

# MEDICARE A Bulletin

A NEWSLETTER FOR FLORIDA MEDICARE PART A PROVIDERS

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

Publications issued after October 1, 1997, are available at no-cost from our provider Web site at [www.fcs.com](http://www.fcs.com).

### Routing Suggestions :

- Medicare Manager
- Reimbursement Director
- Chief Financial Officer
- Compliance Officer
- DRG Coordinator
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



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## Medicare A Bulletin

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### Publication Staff

Millie C. Pérez  
Terri Drury  
Mary Barnes  
Betty Alix

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**  
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## A MESSAGE TO PROVIDERS

### MEDICAL RECORD REVIEW REQUESTS

First Coast Service Option Inc. (FCSO) has received questions from providers regarding medical record review or, more specifically, requests from Medicare for medical records. A statement in both local and national coverage determinations (LCDs and NCDs) notes that medical record documentation maintained by the performing physician or allied provider must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be maintained in the patient's medical record. This information is normally found in the history and physical examination notes, office/progress notes, hospital notes, and/or procedure report.

Medical record reviews are conducted by different entities contracted by the Centers for Medicare & Medicaid Services (CMS) and other government offices, and each has distinct program goals. Under the Medicare Integrity Program enacted by Congress, entities such as FCSO, a carrier (pays Part B provider claims) and fiscal intermediary (pays Part A provider claims), are known as the affiliated contractor (AC), distinct from a program safeguards contractor (PSC). As a general rule, a PSC is accountable for reducing fraud and abuse in the Medicare program; an AC is responsible for reducing the Medicare fee-for-service claim payment error rate. Of course, there may be overlap in responsibilities and programs.

Other Medicare contractors that pay claims and may request records for medical review include the durable medical equipment regional carrier (DMERC) or DME MAC (DME Medicare administrative contractor) and the regional home health and hospice intermediary (RHHI). Though they do not pay claims directly, the quality improvement organizations (QIO) in each state have inpatient acute care hospital claim review responsibility, as well as other initiatives that may entail medical review. Two special PSC contractors administer the Comprehensive Error Rate Testing (CERT) program, and systematically request records for medical review. Also, the Office of the Inspector General (OIG), in the Department of Health & Human Services (which governs the Medicare program), conducts surveys or assessments that involve the claim payment process and necessitates medical review. Medical records for these reviews, and subsequent follow-up reviews, are requested by the entity contracted by the OIG for this purpose.

The following is a brief outline of medical record review: note that each program has a limited impact on the number of providers and/or number of claims reviewed.

**Medical review of initial claims** – the AC requests records in the prepayment development of a claim.

- Claims may have been submitted with procedure code(s) that require additional information for coverage and/or payment (e.g., an unlisted code).
- One of the services on the claim is under formal review based on utilization or other audits (these are usually outlined in a national or local policy or may be a PSC request).

**Progressive correction action (PCA) process medical review** – the AC process to lower the claims payment error rate. This is data-driven with a provider education and/or policy development focus.

- Post payment request for the documentation of claims.
- In some instances, may include prepayment development of a claim for certain codes submitted by a provider.

**CERT program** – The CERT documentation contractor requests records for review by the CERT review contractor. The CERT program randomly samples 200 claims per month per contractor nationally.

- Post payment request for the documentation of claims, usually from the prior year.

**PSC and OIG** – Programs to prevent fraud and abuse.

- Post payment request for the documentation of claims.
- Prepayment medical review related to a program safeguards initiative – requests come from the AC (such as FCSO) since these are new claims, although the documentation will be reviewed by the PSC.

FCSO paid over 90 million claims in fiscal year 2007 for Part A and B providers in Florida and Part B providers in Connecticut. Fortunately, only a small percentage of these claims require submission of medical records for review. If you receive a request for medical records on a Medicare beneficiary and are unsure of your responsibilities, please contact the Medicare Part A Customer Service Center at 1-888-664-4112 for clarification, or call the number on the requesting letter for more details. Your prompt response to a legitimate request will benefit you, the beneficiary, and the Medicare program. ❖

Source: FCSO Office of the Medical Director

## 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

**CROSSOVER MEDICAID DRUG REBATE DATA SUBMITTED ON FORM UB-04 PAPER CLAIMS AND DIRECT DATA ENTRY CLAIMS**

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

**PROVIDER TYPES AFFECTED**

Physicians' offices, hospital outpatient departments and outpatient clinics serving patients who are dually eligible for Medicare and Medicaid and **submit UB-04 paper or DDE claims** to Medicare contractors (fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Part A/B Medicare administrative contractors [A/B MACs]) for physician administered drugs.

**IMPACT ON PROVIDERS**

The Centers for Medicare & Medicaid Service (CMS) issued change request (CR) 5950 so that Medicaid drug rebate information submitted to Medicare on UB-04 CMS-1450 or via the direct data entry (DDE) will crossover to Medicaid. This change request is to notify providers that modifications to Medicare systems will be implemented that will allow CMS to capture and crossover the national drug codes (NDCs). Corresponding quantities are then recorded on claims by Medicare providers. In order to capture the information needed to fulfill the rebate requirements, **providers billing for dual eligible patients will be required to submit the NDCs for physician-administered drugs in the Revenue Description Field (form locator [FL] 43) on the UB-04 in order that this data can be crossed over to Medicaid for the billing of Medicaid rebates.** It is important billing staffs note three items in this change request that impact provider billing, effective October 1, 2008:

1. The requirements only apply when the Medicare provider is submitting claims for physician-administered drugs to Medicare for dual eligible beneficiaries, i.e., those eligible for both Medicare and Medicaid.
2. Medicare will not edit, validate, nor process the NDCs and corresponding quantities received on UB-04 claims, but will pass the data to Medicaid through the coordination of benefits (COB) process.
3. The Medicaid Drug Rebate Reporting instructions are summarized as follows:

Using the Revenue Description Field (FL 43) on the UB-04:

- Report the N4 qualifier in the first two (2) positions, left-justified
- Followed immediately by the 11 character National Drug Code number in the 5-4- 2 format (no hyphens).
- Immediately following the last digit of the NDC (no delimiter) the Unit of Measurement Qualifier. The Unit of Measurement Qualifier codes are as follows:  
 F2 -International Unit  
 GR-Gram  
 ML-Milliliter  
 UN- Unit
- Immediately following the Unit of Measurement Qualifier, the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal).
- Any spaces unused for the quantity are left blank.

Note that the decision to make all data elements left-justified was made to accommodate the largest quantity possible. The Description Field on the UB-04 is 24-characters in length. An example of the methodology is illustrated below.

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	3	4	.	5	6	7	
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	--

**BACKGROUND**

The Deficit Reduction Act (DRA) of 2005 required state Medicaid agencies to provide for the collection of NDC on all claims for certain physician-administered drugs for the purpose of billing manufacturers for Medicaid drug rebates. Prior to the DRA, physicians' offices, outpatient hospital departments and clinics generally used Healthcare Common Procedure Coding System (HCPCS) codes to bill Medicaid for drugs dispensed to Medicaid patients. However, because state Medicaid agencies are required to invoice manufacturers for rebates using NDCs for drugs for which the states have made payments, and they were not receiving NDCs on claims for these drugs, often states were not able to fulfill the rebate requirements for physician-administered drugs. The requirements for the collection of drug rebate data became effective beginning January 1, 2007. In addition, beginning January 1, 2008, in order for federal financial participation (FFP) to be available for these drugs, state Medicaid agencies must be in compliance with the requirements. These requirements were implemented in a final rule published on July 17, 2007.

## Crossover Medicaid Drug Rebate Data Submitted on Form UB-04 Paper Claims and DDE Claims (continued)

### ADDITIONAL INFORMATION

To see the official instruction (CR 5950) issued to your Medicare RHHI, FI and/or A/B MAC, refer to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1496CP.pdf>.

If you have questions, please contact your Medicare RHHI, FI and/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: MM5950

Related Change Request (CR) Number: 5950

Related CR Release Date: May 2, 2008

Related CR Transmittal Number: R1496CP

Effective Date: October 1, 2008

Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 5950, CR 5950

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

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## ASSIGNMENT OF PROVIDERS TO MEDICARE ADMINISTRATIVE CONTRACTORS

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

### PROVIDER TYPES AFFECTED

All physicians, providers and suppliers who submit claims to Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), carriers or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

### IMPACT ON PROVIDERS

This “One Time Notice” change request (CR) describes the Centers for Medicare & Medicaid Services (CMS) approach for assigning providers to MACs and discusses the process of moving providers to MACs.

### BACKGROUND

This article is based on CR 5979 and section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), public law 108–173, amended Title XVIII of the Social Security Act (the Act) to add section 1874A, Contracts with Medicare Administrative Contractors (MACs).

#### I. What Are “MACs?”

Under section 911 of the MMA, Congress requires that CMS replace the current FI and carrier contracts with competitively procured contracts that conform to the Federal Acquisition Regulation (FAR). Under the new MAC contracting authority, CMS has six years – between 2005 and 2011 – to complete the transition of Medicare fee-for-service (FFS) claims processing activities from the FIs and carriers to the MACs.

For information on CMS’ progress in awarding and implementing the MACs, please visit the CMS Web site at <http://www.cms.hhs.gov/MedicareContractingReform/>.

#### II. What is “Provider Nomination?”

“Provider Nomination” is a phrase that describes the former right of an individual provider or a chain of providers to select assignment to the FI of its choice. In section 911(b) of the MMA, Congress repealed the provider nomination provisions of the Social Security Act. Provider nomination

has been replaced with the geographic assignment rule. Generally, a provider will be assigned to the MAC that covers the state where the provider is located. The CMS regulation at 42 CFR 421.404 reflects this policy shift. Other CMS regulations and policy manuals are in the process of being updated.

A moratorium was placed on the “change of intermediary” process for individual providers in October of 2005. Transmittal 291 (CR 5720), dated September 19, 2007, (see on the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R291OTN.pdf>) informed all FIs and A/B MACs that CMS would no longer accept a request to move from one FI/MAC to another FI/MAC from a provider moving in or out of a Medicare chain. There remains one exception for qualified chain providers (QCPs) as discussed in Section V below.

### III. Where Will Providers Eventually Be Assigned in the MAC Environment?

#### A. Home Health & Hospice

All home health and hospice (HH&H) providers will be assigned to the MAC contracted by CMS to administer HH&H claims for the geographic locale in which the provider is physically located. See the following link for a description of the MAC-environment HH&H regions and the four MACs that will administer HH&H claims for those four regions.

[http://www.cms.hhs.gov/MedicareContractingReform/06\\_SpecialtyMACJurisdictions.asp#TopOfPage](http://www.cms.hhs.gov/MedicareContractingReform/06_SpecialtyMACJurisdictions.asp#TopOfPage).

#### B. Durable Medical Equipment

Each supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) will submit claims to the durable medical equipment Medicare administrative contractors (DME MAC) contracted by CMS to administer DMEPOS claims for the geographic locale in which the beneficiary permanently resides. The link above under “A” also provides a description of the MAC-environment DMEPOS regions and the four MACs that will administer DMEPOS claims for those four regions.

**Assignment of Providers to Medicare Administrative Contractors (continued)**

**C. Qualified Railroad Retirement Beneficiaries Entitled to Medicare**

Physicians and other suppliers (except for DMEPOS suppliers) will continue to enroll with and bill the contractor designated by the Railroad Retirement Board (under section 1842(g) of The Act) for Part B services furnished to these beneficiaries. Suppliers of DMEPOS will bill the DME MACs.

**D. Specialty Providers and Demonstrations**

Specialty providers, and providers involved with certain demonstrations, will submit claims to a specific MAC designated by CMS. A list of those specialty services and their designated MACs is reflected in the following table:

**MACs Designated to Process Specialty or Demonstration Claims**

Specialty Service or Demonstration	MAC Jurisdiction
Centralized Billing for Mass Immunizers	4
Indian Health Services	4
Low Vision Demonstration	5,10, 11, 13, and 14
Rural community hospital demonstration	1, 2, 4 and 5
Veterans Affairs Medicare Equivalent Remittance Advice Project	4
Chiropractic Services Demonstration	4 and 5
Home Health Third Party Liability Demonstration Project	14
Medicare Adult Day Care Demonstration	11, 14 and 15
Independent Organ Procurement Organizations	10
Religious Non-medical Health Care Institution (RNHCI)	10
Histocompatibility Lab	10

The following material describes the demonstrations and specialty providers listed above. Generally, a provider will already know whether or not it is participating in one of these categories.

**Centralized Billing for Mass Immunizers** – In order to encourage providers to supply flu and pneumococcal (PPV) vaccinations to Medicare beneficiaries, CMS currently authorizes a limited number of providers to centrally bill for flu and PPV immunization claims. Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type “Mass Immunizer,” as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers processing claims. Centralized billers must send all claims for flu and PPV immunizations to a single carrier for payment, regardless of the carrier jurisdiction in which the vaccination was administered and the carrier must make payment based on the payment locality where the service was provided. IOM Pub. 100-04, chapter 18, sections 10.3 and 10.3.1 provide more specific information related to this activity.

**Indian Health Services** – The Indian health service (IHS) is the primary health care provider to Medicare beneficiaries who are members of federally recognized tribes living on or near reservations. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries via a network of hospitals (including CAHs), freestanding clinics, FQHCs, RHCs and other entities.

While sections 1814(c) and 1835(d) of the Social Security Act (the Act), as amended, generally prohibit payment to any federal agency, passage of the Indian Health Care Improvement Act (IHCIA) in 1976 provided for an exception, amending section 1880 of the Act, for facilities of

the IHS whether operated by such Service or by an Indian tribe or tribal organization (as defined in section 4 of the IHCIA). The exception under section 1880 limited payment to Medicare services provided in hospitals and skilled nursing facilities.

Effective July 1, 2001, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), section 432 extended payment on a fee-for-service (FFS) basis to services of physician and nonphysician practitioners furnished in IHS hospitals and freestanding clinics. This means that clinics associated with hospitals and freestanding clinics that are owned and/or operated by IHS are authorized to bill only the jurisdiction 4 MAC. Additionally, Tribal health facilities operated under Indian Self Determination Education and Assistance Act (ISDEAA) authorities are an extension of the IHS and considered facilities of the IHS. By virtue of this, they are authorized to bill the jurisdiction 4 MAC. ISDEAA authorities provide flexibilities to tribes in the administration of their programs that are not provided to general public providers.

**Low Vision Demonstration** – The Secretary of the Department of Health and Human Services is directed to carry out an outpatient vision rehabilitation demonstration project as part of the fiscal year (FY) 2004 appropriations conference report to accompany public law HR 2673. This demonstration project will examine the impact of standardized Medicare coverage for vision rehabilitation services provided in the home, office, or clinic, under the general supervision of a physician. The services may be supplied by the following:

- Physicians
- Occupational therapists
- Certified low vision therapists
- Certified orientation and mobility specialists
- Certified vision rehabilitation therapists

## Assignment of Providers to Medicare Administrative Contractors (continued)

This demonstration will last for five years through March 31, 2011, and is limited to services provided specifically in New Hampshire, New York City (all five boroughs), North Carolina, Atlanta, Kansas, and Washington state.

**Rural Community Hospital Association** – The RCH Demonstration program was mandated by section 410A of the MMA. The Secretary is required to conduct the RCH Demonstration, lasting five years, to test the advisability and feasibility of establishing RCHs to provide Medicare covered inpatient hospital services in rural areas. This demonstration will allow selected rural hospitals to benefit from cost-based reimbursement for inpatient services.

The Secretary is required to select not more than fifteen (15) hospitals to participate in the demonstration in states with low population densities. Currently, thirteen (13) hospitals participate in the program, serviced by seven different FIs.

**Veteran Affairs (VA) Medicare Equivalent Remittance Advice Project** – Current law permits the Department of VA to collect appropriate Medicare coinsurance and deductible amounts from supplemental insurers for claims for supplies and services ordinarily covered by Medicare but furnished:

- At VA facilities
- For veterans eligible to receive both VA health and Medicare benefits and also having Medicare supplemental insurance.

To facilitate this process, CMS entered into an interagency agreement with the VA whereby the CMS will help the VA work with a CMS contractor to adjudicate these claims to produce a remittance advice equivalent to that ordinarily produced for Medicare claims. The remittance advice, sent to the supplemental insurers, will help the insurers determine payment amounts they owe to the VA. The CMS will not pay these claims. Trailblazer was the contractor selected to perform the work.

**Chiropractic Services Demonstration** – Section 651 of the MMA requires CMS to conduct the Expansion of Coverage for Chiropractic Services Demonstration. The purpose of the demonstration is to evaluate the feasibility and advisability of expanding coverage of chiropractic services under Medicare. The demonstration is for two years and must be conducted in four geographic areas—two rural and two urban.

**Home Health Third Party Liability Demonstration** – The CMS and the states of Connecticut, Massachusetts, and New York have developed a demonstration program that will use a sampling approach to determine the Medicare share of the cost of home health services claims for dual eligible beneficiaries that were submitted to and paid by the Medicaid agencies. Sampling will be used in lieu of individually gathering Medicare claims from home health agencies (HHAs) for every dual eligible Medicaid claim each state may have paid in error. This process will eliminate the need for the HHAs to assemble, copy, and submit large numbers of medical records. The project currently covers the home health claims incurred in FY 2000 through 2007 for Massachusetts and New York and FY 2001 through 2005 for Connecticut.

**Medicare Adult Day Care Demonstration** – Section 703 of the MMA directs CMS to conduct a demonstration project that will test an alternative approach to the delivery of

Medicare home health services. Under this demonstration, Medicare beneficiaries receiving home health may be eligible to receive medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home. The statute requires the demonstration to run for a period of three years at no more than five HHA sites in states that license certified medical adult day care facilities.

Implementation of the demonstration began at five sites on August 1, 2006. Participation of Medicare beneficiaries is voluntary; up to 15,000 beneficiaries at any time will be eligible to enroll in the three-year demonstrations.

**Medicare Home Health Agency Provider Enrollment Demonstration** – This demonstration is designed to combat fraudulent home health activity in the Houston and Los Angeles areas. The principal provider enrollment task will be the revalidation of all HHAs in said areas.

**Independent Organ Procurement Organizations** – An organ procurement organization performs or coordinates the retrieval, preservation, and transportation of organs and maintains a system of locating prospective recipients for available organs.

**Religious Non-Medical Health Care Institutions** – A RNHCI provides care to beneficiaries in need of skilled nursing facility care or hospital care when the beneficiary's religious beliefs preclude admission to one of these institutional providers. This does not mean that the beneficiary will receive hospital or skilled nursing facility (SNF) care in the RNHCI, but that the beneficiary elected to pursue a religious approach to healing. Since the use of diagnoses or medical oversight is prohibited in a RNHCI, they are not candidates for any CMS existing prospective payment (PPS) and continue to be paid using the TEFRA methodology.

**Histocompatibility Laboratories** – Histocompatibility laboratories provide services related to tissue typing testing for possible organ recipients and donors to determine compatibility for an organ transplant. They operate on a cost reimbursement basis and bill transplant centers for their services.

### E. The Geographic-Assignment Rule

Providers that are not within one of the categories described above (HH&H, DME, RRB, or specialty & demos) will be assigned to the MAC that covers the state where the provider is located. There are two exceptions.

First a qualified chain provider (QCP) may request that its member providers be serviced by a single A/B MAC – specifically, the A/B MAC that covers the state where the QCP's home office is located. The regulation at 42 CFR 421.404(b)(2) defines a qualified chain provider (QCP) as:

- Ten or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control, collectively totaling 500 or more certified Medicare beds
- Five or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control in three or more contiguous states, collectively totaling 300 or more certified Medicare beds.



**Assignment of Providers to Medicare Administrative Contractors (continued)**

CMS may assign non-QCP providers, as well as end-stage renal disease (ESRD) providers to an A/B MAC outside of the prevailing geographic assignment rule only to support the implementation of the MACs or to serve some other compelling interest of the Medicare program.

The second exception is for providers that meet the "provider-based" criteria of 42 CFR 413.65. Provider-based entities (other than HH+H providers) will be assigned to the MAC that covers the state where the main ("parent") provider is assigned.

**IV. Where Will Providers Be Assigned in the Interim?**

All existing providers with a Medicare claims history will remain in their current FI assignments until their workload is transferred to an A/B MAC. The "change of intermediary" process ended for individual providers in 2005, and ended for chain providers in 2007. A change of ownership now serves only to update CMS provider data with information about the new owner.

The incoming MAC will absorb the workload currently serviced by a legacy FI within the 12 months following the award of MAC contract. In some situations the workload transition may be delayed by an award protest.

New providers enrolling with Medicare will be assigned to the FI or MAC that covers the state where the provider is physically located, with a few exceptions:

- **The "Multi-Provider Complex/Sub-Unit" Relationship (ref: 42 CFR 483.5[b])** – An initial enrollment for a sub-unit will be assigned to the FI or MAC that currently serves the existing parent hospital – even if the parent hospital is not presently billing in accordance with the "geographic assignment rule."
- **An "Initial Enrollment" Connected with a QCP** – If a QCP acquires a new hospital, skilled nursing facility, or critical access hospital that is located outside home office A/B MAC jurisdiction, then CMS will endeavor to assign the provider to the MAC that covers the state where the QCP's home office is located. This special assignment is available only for "initial enrollments" – providers that are joining the Medicare program with neither an existing administrative contractor assignment nor a Medicare claims history.

The other exceptions track the MAC-world assignment rules discussed in sections III-A through III-D above.

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**V. How Long Will My Interim Assignment Last?**

An "out-of-jurisdiction provider" (OJP) is a provider that is not currently assigned to the A/B MAC or FI in accordance with sections III-A through III-D above (including the geographic assignment rule.) For example, an individual, freestanding provider located in Oregon, but currently assigned to the Florida FI, would be an OJP.

New MACs will initially service some OJPs until CMS undertakes the final reassignment of all OJPs to their destination MACs based on the geographic assignment rule.

CMS will start the overall transfer of OJPs to their final destination MACs after two events have taken place. The first event is when all 15 A/B MACs have been awarded and implemented. The second event is when all the systems and contractors that support the claims processing, provider enrollment, and cost report auditing functions at the departure and destination MACs are capable of supporting the move.

**ADDITIONAL INFORMATION**

For complete details regarding this CR, please see the official instruction (CR 5979) issued to your Medicare FI, A/B MAC, or RHHI. That instruction may be viewed by going to the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R333OTN.pdf>.

To view any of the federal regulations cited in this article or in CR 5979, visit on the Internet <http://www.gpoaccess.gov/cfr/index.html>.

If you have questions, please contact your Medicare FI, A/B MAC, or RHHI at their toll-free number, which may on the CMS Web site 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: MM5979

Related Change Request (CR) Number: 5979

Related CR Release Date: April 18, 2008

Related CR Transmittal Number: R333OTN

Effective Date: May 19, 2008

Implementation Date: May 19, 2008

Source: CMS Pub. 100-20, Transmittal 333, CR 5979

## DMEPOS COMPETITIVE BIDDING NEWS—ROUNDS 1 AND 2

### CMS ANNOUNCES CONTRACT SUPPLIERS FOR ROUND 1 OF DMEPOS COMPETITIVE BIDDING

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for round 1 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding program.

To view additional information Please visit the CMS Web site at <http://www.cms.hhs.gov/DMEPOSCompetitiveBid>.

To view the press release, please click at [http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp).

### REVISED ACCREDITATION DEADLINES FOR DMEPOS COMPETITIVE BIDDING

In order to participate in the Medicare DMEPOS Competitive Bidding program, suppliers must meet quality standards and be accredited by a CMS-approved deemed accreditation organization. Suppliers that are interested in bidding in the second round of the program must be aware of changes to two key deadlines:

- Suppliers must be accredited or have applied for accreditation by July 21, 2008 (change from May 14, 2008), to submit a bid for the second round of competitive bidding. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation by July 21, 2008.
- To be awarded a contract, suppliers will need to be accredited. The accreditation deadline for the second round of competitive bidding is January 14, 2009 (change from October 31, 2008). Suppliers must be accredited before this date to be awarded a contract.

Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

CMS has extended these deadlines because a significant number of suppliers in the 70 metropolitan statistical areas (MSAs) included in round 2 of the DMEPOS competitive bidding program have not yet applied for accreditation. Suppliers in these MSAs that do not meet these accreditation deadlines cannot become DMEPOS competitive bidding contract suppliers, and will therefore be unable to furnish competitively bid items to any beneficiary residing in any part of the competitive bidding area during the contract period.

Suppliers can determine if they are serving beneficiaries in a round 2 MSA by visiting the following Web site: <http://www.census.gov/population/www/estimates/metrodef.html> and looking up their MSAs in the section called "counties with metropolitan and micropolitan statistical area codes." (In this file, MSAs are called CBSAs.) For example, the Los Angeles-Long Beach-Santa Ana, CA MSA is comprised of two counties: Los Angeles and Orange.

We urge all suppliers serving Medicare beneficiaries in the 70 round 2 MSAs to apply for accreditation now.

For a list of the CMS-approved deemed accreditation organizations, visit [http://www.cms.hhs.gov/MedicareProviderSupEnroll/01\\_Overview.asp](http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp).

For information about the Medicare DMEPOS Competitive Bidding program, visit <http://www.cms.hhs.gov/DMEPOSCompetitiveBid/>. ❖

### VISIT THE MEDICARE LEARNING NETWORK ~ IT'S FREE!

Source: CMS Provider Education Resource Message 200805-15

## POWER MOBILITY DEVICES FURNISHED IN COMPETITIVE BIDDING AREAS

CMS will be issuing instructions in the near future about a one-time DMEPOS competitive bidding transition policy for suppliers of purchased Group 3 single or multiple power option power mobility devices (PMDs) furnished to beneficiaries in competitive bidding areas (CBAs). In specific cases described below, suppliers who, prior to July 1, 2008, begin furnishing services related to providing these devices, but do not deliver the final PMD product until July 1, 2008, or later will be paid based on the 2008 fee schedule amounts for furnishing these PMDs to beneficiaries residing in round one CBAs. This transition policy applies to both contract and noncontract suppliers.

The HCPCS codes subject to the transition policy include PMD codes K0856 thru K0864 and related accessories provided at the time the PMD is delivered to a beneficiary who resides in a round one CBA. The specific claims subject to the transition policy are items that are delivered for use in the beneficiary's home on or after July 1, 2008, for which the supplier has:

- A signed order from the physician that is dated between April 1, 2008, and May 31, 2008
- Documentation that the face-to-face beneficiary examination by the physician that is necessary to determine medical necessity for the PMD occurred before July 1, 2008.

This documentation should be maintained by the supplier, but does not need to be submitted at the time the claim for the PMD is submitted. However, it should be made available upon request.

Suppliers should use the date of the physician order as the date of service on the claim (other than this limited, one-time exception, suppliers should be aware that the date of service that is recorded on a DMEPOS claim is the date that the item is delivered). In addition, suppliers should include on the claim for the PMD all accessories provided with the PMD and should use the same date of service used for the PMD for these items. Suppliers should report the date the PMD and related accessories were delivered for use in the beneficiary's home in the narrative section of the claim. ❖

Source: CMS Provider Education Resource Message 200805-16

## AMBULANCE SERVICES

### AMBULANCE FEE SCHEDULE—CONVERSION FACTOR FILE FOR CY 2009

#### AMBULANCE INFLATION FACTOR

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

#### PROVIDER TYPES AFFECTED

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

#### WHAT PROVIDERS NEED TO KNOW

This article is based on change request (CR) 6000, which revises the ambulance fee schedule file layout for calendar year (CY) 2009. Specifically, only the conversion factor field is being modified to:

- Remove the sign in the numeric field.
- Expand the length of the conversion factor field.

For claims with dates of service on or after January 1, 2009, Medicare contractor(s) will recognize the new ambulance fee schedule file layout. For claims with dates of service prior to January 1, 2009, Medicare contractors will recognize the current layout.

#### ADDITIONAL INFORMATION

The official instruction, CR 6000, issued to your carrier, FI, or A/B MAC regarding this change may be viewed on the

Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1499CP.pdf>.

The ambulance fee schedule public use files are available on the CMS Web site at [http://www.cms.hhs.gov/AmbulanceFeeSchedule/02\\_afspuf.asp](http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp).

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

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

MLN Matters Number: MM6000  
 Related Change Request (CR) Number: 6000  
 Related CR Release Date: May 2, 2008  
 Related CR Transmittal Number: R1499CP  
 Effective Date: January 1, 2009  
 Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1499, CR 6000

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**NATIONAL PROVIDER IDENTIFIER**

**PROVIDER AUTHENTICATION BY MEDICARE PROVIDER CONTACT CENTERS**

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

**PROVIDER TYPES AFFECTED**

Physicians, other providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC], or durable medical equipment Medicare administrative contractors, [DME MAC]) for services provided to Medicare beneficiaries.

**WHAT YOU NEED TO KNOW**

*MLN Matters* special edition article SE0814 covers the implementation of the national provider identifier (NPI) and the provider transaction access number (PTAN), effective May 23, 2008, as the provider authentication elements used when providers make telephone or written inquiries to the Medicare fee-for-service contractor provider contact centers.

**Note:** For providers enrolled in Medicare before May 23, 2008, their PTAN initially will be their legacy provider number. New providers enrolling in Medicare on or after May 23, 2008, will be assigned a PTAN as part of the Medicare enrollment process.

**BACKGROUND**

In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare provider contact centers (PCC) must properly authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

Please refer to the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9), chapter 3, section 30 and chapter 6, section 80 for a complete discussion of this PCC authentication update. You may find these manual sections on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/manuals/downloads/com109c03.pdf> and <http://www.cms.hhs.gov/manuals/downloads/com109c06.pdf>.

**Provider Authentication**

The elements for provider authentication of telephone (either customer service representative [CSR] or interactive voice response [IVR]) and written inquiries are presented in the table below.

**Provider Authentication Elements for Telephone & Written Inquiries**

Effective Dates	Inquiry Type	Provider Elements To Be Authenticated*
On or after May 23, 2008	IVR	Provider NPI and PTAN
On or after May 23, 2008	CSR	Provider NPI and PTAN
On or after May 23, 2008	Written, including fax and email	Provider name, and either provider NPI or PTAN

\*All elements must match unless otherwise specified.

**Written Inquiries – Exception to Above Authentication Requirements**

CMS allows an exception for written or faxed inquiries submitted on a provider’s official letterhead, and e-mail inquiries (with an attachment on letterhead). If the provider’s name and address are included in the letterhead and clearly establish the provider’s identity, no NPI or PTAN is required for authentication.

**ADDITIONAL INFORMATION**

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: SE0814  
 Related Change Request (CR) Number: 5089, 5277  
 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 SE0814

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## CHANGES TO INFORMATION REQUIRED WHEN CALLING MEDICARE

Important changes began May 23, 2008, in conjunction with final implementation of the national provider identifier (NPI).

### Remember To Have Your NPI and PTAN Available

Beginning May 23, 2008, Medicare guidelines require that contractors ask providers for both their provider transaction access number (PTAN) and NPI number, via both our interactive voice response (IVR) unit and customer service representative (CSR) lines. Therefore, it is vitally important you have this information available when calling any of our service lines.

### Always Use Your Most Current NPI when Asked To Provide This Information VIA Our Customer Service and/or IVR Service Lines

First Coast Service Options Inc. (FCSO) recognizes that some providers may have new NPI numbers as a result of a change you may have made. When calling our service lines, please be prepared to provide your most current NPI number. Having the most current NPI number can help us in validating this information at the start of each call.

**Note:** If you call the IVR after May 23, 2008, only to obtain status and/or check information, we recommend that you use the PTAN where the services were rendered. Providers will likely receive a faster response to status and check inquiries if this process is followed.

### Providers with One NPI and Multiple PTANs

FCSO is aware that some providers have one NPI and multiple PTANs and multiple NPIs to one PTAN. When

calling the IVR line beginning May 23, 2008, our system will be able to validate multiple NPI/PTAN combinations. However, it is possible you may experience a short delay while your information is being validated. We ask that you be patient and not hang up; the IVR will most likely be able to provide the information you need. Providers are encouraged not to call the CSR line for status, eligibility, and other information currently available via our IVR systems. CSRs are required to redirect providers back to the IVR to obtain any information available via the IVR systems.

### The Medicare Call Centers Are Ready for NPI Implementation Beginning May 23, 2008

FCSO recognizes the importance of the May 23, 2008, NPI implementation. While we will continue our goal to provide the best service possible and answer calls as quickly as we can, we do expect a higher than normal call volume. We ask for your patience with us during this time. If you begin to experience a higher than normal wait time, we recommend that you consider calling back at a different time. The best times to call are between 8:00 a.m. and 9:00 a.m.

**Note:** Providers are encouraged not to call the CSR line for status, eligibility, and other information currently available via our IVR systems. CSRs are required to redirect providers to the IVR to obtain any information available via the IVR systems. ❖

## NPI NEWS FOR MEDICARE FEE-FOR-SERVICE PROVIDERS

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

As of May 23, 2008, Medicare fee-for-service (FFS) are required to send **NPI-only in all** provider identifier fields for all HIPAA and paper transactions where a provider identifier is required. If you send Medicare a transaction with a Medicare legacy identifier in any of the provider fields, your claim will be rejected. These transactions include all electronic and paper claims (837I, 837P, NCPDP, DDE and paper CMS-1500 and UB-04), the 276/277 claims status transaction, the 270/271 eligibility transaction, 835 remittance advice and SPR paper remittance.

If your billing software is set up to continue to send both the NPI and the legacy identifier, and your clearinghouse or billing service has not stripped the legacy identifier from your claim as of May 23, the responsibility falls to the provider to send in the Medicare claim with NPI-only, i.e., **NO legacy identifiers**.

### NPIs FOR SECONDARY PROVIDERS

If the entity that is required to be identified in the secondary provider field (i.e., the ordering/referring/attending/operating/supervising/purchased service/other/service facility provider or prescriber) does not furnish an NPI, the billing provider must attempt to obtain that NPI in order to enter it on the claim. The billing provider may use the NPI registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the secondary provider's NPI or it may need to directly contact the ordering/referring/attending/operating/supervising/purchased service/other/service facility or prescriber in order to obtain the NPI.

Stay abreast of the latest clinical guidelines for prevention, diagnosis, and treatment

- If the billing provider has exhausted all possibilities of finding the NPI of the ordering/referring/attending/operating/supervising/purchased service/other or prescriber, Medicare FFS is permitting the billing provider (in the X12N 837 transactions) or the service provider (in the NCPDP 5.1 transaction) to use their own NPI as the identifier for those secondary providers. Medicare will reject claims if Medicare policy requires a secondary identifier and there is no NPI present.
- For service facility location loop, if the billing provider is still unable to obtain the NPI of the entity, no identifier should be reported in that loop.

### ***NPI News for Medicare Fee-for-Service Providers (continued)***

#### **TRANSCRIPT FOR APRIL 17 NPI ROUNDTABLE NOW AVAILABLE**

View the transcript on the CMS Web site at

[http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Transcript\\_for\\_April\\_17th\\_NPI\\_Roundtable.pdf](http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Transcript_for_April_17th_NPI_Roundtable.pdf).

#### **NEED MORE INFORMATION?**

Still 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 200805-10/200805-20

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## GENERAL COVERAGE

### BLOOD-DERIVED PRODUCTS FOR CHRONIC NON-HEALING WOUNDS

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

#### PROVIDER TYPES AFFECTED

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

#### PROVIDER ACTION NEEDED

##### STOP – IMPACT TO YOU

This article is based on change request (CR) 6043, which provides the Centers for Medicare & Medicaid Services (CMS) updated policy regarding autologous blood-derived products for chronic non-healing wounds.

##### CAUTION – WHAT YOU NEED TO KNOW

Effective March 19, 2008, CMS is maintaining its current noncoverage determination for autologous platelet rich plasma (PRP) for the treatment of chronic non-healing cutaneous wounds, and issuing a noncoverage determination for acute surgical wounds when the autologous PRP is applied directly to the closed incision and for dehiscent wounds.

##### GO – WHAT YOU NEED TO DO

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

#### BACKGROUND

In 1992, the Centers for Medicare & Medicaid Services (CMS) issued a national noncoverage determination for autologous, platelet-derived wound healing formulas intended to treat patients with chronic non-healing wounds.

In December 2003, CMS issued a national noncoverage determination for use of autologous platelet rich plasma (PRP) for the treatment of chronic non-healing cutaneous wounds except for routine costs when used in accordance with the clinical trial policy defined in the *Medicare National Coverage Determinations (NCD) Manual* (section 310.1; on the CMS Web site at [http://www.cms.hhs.gov/manuals/downloads/ncd103c1\\_Part4TXT.pdf](http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4TXT.pdf)).

In April 2005, CMS issued an NCD to correct the erroneous potential for local coverage of becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous wounds, stating that, because it is usually self-administered, it would remain nationally noncovered under Part B based on the Social Security Act (section 1861(s)(2)(A) and (B); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) on the Internet).

On March 19, 2008, CMS issued a decision memorandum following a national coverage analysis to evaluate the use of autologous blood-derived products for the treatment of chronic non-healing cutaneous wounds, specifically the use of autologous PRP for the treatment of acute wounds where PRP is applied directly to the closed incision site, or for dehiscent wounds.

CMS determined that the evidence is inadequate to conclude that autologous PRP for the treatment of chronic non-healing cutaneous wounds, acute surgical wounds when the autologous PRP is applied directly to the closed incision, or dehiscent wounds, improves health outcomes in the Medicare population.

Therefore, effective March 19, 2008, CMS is maintaining its current noncoverage determination for autologous PRP for the treatment of chronic non-healing cutaneous wounds, and issuing a noncoverage determination for acute surgical wounds when the autologous PRP is applied directly to the closed incision and for dehiscent wounds. Effective for claims with dates of service on or after March 19, 2008, the use of autologous PRP for the treatment of acute surgical wounds where the PRP is applied directly to the closed incision, or dehiscent wounds, will be denied by Medicare contractors.

#### ADDITIONAL INFORMATION

The official instruction, CR 6043, issued to your 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/R83NCD.pdf>.

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

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

MLN Matters Number: MM6043  
Related Change Request (CR) Number: 6043

Related CR Release Date: May 2, 2008

Related CR Transmittal Number: R83NCD

Effective Date: March 19, 2008

Implementation Date: June 2, 2008

Source: CMS Pub. 100-03, Transmittal 83 CR 6043

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**LOCAL COVERAGE DETERMINATIONS**

In accordance with publications specified by CMS, Medicare contractors no longer distribute full-text local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LCDs from our provider education Web site <http://www.fcso.com>.

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

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

**EFFECTIVE AND NOTICE DATES**

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

**ELECTRONIC NOTIFICATION**

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

**MORE INFORMATION**

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

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

**Local Coverage Determination Table of Contents**

**Additions/Revisions to Existing LCDs**

AJ0129: Abatacept ..... 17

**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>.**

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**ADDITIONS/REVISIONS TO EXISTING LCDs****AJ0129: ABATACEPT—REVISION TO THE LCD**

The local coverage determination (LCD) for abatacept was effective on June 30, 2007. Since that time, a revision was made to the sections below to update the language for approved indications based on the Food and Drug Administration (FDA) drug label and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI).

- Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, the requirement that adult patients have an inadequate response to one or more DMARDS such as methotrexate or TNF antagonists was deleted and the indication of juvenile idiopathic arthritis was added.
- Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, ICD-9-CM 714.30 was added for the indication of juvenile idiopathic rheumatoid arthritis.
- Under the “Documentation Requirements” section of the LCD, required documentation for a history of failed treatment regimens with DMARDS and medical records required to support why other treatment regimens were omitted prior to treatment with abatacept have been deleted.

Additionally, the “Sources of Information and Basis for Decision” section of the LCD was updated.

**EFFECTIVE DATE**

This revision to the LCD is effective for claims processed on or after June 5, 2008, for services provided **on or after April 8, 2008**. The full text of this LCD (L24536) is available through our provider education Web site <http://www.fcso.com>. ❖

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**HOSPITAL SERVICES**

**ADJUSTING INPATIENT PROSPECTIVE PAYMENT SYSTEM REIMBURSEMENT FOR REPLACED DEVICES OFFERED WITHOUT COST OR WITH CREDIT**

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

**PROVIDER TYPES AFFECTED**

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

**PROVIDER ACTION NEEDED**

**STOP – IMPACT TO YOU**

This article is based on change request (CR) 5860, which provides instructions for billing replaced devices that are received without cost or with a credit. It also includes Medicare contractor instructions for how to reduce the inpatient prospective payment system (IPPS) payment based on the amount of the credit received by the hospital for the replaced device.

**CAUTION – WHAT YOU NEED TO KNOW**

CR 5860 instructs that Medicare is not responsible for the full cost of a replaced device if a hospital receives a partial or full credit, either due to a recall or service during the warranty period. Therefore, when a hospital receives a credit for a replaced device that is 50 percent or greater than the cost of the device, hospitals are required to bill the amount of the credit in the amount portion for value code FD.

**GO – WHAT YOU NEED TO DO**

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

**BACKGROUND**

In recent years, there have been several field actions and recalls with regard to failure of implantable cardiac defibrillators (ICDs) and pacemakers. In many of these cases, the manufacturers have offered replacement devices

without cost to the hospital or offered credit for the device being replaced if the patient required a more expensive device. In some circumstances, manufacturers have also offered, through a warranty package, to pay specified amounts for un-reimbursed expenses to persons who had replacement devices implanted.

The Centers for Medicare & Medicaid Services (CMS) believes that incidental device failures that are covered by manufacturer warranties occur routinely. Though device malfunctions may be inevitable as medical technology grows increasingly sophisticated, CMS believes that early recognition of problems would reduce the number of people who would be potentially adversely affected by these device problems.

In addition to concerns for overall public health, CMS also has a fiduciary responsibility to the Medicare trust fund to ensure that Medicare pays only for covered services. Therefore, CMS believes it is appropriate to reduce the Medicare payment in cases in which an implanted device is replaced:

- At reduced or no cost to the hospital; or
- With partial or full credit for the removed device.

To address the issue, CMS issued CR 4058 (transmittal 741, November 4, 2005, which may be found on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R741CP.pdf>, and you may find its corresponding MLN Matters article on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4058.pdf>.

CR 4058 provided instructions for billing and processing claims with the following condition codes 49 and 50, which allow CMS to identify and track claims billed for replacement devices.

Condition Code	Title	Description
49	Product Replacement within Product Lifecycle	Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
50	Product Replacement for Known Recall of a Product	Manufacturer or FDA has identified the product for recall and therefore replacement.

Medicare is not responsible for the full cost of the replaced device if the hospital is receiving a partial or full credit, either due to a recall or due to service during the warranty period.

Therefore, hospitals are required to bill the amount of the credit in the amount portion for value code FD when the hospital receives a credit for a replaced device that is 50 percent or greater than the cost of the device.

Beginning with discharges on or after October 1, 2008, Medicare will reduce the hospital reimbursement, for one of the applicable Medicare severity-diagnosis related groups (MS-DRGs) listed in the table below, by the full or partial credit a provider received for a replaced device. This adjustment is consistent with the Social Security Act (section 1862(a)(2)), which excludes from Medicare coverage an item or service for which neither the beneficiary, nor anyone on his or her behalf, has an obligation to pay. Section 1862 (a)(2) of the Social Security Act may be found on the Internet at [http://www.ssa.gov/OP\\_Home/ssact/title18/1862.htm](http://www.ssa.gov/OP_Home/ssact/title18/1862.htm).

**Adjusting IPPS Reimbursement for Replaced Devices Offered Without Cost or With Credit (continued)**

For discharges on or after October 1, 2008:

- Hospitals must use the combination of condition code 49 or 50, along with value code FD to correctly bill for a replacement device that was provided with a credit or no cost. The condition code 49 or 50 will identify a replacement device while value code FD will communicate to Medicare the amount of the credit, or cost reduction, received by the hospital for the replaced device.
- Medicare will deduct the partial/full credit amount, reported in the amount for value code FD from the final IPPS reimbursement when the assigned MS-DRG is one of the MS-DRGs applied to this policy.

**Diagnosis Related Groups (DRGs) Subject to Final Policy**

Major Diagnostic Category (MDC)	MS-DRG	Narrative Description of DRG
PRE	1 & 2	Heart Transplant or Implant of Heart Assist System with and without MCC, respectively (former CMS-DRG 103, Heart Transplant or Implant of Heart Assist System)
1	25 & 26	Craniotomy and Endovascular Intracranial Procedure with MCC or with CC, respectively (former CMS-DRG 1, Craniotomy Age > 17 With CC)
1	26 & 27	Craniotomy and Endovascular Intracranial Procedure with CC or without CC/MCC, respectively (former CMS-DRGs 2, Craniotomy Age > 17 Without CC)
1	40 & 41	Peripheral & Cranial Nerve & Other Nervous System Procedure with MCC; or with CC or Peripheral Neurostimulator, respectively (former CMS-DRG, 7 Peripheral & Cranial Nerve & Other Nervous System Procedures With CC)
1	42	Peripheral & Cranial Nerve & Other Nervous System Procedure without CC/MCC (former CMS-DRG 8, Peripheral & Cranial Nerve & Other Nervous System Procedures without CC)
1	23 & 24	Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis with MCC or Chemotherapy Implant; and without MCC [or Chemotherapy Implant], respectively (former CMS-DRG 543, Craniotomy With Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis)
3	129 & 130	Major Head & Neck Procedures with CC/MCC or Major Device; or without CC/MCC, respectively (former CMS-DRG 49, Major Head & Neck Procedures)
5	216, 217, & 218	Cardiac Valve & Other Major Cardiothoracic Procedure with Cardiac Catheterization With MCC; or with CC; or without CC/MCC, respectively (former CMS-DRG 104, Cardiac Valve & Other Major Cardiothoracic Procedures with Cardiac Catheterization)
5	219, 220, & 221	Cardiac Valve & Other Major Cardiothoracic Procedure without Cardiac Catheterization with MCC; or with CC, or without CC/MCC, respectively (former CMS-DRG 105, Cardiac Valve & Other Major Cardiothoracic Procedures Without Cardiac Catheterization)
5	237	Major Cardiovascular Procedures with MCC or Thoracic Aortic Aneurysm Repair (former CMS-DRG 110, Major Cardiovascular Procedures With CC)
5	238	Major Cardiovascular Procedures without MCC (former CMS-DRG 111, Major Cardiovascular Procedures without CC)
5	260, 261, & 262	Cardiac Pacemaker Revision Except Device Replacement with MCC, or with CC, or without CC/MCC, respectively (former CMS-DRGs 117, Cardiac Pacemaker Revision Except Device Replacement)
5	258 & 259	Cardiac Pacemaker Device Replacement With MCC, and Without MCC, respectively (former CMS-DRG 118, Cardiac Pacemaker Device Replacement)
5	226 & 227	Cardiac Defibrillator Implant without Cardiac Catheterization with MCC and without MCC, respectively (former CMS-DRG 515, Cardiac Defibrillator Implant without Cardiac Catheterization)
5	215	Other Heart Assist System Implant (former CMS-DRG 525, Other Heart Assist System Implant)
5	222 & 223	Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction/Heart Failure/Shock with MCC and without MCC, respectively (former CMS-DRGs 535, Cardiac Defibrillator Implant with Cardiac Catheterization with Acute Myocardial Infarction/Heart Failure/Shock)
5	224 & 225	Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction/Heart Failure/Shock with MCC and without MCC, respectively (former CMS-DRG 536, Cardiac Defibrillator Implant with Cardiac Catheterization without Acute Myocardial Infarction/Heart Failure/Shock)

## Adjusting IPPS Reimbursement for Replaced Devices Offered Without Cost or With Credit (continued)

Major Diagnostic Category (MDC)	MS-DRG	Narrative Description of DRG
5	242, 243, & 244	Permanent Cardiac Pacemaker Implant with MCC, with CC, and without CC/MCC, respectively (MS-DRG 551, Permanent Cardiac Pacemaker Implant with Major Cardiovascular Diagnosis or AICD Lead or Generator)
5	242, 243, & 244	Permanent Cardiac Pacemaker Implant with MCC, with CC, and without CC/MCC, respectively (former CMS-DRG 552, Other Permanent Cardiac Pacemaker Implant without Major Cardiovascular Diagnosis)
5	245	AICD Lead and Generator Procedures (this is a new MS-DRG, created from AICD and generator codes moved out of CMS DRG 551)
8	461 & 462	Bilateral or Multiple Major Joint Procedures of Lower Extremity with MCC, or without MCC, respectively (former CMS-DRG 471, Bilateral or Multiple Major Joint Procedures of Lower Extremity)
8	469 & 470	Major Joint Replacement or Reattachment of Lower Extremity with MCC or without MCC, respectively (former CMS-DRG 544, Major Joint Replacement or Reattachment of Lower Extremity)
8	466, 467, & 468	Revision of Hip or Knee Replacement with MCC, with CC, or without CC/MCC, respectively (former CMS-DRG 545, Revision of Hip or Knee Replacement)

**Note:** MDC 1 (Diseases and Disorders of the Nervous System); MDC 3 (Ear, Nose, Mouth and Throat); MDC 5 (Circulatory System); MDC 8 (Musculoskeletal and Connective Tissue).

### ADDITIONAL INFORMATION

The official instruction, CR 5860, 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/R1509CP.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: MM5860

Related Change Request (CR) Number: 5860

Related CR Release Date: May 16, 2008

Related CR Transmittal Number: R1509CP

Effective Date: October 1, 2008

Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1509, CR 5860

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**BILLING BLOOD AND BLOOD PRODUCTS**

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

**PROVIDER TYPES AFFECTED**

All providers who submit claims for blood and blood products to Medicare administrative contractors (A/B MACs), and fiscal intermediaries (FIs) for services provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5867 to clarify for providers that:

- Medicare does not pay for the first three units of whole blood or packed red cells that are furnished under Part A or Part B in a calendar year.
- The Part B blood deductible is reduced to the extent that it has been met under Part A, and vice versa.
- The blood deductible does not apply to the costs of processing, storing, and administering blood.
- To meet the blood deductible, beneficiaries have the option of paying the hospital charges for the blood or packed red cells or arranging for it to be replaced.
- Beneficiaries are not responsible for the blood deductible if the provider obtained the whole blood or packed red cells at no charge other than the processing charge.

**BACKGROUND**

CMS became aware that inconsistencies exist among billing/claim processing requirements for blood services. CR 5867 instructs Medicare system maintainers to modify blood edits to align with existing Part A and hospital Part B policies for paying blood services and assigning blood deductible, as

well as with current revenue code standards set by the National Uniform Billing Committee (NUBC). Key points of CR 5867 are:

- Hospitals shall report charges for **red blood cells using revenue code 381, and charges for whole blood using revenue code 382. Failure to report the correct revenue code will cause your claim to be returned.**
- **Revenue code 380 is not a valid revenue code for Medicare.**

**ADDITIONAL INFORMATION**

To see the official instruction (CR 5867) issued to your Medicare FI or A/B MAC refer to the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1495CP.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: MM5867  
 Related Change Request (CR) Number: 5867  
 Related CR Release Date: May 2, 2008  
 Related CR Transmittal Number: R1495CP  
 Effective Date: October 1, 2008  
 Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1495, CR 5867

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## SKILLED NURSING FACILITY SERVICES

### MEDICAL AND OTHER HEALTH SERVICES FURNISHED TO SKILLED NURSING FACILITY PATIENTS

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

#### PROVIDER TYPES AFFECTED

Skilled nursing facilities (SNFs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for Part B services, including outpatient therapy services provided to Medicare beneficiaries.

#### PROVIDER ACTION NEEDED

This article is based on change request (CR) 5991, which revises the Medicare Benefit Policy Manual (Pub. 100-02, chapter 8, section 70) to clarify coverage of Part B services paid in SNFs, including outpatient physical therapy services, outpatient occupational therapy services, and outpatient speech pathology services.

#### BACKGROUND

The Social Security Act (Section 1861) provides for the coverage of medical and other health services that are paid through Medicare Part B, including the provision of outpatient physical therapy services and outpatient occupational therapy services. You can review Section 1861 of the Social Security Act on the Internet at [http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm).

With CR 5991, the Centers for Medicare & Medicaid Services (CMS) is making a slight modification to section 70, chapter 8 of the Medicare Benefit Policy Manual. Previously, that section of the manual began with the following paragraph:

The medical and other health services listed below and described in the Medicare Benefit Policy Manual, Chapter 6, "Hospital Services Covered Under Part B," section 10, are covered under Part B when furnished by a participating SNF either directly or under arrangements to: inpatients who are not entitled to have payment made under Part A (e.g., benefits exhausted or 3-day prior-stay requirement not met); **or outpatients.** (Emphasis added on "or outpatients.")

To avoid confusion, CMS is deleting the words "or outpatients" from the end of that quoted paragraph. That is the key change that CR 5991 makes, as none of the other services listed in this section of the manual can be provided by an SNF on an outpatient basis other than physical and occupational therapy and speech pathology services.

Outpatient physical and occupational therapy and outpatient speech pathology services may be provided by an SNF to its "outpatients," including:

- Those of its own patients in their homes

- Patients who come to the SNF outpatient department
- Inpatients of other institutions
- The SNFs own inpatients who have exhausted their Part A benefits or who are not otherwise eligible for Part A benefits.

In addition, CR 5991 reminds SNFs of the following existing policies:

- SNFs may furnish physical therapy, occupational therapy, or speech language pathology services to their inpatients without having to set up facilities and procedures for furnishing the same services to outpatients. However, if the SNF chooses to furnish the therapy services mentioned in this article, the SNF must bill the program under Part B and may only charge the patient for the applicable deductible and coinsurance.
- In the case of a distinct part SNF, the certified part must bill the program under Part B for any outpatient physical therapy, occupational therapy, or speech language pathology services that the certified distinct part itself furnishes to inpatients of the non-certified part.
- Alternatively, residents of the non-certified part can receive outpatient therapy services from a hospital that exceed the Part B therapy caps, in accordance with CR 2674 (Program Memorandum A-03-040, May 9, 2003) which may be found on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/A03040.pdf>.

#### ADDITIONAL INFORMATION

The official instruction, CR 5991, issued to your FI or A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R89BP.pdf>.

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

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

MLN Matters Number: MM5991

Related Change Request (CR) Number: 5991

Related CR Release Date: May 16, 2008

Related CR Transmittal Number: R89BP

Effective Date: June 16, 2008

Implementation Date: June 16, 2008

Source: CMS Pub. 100-02, Transmittal 89, CR 5991

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**JULY QUARTERLY UPDATE TO 2008 ANNUAL UPDATE OF HCPCS CODES USED FOR SNF CONSOLIDATED BILLING ENFORCEMENT**

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

**PROVIDER TYPES AFFECTED**

Providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries in skilled nursing facilities (SNFs).

**PROVIDER ACTION NEEDED**

This notification provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing (CB) provision of the SNF prospective payment system (PPS). Change request (CR) 6009 adds HCPCS code J9303 (Injection, panitumumab, 10 mg) to the *Major Category III.A. Chemotherapy Services FI/A/B MAC Exclusion List* retroactive to January 1, 2008.

**BACKGROUND**

The Social Security Act (Section 1888) codifies the SNF PPS and CB. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services are added by these routine updates; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are not subject to the consolidated billing provision of the SNF PPS. Services not appearing on this list submitted on claims to FIs/A/B MACs, A/B MACs, and carriers/A/B MACs, including DME MACs, will not be paid by Medicare to providers, other than an SNF, when included in SNF CB.

For non-therapy services, SNF CB applies only when the services are furnished to an SNF resident during a covered Part A stay. However, SNF CB applies to physical

and occupational therapies and speech-language pathology services whenever they are furnished to an SNF resident, regardless of whether Part A covers the stay. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in an SNF stay. In order to assure proper payment in all settings, Medicare systems will edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

CR 6009 adds HCPCS code J9303 to the *Major Category III.A. Chemotherapy Services FI/A/B MAC Exclusion List* retroactive to January 1, 2008.

Medicare contractors will reopen and reprocess claims affected by this instruction when providers bring such claims to their contractor's attention.

**ADDITIONAL INFORMATION**

The official instruction, CR 6009, issued to your 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/R1501CP.pdf>.

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

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

MLN Matters Number: MM6009  
 Related Change Request (CR) Number: 6009  
 Related CR Release Date: May 9, 2008  
 Related CR Transmittal Number: R1501CP  
 Effective Date: January 1, 2008  
 Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1501, CR 6009

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## ESRD SERVICES

### REVISIONS TO THE BILLING REQUIREMENTS FOR ESRD-RELATED EPOTEIN ALFA (EPO) AND DARBEPOETIN ALFA (ARANESP) ADMINISTRATIONS

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

#### PROVIDER TYPES AFFECTED

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

#### IMPACT ON PROVIDERS

This article is based on change request (CR) 6047 which revises the billing of end-stage renal disease (ESRD) related epotein alfa (EPO) and darbepoetin alfa (Aranesp®) administrations provided during unscheduled or emergency dialysis treatment in an outpatient hospital setting.

#### BACKGROUND

CR 3184 dated June 4, 2004 established Medicare system edits that require the presence of hospital emergency room visit revenue code 045x in order to allow payment for ESRD related epotein alfa (EPO) and darbepoetin alfa (Aranesp) provided in conjunction with an emergency dialysis treatment. Effective October 1, 2008, revenue code 045x will no longer be required in order to allow for EPO and Aranesp payment related to an unscheduled or emergency dialysis treatment.

CR 6047 revises current Medicare system edits associated with unscheduled and emergency dialysis treatments in the hospital outpatient setting to allow for the payment of EPO and Aranesp, Healthcare Common Procedure Coding System (HCPCS) codes Q4081 and J0882 **only** when HCPCS code G0257 is present on the same claim.

The definition for HCPCS code G0257 is as follows: Unscheduled or emergency dialysis treatment for an ESRD

patient in a hospital outpatient department that is not certified as an ESRD facility.

CR 6047 instructs Medicare contractors to:

- Only make payment for ESRD-related EPO or Aranesp in the outpatient hospital setting (13x and 85x bill types) when HCPCS code G0257 appears on the same claim.
- Return to the provider any outpatient hospital claims containing ESRD-related EPO or Aranesp when HCPCS code G0257 does not appear on the same claim.

#### ADDITIONAL INFORMATION

The official instruction, CR 6047, issued to FIs and A/B MACs regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1503CP.pdf>.

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

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

MLN Matters Number: MM6047

Related Change Request (CR) Number: 6047

Related CR Release Date: May 16, 2008

Related CR Transmittal Number: R1503CP

Effective Date: October 1, 2008

Implementation Date: October 6, 2008

Source: CMS Pub. 100-04, Transmittal 1503, CR 6047,

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## CORF SERVICES

### THErapy PERSONNEL QUALIFICATIONS AND POLICIES EFFECTIVE JANUARY 1, 2008

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

#### PROVIDER TYPES AFFECTED

Physicians, nonphysician practitioners (NPPs) and other providers who bill Medicare carriers, fiscal intermediaries (FI) or Medicare administrative contractors (A/B MAC) for outpatient therapy services provided to Medicare beneficiaries.

#### WHAT PROVIDERS NEED TO KNOW

Change request (CR) 5921, from which this article is taken, provides guidance for new regulations (see the *Federal Register* of November 27, 2007 for the discussion in the Medicare physician fee schedule [MPFS] final rule of 2008) that address outpatient therapy services, including personnel qualifications and the timing of recertification of plans of care for Part B services. This article summarizes these regulations.

#### BACKGROUND

Professional standards have changed since the qualifications for individuals providing outpatient therapy services (physical therapy, occupational therapy and speech-language pathology services in 42CFR484.4 was last modified. In the calendar year 2008 MPFS final rule with comments, the Centers for Medicare & Medicaid Services (CMS) updated them to address more modern requirements. CR 5921, from which this article is taken, provides guidance for these new regulations.

Effective January 1, 2008, these personnel requirements are being applied to all settings except inpatient hospital, including critical access hospital services, and post-hospital skilled nursing facility (SNF) care.

Effective July 1, 2008, these personnel qualifications are being applied consistently in all Medicare settings where therapy services are furnished.

Certain other policies concerning therapy services, and policies concerning recertification of plans of care for Part B services, some of which differ by setting are also effective January 1, 2008.

**Note:** Regulations in 42CFR409.17 concerning inpatient hospital services and inpatient critical access hospital services, and those in 42CFR409.23 concerning post hospital SNF care will become effective July 1, 2008. Only the personnel qualifications for those settings are addressed in this CR.

#### Qualifications for Individuals Providing Outpatient Therapy Services

##### Practice of Physical Therapy

For Medicare program coverage purposes, the new personnel qualifications for physical therapists were discussed in the 2008 MPFS. See the *Federal Register* of November 27, 2007 for the full text. See also the correction notice for this rule, published in the *Federal Register* on January 15, 2008. To view the official qualifications for physical therapists, see the revised chapter 15, section

230.1, of the *Medicare Benefit Policy Manual*, which is attached to CR 5921 on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf>.

##### Practice of Occupational Therapy

The new personnel qualifications for occupational therapists (OT) were also discussed in the 2008 physician fee schedule. See the *Federal Register* of November 27, 2007 for the full text. See also the correction notice for this rule, published in the *Federal Register* on January 15, 2008. The official personnel qualifications of OTs are in the revised chapter 15, section 230.2 of the *Medicare Benefit Policy Manual* attached to CR 5921.

##### Practice of Speech-Language Pathology

A qualified speech-language pathologist for program coverage purposes meets one of the following requirements:

- The education and experience requirements for a certificate of clinical competence in (speech-language pathology) granted by the American Speech-Language Hearing Association
- Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

For outpatient speech-language pathology services that are provided incident to the services of physicians/NPPs, the requirement for speech-language pathology licensure does not apply; all other personnel qualifications do apply. Therefore, qualified personnel providing speech-language pathology services incident to the services of a physician/NPP must meet the above qualifications.

##### Timing of Recertification of Plans for Care for Part B Services

CR 5921 also addresses the timing of recertification of plans for care for Part B services. The following summarizes the changes articulated in the *Medicare Benefit Policy Manual*, chapter 15 (Covered Medical and Other Health Services), section 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care).

First, please note that the physician's/NPP's certification of the plan (with or without an order) satisfies all of the certification requirements for the duration of the episode of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan.

The timing of plan recertification changed on January 1, 2008. Therefore, those certifications that were signed on, or prior to December 31, 2007, follow the rule in effect at that time; which required recertification every 30-calendar days. However, certifications that are signed on, or after January 1, 2008, follow the new rules in CR 5921 and are effective for an appropriate episode length based on individual patient condition up to 90-calendar days from the initial therapy treatment.

## Therapy Personnel Qualifications and Policies Effective January 1, 2008 (continued)

Specifically, a physician/NPP may certify or recertify a plan for whatever duration of treatment episode they determine is appropriate, up to a maximum of 90-calendar days. A certification interval will be the same length as an episode, if the episode is less than 90-calendar days. If the episode of care is anticipated to extend beyond the 90-calendar day limit for certification, it is appropriate (although not required) that the clinician who develops the plan estimate the duration of the entire episode for that setting.

**Note:** The progress report period has not changed.

Progress reports are due at least once every 10-treatment days or at least once during each 30-calendar days, whichever is less. The first day of the first reporting period is the same as the first day of the certification period and the first day of treatment (including evaluation). The first day of the second reporting period is the treatment day after the end of the first reporting period.

### Other Issues in Change Request 5921

Other issues discussed in CR 5921 include:

- Medicare contractors will require that a new or significantly modified (changed) plan of care for outpatient therapy services be certified no more than 30-calendar days after the initial therapy treatment under that plan. Rules for delayed certification have not changed.
- Payment and coverage conditions require that the plan must be reviewed, as often as necessary but at least whenever it is certified or recertified. It is not required that the same physician/NPP who participated initially in recommending or planning the patient's care certifies and/or recertifies the plans.
- Medicare contractors will require recertification of outpatient therapy plans of care in intervals not to exceed 90-calendar days after the initial treatment day.
- Physicians/NPPs who feel that a visit for an examination is necessary prior to certifying the plan, or during the episode of treatment should indicate their requirement for visits, preferably on an order preceding the treatment, or on the plan of care that is certified. If the physician wishes to restrict the patient's treatment beyond a certain date when a visit is required, the physician should certify a plan only until the date of the visit. After that date, services will not be considered reasonable and necessary due to lack of a certified plan.
- Policies continue to allow delayed certification of plans of care. Certifications are acceptable, even when late, if the services appear to have been provided under the care of any physician (not only the one who certifies). Appearance of a physician's care may be in any form and includes orders, e.g., notes, phone conferences, team conferences and billing for physician services during which the medical record or the patient's history would, in good practice, be reviewed and would indicate therapy treatment is in progress.

- The guidance for delayed certification has not changed. A new plan of care is either an initial plan of care or a plan of care that has been significantly modified or changed, resulting in a change in long-term goals. It is expected that modifications to the plan concerning short-term goals or treatment techniques will be made frequently and these changes do not require certification or recertification.
- Medicare contractors will not require a certification "statement" at the time of certification.
- Medicare contractors will require a clinician or facilities that appropriately furnish aquatic therapy in a community pool to rent or lease at least a portion of the community pool for the exclusive use of the therapist's patients.
- The same policies, e.g., concerning safety and medical necessity, continue to apply to services provided in part of a pool as were applied when the policy required use of the entire pool.

### ADDITIONAL INFORMATION

You may find more information about the new therapy personnel qualification requirements and the timing of recertification of plans of care (effective January 1, 2008) by going to CR 5921, located on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf>.

The updated Medicare *Benefit Policy Manual*, chapter 15 (Covered Medical and Other Health Services), sections 220 (Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance), 220.1.2 (Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services), 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care), 220.3 (Documentation Requirements for Therapy Services), 230.1 (Practice of Physical Therapy), 230.2 (Practice of Occupational Therapy), 230.3 (Practice of Speech-Language Pathology), 230.4 (Services Furnished by a Physical or Occupational Therapist in Private Practice) may be found as an attachment to that CR.

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

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

MLN Matters Number: MM5921  
Related Change Request (CR) Number: 5921  
Related CR Release Date: May 7, 2008  
Related CR Transmittal Number: R88BP  
Effective Date: January 1, 2008  
Implementation Date: June 9, 2008

Source: CMS Pub. 100-02, Transmittal 88, CR 5921

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

**PROVIDER AUDIT ISSUES**

**IMPLEMENTATION OF THE 2007-2008 UPDATE TO THE MEDICARE WAGE INDEX OCCUPATIONAL MIX SURVEY (FORM CMS-10079 [2008])**

**Effective Date: June 9, 2008**

**Implementation Date: June 9, 2008**

**BACKGROUND**

Section 304 (c) of Public Law 106-554 amended Section 1886(d)(3)(E) of the Act requiring the Centers for Medicare & Medicare Services (CMS) to collect data at least every three years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, beginning October 1, 2004.

CMS collects data for the occupational mix adjustment on the Medicare Wage Index Occupational Mix Survey, Form CMS-10079. Data from the 2006 update (change request 3043) were used to calculate the fiscal years (FYs) 2007, 2008, and 2009-wage index. In order to comply with the statutory requirement, CMS is administering a new survey, the 2007-2008 update, to be used in computing the wage index beginning with FY 2010.

On February 2, 2007, CMS published a notice of intent with comment regarding a new occupational mix survey (72 FR 5055). This new survey is the 2007-2008 Medicare Occupational Mix Survey – [Form CMS-10079 \(2008\)](#). The final notice with comments was published on September 14, 2007, (72 FR 52568).

The 2007-2008 survey provides for the collection of hospital-specific wages and hours data for a one-year prospective reporting period (that is, from July 1, 2007 through June 30, 2008), additional clarifications to the survey instructions, the elimination of the RN subcategories, some refinements to the definitions for the occupational categories, and the inclusion of additional cost centers that typically provide nursing services. The survey and supporting documentation may be accessed through CMS Web site at: <http://www.cms.hhs.gov/PaperWorkReductionActof1995>.

The Office of Management and Budget approved the survey on February 1, 2008 (OMB Control Number: 0938-0907).

Source: CMS Pub. 100-20, Transmittal 339, CR 5992

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

**EDUCATIONAL EVENTS**

**UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS**

**MAY 2008 – SEPTEMBER 2008**

**Ask the Contractor – Topics: Overview of New Medicare Competitive Bidding Program for DMEPOS**

When: Tuesday, June 10, 2008  
Time: 11:00 a.m. – 1:00 p.m. Eastern Standard Time

Type of Event: Teleconference

**Hot Topics – Medicare Updates**

When: Tuesday, July 15, 2008  
Time: 11:30 a.m. – 12:30 p.m. Eastern Standard Time

Type of Event: Teleconference

**Hot Topics – Medicare Updates**

When: Tuesday, September 9, 2008  
Time: 11:30 a.m. – 12:30 p.m. Eastern Standard Time

Type of Event: Teleconference

**TWO EASY WAYS TO REGISTER**

**ONLINE** – Log on to your account on our provider training Web site at [www.fcsomedicaretraining.com](http://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](http://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](http://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](http://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 [fsohelp@geolearning.com](mailto:fsohelp@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

### MAY IS NATIONAL OSTEOPOROSIS AWARENESS AND PREVENTION MONTH

In conjunction with the National Osteoporosis Awareness and Prevention Month, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of bone mass measurements for beneficiaries at clinical risk for osteoporosis.

Osteoporosis, or porous bone, is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased risk of fractures of the hip, spine, and wrist. Both men and women are affected by osteoporosis. One out of every two women and one in four men over 50 will have an osteoporosis-related fracture in their lifetime. The good news is that osteoporosis is a disease that can be prevented and treated. Medicare's bone mass measurement benefit can aid in the early detection of osteoporosis before fractures occur, provide a precursor to future fractures, and determine rate of bone loss.

As a health care professional, you play a crucial role in helping your patients maintain strong, healthy bones throughout their life. CMS needs your help to ensure that all eligible Medicare beneficiaries take full advantage of the bone mass measurement benefit. Please join with CMS in spreading the word about prevention and early detection of osteoporosis and the bone mass measurement benefit covered by Medicare.

#### HOW CAN I HELP?

National Osteoporosis Awareness and Prevention Month provides an excellent opportunity for health care professionals to help increase awareness, knowledge and understanding of prevention, early detection, and treatment of osteoporosis as well as strategies for managing the disease. You can help in a number of ways:

- 1) Stay abreast of the latest clinical guide lines for prevention, diagnosis, and treatment
- 2) Become familiar with Medicare's coverage of bone mass measurements
- 3) Talk with your patients about their risks factors for osteoporosis, prevention measures they can take to reduce their risk factors, and the importance of utilizing bone mass measurements
- 4) Encourage eligible Medicare patients to take full advantage of Medicare's bone mass measurement benefit.

Together we can help Medicare beneficiaries reduce bone fractures and maintain strong healthy bones.

#### FOR MORE INFORMATION

- For more information about Medicare's coverage of bone mass measurements, please visit the CMS Web site at <http://www.cms.hhs.gov/BoneMassMeasurement/>.
- The *Medicare Learning Network (MLN) Bone Mass Measurements Brochure* – this tri-fold brochure provides fee-for-services health care professionals and their staff with an overview of Medicare's coverage of bone mass measurements and it is available at [http://www.cms.hhs.gov/MLNProducts/downloads/Bone\\_Mass.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Bone_Mass.pdf).

To learn more about National Osteoporosis Awareness and Prevention Month, please visit The National Osteoporosis Foundation Web site at <http://www.nof.org/>. ❖

**“Osteoporosis – It’s Beatable. It’s Treatable.”**

Thank you for your support.

Source: CMS Provider Education Resource Message 200805-02

*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.*



### OTHER EDUCATIONAL RESOURCES

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#### MEDICARE GUIDE TO RURAL HEALTH SERVICES INFORMATION

The April 2008 version of the *Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians*, which contains rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.pdf>. ❖

Source: CMS Provider Education Resource Message 200805-14

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#### CLINICAL LABORATORY FEE SCHEDULE FACT SHEET NOW AVAILABLE

The *Clinical Laboratory Fee Schedule Fact Sheet*, which provides general information about the clinical laboratory fee schedule, coverage of clinical laboratory services, and how payment rates are set, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network.

To place your order, visit <http://www.cms.hhs.gov/mlngeninfo/>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.” ❖

Source: CMS Provider Education Resource Message 200805-05

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#### UPDATED MLN QUICK REFERENCE INFORMATION CHARTS

The following Medicare Learning Network (MLN) products have been updated and are now available to download from the CMS Web site or may be ordered, free of charge, from the MLN Product Ordering Page, at [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5).

- **The Quick Reference Information: Medicare Preventive Services Chart** – This two-sided laminated reference chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare’s preventive services and screenings. (Feb. 2008) [http://www.cms.hhs.gov/MLNProducts/downloads/MPS\\_QuickReferenceChart\\_1.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf).
- **The Quick Reference Information: Medicare Part B Immunization Billing Chart** – This two-sided laminated reference chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines, and their administration. (Feb. 2008) [http://www.cms.hhs.gov/MLNProducts/downloads/qr\\_immun\\_bill.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf). ❖

Source: CMS Provider Education Resource Message 200804-21

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## 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 Government Benefit Administrators – Gulf Coast  
34650 US Highway 19 North,  
Suite 202  
Palm Harbour, FL 34684-2156

### **RAILROAD MEDICARE**

#### **Railroad Retiree Medical Claims**

Palmetto Government 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 Government 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](http://www.floridamedicare.com)

#### **Centers for Medicare & Medicaid Services**

[www.cms.hhs.gov](http://www.cms.hhs.gov)

### **BENEFICIARIES**

#### **Centers for Medicare & Medicaid Services**

[www.medicare.gov](http://www.medicare.gov)



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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***MEDICARE A BULLETIN***

*First Coast Service Options, Inc ♦ P.O. Box 2078 ♦ Jacksonville, FL 32231-0048*

**♦ ATTENTION BILLING MANAGER ♦**

