from this demonstration by statute.
- Requirements under the Clinical Laboratory Improvement Amendments (CLIA) program as mandated in section 353 of the Public Health Service Act are applicable.
- Claims for phlebotomy, Healthcare Common Procedure Coding System (HCPCS) code 36415 (Collection of venous blood by venipuncture) must identify the place of service (POS), e.g., Skilled Nursing Facility (POS 31), Home (POS 12), ESRD treatment facility (POS 65), Physician's office (POS 11) or Independent laboratory (POS 81). If the specimen is collected at an independent laboratory draw station, you should use POS 81. For this demonstration, when the specimen is collected at a hospital laboratory or draw station that is acting as an independent laboratory, you should indicate the place of service for CPT code 36415 as POS 81.
- Referring and reference laboratories may be paid under the demonstration with some restrictions:
  - A winning or passive laboratory can refer out and bill for the reference laboratory service and be paid directly by Medicare.
  - A reference laboratory that was required to bid in the competitive bidding process but was not a winner under the demonstration can perform reference laboratory services but cannot bill Medicare directly or bill the beneficiary.
  - A reference laboratory that was not required to bid in the competitive bidding process can choose to bill for services that other laboratories refer to them. However, these laboratories are restricted to receiving payment less than $100,000 a year (for demonstration tests provided to FFS beneficiaries residing in the CBA), and if they exceed the $100,000 limit, they will be considered a non-winner and Medicare payment will not be allowed.
- **Non-winner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare denies payment for the test, nor may they charge the beneficiary for such a test.** However, non-winners may continue to furnish tests (that are outside the scope of the demonstration) to beneficiaries residing within the CBA, receive Medicare payment for such tests, and may appeal denial decisions for these services.
- Effective for claims with dates of services between July 1, 2008 and June 30, 2011, Medicare contractors will pay competitive bidding demonstration fee schedule amounts for claims that winning and/or passive laboratories submit for demonstration-covered services (including reference laboratory services) provided to beneficiaries residing in the CBA1. Moreover, CMS is aware that the allowed amount under the demonstration could be less than the regular fee schedule allowed amount. Therefore, contractors will add the following message for a demonstration remittance advice:

  M114 – This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, contact your local contractor.

- Laboratory tests which are exempt from the demonstration (e.g., pap smears, colorectal cancer screening tests), as well as new procedure codes that are added subsequent to the start of the demonstration will be paid in accordance with the existing CLFS.

Implementation of the Medicare Clinical Laboratory Services Competitive Bidding Demonstration (continued)

Laboratory tests provided to beneficiaries enrolled in the Medicare program other than FFS or residing outside the CBA will be paid in accordance with the existing Part B CLFS.

- Effective for claims with dates of services on or after July 1, 2008 through June 30, 2011, carriers will deny, and intermediaries will reject, claims submitted by non-winner laboratories for demonstration-covered services provided to beneficiaries residing in the CBA1, using the following remittance advice reason code and remark codes:

  Reason code 96 – Noncovered charge(s).

  Remark Code M114 – This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.

  Remark Code M115 (For carriers) – No appeal rights. This item is denied when provided to this patient by a non-contract or non-demonstration supplier.

  Remark Code N83 (For intermediaries) – No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

  - Effective for claims with dates of services on or after July 1, 2008 through June 30, 2011, carriers will not reject claims with a modifier "90" (Reference (Outside) Laboratory) submitted by a winning or passive laboratory for demonstration-covered services provided to beneficiaries residing in the CBA1. However, they will reject claims from non-winning laboratories for demonstration covered services provided to such beneficiaries, even with modifier "90" present.
  - Finally, all of the other business rules provided in CR 5205 and CR 5359 remain applicable, and are not changed by CR 5772.

Additional Information

You may find the official instructions given to your carrier, FI, or A/B MAC in CR 5772 located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R56DEMO.pdf*.

You might also want to look at MLN Matters article MM5359 (Laboratory Competitive Bidding Demonstration), which you may find on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5359.pdf*. (MM5359 superseded MM5205.)

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: MM5772
Related Change Request (CR) Number: 5772
Related CR Release Date: February 1, 2008
Related CR Transmittal Number: R56DEMO
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-19, Transmittal 56, CR 5772

Legislative Change Affecting the 2008 Medicare Physician Fee Schedule and Extension of the 2008 Participation Open Enrollment Period

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

Provider Types Affected

Physicians and other providers who bill Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], carriers, and Medicare administrative contractors [A/B MAC]) for professional services paid under the MPFS.

What You Need to Know

Chang request (CR) 5944, from which this article is taken, provides Medicare contractors with information about (and instructions for implementing) legislative changes to the 2008 Medicare physician fee schedule (MPFS), and about the extension of the participation open enrollment period for 2008.

Effective for claims with dates of service January 1, 2008 through June 30, 2008, the update to the conversion factor will be 0.5 percent; and for claims with dates of service July 1, 2008 and after, will revert back to the previous payment methodology (the -10.1 percent update) that was outlined in the final rule, published in the *Federal Register* on November 27, 2007.

Additionally, the Centers for Medicare & Medicaid Services (CMS) has extended the 2008 participation open enrollment period from December 31, 2007, to February 15, 2008, therefore, it now runs from November 15, 2007 through February 15, 2008.

Background

The Medicare, Medicaid, and SCHIP Extension Act of 2007 changes the rates of the 2008 MPFS. CR5944 informs Medicare contractors of this legislative change to the 2008 MPFS; the release of the new MPFS files for them to load; the need to be ready to process beginning January 7, all claims with dates of service on or after January 1, 2008, which contain MPFS services; and the extension of the participation open enrollment period for 2008.

Legislative Change Affecting the 2008 MPFS and Extension of the 2008 Participation Open Enrollment (continued)

MPFS Rate Change

Effective for claims with dates of service January 1, 2008 through June 30, 2008, the update to the conversion factor will be 0.5 percent.

It is important that you understand, however, that this new legislation only impacts the MPFS rates during the first half of 2008 (claims with dates of service January 1, 2008, through June 30, 2008). Claims with dates of service July 1, 2008 and after will revert back to the previous payment methodology (the **-**10.1 percent update) that was outlined in the final rule, published in the *Federal Register* on November 27, 2007.

Note: The legislation also extends the 1.0 floor on the work geographic practice cost index for six months, i.e., through June 30, 2008.

This MPFS rate change also impacts several other fee schedule rates which are MFPS-derived, including the anesthesia conversion factors, purchased diagnostic file, and ambulatory surgical center (ASC) facility rates; but does not impact services that are not paid under the MPFS (e.g., DME, clinical lab, etc.).

Physicians do not need to take any additional action in order for their claims to be paid at the new 0.5 percent rate. Medicare contractors are able to process claims for services paid under the Medicare physician fee schedule that contain dates of service January 1 and after with the new 2008 rates. No adjustments should be necessary. Your Medicare contractors have been instructed to be ready to process all claims with 2008 dates of service with the new MPFS fees beginning January 7, 2008.

2008 Participation Open Enrollment Period Extension

Because this new legislation changes the 2008 MPFS rates, CMS has extended the 2008 participation open enrollment period from December 31, 2007 to February 15, 2008, therefore, it now runs from November 15, 2007 through February 15, 2008.

The effective date for any participation status change during the extension, however, remains January 1, 2008; and will be in force for the entire year. You should make your participation decision for 2008 based on the two new fee rates (i.e., the 0.5 percent update that is effective January through June, and the -10.1 percent update that is effective July through December).

Note: *CR 5944 revises CR 5732 (*Transmittal 1356 – Calendar Year (CY) 2008 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures, dated October 19, 2007*) to reflect the extension.*

CR 5944 also contains additional Medicare contractor instructions:

- Any contractor unable to meet the January 7, 2008 for processing claims date, can hold affected claims for up to 14 calendar days after receipt; but all held claims must be released for payment no later than January 15, 2008.
- Contractors will not automatically make adjustments for providers who change their participation status after January 1, 2008 (you should begin billing claims according to the participation decision that you have made). However, they will adjust claims based on participation status changes that you bring to their attention.
- Your contractor will make the participation agreement available to you by placing it on their Web sites with participation enrollment (and termination) instructions. They will mail (at no charge) hard copies of the new 2008 MPFS, on request, to any physicians/practitioners who do not have Internet access and are unable to view the new fees on the contractor Web site. They will, however, charge a reasonable fee for mailing a hard copy of the 2008 MPFS to providers that do have Internet access, but who want a hard copy for convenience. Further, they will handle physicians/practitioners' requests for copies of the 2008 MPFS as customer services matters, and not as Freedom of Information Act (FOIA) requests; but will handle such requests from other members of the public as FOIA requests.
- Contractors will post the new fees on their Web sites as early as possible.
- Contractors will accept and process any participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before February 15, 2008.

Additional Information

You may find the official instruction, CR 5944, issued to your carrier, FI, RHHI, or A/B MAC by visiting the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R312OTN.pdf*.

If you have any questions, please contact your carrier, FI, RHHI, 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: MM5944
Related Change Request (CR) Number: 5944
Related CR Release Date: February 1, 2008
Related CR Transmittal Number: R312OTN
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-20, Transmittal 312, CR 5944

EMERGENCY UPDATE TO THE 2008 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

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

PROVIDER TYPES AFFECTED

Physicians, other practitioners, providers, and suppliers 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 and paid under the Medicare physician fee schedule (MPFSDB).

PROVIDER ACTION NEEDED

The article is based on change request (CR) 5902 which amends payment files that were issued to Medicare contractors based upon the November 1, 2007, MPFS final rule.

BACKGROUND

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* on the Internet) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services. Previously, payment files were issued to Medicare contractors based upon the November 1, 2007, MPFS final rule. CR 5902 amends those payment files.

In summary, CR 5902 instructs your Medicare contractor to:

- Manually update their systems to reflect 5 base units for *Current Procedural Terminology (CPT)* code *01916*.
- Manually update their Healthcare Common Procedure Coding System (HCPCS) file to include the laboratory certification code (LC) 400 for *CPT* code *89060* on or after January 1, 2008.

Note: See Attachment 1 of CR 5902 for a list of detailed changes for certain CPT/HCPCS codes included in the Emergency Update to the 2008 Medicare Physician Fee Schedule Database (MPFSDB). The Web address for accessing CR5902 is in the next section of this article.

ADDITIONAL INFORMATION

The official instruction, CR 5902, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1435CP.pdf*.

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

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

MLN Matters Number: MM5902
Related Change Request (CR) Number: 5902
Related CR Release Date: February 5, 2008
Related CR Transmittal Number: R1435CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1435, CR 5902

2008 MEDICARE PART B PARTICIPATING PHYSICIAN AND SUPPLIER DIRECTORY

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD will be available on the Connecticut and Florida Medicare Part B Web sites no later than March 17, 2008, at *http://www.floridamedicare.com/Reference/MEDPARD/index.asp*. ❖

Source: CMS Pub. 100-20, Transmittal 312, CR 5944

WEBCAST RECORDINGS OFFERED THROUGH FCSO MEDICARE TRAINING WEB SITE

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1. From the welcome page, click the Library tab.
2. From the Library page, click the Online Resources sub-tab.
3. You will be able to select recordings and presentations for Ask the Contractor, Hot Topics, Ambulatory Surgical Centers (ASC), Provider Enrollment, Evaluation and Management, and The Final Rule Webcasts.

Recordings are available 24 hours a day, seven days a week. Upon clicking on the title of a recording, a player is launched. Recordings play both the audio and visual of the Webcast right on your computer screen, providing you the ability to move to specific sections of the Webcast. For your convenience, we also provide you with the presentation materials used during the Webcast.

FIRST-TIME USER?

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NATIONAL PROVIDER IDENTIFIER

MEDICARE FEE FOR SERVICE LEGACY PROVIDER IDS PROHIBITED ON FORM CMS-1500 CLAIMS AFTER NPI REQUIRED DATE

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 CMS-1500 and CMS-1450 (UB-04) claims to Medicare carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME MACs), and/or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

STOP – IMPACT TO YOU

Effective May 23, 2008, if you report a provider legacy identifier on Medicare CMS-1500 or CMS-1450 (UB-04) claims, your contractors will return them as unprocessable.

CAUTION – WHAT YOU NEED TO KNOW

Change request (CR) 5858, from which this article is taken, announces that provider legacy identifiers are not to be reported on Medicare CMS-1500 or CMS-1450 claims received on or after May 23, 2008 (the date at which the national provider identifier (NPI) is required to be reported on claims). After that date, claims containing legacy identifiers will be returned as unprocessable.

GO – WHAT YOU NEED TO DO

Make sure that your billing staffs are aware that effective May 23, 2008, only NPIs are to be reported on Medicare CMS-1500 and CMS-1450 claims.

BACKGROUND

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique NPI to each physician, supplier, and other health care provider who conducts HIPAA standard electronic transactions. In accordance with this act, CMS began issuing NPIs on May 23, 2005.

Further, on April 2, 2007, the Department of Health & Human Services (DHHS) provided covered entities guidance regarding contingency planning for NPI implementation. In this guidance, as long as a health plan was compliant, meaning they could accept and send NPIs on electronic transactions, they could establish contingency plans to facilitate the compliance of their trading partners.

As a compliant health plan, on April 20, 2007 Medicare fee-for-service (FFS) established a contingency plan that followed this guidance. Since then, CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only
- Medicare legacy only (PINs, UPINs, or national supplier clearinghouse number)
- NPI and legacy combination.

CR 5858, from which this article is taken, announces that beginning on May 23, 2008, CMS requires the NPI to be submitted on the Form CMS-1500 and CMS-1450 paper claims; and legacy numbers will NOT be permitted on claims received on or after that date. Effective that date, Form CMS-1500 and CMS-1450 claims containing legacy identifiers will be returned as unprocessable, without appeal rights.

When returning these claims, your contractors will use an appropriate message and remittance advice remark code, such as:

N257 Missing/incomplete/invalid billing provider primary identifier.

Note: Contractors will not return claims in certain situations where an NPI is not required (e.g., foreign claims, deceased provider claims, and other situations as allowed by CMS in the future). Such claims will be processed with established procedures for such claims.

ADDITIONAL INFORMATION

You may find more information about the prohibition of Medicare fee for service legacy provider IDs on Form CMS-1500 and CMS-1450 claims after the NPI required date by going to CR 5858, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1432CP.pdf*.

You will find updated *Medicare Claims Processing Manual* (100-04), Chapter 26 (Completing and Processing Form CMS-1500 Data Set), Section 10.4 (Items 14-33 - Provider of Service or Supplier Information) as an attachment to that CR.

If you have any questions, please contact your 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: MM5858
Related Change Request (CR) Number: 5858
Related CR Release Date: February 1, 2008
Related CR Transmittal Number: R1432CP
Effective Date: Claims received on or after May 23, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1432, CR 5858

IMPORTANCE OF "COMPLETE" MEDICARE ENROLLMENT APPLICATIONS

NPI IS HERE. NPI IS NOW. ARE YOU USING IT?

Important National Plan and Provider Enumeration System (NPPES) Information for Organization Providers

When organization health care providers apply for the national provider identifications (NPIs), it is important that they enter their correct legal business name and employer identification number (EIN).

NPPES will be establishing a verification process with the Internal Revenue Service (IRS) to verify the legal business name and the associated EIN submitted on the NPPES applications and updates.

Providers will be notified as CMS develops and implements this process. In the meantime, CMS encourages providers to be proactive and verify that this information is correct in order to avoid any potential issues in the future.

Important Information for Medicare Providers

Importance of "Complete" Medicare Provider/ Supplier Enrollment Applications

Correcting your CMS-855 enrollment form can be critical to assuring your claims are processed. CMS is urging providers to avoid delays in CMS-855 processing that are caused by missing or incomplete information.

CMS has instructed its Medicare fee-for-service (FFS) contractors to process complete Medicare provider/supplier enrollment applications that contain all supporting documentation, including the electronic funds transfer authorization agreement (CMS-588) and licensing information, within prescribed processing timeframes. Incomplete or incorrect application information will result in an extension of these processing times for as long as it takes to obtain the correct information from the provider. This wastes precious time, especially for those seeking to rectify NPI/legacy conflicts and poses unnecessary work for both the contractor and the provider.

For an enrollment application to be considered complete:

1. All applicable sections of the CMS-855 and fields, including check boxes, within a section must be filled-out at the time of filing.
2. The application must contain an original signature (blue ink is preferred) and date of signature (blue ink is preferred).
3. The application must be accompanied by all supporting documentation listed in section 17 of the enrollment application.

Make Sure You Understand the Key Dates: New *MLN Matters* Article now Available

The latest NPI-related *MLN Matters* article is now available and illustrates information, in chart form, regarding the difference between the March 1st and May 23rd FFS Medicare NPI implementation dates. To view this article, visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0802.pdf*.

Reminder for Medicare FFS Physicians, Non-physician Practitioners and Other Suppliers

Effective March 1, 2008, all 837P and CMS-1500 claims must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject.

For more details, visit the CMS NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp*.

TEST NPI-only NOW

If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number).

If the Medicare NPI crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims rejects, go into your NPPES record and validate that the information you are sending on the claim is the same information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or the national supplier clearinghouse for advice right away. Have a copy of your NPPES record available. The enrollment telephone numbers are likely to be quite busy, so don't wait.

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*. ❖

Source: CMS Provider Education Resource 200802-08

GENERAL COVERAGE

NEW AUTOMATED TEST FOR THE AUTOMATED MULTI-CHANNEL CHEMISTRY CODE PANEL PAYMENT ALGORITHM

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

PROVIDER TYPES AFFECTED

All physicians and providers, who submit claims for the automated multi-channel chemistry (AMCC) to Medicare contractors (carriers, Medicare administrative contractors [A/B MACs], and fiscal intermediaries [FIs]) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

STOP – IMPACT TO YOU

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5874 to alert providers that existing *current procedural terminology (CPT)* code *82330 – calcium; ionized* is being paid as in individual test and was not included in the AMCC panel payment algorithm. That changes effective July 1, 2008.

CAUTION – WHAT YOU NEED TO KNOW

Effective July 1, 2008, *CPT* code *82330* will become an automated chemistry test within the AMCC panel payment algorithm for payment purposes.

GO – WHAT YOU NEED TO DO

Make certain your office staffs are aware of this change.

BACKGROUND

Effective January 1, 2008, the *CPT* Editorial Panel created a new code *80047 – basic metabolic panel (calcium, ionized)* which is an automated multi-channel chemistry (AMCC) code and is currently included in the automated multi-channel chemistry code (AMCC) Panel Payment Algorithm. The new *CPT* code *80047* is comprised of eight component test codes (see table below). Also, new *CPT* code *80047* is not a replacement for *CPT* code *80048 – basic metabolic panel*. Both *CPT* codes *80048* and *80047* are included in the 2008 clinical laboratory fee schedule.

KEY POINTS

- In order to determine payment for the new code *80047* using the AMCC panel payment algorithm, existing code *82330 – calcium; ionized,* will be added as an AMCC panel code.
- Payment code *ATP23* has also been included in the clinical laboratory fee schedule data file to correspond to the AMCC panel code addition.
- The *CPT* code *80047 – basic metabolic panel (calcium, ionized)* is comprised of:
  - *Calcium; ionized (82330)*
  - *Carbon dioxide (82374)*
  - *Chloride (82435)*
  - *Creatinine (82565)*
  - *Glucose (82947)*
  - *Potassium (84132)*
  - *Sodium (84295)*
  - *Urea nitrogen (BUN) (84520*)

For ESRD dialysis patients, *CPT* code *82330 – calcium; ionized* will be included in the calculation for the 50/50 rule (Pub 100-04, Chapter 16, Section 40.6). When *CPT* code *82330* is billed as a substitute for *CPT* code *82310 – calcium; total*, it should be billed with modifier CD or CE. When *CPT* code *82330* is billed in addition to *CPT* code *82310*, it should be billed with modifier CF.

Note: In accordance with the *Medicare Claims Processing* manual, section 40.6.1, the new panel *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. The *Medicare Claims Processing* manual is available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

ADDITIONAL INFORMATION

To see the official instruction (CR 5874) issued to your Medicare carrier, FI, or A/B MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R83BP.pdf*.

If you have questions, please contact your Medicare Carrier, FI, or A/B MAC at their toll-free number, which may be found on the CMS 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: MM5874
Related Change Request (CR) Number: 5874
Related CR Release Date: February 15, 2008
Related CR Transmittal Number: R83BP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1451, CR 5874,

ERYTHROPOIESIS STIMULATING AGENTS IN CANCER AND RELATED NEOPLASTIC CONDITIONS

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

PROVIDER TYPES AFFECTED

Providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC] and durable medical equipment Medicare administrative contractors [DME MAC]) for administering or supplying erythropoiesis stimulating agents (ESAs) for cancer and related neoplastic conditions to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Following a national coverage analysis (NCA) to evaluate the uses ESAs in non-renal disease applications, the Centers for Medicare & Medicaid Services (CMS), on July 30, 2007, issued a decision memorandum (DM) that addressed ESA use in non-renal disease applications (specifically in cancer and other neoplastic conditions).

Change request 5818 communicates the NCA findings and the coverage policy in the national coverage determination (NCD). Specifically, CMS determines that ESA treatment is reasonable and necessary for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions; and not reasonable and necessary for beneficiaries with certain other clinical conditions, as listed below.

The HCPCS codes specific to non-end-stage renal disease (ESRD) ESA use are J0881 and J0885. Claims processed with dates of service July 30, 2007, through December 31, 2007,do not have to include the ESA modifiers as the modifiers are not effective until January 1, 2008. However, providers are to begin using the modifiers as of January 1, 2008, even though full implementation of related system edits are not effective until April 7, 2008.

Make sure that your billing staffs are aware of this guidance regarding ESA use.

BACKGROUND

Emerging safety concerns (thrombosis, cardiovascular events, tumor progression, and reduced survival) derived from clinical trials in several cancer and non-cancer populations prompted CMS to review its coverage of ESAs. In so doing, on March 14, 2007, CMS opened an NCA to evaluate the uses of ESAs in non-renal disease applications, and on July 30, 2007, issued a DM specifically narrowed to the use of ESAs in cancer and other neoplastic conditions.

Reasonable and Necessary ESA Use

CMS has determined that ESA treatment for the anemia secondary to a regimen of myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is reasonable and necessary only under the following specified conditions:

- The hemoglobin level immediately prior to the first administration is < 10 g/dL (or the hematocrit is < 30%) and the hemoglobin level prior to any maintenance administration is < 10g/dL (or the hematocrit is < 30%.).
- The starting dose for ESA treatment is up to either of the recommended Food and Drug Administration (FDA) approved label starting doses for cancer patients receiving chemotherapy, which includes the, 150 U/kg/ three times weekly or the 40,000 U weekly doses for epoetin alfa and the 2.25 mcg/kg/weekly or the 500 mcg once every three week dose for darbepoetin alpha.
- Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is > 1g/dL (hematocrit > 3%).
- For patients whose hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains < 10 g/dL after 4 weeks of treatment (or the hematocrit is < 30%), the recommended FDA label starting dose may be increased once by 25 percent. Continued use of the drug is not reasonable and necessary if the hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline by 8 weeks of treatment.
- Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3%) over any 2-week period of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30%). Continuation and reinstitution of ESA therapy must include a dose reduction of 25 percent from the previously administered dose.
- ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen.

Not Reasonable and Necessary ESA Use

Either because of a deleterious effect of ESAs on the underlying disease, or because the underlying disease increases the risk of adverse effects related to ESA use, CMS has also determined that ESA treatment is not reasonable and necessary for beneficiaries with the following clinical conditions:

- Any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), or bone marrow fibrosis.
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Anemia of cancer not related to cancer treatment.
- Any anemia associated only with radiotherapy.
- Prophylactic use to prevent chemotherapy-induced anemia.
- Prophylactic use to reduce tumor hypoxia.
- Erythropoietin-type resistance due to neutralizing antibodies.

Erythropoiesis Stimulating Agents in Cancer and Related Neoplastic Conditions (continued)

- Anemia due to cancer treatment if patients have uncontrolled hypertension.

Claims Processing

Effective for claims with dates of service on or after January 1, 2008, Medicare will deny non-ESRD ESA services for J0881 or J0885 when:

- Billed with modifier EC (ESA, anemia, non-chemo/radio) when a diagnosis on the claim is present for any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Billed with modifier EC for any anemia in cancer or cancer treatment patients due to bone marrow fibrosis, anemia of cancer not related to cancer treatment, prophylactic use to prevent cancer-induced anemia, prophylactic use to reduce tumor hypoxia, erythropoietin-type resistance due to neutralizing antibodies, and anemia due to cancer treatment if patients have uncontrolled hypertension.
- Billed with modifier EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.
- Billed with modifier EB (ESA, anemia, radio-induced).

Note: Denial of claims for non-ESRD ESAs for cancer and related neoplastic indications as outlined in NCD 110.21 are based on reasonable and necessary determinations. A provider may have the beneficiary sign an Advance Beneficiary Notice (ABN), making the beneficiary liable for services not covered by Medicare. When denying ESA claims, contractors will use Medicare Summary Notice 15.20, *The following policies [NCD 110.21] were used when we made this decision*, and remittance reason code 50, *These are non-covered services because this is not deemed a 'medical necessity' by the payer*. However, standard systems shall assign liability for the denied charges to the provider unless documentation of the ABN is present on the claim. Denials are subject to appeal and standard systems shall allow for medical review override of denials. Contractors may reverse the denial if the review results in a determination of clinical necessity.

Medicare contractors have discretion to establish local coverage policies for those indications not included in NCD 110.21.

Medicare contractors shall not search files to retract payment for claims paid prior to April 7, 2008. However, contractors shall adjust claims brought to their attention.

Additional Information

This addition/revision of section 110.21 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

The official instruction, CR 5818, was issued to your contractor in two transmittals. The first is the NCD transmittal and that is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R80NCD.pdf*.

The second transmittal revises the *Medicare Claims Processing Manual* and it is on the same site at *http://www.cms.hhs.gov/Transmittals/downloads/R1413CP.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: MM5818
Related Change Request (CR) Number: 5818
Related CR Release Date: January 14, 2008
Related CR Transmittal Number: R80NCD and R1413CP
Effective Date: July 30, 2007
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1413, CR 5818,

SMOKING AND TOBACCO USE CESSATION COUNSELING BILLING CODE UPDATE TO MEDICARE

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

PROVIDER TYPES AFFECTED

Physicians and providers who bill Medicare contractors (fiscal intermediaries [FI], carriers, or Medicare administrative contractors [A/BMAC]) for smoking and tobacco use cessation counseling.

PROVIDER ACTION NEEDED

STOP – IMPACT TO YOU

Effective for services on or after January 1, 2008, you must bill for smoking and tobacco use cessation counseling services with new *CPT* codes (*99406* or *99407*). If you bill using the former HCPCS codes (G0375 and G0376) for services provided after December 31, 2007, your claims will not be paid.

CAUTION – WHAT YOU NEED TO KNOW

Change request (CR) 5878, from which this article is taken, announces that the 2008 Medicare physician fee schedule database (MPFSDB) includes two new *CPT* codes for smoking and tobacco use cessation counseling services; replacing the temporary HCPCS G codes (G0375 and G0376) currently in use for billing these services. These new codes (effective on and after January 1, 2008) are:

99406 *Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*

99407 *Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes*

GO – WHAT YOU NEED TO DO

Make sure that your billing staffs are aware of these newly required *CPT* codes for smoking and tobacco use cessation counseling services.

BACKGROUND

CR 5878, from which this article is taken, announces that the temporary HCPCS G codes G0375 and G0376, which are currently used to bill for smoking and tobacco use cessation counseling services, are effective only through December 31, 2007.

They are being replaced by two new *CPT* codes (*99406 – Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*; and *99407 – Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes*). These new CPT codes, which are included in the 2008 Medicare physician fee schedule database (MPFSDB), become effective for claims with dates of service January 1, 2008 and later.

FIs, carriers, and A/B MACs will pay for counseling services billed with HCPCS codes G0375 and G0376 for dates of service performed on and after March 22, 2005 through December 31, 2007, and with *CPT* codes *99406* and *99407* for dates of service on or after January 1, 2008.

ADDITIONAL INFORMATION

You may find CR 5878 on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1433CP.pdf*.

You will find the updated *Medicare Claims Processing Manual, c*hapter 32 *(*Billing Requirements for Special Services), sections 12.1(HCPCS and Diagnosis Coding), 12.2 (Carrier Billing Requirements), and 12.3 (FI Billing Requirements) as an attachment to that CR.

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

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

MLN Matters Number: MM5878
Related Change Request (CR) Number: 5878
Related CR Release Date: February 1, 2008
Related CR Transmittal Number: R1433CP
Effective Date: January 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1433, CR 5878

USE OF HCPCS CODE V2787 WHEN BILLING APPROVED ASTIGMATISM-CORRECTING INTRAOCULAR LENS

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

STOP – IMPACT TO YOU

This article is based on change request (CR) 5853 which provides instructions regarding the use of HCPCS code V2787 when billing for intraocular lens procedures and services involving recognized astigmatism-correcting

Use of HCPCS Code V2787 When Billing Approved Astigmatism-Correcting Intraocular Lens (continued)

intraocular lens (A-C IOLs) and taking place in ambulatory surgery centers (ASCs), physician offices, or hospital outpatient departments (HOPDs).

CAUTION – What You Need to Know

Effective for dates of service January 1, 2008 and later, when providing services to a Medicare beneficiary that involve the insertion of recognized A-C IOLs, and the service/procedure takes place in an ASC, HOPD, or physician office, then HCPCS code V2787 should be billed to report the noncovered charges for the A-C IOL functionality of the inserted intraocular lens. **V2788 should not be used to report noncovered charges of the A-C IOLs on or after January 1, 2008**.

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) previously announced in CR 5527 (transmittal 1228, April 27, 2007) a new administrator ruling regarding the insertion of A-C IOLs following cataract surgery. In that CR, CMS provided payment policies and billing instructions for services related to intraocular lens (IOL) procedures preformed with approved conventional IOLs or astigmatism-correcting intraocular lens (A-C IOLs) in (ASCs), HOPDs, or physician offices. In addition, that CR instructed providers to:

- Bill the noncovered charges of the A-C IOL functionality of the lens using HCPCS code V2788 when inserting an A-C IOL.
- Continue to bill HCPCS code V2632, as appropriate, for the charges associated with the insertion of a conventional lens or the conventional functionality when an A-C IOL was inserted.

You may review CR 5527 on the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R1228CP.pdf* and its corresponding MLN Matters article, MM5527, on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5527.pdf*.

CR 5853 instructs that, effective for dates of service on or after January 1, 2008, services provided to Medicare beneficiaries involving the insertion of an recognized A-C IOL in an ASC, HOPD, or physician office, HCPCS Code V2787 should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens.

Note that (effective for dates of service on or after January 1, 2008) HCPCS Code V2788:

- **Is no longer valid** to report non-covered charges associated with the **A-C IOL**, **but**
- **Continues to be valid** to report non-covered charges associated with the **Posterior Chamber IOL (P-C IOL)**.

Physician offices should continue to bill HCPCS code V2632 for the payable conventional IOL functionality of the A-C IOL. The payment for the conventional lens portion of the A-C IOL lens continues to be bundled with the facility procedure payment for ASCs and HOPDs.

As of March 3, 2008, your Medicare contractor(s) will accept HCPCS code V2787 for dates of service on or after January 1, 2008 to report noncovered charges incurred for services provided to a Medicare beneficiary involving the insertion an A-C IOL in a physician's office, an ASC facility, or a hospital outpatient setting. The annual HCPCS update will include the definition of HCPCS code V2787 as follows:

HCPCS Code	Descriptor
V2787	Astigmatism correcting function of intraocular lens. Non-covered by Medicare statue.

When Medicare denies A-C IOLs billed with V2787, they will return remittance reason code 96 (Noncovered charges) and remark code N425 (Statutorily excluded service(s)) or they may use reason code 204 (This service/equipment/drug is not covered under the patient's current benefit plan).

Note that your Medicare contractor will not search their files to reprocess claims for HCPCS code V2787 that may have been denied prior to the implementation date for this change. However, they will adjust such claims if you bring them to the contractor's attention.

Additional Information

The official instruction, CR 5853, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1430CP.pdf*.

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

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

MLN Matters Number: MM5853
Related Change Request (CR) #: 5853
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R1430CP
Effective Date: January 1, 2008
Implementation Date: March 3, 2008

Source: CMS Pub. 100-04, Transmittal 1430, CR 5853.

REPORTING OF HEMATOCRIT OR HEMOGLOBIN LEVELS FOR THE ADMINISTRATION OF ERYTHROPOIESIS STIMULATING AGENTS

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this *MLN Matters* article on February 15, 2008, to add clarifying information to bullets 1 and 3. All other information remains the same. The *MLN Matters* article MM5699 was published in the February 2008 *Medicare A Bulletin* (pages 24-25).

PROVIDER TYPES AFFECTED

Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], competitive acquisition plan [CAP] designated carriers, and A/B Medicare administrative contractors [A/B MACs]) for providing erythropoiesis stimulating agents (ESAs) and related anti-anemia administration services to Medicare beneficiaries.

IMPACT ON PROVIDERS

Effective for services on or after January 1, 2008, you must report the most recent hemoglobin or hematocrit levels on any claim for a Medicare patient receiving: (1) ESA administrations, or (2) Part B anti-anemia drugs other than ESAs used in the treatment of cancer that are not self-administered. In addition, non-end-stage renal disease (ESRD) claims for the administration of ESAs must also contain one of three new Healthcare Common Procedure Coding System (HCPCS) modifiers effective January 1, 2008.

Failure to report this information will result in your claim being returned as unprocessed. (**Note that renal dialysis facilities are already reporting this information on claim types 72x, so change request (CR) 5699 applies to providers billing with other types of bills.**) See the rest of this article for reporting details.

BACKGROUND

Medicare Part B provides payment for certain drugs used to treat anemia caused by the cancer itself or by various anti-cancer treatments, including chemotherapy, radiation, and surgical therapy. The treatment of anemia in cancer patients commonly includes the use of drugs, specifically ESAs such as recombinant erythropoietin and darbepoetin. Emerging data and recent research has raised the possibility that ESAs administered for a number of clinical indications may be associated with significant adverse effects, including a higher risk of mortality in some populations.

Most recently, section 110 of Division B of the Tax Relief and Health Care Act (TRHCA) of 2006 directs the Secretary to amend Section 1842 of the Social Security Act by adding at the end the following new subsection: "*Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual.*"

In light of the health and safety factors and the TRHCA legislation, effective January 1, 2008, the Centers for Medicare & Medicaid Services (CMS) is implementing an expanded reporting requirement for all claims billing for administrations of an ESA. Hematocrit and /or hemoglobin readings are already required for ESRD claims for administrations of an ESA. Effective with the implementation of change request (CR) 5699, all other claims for ESA administrations will also require the reporting of the most recent hematocrit or hemoglobin reading, along with one of three new HCPCS modifiers effective January 1, 2008.

In addition, CR 5699 requires the reporting of the most recent hematocrit or hemoglobin readings on all claims for the administration of Part B anti-anemia drugs **other than** ESAs used in the treatment of cancer that are not self-administered.

WHAT YOU NEED TO KNOW

CR 5699, from which this article is taken, instructs all providers and suppliers that:

1. Effective January 1, 2008, all claims billing for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent hematocrit or hemoglobin reading available when the billed ESA dose was administered. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month. Claims submitted prior to the publication of CR 5699 that were not completed per the instructions in CR 5699 should be re-submitted.

    - For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Such claims for ESAs not reporting a value code 48 or 49 will be returned to the provider.
    - Effective for services on or after January 1, 2008, for professional paper claims, test results are reported in item 19 of the CMS-1500 claim form. For professional electronic claims (837P) billed to carriers or A/B MACs, providers report the hemoglobin or hematocrit readings in Loop 2400 MEA segment.

      The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results. The test results should be entered as follows: TR= test results, R1=hemoglobin or R2=hematocrit (a 2-position alpha-numeric element), and the most recent numeric test result (a 3-position numeric element, decimal implied [xx.x]). Results exceeding 3-byte position numeric elements (10.50) are reported as 10.5.

Reporting of Hematocrit or Hemoglobin Levels for the Administration of Erythropoiesis Stimulating Agents (continued)

Examples: If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter: TR/R2/32.3.

- Effective for dates of service on and after January 1, 2008, contractors will return to provider paper and electronic professional claims, or return as unprocessable paper and electronic institutional claims for ESAs when the most recent hemoglobin or hematocrit test results are not reported.
- When Medicare returns a claim as unprocessable for ESAs with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 for failure to report the most recent hemoglobin or hematocrit test results, it will include claim adjustment reason code 16 (Claim/ service lacks information which is needed for adjudication.) and remittance advice code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)

1. Effective January 1, 2008, all non-ESRD ESA claims billing HCPCS J0881 and J0885 must begin reporting one **(and only one)** of the following three modifiers on the same line as the ESA HCPCS:
    - EA: ESA, anemia, chemo-induced
    - EB: ESA, anemia, radio-induced; or
    - EC: ESA, anemia, non-chemo/radio
    - Non-ESRD ESA institutional claims that do not report one of the above three modifiers along with HCPCS J0881 or J0885 will be returned to the provider.
    - Non-ESRD ESA professional claims that are billed without one of the three required modifiers as line items along with HCPCS J0881 or J0885 will be returned as unprocessable with reason code 4 and remark code MA130. If more than one modifier is reported, the claim will be returned with reason code 125 and remark code N63.
1. Effective January 1, 2008, all non-ESRD, non-ESA claims billing for the administration of Part B anti-anemia drugs used in the treatment of cancer that are not self-administered must report the most recent hematocrit or hemoglobin reading. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month.
    - Institutional claims that do not report the most recent hematocrit or hemoglobin reading will be returned to the provider.
    - Professional claims that do not report the most recent hematocrit or hemoglobin reading will be returned as unprocessable using reason code 16, and remarks codes MA130 and N395
    - Your Medicare contractor will not search for claims with dates of service on or after January 1, 2008, processed prior to implementation of this CR, but will adjust such claims when you bring them to the attention of your contractor.

ADDITIONAL INFORMATION

For complete details regarding this CR please see the official instruction (CR 5699) issued to your Medicare carrier, FI, DME MAC, CAP designated carrier, and A/B MAC. That instruction may be viewed by going to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1412CP.pdf*.

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

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

MLN Matters Number: MM5699 – Revised
Related Change Request (CR) Number: 5699
Related CR Release Date: January 11, 2008
Related CR Transmittal Number: R1412CP
Effective Date: January 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1412, CR 5699

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

Local Coverage Determination Table of Contents

Additions/Revisions to Existing LCDs

ADVANCE BENEFICIARY NOTICE

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

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

ADDITIONS/REVISIONS TO EXISTING LCDS

AJ0881: ERYTHROPOIESIS STIMULATING AGENTS—REVISION TO LCD

The local coverage determination (LCD) for epoetin alfa was last revised on January 18, 2008. Since that time, the LCD has been revised. First Coast Service Options, Inc. (FCSO) published a draft LCD for erythropoiesis stimulating agents (ESAs) for notice and comment during the October 2007 LCD cycle. FCSO elected to delay the finalization and implementation of this draft LCD pending the release of final contractor instructions for implementing the national coverage decision (NCD) on ESAs use in cancer and related neoplastic diseases (change request 5818, transmittals 80 and 1413). These final instructions were received on January 14, 2008 and FCSO has made the necessary revisions to the draft LCD. With finalization of this draft LCD, FCSO has done a major revision to the epoetin alfa LCD by incorporating the content of the darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP] LCD into this new ESAs LCD. With the implementation of the ESAs LCD, the darbepoetin alfa (Aranesp®) (NESP) LCD will be retired.

Revisions include updating the "Indications and Limitations of Coverage and/or Medical Necessity," Utilization Guidelines" and "Documentation Requirements" sections of the LCD according to the revised product labels and including language related to the information published regarding the black box warnings on ESA use. Language related to the coverage and noncoverage restrictions imposed by the NCD have also been outlined in the LCD. ICD-9-CM coding has been revised to outline covered ICD-9-CM codes for each HCPCS code. The coding guideline attachment has been revised to include language regarding the new expanded reporting requirements for Hgb and Hct and also the requirements for including one of the new non-ESRD ESA modifiers on each claim for ESAs. A complete discussion for these new requirements may be found in CR 5699, transmittal 1412, dated January 11, 2008. The nationally noncovered ICD-9-CM codes listed in the NCD are included in the coding guideline attachment of the LCD. ICD-9-CM codes for the indications covered by the NCD are listed in the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

As noted below the effective date of this LCD revision is April 7, 2008. Please note however, that the requirements outlined in the LCD related to the NCD were effective on the day the Centers for Medicare & Medicaid Services (CMS) released the NCD as effective, July 30, 2007. Providers have been required to follow the NCD provisions as of July 30, 2007. Revisions made in the coding guideline attachment of the LCD related to change request 5699 are effective April 7, 2008 for services provided on or after January 1, 2008.

EFFECTIVE DATE

This revision is effective for services provided **on or after April 7, 2008**. The full text of this LCD is available through our provider education Web site on or after this effective date at *http://www.fcso.com*.

The retirement of the darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP] LCD is effective for services provided **on or after April 7, 2008**. ❖

HOSPITAL SERVICES

MODIFICATION OF PAYMENT WINDOW EDITS FOR LINE ITEM DATES OF SERVICE ON OUTPATIENT CLAIMS

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

STOP – IMPACT TO YOU

This article is based on change request (CR) 5880, which modifies the payment window edits in the CWF to look at the line item date of service (LIDOS) of the outpatient bill.

CAUTION – WHAT YOU NEED TO KNOW

Currently, the common working file (CWF) system looks at the 'statement covers through' date of the outpatient claim. The modification of the payment window edits in the CWF is to look at the LIDOS of the outpatient bill. This will allow providers to more easily separate out the services that occur prior to the payment window. CR 5880 also incorporates a few missing revenue codes into the *Medicare Claims Processing Manual.*

GO – WHAT YOU NEED TO DO

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

BACKGROUND

Currently, the edits within Medicare CWF system look at the '*statement covers through date*' of outpatient claims in order to determine what services fall within the payment window relative to an inpatient stay. CR 5880 modifies the payment window edits (both diagnostic and therapeutic) to look at the '*Line Item Dates of Service*' **(**LIDOS) of the outpatient bill instead of the '*statement covers through date.*' This modification will make it easier to distinguish between the outpatient preadmission services that should be bundled on the inpatient bill from those that may be reimbursed separately.

Effective for services on or after July 1, 2008, Medicare's CWF will reject services for payment when the outpatient service's LIDOS falls on the day of admission or any of the three days immediately prior to admission of the beneficiary to an IPPS (inpatient prospective payment system) or Maryland-waiver hospital or on the day of admission or one day prior to that admission for hospitals excluded from the IPPS, such as an inpatient rehabilitation or an inpatient psychiatric facility.

The payment window policy is a longstanding Medicare policy. The Social Security Act (Section 1886(a)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm* on the Internet) and the *Code of Federal Regulations* (42 CFR 412.2(c)(5) and 413.40(c)(2); see *http://www.gpoaccess.gov/cfr/retrieve.html* on the Internet) define the operating costs of inpatient services under the prospective payment system (PPS) to include certain preadmission services furnished by the admitting hospital (or by an entity wholly owned or operated by the admitting hospital or by another entity under arrangements with the admitting hospital). For details as to which services are considered preadmission services and should therefore be bundled into the inpatient bill, refer to the *Medicare Claims Processing Manua*l (chapter 3, section 40.3), which is attached to CR 5880.

In summary, CR 5880 instructs your Medicare contractor to:

- Modify all of the payment window edits to look at the outpatient service by the LIDOS.
- Remove revenue code 048x and replace with 0481,0482, 0483, and 0489 in the diagnostic payment window edits.
- Include the following *CPT* codes for revenue codes 0481 and 0489*: 93501, 93503, 93505, 93508, 93510, 93526, 93541, 93542, 93543, 93544, 93556, 93561*, or *93562* in the diagnostic payment window edits. These *CPT* codes and their descriptors are included in the following table:

CPT Code	Descriptor
93501	*Right heart catheterization*
93503	*Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes*
93505	*Endomyocardial biopsy*
93508	*Catheter placement in coronary artery (s), arterial coronary conduit (s), and/or venous coronary bypass graft (s) for coronary angiography without concomitant left heart catheterization*
93510	*Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous*
93526	*Combined right heart catheterization and retrograde left heart catheterization*
93541	*Injection procedure during cardiac catheterization for pulmonary angiography*
93542	*Injection procedure during cardiac catheterization for selective right ventricular or right atrial angiography*
93543	*Injection procedure during cardiac catheterization for selective left ventricular or left atrial angiography*

Modification of Payment Window Edits for Line Item Dates of Service on Outpatient Claims (continued)

93544 Injection procedure during cardiac catheterization for aortography

93556 pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)

93561 Indicator dilution studies such as dye or thermal dilution, including arterial and/ or venous catheterization; with cardiac output measurement (separate procedure)

93562 subsequent measurement of cardiac output

ADDITIONAL INFORMATION

The official instruction, CR 5880, 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/R1429CP.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: MM5880
Related Change Request (CR) Number: 5880
Related CR Release Date: February 1, 2008
Related CR Transmittal Number: R1429CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1429, CR 5880

FULL RECOVERY AUDIT CONTRACTOR INPATIENT DENIALS

The Centers for Medicare & Medicaid Services (CMS) has amended previous instructions regarding inpatient denials identified by a recovery audit contractor to include type of bill (TOB) 13x for any services provided on the inpatient bill that could be billed as outpatient. The previous instructions were published in the February 2007 *Medicare A Bulletin* (page 13).

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 306) directs the Secretary of the U.S. Department of Health & Human Services (HHS) to demonstrate the use of recovery audit contractors (RACs) under the Medicare Integrity program in:

- **Identifying** underpayments and overpayments.
- **Recouping** overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

In some cases the RAC will request and review medical records, and will make a determination based on the CMS guidelines of medical necessity.

This instruction is only in relation to claims in which medical records were reviewed for hospital inpatient cases TOB 11x. These cases were audited by the RAC and were determined that the services provided while the patient was admitted did not support admission into an inpatient stay. CMS is providing instructions to providers on how to re-bill for ancillary services (TOB 12x) provided to the beneficiary and for any services provided on the inpatient bill that could be billed as outpatient (TOB 13x) when timely filing is a factor.

Some of the claims reviewed by the RAC have passed the timely filing requirements. In order for the provider to re-bill the claim for ancillary charges only, specific justification remarks shall be listed on the claim and shall only be used for this specific reason.

ACTION REQUIRED BY AFFECTED PROVIDERS

Remarks **must include the document control number (DCN)** of the denied inpatient claim that coincides with the re-billed ancillary claim. If these remarks are not on the claim it will reject for timely filing.

The following remarks are required on the claim for timely filing to be overridden by the fiscal intermediary (FI):

> **Justify: Recovery Audit Contractor (RAC) Involvement.** Inpatient-take back. Re-bill of ancillary charges. Refer to (Input DCN number of denied inpatient claim).

WHAT WILL HAPPEN NEXT

Once the appropriate remarks are reviewed by the FI, the ancillary claim will be overridden for processing.

Once processed, the provider **shall refund any excess funds collected from the beneficiary.** This could include the inpatient deductible or a coinsurance amount. Providers shall not collect any additional coinsurance from the beneficiary.

Providers should not re-bill for the ancillary services if the provider is appealing the RAC determination. Providers should wait until they have completed the appeal process before submitting the re-bill for the ancillary services. If the provider is not appealing the RAC determination, the provider should re-bill for the ancillary services once the inpatient claim has been adjusted. ❖

Source: CMS JSM 08168, February 7, 2008

LEGISLATIVE CHANGES TO THE 75 PERCENT RULE FOR CLASSIFYING INPATIENT REHABILITATION FACILITIES

Section 115 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 amended section 2005 of the Deficit Reduction Act of 2005 to revise the following elements of the 75 percent rule that are used to classify inpatient rehabilitation facilities (IRFs):

- The compliance percentage that IRFs must meet to be excluded from the acute care inpatient hospital prospective payment system (PPS) and to be paid under the IRF PPS will be set permanently at 60 percent for cost reporting periods beginning on or after July 1, 2005.
- This statutory change effectively eliminates the increase to 65 percent that had already taken effect for cost reporting periods beginning on or after July 1, 2007, and also eliminates the increase to 75 percent that was scheduled to take effect for cost reporting periods beginning on or after July 1, 2008. All IRF cost reporting periods (or portions of cost reporting periods) beginning on or after July 1, 2005, will be evaluated using the 60 percent threshold.
- Patient comorbidities that satisfy the criteria specified in 42 *Code of Federal Regulations* (CFR) section 412.23(b)(2)(i) will be permanently included in the calculations used to determine whether an IRF meets the 60 percent compliance percentage.

To minimize the level of effort required from Medicare contractors and IRFs, contractors may now combine the two portions of cost reporting periods that are both reviewed at the 60 percent level into one continuous 12-month review period.

For example, an IRF's compliance review period for the cost reporting period beginning May 1, 2008, was divided into two periods: one from January 1, 2007, through April 30, 2007, and a separate review period from May 1, 2007, through December 31, 2007.

Since both of these review periods will now be evaluated at the 60 percent compliance threshold, contractors may now instead draw one combined random sample of the IRF's cases from the 12-month period as a whole (from January 1, 2007, through December 31, 2007) to determine the facility's compliance with the 60 percent threshold.

The Centers for Medicare & Medicaid Services will provide further guidance on this issue in an upcoming revision of the Internet-only manual. ❖

Source: CMS JSM 08178, February 20, 2008

UPDATE TO COMMON WORKING FILE (CWF) EDITS 7284 AND 7548

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

PROVIDER TYPES AFFECTED

Indian health service (IHS) or tribal hospitals billing Medicare contractors (Medicare administrative contractors [A/B MACs] or fiscal intermediaries [FIs]) for services provided to American Indian/Alaskan Native (AI/AN) Medicare beneficiaries admitted to an IHS/tribal facility for social reasons.

IMPACT ON PROVIDERS

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5907 in order to clarify instructions for IHS or tribal hospitals regarding payment methodology for social admissions and outpatient services rendered at separate facilities.

BACKGROUND

CR 3452, transmittal 596 issued on June 24, 2005 implemented instructions to edit IHS and tribal facility claims for social admissions. A related *MLN Matters* article may be reviewed by going to the CMS Web site *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3452.pdf*.

KEY POINTS OF CHANGE REQUEST 5907

For patients in a social admission status requiring outpatient services at another facility, Medicare disallows payment for inpatient Part B ancillary services, type of bill (TOB) 12x during a social admission stay when there is another bill from a different facility for an outpatient service, TOB 13x or 72x. The CWF returns an A/B crossover edit and an IUR is created in any of these situations.

- The IUR 7284 is created for TOB 12x with an IHS provider number when the date of service on the claim is equal to or overlaps a claim in history with TOB 13x or 72x.
- The IUR 7548 is created for TOB 12x with an IHS provider number with a line item date of service is equal to or the day following the discharge date on a TOB 11x.
- The IURs 7284 or 7548 are bypassed when the beneficiary was not entitled to Medicare Part A at the time the services on TOB 12x were rendered.

ADDITIONAL INFORMATION

To see the official instruction (CR 5907) issued to your Medicare FI or A/B MAC, refer to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1446CP.pdf*.

If you have questions, please contact your Medicare FI or A/B MAC at their toll-free number, which may be found on the CMS, 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: MM5907
Related Change Request (CR) Number: 5907
Related CR Release Date: February 8, 2008
Related CR Transmittal Number: R1446CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1446, CR 5907

INTERIM GUIDELINES FOR CLAIMS SUBJECT TO THE MAMMOGRAPHY QUALITY STANDARDS ACT

The Mammography Quality Standards Act (MQSA) requires that all facilities providing mammography services meet national quality standards. The Food and Drug Administration (FDA) is responsible for certifying facilities and assigning a six-digit certification number. The Centers for Medicare & Medicaid Services (CMS) provides this certification data on a weekly basis to Medicare contractors to ensure accuracy in their claim processing systems. This seven-day gap may result in erroneous claim rejections/denials from valid certified facilities.

In addition some facilities are submitting claims for these services the following day after receiving certification from the American College of Radiology not allowing enough time for the Medicare processing systems to be updated with new certification data.

ACTION REQUESTED FROM PROVIDERS

To avoid unnecessary claim rejections/denials CMS suggests that providers hold mammography claims for **seven-business days** after receiving a new or changed certification to allow for the certification data to be uploaded accordingly.

Note: CMS is currently working on implementing an automatic upload process to reduce processing time and upon implementation of this automated process, First Coast Service Options, Inc will notify providers to discontinue holding their claims. ❖

Source: CMS JSM 08161, February 4, 2008

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM FACT SHEET IS NOW AVAILABLE

*The Hospital Outpatient Prospective Payment System Fact Shee*t (revised January 2008), which provides general information about the hospital outpatient prospective payment system, ambulatory payment classifications, and how payment 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/HospitalOutpaysysfctsht.pdf*.

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

Source: CMS Provider Education Resource 200802-06

NOTIFYING MEDICARE PATIENTS ABOUT LIFETIME RESERVE DAYS

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 January 31, 2008, to update the deductible and coinsurance rates to reflect the 2008 rates. In addition, some editorial changes were added to provide further clarification and references to the Part A/B Medicare administrative contractors (MACs). The *MLN Matters* article SE0663 was published in the November 2006 *Medicare A Bulletin* (pages 18-20).

PROVIDER TYPES AFFECTED

Providers billing Medicare fiscal intermediaries (FIs) or Part A/B MACs for inpatient hospital services furnished during a spell of illness.

PROVIDER ACTION NEEDED

This special edition article is for informational purposes only and reflects no change in Medicare policy. The article is based on information contained in the *Medicare Benefit Policy Manual* (Publication 100-02, chapter 5, sections 30 - 30.4). This manual is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*.

BACKGROUND

Under the Social Security Act (Section 1861; *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* on the Internet), a Medicare beneficiary is entitled to an unlimited number of benefit periods, each of which includes 90 days of covered inpatient hospital services. A benefit period, or "spell of illness," begins on the first day the beneficiary is furnished inpatient hospital services, inpatient critical access hospital services or long term care services. The benefit period ends with the close of the first period of 60 consecutive days thereafter on each of which he/she is neither an inpatient of a hospital or a critical access hospital nor an inpatient of a skilled nursing facility.

The Social Security Act (Section 1812; *http://www.ssa.gov/OP_Home/ssact/title18/1812.htm*) further defines the scope of inpatient hospital benefits for Medicare beneficiaries and includes an additional provision regarding 60 nonrenewable lifetime reserve days (LRDs), which a beneficiary may draw upon if hospitalized for more than 90 days in a benefit period.

For inpatient hospital services furnished during a spell of illness, Medicare beneficiaries are responsible for an inpatient hospital deductible amount (which is deducted from the amount payable by the Medicare program to the hospital). For the first 60 days of covered care during a spell of illness the beneficiary is not liable for paying a co-insurance.

For the 61st through the 90th day that beneficiaries receive inpatient hospital services (during a spell of illness), they are responsible for a coinsurance amount equal to one-fourth (25 percent) of the inpatient hospital deductible per day.

After the 90th day spent in the hospital during a spell of illness, beneficiaries may elect to use their 60 LRDs of coverage. Their daily coinsurance amount is then equal to one-half (50 percent) of the inpatient hospital deductible (42CFR409.83 (Inpatient hospital coinsurance); on the Internet) *http://www.gpoaccess.gov/cfr/retrieve.html*.

Notifying Medicare Patients about Lifetime Reserve Days (continued)

In 2008, the inpatient hospital deductible is $1,024.00 per benefit period or spell of illness; therefore, **beneficiaries pay the following daily coinsurance amounts for 2008:**

- **For in each period** in an ACH, $256.00 a day for days 61 through 90
- **For each LRD used,** $512.00 a day for days 91 through 150.

Election Not To Use Lifetime Reserve Days

An election not to use LRDs may be made by the beneficiary (or by someone who may act on his or her behalf) at the time of admission to a hospital or at any time thereafter, subject to the limitations on retroactive elections described below in the section II (Election Made Retroactively).

Hospitals are required to notify patients who have already used or will use 90 days of benefits in a benefit period that they can elect not to use their LRDs for all or part of a stay.

The hospital should give notice of the option to elect to not use LRDs **when the beneficiary has five regular coinsurance days left** and is expected to be hospitalized beyond that period. Where the hospital discovers **the patient has fewer than five regular coinsurance days left,** it should **immediately notify the patient of this option (if notice was not provided earlier.)**

The hospital should:

- Annotate its records at the time that it informed the patient of this option.
- Make available an appropriate election statement or form to be included in the patient's hospital record if the patient elects not to use LRDs. (See the *Medicare Benefit Policy Manual, c*hapter 5, section 40.1 for sample election format *http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf*).

If a patient elects not to use LRDs, some of the hospital services may be covered by Medicare Part B. These covered Part B services are billed to the intermediary or A/B MAC on Form CMS-1450 or the electronic equivalent.

Note: A Medicare beneficiary who is eligible for medical assistance (Medicaid) under a state plan should be advised that such assistance would not be available if the beneficiary elects not to use the LRDs. However, this restriction on medical assistance payments does not apply to cases where the beneficiary is deemed to have elected not to use LRDs.

Beneficiary Deemed To Have Elected Not To Use Lifetime Reserve Days

A Medicare beneficiary **will be deemed to have elected not to use LRDs** in the following situations:

1. The average daily charge for covered services furnished during a lifetime reserve billing period **is equal to or less than the coinsurance amount for LRDs; and**

- The hospital is reimbursed on a cost reimbursement basis; or
- The hospital is reimbursed under a prospective payment system (PPS) and LRDs are needed to pay for all or a portion of the outlier stay. See s*ection IIIB (Hospitals Reimbursed Under the Prospective Payment System*) below and the *Medicare Benefit Policy Manua*l, chapter 5, section 10.2 on the CMS Web site *http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf*.

2. **For the nonoutlier portion of a stay in a hospital** reimbursed under a PPS, if the beneficiary has **one or more regular days (non-LRDs) remaining** in the benefit period upon admission to the hospital [i.e. an acute care hospital (ACH), inpatient rehabilitation facility (IRF), and a normal stay under long term care hospital (LTCH) (i.e., not a short stay)]. (See s*ection IIIB Hospitals Reimbursed Under the Prospective Payment System* below.)

3. **The beneficiary has no regular days available at the time of admission** to a hospital reimbursed under the prospective payment system and **the total charges** for which the beneficiary would be liable (if LRDs are not used) **is equal to or less than** the **charges for which the beneficiary would be liable** if LRDs were used (i.e., the sum of the coinsurance amounts for the LRDs that would be used plus the total charges for outlier days (if any) for which no LRDs would be available because LRDs are exhausted. (See *Section IIIB – Hospitals Reimbursed Under the Prospective Payment System* below.)

   Exception: Even though a beneficiary would otherwise be deemed to have elected not to use LRDs, they will not be so deemed where:

   - Benefits are available from another third party payer to pay some or all of the charges.
   - The third party requires (as a condition for payment) that LRDs be used.

In such cases, LRDs will be used unless the beneficiary specifically elects not to use them.

I. Election Made Prospectively

Ordinarily, an election **not to use LRDs will apply prospectively.** If the election is filed at the time of admission to a hospital, it may be made effective **beginning with the first day of hospitalization, or any day thereafter.** If the election is filed later, it may be made effective **beginning with any day after the day it is filed.**

II. Election Made Retroactively

A beneficiary may retroactively elect not to use LRDs provided when:

- The beneficiary (or some other source) offers to pay the hospital for any of the services not payable under Part B.
- The hospital agrees to accept the retroactive election.

In this case, the hospital will contact the FI for procedures for correcting any claims already submitted.

A retroactive election not to use the LRDs must be filed **within 90 days following the beneficiary's discharge** from the hospital **unless:**

- Benefits are available from a third party payer to pay for the services.

Notifying Medicare Patients about Lifetime Reserve Days (continued)

- The hospital agrees to the retroactive election.

In this case, the beneficiary may file an election not to use the LRDs later than 90 days following discharge.

EXAMPLE 1

Prior to July 1, Mr. Jones had used 90 days of inpatient hospital services in a benefit period. Beginning July 1, he was hospitalized for 10 additional days in that same benefit period. He was informed of his election right on July 1 at the time of admission, and he indicated that he wanted to use his LRDs for that stay. One month after being discharged from the hospital, Mr. Jones informed the hospital's billing office that he now wished to save his LRDs for a future stay. Mr. Jones agreed to pay the hospital for the services he received during the 10 days of hospitalization which were not payable under Part B, and the hospital agreed to the request. He was permitted to file a retroactive election not to use his LRDs, effective July 1.

EXAMPLE 2

On July 1, Mrs. Smith was discharged from a hospital after being hospitalized for 105 days. The hospital billed Medicare for 90 regular days plus 15 LRDs. On October 20 (more than 90 days following discharge), Mrs. Smith learned that a private insurer could pay for the last 15 days of the stay. She informed the hospital that she wished to file a retroactive election not to use LRDs for the last 15 days of the stay. The hospital agreed to the request, and Mrs. Smith filed an election form. The hospital refunded the Medicare payment and billed the private insurer instead.

III. Period Covered by Election

A. Hospitals Not Reimbursed Under Prospective Payment System

A beneficiary election not to use LRDs for a particular hospital stay:

- May apply to the entire stay, or
- May apply to a single period of consecutive days in the stay, but
- Cannot apply to selected days in a stay.

If an election not to use LRDs (whether made prospectively or retroactively) is made effective:

- Beginning with the first day for which LRDs are available, it may be terminated at any time.

  (After termination of the election, all hospital days would be covered to the extent that LRDs are available. Thus, an individual who has private insurance that covers hospitalization beginning with the first day after 90 days of benefits have been exhausted, may terminate the election as of the first day not covered by the insurance plan.); or

- Beginning with any day after the first day for which LRDs are available, it must remain in effect until the end of that stay unless the entire election is revoked in accordance with the *Medicare Benefit Policy Manual* (Pub. 100-02, chapter 5, section 40.2); on the CMS Web site *http://www.cms.hhs.gov/manuals/Downloads/bp102c05.pdf*.

B. Hospitals Reimbursed Under Prospective Payment System

The rules described in Section IIIA above apply. In addition, for PPS discharges occurring on or after October 1, 1997, involving high cost outlier status, a beneficiary whose 90 days of benefits are exhausted before high cost outlier status is reached must elect to use LRDs for the hospital to be paid high cost outlier payments.

High cost outlier status is reached on the day that charges reach the high cost outlier status for the applicable DRG for inpatient PPS and LTCH PPS or case-mix group (CMG) in the case of IRF PPS. Use of LRDs must begin on the day following that day, to permit payment for high cost outlier charges.

If the beneficiary elects not to use LRDs where benefits are exhausted, the hospital may charge the beneficiary for the charges that would have been paid as a high cost outlier.

ADDITIONAL INFORMATION

If you have any questions, please contact your 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: SE0663
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0663

REVISION TO CERTIFICATION FOR HOSPITAL SERVICES COVERED BY THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM AS IT PERTAINS TO AMBULANCE SERVICES

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

Note: The Centers for Medicare & Medicaid Services (CMS) has rescinded change request (CR) 5684 and replaced it with CR 5833. The *MLN Matters* article related to CR 5833 is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5833.pdf*. The *MLN Matters* article for CR 5833 (MM5833) was published in the February 2008 *Medicare A Bulletin* (page 39).

MLN Matters Number: MM5684 – Rescinded
Related Change Request (CR) Number: 5684
Related CR Release Date: August 17, 2007
Related CR Transmittal Number: R47GI
Effective Date: September 17, 2007
Implementation Date: September 17, 2007

Source: CMS Pub. 100-01, Transmittal 47, CR 5684

CRITICAL ACCESS HOSPITAL SERVICES

EXTENSION OF THE DATES OF SERVICE ELIGIBLE FOR THE PHYSICIAN SCARCITY AREA BONUS PAYMENT

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

PROVIDER TYPES AFFECTED

Physicians, and other providers, who bill Medicare contractors (fiscal intermediaries [FI], carriers, or Medicare administrative contractors [A/B MAC]) for providing services to Medicare beneficiaries in designated physician scarcity areas (PSAs).

WHAT YOU NEED TO KNOW

CR 5937, from which this article is taken, announces the extension of the PSA bonus payment for dates of service through June 30, 2008. You should make sure that your billing staffs are aware of this PSA bonus payment extension.

BACKGROUND

Section 413(a) of the Medicare Modernization Act of 2003 (MMA) required the Centers for Medicare & Medicaid Services (CMS) to pay a 5 percent bonus to physicians in a designated PSA for dates of service from January 1, 2005 through December 31, 2007. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 amended Section 1833(u)(1) of the Social Security Act, extending the payment of the PSA bonus for dates of service through June 30, 2008. CR 5937, from which this article is taken, announces this extension and provides Medicare contractors with implementing instructions.

Medicare contractors will continue to pay PSA bonuses for dates of service from January 1, 2005 through June 30, 2008, regardless of whether the bonus is requested through submission of a modifier or made through an automated payment based on ZIP code. The primary care and specialty care scarcity areas in effect on December 31, 2007 will be used for 2008 services. FI and A/B MACs processing Part A claims will implement this CR on January 7, 2008, and carriers and A/B MACs processing Part B claims will implement it 30 days from issuance.

Carriers and A/B MACs processing Part B claims will Identify claims that contain modifier AR (physician providing services in a PSA) and are submitted with dates of service on or after January 1, 2008, and processed prior to this CR's implementation so that they may be included in the calculation in the first quarterly 2008 bonus payment. Additionally, when brought to their attention, carriers and A/B MACs processing Part B claims will re-open and re-process claims with these dates of service that are processed prior to the CR's implementation date in order to include modifier AR and make the appropriate bonus payment.

ADDITIONAL INFORMATION

You may find the official instruction, CR 5937, issued to your FI, carrier, or A/B MAC by visiting the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1434CP.pdf*.

The updated *Medicare Claims Processing* manual, chapter 4 (Part B Hospital [Including Inpatient Hospital Part B and OPPS]), sections 250.2.1 (Billing and Payment in a Physician Scarcity Area [PSA]) and 250.2.2 (ZIP Code Files); and *Medicare Claims Processing Manual*, chapter 12 (Physicians/Nonphysician Practitioners, sections 90.5 (Billing and Payment in a Physician Scarcity Area [PSA]) and 90.5.2 (Identifying Physician Scarcity Area Locations) are attachments to that CR.

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

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

MLN Matters Number: MM5937
Related Change Request (CR) Number: 5937
Related CR Release Date: February 5, 2008
Related CR Transmittal Number: R1434CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008 for contractors processing claims from institutions; no later than 30 days from issuance for carriers and A/B MACs processing professional claims.

Source: CMS Pub. 100-04, Transmittal 1434, CR 5937

2007 UPDATE OF HCPCS CODES AND PAYMENTS FOR AMBULATORY SURGICAL CENTERS

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 January 24, 2008, to add a reference to SE0742. SE0742 announced that CMS was implementing significant revisions to the payment system for ASC services beginning with services rendered on or after January 1, 2008. SE0742 may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0742.pdf*. All other information remains the same. The *MLN Matters* article MM5211 was published in the January 2007 *Medicare A Bulletin* (page 45).

PROVIDER TYPES AFFECTED

Ambulatory surgical centers (ASCs) submitting claims to Medicare carriers or fiscal intermediaries (FIs) for ASC services provided to Medicare beneficiaries.

IMPACT ON PROVIDERS

This article is based on change request (CR) 5211, which updates the 2007 HCPCS codes and ASC payment rates, effective for services furnished on or after January 1, 2007.

BACKGROUND

Section 5103 of the Deficit Reduction Act of 2005 (DRA) limits ASC payments to:

- The lesser of the Medicare Hospital Outpatient Prospective Payment System (OPPS) payment amount; or
- The ASC payment amount for services furnished on or after January 1, 2007.

Also, section 1833(i)(1) of the Social Security Act requires that the list of payable ASC procedures be updated as least every two years.

CR 5211, from which this article is taken, implements the required biennial ASC update, which includes changes made by the American Medical Association for the calendar year (CY) 2007 *Common Procedural Terminology (CPT)*. These changes include replacing the ASC two-digit payment group code designation next to the ASC-approved Healthcare Common Procedure Coding System (HCPCS) codes with a "yy" designation for these codes, which will be defined as "the procedure is approved to be performed in an ambulatory surgical center."

CR 5211 also revises the manner in which ASC payment groups are defined. The number of ASC payment groups that carriers and fiscal intermediaries (FI) currently use to identify ASC payment amounts for individual HCPCS codes is being expanded in order to accommodate the new payment amounts that will be assigned to certain ASC services in CY 2007 under the DRA requirement. The ASC payment groups will now be called ASC PRICER groups.

The additional ASC PRICER groups reflect the DRA-driven payment amounts, which will be included in the ASC PRICER files that carriers, and certain FIs, use to process ASC facility claims.

And lastly, CR 5211 includes payment file retrieval instructions that your carriers and FIs will use to access the final payment files on, or after, the specified retrieval date provided in CMS's notification.

You should be aware that final ASC payment rates are established after publication of the OPPS final rule and the code change update will be published as part of the OPPS final rule in the *Federal Register*. This publication usually occurs in late October. Shortly after publication, you can reach this rule through a link on the CMS Web site at *http://www.cms.hhs.gov/center/asc.asp*.

Also note that your carriers and FIs will continue to use the wage index values contained in Transmittal 51, dated February 4, 2004, to calculate payment amounts for all type of service F Healthcare Common Procedural Coding System (HCPCS) codes until further notice. This transmittal is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R51OTN.pdf*.

ADDITIONAL INFORMATION

For complete details, please see CR 5211, the official instruction issued to your carrier/intermediary regarding this change, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1134CP.pdf*.

The "2007 ASC Approved HCPCS Codes and Payment Rates" changes are available on the CMS Web site at *http://www.cms.hhs.gov/ASCPayment/01_Overview.asp*.

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

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

MLN Matters Number: MM5211 – Revised
Related Change Request (CR) Number: 5211
Related CR Release Date: December 20, 2006
Related CR Transmittal Number: R1134CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Source: CMS Pub. 100-04, Transmittal 1134, CR 5211

SKILLED NURSING FACILITY SERVICES

UPDATE TO THE COMMON WORKING FILE TO ALLOW THE POSTING OF SKILLED NURSING FACILITY AND SWING BED CLAIMS TO THE BENEFICIARY'S SPELL OF ILLNESS WHEN QUALIFYING STAY CRITERIA ARE NOT MET

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

PROVIDER TYPES AFFECTED

Providers submitting skilled nursing facility (SNF) and swing bed (SB) 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

Change request (CR) 5872 modifies Medicare's common working file (CWF) to allow the posting of SNF and SB claims to the beneficiary's spell of illness dates when no prior qualifying stay or readmission exists. Medicare will only update the spell of illness dates for claims that do not meet the qualifying stay criteria. Benefit days will not be deducted from the beneficiary.

BACKGROUND

SNF providers are required to submit claims to Medicare for beneficiaries who receive a skilled level of care. This includes beneficiaries who do not meet the qualifying stay or transfer criteria. Although Medicare will not pay for these claims, providers must submit these claims as covered in order to update the beneficiary' spell of illness in the CWF system. Currently, claims that are denied due to not meeting the prior qualifying stay criteria are not updating the beneficiary's spell of illness in the CWF. Therefore, CR 5872 modifies the CWF to allow these claims to update the beneficiary's spell of illness dates.

ADDITIONAL INFORMATION

The official instruction, CR 5872, 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/R1450CP.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: MM5872
Related Change Request (CR) Number: 5872
Related CR Release Date: February 15, 2008
Related CR Transmittal Number: R1450CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1450, CR 5872

RURAL HEALTH CLINIC SERVICES

ANNOUNCEMENT OF MEDICARE RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS PAYMENT RATE INCREASES

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

PROVIDER TYPES AFFECTED

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs], 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) 5896 which provides instructions for the calendar year (CY) 2008 payment rate increases for rural health clinic (RHC) and federally qualified health center (FQHC) services.

BACKGROUND

In accordance with the Social Security Act (Section 1833(f) at *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm* on the Internet) the Centers for Medicare & Medicaid Services (CMS) is increasing the CY payment rates for RHCs and FQHCs effective for services on or after January 1, 2008, through December 31, 2008 (i.e., CY 2008) as follows:

- The rural health clinics upper payment limit per visit is increased from $74.29 to $75.63. The 2008 rate reflects a 1.8 percent increase over the 2007 payment limit in accordance with the rate of increase in the Medicare economic index (MEI) as authorized by the Social Security Act (Section 1833(f)).
- The federally qualified health centers upper payment limit per visit **for urban FQHCs** is increased from $115.33 to $117.41, and the maximum Medicare payment limit per visit **for rural FQHCs** is increased from $99.17 to $100.96. The 2008 FQHC rates reflect a 1.8 percent increase over the 2007 rates, in accordance with the rate of increase in the MEI.

To avoid any unnecessary administrative burden, Medicare contractors will **not** retroactively adjust individual RHC/FQHC bills paid at previous upper payment limits. However, they will adjust such claims that you bring to their attention. Also, they retain the discretion to make adjustments to the interim payment rate or a lump sum adjustment to total payments already made to take into account any excess or deficiency in payments to date.

ADDITIONAL INFORMATION

The official instruction, CR 5896, issued to your Medicare FI or A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1426CP.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: MM5896
Related Change Request (CR) Number: 5896
Related CR Release Date: February 1, 2008
Related CR Transmittal Number: R1426CP
Effective Date: January 1, 2008
Implementation Date: February 12, 2008

Source: CMS Pub. 100-04, Transmittal 1426, CR 5896,

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM REFINEMENT AND RATE UPDATE FOR CALENDAR YEAR 2008

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

PROVIDER TYPES AFFECTED

Home health agencies (HHA) who bill regional home health intermediaries (RHHI) or Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change request (CR) 5879, from which this article is taken, updates the 60-day national episode rates and the national per-visit amounts under the home health prospective payment system (HH PPS) for calendar year (CY) 2008. It also refines the case-mix methodology and rebases and revises the home health market basket for CY 2008.

For CY 2008 (effective January 1, 2008), Medicare home health payments for HHAs that report quality data (described below) will be increased by 3.0 percent, while payments for those HHAs that do not report quality data will be increased 1 percent.

BACKGROUND

Section 5201 of the Deficit Reduction Act (DRA) requires that Medicare home health payments be updated by the applicable market basket percentage increase for CY 2008. CR 5879, from which this article is taken, announces that this increase for CY 2008 is 3.0 percent (effective January 1, 2008).

CR 5879 also announces that the Centers for Medicare & Medicaid Services (CMS) is revising:

- The fixed dollar loss ratio (which is used in the calculation of outlier payment) from 0.67 in CY 2007 to 0.89 for CY 2008. The loss-sharing ratio of 0.80 remains unchanged.
- The labor and non-labor percentages applied in the wage-index adjustment (in addition to the new case-mix adjustment that will be applied to 60-day episode payments).

The labor portion applied will be .77082, and the non-labor portion applied will be .22918. The labor adjustment to the PPS rates will continue to be based on the site of service of the beneficiary as set forth in 42 CFR 484.220 and 484.230.

Notes: The labor adjustment is applied to both 60-day episode and per-visit payments and the CY 2008 payment rates apply to episodes that end on or after January 1, 2008, and before January 1, 2009.

CR 5879 also discusses the HHAs' reporting of quality data.

Section 5201 of the DRA also requires that HHAs report quality data (as determined by the Secretary of Health & Human Services (HHS)), or be subject to a 2 percent reduction to the home health market basket percentage increase applicable to HH PPS payments for CY 2008 (as described above).

The following sets of tables display the payments to HHAs that do report the required quality data (tables 1, 2, and 3), and to those that do not (tables 4, 5, and 6).

PAYMENTS TO HHAS THAT DO REPORT REQUIRED QUALITY DATA

1. National standardized 60-day episode payment rate for episodes beginning in cy 2007 and ending in CY 2008 made to HHAs that do report quality data

The annual CY 2008 update is for all episodes that end on, or after, January 1, 2008 and before January 1, 2009. Therefore, for episodes that begin in CY 2007 and end in CY 2008, the new 153 home health resource group (HHRG) case-mix model (and associated GROUPER) will not yet be in effect; and these episodes will be paid at the rate of $2,337.06, and be further adjusted for wage differences and for case-mix, based on the CY 2007, 80 HHRG case-mix model.

This payment methodology appropriately recognizes (by paying $2,337.06 for episodes that begin in CY 2007 and end in CY 2008) that these episodes are entitled to receive the CY 2008 home health market, even though the new case-mix model will not yet be in effect. This payment is displayed in Table 1.

Table 1 – National Standardized 60-Day Episode Payment Rate for Episodes Beginning in CY 2007 and Ending in CY 2008 (HHAs that Report Quality Data)

Total CY 2007 National Standardized 60-Day Episode Payment Rate	Multiply by the Home Health Market Basket Update (3 Percent)	Reduce by 2.75 Percent for Nominal Change in Case-Mix	Adjusted to Account for the 5 Percent Outlier Policy	National Standardized 60-Day Episode Payment Rate for Episodes Beginning in CY 2007 and Ending in CY 2008
$2,339.00	X 1.030	X 0.9725	X 1.05 X 0.95	$2,337.06

Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 (continued)

2. CY 2008 national standardized 60-day episode payment rate for episodes beginning and ending in CY 2008

In order to establish new rates based on a new case-mix system, the CY 2007 national standardized 60-day episode payment rate is increased by the rebased and revised home health market basket update (3.0 percent) ($2,339.00 multiplied by 1.030 = $2,409.17). The dollars associated with the outlier-targeted estimates are then put back into the base rate.

In the July 3, 2000 HH PPS final rule (65 FR 41184), the base rate was divided by 1.05 to account for the outlier target policy (multiplying the $2,409.17 by 1.05, resulting in $2,529.63). This amount is then reduced to pay for each of CMS final policies (as noted previously, based upon the change to the low utilization payment adjustments (LUPA) payment, the non-routine supplies (NRS) redistribution, and the elimination of the significant change in condition (SCIC) policy, the amounts needed to account for outlier payments, and the reduction to account for the 2.75 percent case-mix change adjustment). Therefore, the national standardized 60-day episode payment rate is reduced by $5.51, $44.38, $10.61, $123.09, and $75.72, respectively; and the CY 2008 updated national standardized 60-day episode payment rate, for episodes beginning and ending in CY 2008, is $2,270.32. These episodes would be further adjusted for case-mix based on the 153 HHRG case-mix model for episodes beginning and ending in CY 2008. As noted in the August 29, 2007 final rule with comment, the case-mix weights were increased by a budget neutrality factor of 1.238848031. This payment is displayed in Table 2.

Table 2 – CY 2008 National Standardized 60-Day Episode Payment Rate for Episodes Beginning and Ending in CY 2008 (HHAs that Report Quality Data)

Total CY 2007 National Standardized 60-Day Episode Payment Rate	Multiply by the Home Health Market Basket Update 3 Percent)	Adjusted to Return the Outlier Funds to the National Standardized 60-Day Episode Payment Rate	Updated and Outlier Adjusted National Standardized 60-Day Episode Payment	Changes to Account for LUPA Adjustment ($5.51), NRS Payment ($44.38), Elimination of SCIC Policy ($10.61), Outlier Policy ($123.09), and 2.75 Percent Reduction for Nominal Change in Case-Mix ($75.72) for Episodes Beginning and Ending in CY 2008	CY 2008 National Standardized 60-Day Episode Payment Rate for Episodes Beginning and Ending in CY 2008
$2,339.00	X 1.030	X 1.05	$2,529.63	-$259.31	$2,270.32

3. Low utilization payment adjustments (LUPAs) and outlier payments

The national standardized per-visit amounts are used to calculate LUPAs and outlier payments. These payments are displayed in Table 3.

Table 3 – Low Utilization Payment Adjustments (LUPAs) and Outlier Payments (HHAs that Report Quality Data)

Home Health Discipline Type	Final CY 2007 Per-Visit Amounts Per 60-Day Episode for LUPAs	Multiply by the Home Health Market Basket (3 Percent)	Adjusted to Account for the 5 Percent Outlier Policy	CY 2008 Per-Visit Payment Amount Per Discipline
Home Health Aide	$46.24	X1.030	X 1.05 X 0.95	$47.51
Medical Social Services	$163.68	X1.030	X 1.05 X 0.95	$168.17
Occupational Therapy	$112.40	X1.030	X 1.05 X 0.95	$115.48
Physical Therapy	$111.65	X1.030	X 1.05 X 0.95	$114.71
Skilled Nursing	$102.11	X1.030	X 1.05 X 0.95	$104.91
Speech-Language Pathology	$121.32	X1.030	X 1.05 X 0.95	$124.65

PAYMENTS TO HHAS THAT DO NOT REPORT REQUIRED QUALITY DATA

The DRA provides that if an HHA does not submit the required quality data, the home health market basket percentage increase applicable to that provider's payments will be reduced by 2 percent. Therefore, the increase that is applied to CY 2008 payments to HHAs that do not report the required quality data is 1.0 percent (CY 2008 market basket update of 3 percent minus 2 percent%).

4. The 60-day national episode payment made to HHAs that do not report the required quality data for episodes that begin in CY 2007 and end in CY 2008

Table 4 displays the 60-day national episode payment made to HHAs that do not report the required quality data for episodes that begin in CY 2007 and end in CY 2008.

Table 4 – 60-Day National Episode Payment for Episodes that Begin in CY 2007 and End in CY 2008 (HHAs that Do Not Report the Required Quality Data)

Total CY 2007 National Standardized 60-Day Episode Payment Rate	Multiply by the Home Health Market Basket Update (3 Percent) Minus 2 Percent	Reduce by 2.75 Percent for Nominal Change in Case-Mix	Adjusted to Account for the 5 Percent Outlier Policy	National Standardized 60-Day Episode Payment Rate for Episodes Beginning in CY 2007 and Ending in CY 2008 for HHAs that Do Not Submit Required Quality Data
$2,339.00	X 1.010	X 0.9725	X 1.05 X 0.95	$2,291.68

Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008 (continued)

5. The 60-day national episode payment made to HHAs that do not report the required quality data for episodes that begin and end in CY 2008

Table 5 displays the 60-day national episode payment made to HHAs that do not report the required quality data for episodes that begin and end in CY 2008.

Table 5 – The 60-Day National Episode Payment for Episodes that Begin and End in CY 2008 (HHAs That Do Not Report the Required Quality Data)

Total CY 2007 National Standardized 60-Day Episode Payment Rate	Multiply by the Home Health Market Basket Update (3 Percent) Minus 2 Percent	Adjusted to Return the Outlier Funds to the National Standardized 60-Day Episode Payment Rate	Updated and Outlier Adjusted National Standardized 60-Day Episode Payment	Changes to Account for LUPA Adjustment ($5.51), NRS Payment ($44.38), Elimination of SCIC Policy ($10.61), Outlier Policy ($123.09), and 2.75 Percent Reduction for Nominal Change in Case Mix ($75.72) = $259.31; Minus 2 Percentage Points off of the Home Health Market Basket Update (3 Percent) 1 for Episodes Beginning and Ending in CY 2008	CY 2008 National Standardized 60-Day Episode Payment Rate for Episodes Beginning and Ending in CY 2008 that Do Not Submit Required Quality Data
$2,339.00	X 1.010	X 1.05	$2,480.51	$254.27	$2,226.24

6. The per-visit amounts applied to LUPA and outlier payments to HHAs that do not report the quality data

Table 6 displays the per-visit amounts applied to LUPA and outlier payments to HHAs that do not report the quality data.

Table 6 – The Per-Visit Amounts Applied to LUPA and Outlier Payments (HHAs that Do Not Report the Required Quality Data)

Home Health Discipline Type	Final CY 2007 Per-Visit Amounts Per 60-Day Episode for LUPAs	Multiply by the Home Health Market Basket (3 Percent) 1 Minus 2 Percent	Adjusted to Account for the 5 Percent Outlier Policy	CY 2008 Per-Visit Payment Amount Per Discipline for A Beneficiary Who Resides in a Non-MSA for HHAs that Do Not Submit Required Quality Data
Home Health Aide	$46.24	X1.010	X 1.05 X 0.95	$ 46.59
Medical Social Services	$163.68	X1.010	X 1.05 X 0.95	$ 164.90
Occupational Therapy	$112.40	X1.010	X 1.05 X 0.95	$ 113.24
Physical Therapy	$111.65	X1.010	X 1.05 X 0.95	$ 112.48
Skilled Nursing	$102.11	X1.010	X 1.05 X 0.95	$ 102.87
Speech-Language Pathology	$121.32	X1.010	X 1.05 X 0.95	$ 122.23

Note: Your RHHI will contact you if you are to receive reduced payments for CY 2008.

ADDITIONAL INFORMATION

You may find more information about the updates to the CY 2008 60-day national episode and per-visit payment rates under the HH PPS, the refined case mix methodology; and the rebased and revised home health market basket for CY 2008 by going to CR 5879, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1443CP.pdf*.

If you have any questions, please contact your RHHI 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: MM5879
Related Change Request (CR) Number: 5879
Related CR Release Date: February 7, 2008
Related CR Transmittal Number: R1443CP
Effective Date: January 1, 2008
Implementation Date: March 7, 2008

Source: CMS Pub. 100-04, Transmittal 1443, CR 5879

EDUCATIONAL EVENTS

UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS

MARCH 2008 – MAY 2008

Hot Topics – Medicare Updates

When: Tuesday, March 11, 2008

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

Type of Event: Teleconference/Webcast

2008 Medicare Symposium

When: Tuesday & Wednesday, May 6 & 7, 2008

Where: Marriot Orlando Downtown
400 West Livingston Street, Orlando, FL 32801
1-407-843-6664

Type of Event: In Person Seminar

Hot Topics – Medicare Updates

When: Tuesday, May 13, 2008

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

TWO EASY WAYS TO REGISTER

ONLINE – Log on to your account on our provider training Web site at *www.fcsomedicaretraining.com* and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event. **First-time user?** Set up an account using the instructions at *www.floridamedicare.com/Education/108651.asp* to register for a class and obtain materials.

FAX – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.
Keep checking our Web site, *www.floridamedicare.com*, or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled educational events (teleconferences, webcasts, etc.).

TIPS FOR USING THE FCSO PROVIDER TRAINING WEB SITE

To search and register for Florida events on *www.fcsomedicaretraining.com* click on the following links:

- "Course Catalog" from top navigation bar
- "Catalog" in the middle of the page
- "Browse Catalog" on the right of the search box
- "FL – Part B or FL – Part A" from list in the middle of the page.

Select the specific session you're interested in, click the "Preview Schedule" button at the bottom of the page. On the Instructor-Led Training (ILT) Schedule page, locate the line that has the course you are interested in and click the "Register" link in the Options column.
If you need assistance, please contact our FCSO Medicare training help desk by calling 866-756-9160 or sending an email to fcsohelp@geolearning.com.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

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.) are being planned to help providers with hot issues. Keep checking our Web site *http://www.floridamedicare.com* or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events. ❖

PREVENTIVE SERVICES

FEBRUARY IS AMERICAN HEART MONTH

Since 1999, the rate of deaths from coronary heart disease and stroke in American has declined. While much progress has been achieved in reducing the death rate, heart disease and stroke still remain the number 1 and number 3 causes of death in the U.S., and a major cause of disability and reduced quality of life. Found more often among people aged 65 or older, heart disease is largely preventable. The Centers for Medicare & Medicaid Services (CMS) is taking this opportunity to remind health care professionals that Medicare beneficiaries are covered for certain cardiovascular screening blood tests. This screening can help beneficiaries learn if they have an increased risk of heart disease and stroke.

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

Total cholesterol test

Cholesterol test for high-density lipoproteins

Triglycerides test

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

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

SPREAD THE WORD

CMS needs your help getting the word out about the cardiovascular screening benefit covered by Medicare. Talk with your patients about their risk factors for cardiovascular disease and how they can help lessen their risk through lifestyle modifications such as diet, physical activity, better control of cholesterol, and smoking cessation or if necessary with medication. Encourage your Medicare patients not previously diagnosed with cardiovascular disease to take full advantage of the cardiovascular screening blood tests covered by Medicare. **It could save their lives!**

FOR MORE INFORMATION

CMS has developed a variety of educational products and resources to help health care professionals and their staff learn more about coverage, coding, billing, and reimbursement for preventive and screening services covered by Medicare.

The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for MLN preventive services educational products and resources for health care professionals and their staff.

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

Expanded Benefits Brochure – This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of the IPPE, ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests.

http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf

To order copies of the brochure, go to the Medicare Learning Network Product Ordering System located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

The CMS Web site provides additional information about cardiovascular screening benefit at *http://www.cms.hhs.gov/CardiovasDiseaseScreening/*.

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

For information about American Heart Month, please visit the American Heart Association's Web site at *http://www.americanheart.org/presenter.jhtml?identifier=1200000* and the Centers for Disease Control and Prevention's Web site at *http://www.cdc.gov/DHDSP/announcements/american_heart_month.htm*. ❖

Source: CMS Provider Education Resource 200802-04/200801-26

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.

FEBRUARY FLU SHOT REMINDER

It's Not Too Late to Get the Flu Shot. In the U.S., the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one-time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot.

DON'T GET THE FLU. DON'T GIVE THE FLU. GET VACCINATED!

Remember Influenza vaccination is a covered Part B benefit. Note that 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 the 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 200801-26

OTHER EDUCATIONAL RESOURCES

GUIDED PATHWAYS TO MEDICARE RESOURCES FOR MEDICARE FEE-FOR-SERVICE HEALTH CARE

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of the latest Medicare Learning Network provider education product entitled, "Guided Pathways to Medicare Resources for Medicare Fee-for-Service Health Care Professionals."

Guided Pathways has been developed as an educational tool for fee-for-service (FFS) health care staff who are relatively unfamiliar with the Medicare program, as well as for those professionals looking for easy access to the many resources on the CMS Web site. Using a "road trip" motif, the pathways lead users through nine broad sections of information covering the Medicare program, with links to further pertinent information. The pathways also provide links to other government resources pertaining to Medicare FFS items. Guided Pathways may be accessed on the CMS Web site at *http://www.cms.hhs.gov/apps/training/guidedpathways/index.html*.

Located in the Provider Communications Group within CMS, the *Medicare Learning Network* (MLN) is the brand name for official CMS educational products designed to promote national consistency of information developed for Medicare FFS initiatives. Most importantly, it is available to help you! Each quarter the MLN will send updates on the latest products available – so be on the lookout!

For more information on the Medicare Learning Network, please visit on the CMS Web site *www.cms.hhs.gov/MLNGenInfo*.

Questions and requests for additional information may be sent to the MLN Mailbox at MLN@cms.hhs.gov. ❖

Source: CMS Provider Education Resource 200801-24

REVISED MEDICARE LEARNING NETWORK PRODUCTS

The following products are now available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network:**

- The revised Medicare Physician Fee Schedule Fact Sheet (January 2008), which provides general information about the Medicare physician fee schedule, may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*.
- The *revised Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart* (January 2008), which provides Medicare claims processing information related to SNF spells of illness, may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/SNFSpellIllnesschrt.pdf*. ❖

Source: CMS Provider Education Resource 200802-10

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM FACT SHEET AVAILABLE FOR ORDERING

The Home Health Prospective Payment System Fact Sheet, which provides information about coverage of home health services and elements of the home health 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." ❖

Source: CMS Provider Education Resource 200801-25

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IMPORTANT ADDRESS, TELEPHONES NUMBERS AND WEB SITES

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

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

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 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)
Attn: FOIA PARD – 16T
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

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

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

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