MEDICARE A Bulletin

A NEWSLETTER FOR FLORIDA MEDICARE PART A PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

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

Routing Suggestions :

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

Table of Contents

Medicare A Bulletin

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February 2008

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

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

Medicare Publications
1-904-361-0723

A Message to Providers

2008 Medifest Symposium—Mark Your Calendars

May 6 – 7, 2008 in Orlando

Have you heard the news? Our popular 2008 Medifest Symposium is coming to Florida providers on May 6 – 7 in Orlando, FL. This popular educational seminar brings together Medicare experts, providers, billing staff, coders, and suppliers throughout Florida to learn the latest on the Medicare program and to network with their peers.

Our Provider Outreach and Education team is working hard to make this the most rewarding and convenient Medifest ever.

What's New This Year

We are excited to announce new enhancements to this year's Medifest:

Two 1-Day Events

To better accommodate your busy schedule, we will offer Medifest as two one-day sessions, conducting general classes in the morning and specialty courses in the afternoon. Come for one day or stay for two, there will still be a diversity of classes for you to choose.

Panel Discussions

This new event is the direct result of your feedback. During this three-hour session, you will have the opportunity to discuss the latest issues with a panel of representatives from FCSO leadership, as well as to network with your peers.

More Advanced Classes

Based on your recommendations, we will conduct all courses at a more advanced level this year. To ensure everyone benefits from this new curriculum, participants must complete one Web-based training (WBT) course prior to registering for each class. These pre-requisite WBTs will be made available in February 2008 through our Learning Management System.

Medifest Classes

Our classes are based on the latest hot topics and data analysis trends.

The **morning** session offers a menu of general Medicare courses on:

- Reimbursement Efficiency – Part A/B
- Provider Self-Service Techniques – Part A/B
- Evaluation and Management Coding – Part B
- Florida Hospital Association (FHA) – Part A
- Fraud and Abuse – Part A /B
- Medical Review/Data Analysis – Part A/B

The **afternoon** session focuses on specialty classes and panel discussions:

- Evaluation and Management Documentation – Part A/B
- Rehabilitation – Part A/B
- Skilled Nursing Facility (SNF) – Part A
- Independent Diagnostic Testing Facility – Part B
- Panel Discussion – Part A/B

Don't Forget to Mark Your Calendars

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

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

What: 2008 Medifest Symposium

When: May 6 & 7, 2008

Where: Marriott Orlando Downtown
400 West Livingston Street, Orlando, FL 32801
(407) 843-6664 or (800) 574-3160
http://www.marriott.com/default.mi

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

Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)

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 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 or supplied to Medicare beneficiaries.

What You Need to Know

Change request (CR) 5836, from which this article is taken, modifies the Reconsideration Request Form that is included with the model Medicare redetermination notice (for partly or fully unfavorable redeterminations), to clarify the minimum set of elements on the form that you must complete in order for the request to be considered valid for reconsideration.

You should make sure that your billing staffs are aware that they must complete items 1, 2a, 6, 7, 11 & 12 on this Reconsideration Request Form.

Background

The Reconsideration Request Form modification that CR 5836 requires is necessary because the current Medicare manual instructions do not clearly identify all of the elements required for a reconsideration request to be considered valid in accordance with Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) Section 405.964(b).

The modification to the form is as follows: **"**Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, 11 & 12 but to help us serve you better, please include a copy of the redetermination notice with your request."

Those elements that, as a minimum, you must complete in the form are:

1. Name of beneficiary

2a. Medicare number

6. Item or service you wish to appeal

7. Date of the service (From and To dates)

11. Name of person appealing

12. Signature of person appealing/date

Additional Information

You may find more information about the modification to the model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations) by going to CR 5836, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1408CP.pdf*.

The updated *Medicare Claims Processing Manual*, Chapter 29, section 320.7 (Medicare Redetermination Notice [for partly or fully unfavorable redeterminations]) is an attachment to that CR. The Reconsideration Request form is also attached to CR 5836.

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

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

MLN Matters Number: MM5836
Related Change Request (CR) Number: 5836
Related CR Release Date: January 11, 2008
Related CR Transmittal Number: R1408CP
Effective Date: January 1, 2008
Implementation Date: February 11, 2008

Source: CMS Pub. 100-04, Transmittal 1408, CR 5836

Information Regarding the New 2008 Medicare Physician Fee Schedule

Note: This article informs Medicare Part A providers of the final legislative change affecting the 2008 Medicare physician fee schedule. Other notification in this article is informational only and no action is required from Medicare Part A providers.

In previous messages, the Centers for Medicare & Medicaid Services (CMS) indicated that the Medicare, Medicaid and SCHIP Extension Act of 2007 replaced the scheduled 10.1 percent reduction in the Medicare physician fee schedule (MPFS) conversion factor with a 0.5 percent increase for dates of service beginning January 1, 2008, through June 30, 2008. CMS has received a number of inquiries asking whether physicians need to take any special action to get paid at the rates required by the statute.

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

We are also taking this opportunity to reiterate two points made in earlier messages:

1. The new fees have been posted on your local contractor's Web site by January 11, 2008. The "Medicare Physician Fee Schedule Look-Up" link on the CMS Web site, which allows you to customize your search, was updated with the new 2008 fees during the week of January 21, 2008. However, the carrier specific public use files are available now on the CMS Web site for the new 2008 MPFS rates at the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/PFSCSF/list.asp#TopOfPage*.
2. CMS extended the participation decision period an additional 45 days. The participation decision period now runs through February 15, 2008, instead of ending on December 31, 2007. All participating status changes will be effective January 1, 2008. Contractors will accept and process any participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before February 15, 2008.

To become a participating physician, complete the CMS-460 form, which may be found on the CD that was mailed to physicians in November. The form is also available on the CMS Web site at *http://www.cms.hhs.gov/cmsforms/downloads/cms460.pdf*.

The CMS-460 form must be post-marked by February 15, 2008, and sent to the following address:

Provider Enrollment
P O Box 44021
Jacksonville, FL 32231-4021

Also, if changing your participation status to nonparticipation, please send your request in a letter to the above address, post-marked by February 15, 2008.

Contractors will not automatically make adjustments for providers who change their participation status after January 1, 2008 (you should begin billing claims according to the participation decision that you have made). However, they will adjust claims based on participation status changes that you bring to their attention.

An official CMS change request and an *MLN Matters* article will be forthcoming. ❖

Source: CMS Provider Education Resource 200801-11
CMS Pub. 100-20, Transmittal 312, CR 5944

January 2008 Quarterly Average Sales Price Medicare Part B Drug Pricing Files and Revisions to Previous Pricing Files

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, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

What You Need to Know

Change request (CR) 5852, from which this article is taken, instructs Medicare contractors to download and implement the January 2008 average sales price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised January 2007, April 2007, July 2007, October 2007, April 2006, July 2006, and October 2006 files.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the outpatient prospective payment system (OPPS), are paid based on the ASP methodology.

January 2008 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Previous Pricing Files (continued)

The ASP methodology is based on quarterly data that drug manufacturers submit to CMS, which CMS then provides (quarterly) to Medicare contractors (carriers, *DME* MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms "single source drug," "multiple source drug," and "biological product" have been operationalized in the context of payment under section 1847A.

For the purpose of identifying "single source drugs" and "biological products" subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

1. The Food and Drug Administration (FDA) approval
2. Therapeutic equivalents as determined by the FDA
3. The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are **not** two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of "not otherwise classified, (NOC)" HCPCS codes.

ASP Methodology

In general, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on the ASP methodology for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities)
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS.

Summary of Exceptions to this General Rule

1. Except for blood clotting factors, the payment allowance limits for **blood and blood products** (that are not paid on a prospective payment basis) are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia; and will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.

   Note: For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for a new blood clotting factor when a new blood clotting factor is not included on the ASP file. For 2008, a separate fee of $0.158 per I.U. of blood clotting factor furnished is payable when separate payment for the blood-clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

2. Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment (DME)** on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or incident to a professional service. **The payment allowance limits will not be updated in 2008.**
   Similarly, payment allowance limits for **infusion drugs furnished through a covered item of DME** that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or furnished incident to a professional service.

3. The payment allowance limits for **influenza, pneumococcal and hepatitis B vaccines** are 95 percent of the AWP as reflected in the published compendia except, when administered in a hospital outpatient department, the vaccines are paid at reasonable cost.

4. Except for new drugs and biologicals that are produced, or distributed, under a new drug application (or other application) approved by the Food and Drug Administration (FDA), the payment allowance limits for **drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File**, are based on the published wholesale acquisition cost (WAC) or invoice pricing (except under OPPS in which the payment allowance limit is 95 percent of the published AWP).
   In determining the payment limit based on WAC, contractors will follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP but will substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC.

January 2008 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Previous Pricing Files (continued)

5. The payment allowance limits for **new drugs and biologicals** that were first sold on or after January 1, 2005; and are: 1) Produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration, and 2) Not included in the ASP Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file; are based on 106 percent of the WAC (or invoice pricing if the WAC is not published) except under OPPS in which the payment allowance limit is 95 percent of the published AWP.
6. The payment allowance limits for **radiopharmaceuticals** are not subject to the ASP payment methodology. Contractors should determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.
7. The payment methodology for **drugs furnished incident to the filling or refilling of an implantable pump or reservoir** is determined under the ASP methodology (as described above) unless the drug furnished incident to the filling or refilling of an implantable pump or reservoir is a compounded drug, then pricing is performed by the local contractor.
   Physicians (or a practitioner described in Section 1842(b) (18) (C)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary that they perform the service. Contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.
   If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is:
   - Accepted as a safe and effective treatment of the patient's illness or injury,
   - There is a medical reason that the medication cannot be taken orally.
   - The skills of the nurse are needed to infuse the medication safely and effectively.

On or after December 18, 2007, the January 2008 ASP file and ASP NOC files will be available for retrieval from the CMS ASP Web page. If CMS determines that revisions to the January 2007, April 2007, July 2007, October 2007, April 2006, July 2006 and October 2006 ASP payment files are necessary, the revised files will also be available for retrieval from the CMS webpage on or after December 18, 2007. The revised payment files will be applied to claims processed or reprocessed on or after this CR (5852) effective date.

Table 1 below displays the payment allowance limit revision dates, and the applicable dates of service.

Payment Allowance Limit Revision Date	Applicable Dates of Service
January 2008	January 1, 2008 through March 31, 2008
Revised January 2007*	January 1, 2007 through March 31, 2007
Revised April 2007*	April 1, 2007 through June 30, 2007;
Revised July 2007*	July 1, 2007 through September 30, 2007
Revised October 2007*	October 1, 2007 through December 31, 2007
Revised April 2006*	April 1, 2006 through June 30, 2006;
Revised July 2006*	July 1, 2006 through September 30, 2006
Revised October 2006*	October 1, 2006 through December 31, 2006

*If made available by CMS

Note: The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

Final Notes: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Contractors (at their discretion) may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files, or that CMS has not otherwise made available on its Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

Contractors will not search for, and adjust, a claim that has already been processed unless you bring it to their attention.

Implementation

The implementation date is January 7, 2008.

January 2008 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Previous Pricing Files (continued)

Additional Information

For complete details, please see the official instruction (CR 5852) issued to your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change, by visiting the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1406CP.pdf*.

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

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

MLN Matters Number: MM5852
Related Change Request (CR) Number: 5852
Related CR Release Date: January 8, 2008
Related CR Transmittal Number: R1406CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1406, CR 5852

Medicare Health and Part D Plan Enrollees Expected Smooth Transition to 2008

Medicare beneficiaries who have chosen to change their health and drug coverage for 2008 should experience very few difficulties when getting their covered prescription drugs through Medicare Part D, the Centers for Medicare & Medicaid Services (CMS) has announced.

"A top priority throughout the fall open enrollment season has been to help beneficiaries prepare and compare their plan choices so that they could make informed decisions about switching plans. In addition, we've been working hard to ensure a smooth enrollment process," said CMS Acting Administrator Kerry Weems.

CMS has taken multiple steps to ensure that pharmacies can obtain accurate enrollment information in 2008, particularly for low-income beneficiaries. CMS has improved procedures for getting accurate plan information into the E1 eligibility system, which is the computer system that pharmacists use to identify current plan enrollment, often for beneficiaries who were reassigned to new plans, or who may not have received their new drug card. CMS has also implemented better processing requirements for all enrollees, and CMS continues support a point-of-sale facilitated enrollment process that provides immediate coverage for people with Medicare who have Medicaid or have qualified for extra help, but aren't enrolled in a Medicare drug plan.

CMS also has worked aggressively to ensure a smooth transition for low-income subsidy (LIS) eligible beneficiaries who would be responsible for paying a portion of their plan premium in 2008. Earlier this fall, these beneficiaries received letters explaining steps they could take to remain in their plan by paying a small premium and a list of all the zero premium plans available in their community.

Blue reassignment letters were mailed to people who qualify for the full extra help and who will be reassigned to a new plan in 2008. Tan letters were sent to beneficiaries receiving the LIS who selected a plan, but who will be responsible for paying a portion of their plan premium beginning in January 2008 unless they join a new plan. Beneficiaries who received one of these letters can receive personalized assistance at their local State Health Insurance Assistance Program (SHIP) office or their local Social Security office.

While CMS does not expect beneficiaries to encounter difficulties at the pharmacy counter due to the collaborative work among beneficiaries, partners and advocates, pharmacies, and plans, nevertheless, those beneficiaries who have newly enrolled or changed plans should keep these four tips in mind when visiting the pharmacy:

1. Bring the red, white, and blue Medicare card, a photo ID, and the new drug plan membership card – these items will help the pharmacist in verifying coverage.
2. Bring an enrollment acknowledgement, confirmation letter, or the name of the new drug plan if the beneficiary has not received a plan membership card – the enrollment search might take longer, but these items will assist the pharmacist in verifying the coverage.
3. Keep copies of the receipts – in the rare instance where the pharmacist cannot confirm enrollment, the beneficiary can work with the new plan prospectively to obtain reimbursement.
4. Don't leave the pharmacy counter without the medicine – if the beneficiary cannot pay out of pocket, call 1-800 MEDICARE for assistance or ask the pharmacist to dial the special hotline for these cases.

In addition, CMS and others have taken the following measures to smooth beneficiaries' transition into 2008:

Online Enrollment and Toll-Free Assistance: Since November 15, 2007, Medicare's online enrollment center has processed more than 347,000 enrollments.

Medicare Health and Part D Plan Enrollees Expected Smooth Transition to 2008 (continued)

In the same period, its Web site has recorded over 36 million page views on *www.medicare.gov* and over 19 million page views of the Medicare Prescription Drug Plan Finder.

Since November 15, 2007, 1-800-MEDICARE has received more than three million calls and more than 3,000 customer service representatives are ready to answer questions about enrollment status. The Medicare ombudsman's office has senior casework analysts available to resolve problems for beneficiaries who need individualized assistance because of a critical health need or financial circumstance.

At the Pharmacy: National and local chains and independent pharmacies have worked closely with beneficiaries to provide information and assistance during the open enrollment period.
Thousands of pharmacies have helped beneficiaries through in-store informational days, medication reviews, and community presentations. For example, Rotz Pharmacy, an independent pharmacy in Winchester, Va., provides a navigation guide to the www.medicare.gov Medicare Drug Plan Finder, other comparison tools as well as personalized consultation to beneficiaries who need help in finding a plan that best suits their needs. In-person counseling and other enrollment assistance has been provided nationwide and regionally by many chains, including: CVS; Kroger; Longs Pharmacy; Medicine Shoppe International; Rite-Aid; Target; Stop & Shop, Giant Foods and Giant Food Stores; Walgreens; and Wal-Mart.

In-person: At more than 10,000 events held nationwide, Medicare has worked closely with its partner organizations, including the National Aging Services network of state, local and community service providers, to provide enrollment counseling and sign-up opportunities where people with Medicare live, work, play and pray.

The 2007 CMS Mobile Office Tour visited 128 communities across the nation sharing information about Part D with beneficiaries. That tour highlights the personalized assistance provided by the many thousands of partners across the country who are helping beneficiaries compare their drug plan options and change enrollment if necessary.

Through the Secret Shopper initiative, CMS officials have attended over 220 events to ensure that health plans are adhering to marketing and enrollment guidelines.

Recent surveys show that a large majority of seniors enrolled in the Medicare drug benefit are satisfied with their plan and few intend to change their plan in 2008. A Wall St. Journal /Harris Interactive survey of U.S. adults age 65 or older shows that 87 percent of Medicare drug benefit enrollees are satisfied with their plan. "Our educational efforts are paying off and we will continue to provide information and assistance throughout 2008," said Weems.

The annual open enrollment period for prescription drug coverage began on November 15, 2008, and runs through December 31, 2007. For Medicare Advantage plans only, beneficiaries can make one change in enrollment – enrolling in a new plan, changing plans or canceling a plan – between January 1, 2008, and March 31, 2008. However, beneficiaries cannot join or drop Medicare drug coverage during this time.

Beneficiaries eligible for the LIS have the ability to change plans at any time. They can continue to visit *www.medicare.gov* and view all the health and prescription plans available in their area. Users can compare plans based on costs, coverage, customer service and quality of each plan. They can also receive the same online information by calling 1-800-MEDICARE.

For more information on where to find a SHIP counselor available to provide free one-on-one help with your Medicare questions or problems, visit *www.medicare.gov/contacts/static/allStateContacts.asp*. ❖

Source: CMS Provider Education Resource 200801-07

Use of an Eight-Digit Registry Number on Clinical Trial Claims

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], Medicare administrative contractors (A/B MACs) and durable medical equipment Medicare administrative contractors [DME MACs]) for services provided to Medicare beneficiaries in clinical research studies.

Provider Action Needed

This article is based on change request (CR) 5790 that notifies providers and suppliers that Medicare claims forms will be modified to accommodate the eight-digit clinical trial number for claims that Medicare receives on or after April 1, 2008. Reporting this number is voluntary and claims submitted without the clinical trial number will be paid the same as claims containing a number. While reporting is voluntary, the number will assist the Centers for Medicare & Medicaid Services (CMS) in informing beneficiaries about the availability of clinical trials and to use claims information to inform coverage decisions. Be sure your billing staff is aware of this rule.

Background

The purpose of CR 5790 is to instruct providers and suppliers on new, voluntary reporting for placing a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the *Medicare National Coverage Determination* manual, publication 100-03, section 310.1. That publication is available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Use of an Eight-Digit Registry Number on Clinical Trail Claims (continued)

The clinical trial number that the CMS is requesting to be voluntarily reported is the number assigned by the National Library of Medicine (NLM) Clinical Trial Data Bank when a new study is registered by a sponsor or investigator. Information regarding NLM clinical trials is available on the Internet at *http://clinicaltrials.gov/*.

CMS will use this number to identify all items and services provided to beneficiaries during their participation in a clinical trial. Furthermore, this identifier will permit CMS to meet the recommendations of the 2000 Institute of Medicine report that led to the Executive Memorandum to increase participation of Medicare beneficiaries in clinical trials and the development and implementation of the CMS clinical trials policy.

Recommendations from The White House Executive Memorandum included:

- Tracking Medicare payments.
- Ensuring that the information gained from the research is used to inform coverage decisions.
- Making certain that the research focuses on issues of importance to the Medicare population.
- Enabling CMS to better inform Medicare beneficiaries about the clinical studies available for their participation.

Key Points

- Claims submitted without the clinical trial number will be paid the same as claims containing a number.
- Institutional clinical trial claims are identified through the presence of **all** of the following elements:
  - Value code D4 and corresponding eight-digit clinical trial number (when present on the claim).
  - ICD-9 diagnosis code V70.7.
  - Condition code 30.
  - HCPCS modifier Q1: outpatient claims only. (See MM5805 related to CR 5805 for more information regarding modifier Q1.)
- Practitioner/DME clinical trial claims are identified through the presence of **all** of the following elements:
  - ICD-9 diagnosis code V70.7
  - HCPCS modifier Q1
  - Eight-digit clinical trial number (when present on the claim).
- On institutional claims, the 8-digit numeric clinical trial number should be placed in the value amount of value code D4 on the paper claim UB-40 (form locators 39-41) or in Loop 2300, HI – Value Information segment, qualifier BE on the 837I.
- On professional claims, the clinical trial registry number should be preceded by the two alpha characters of "CT" and placed in Field 19 of the paper Form CMS-1500 or it should be entered WITHOUT the "CT" prefix in the electronic 837P in Loop 2300 REF02(REF01=P4).

Additional Information

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

You may see the official instruction (CR 5790) issued to your Medicare A/B MAC, FI, DME/MAC, or carrier by going to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R310OTN.pdf*.

You may see the article related to the Q1 modifier, MM5805, on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5805.pdf*.

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

MLN Matters Number: MM5790
Related Change Request (CR) Number: 5790
Related CR Release Date: January 18, 2008
Related CR Transmittal Number: R310OTN
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-20, Transmittal 310, CR 5790

New Healthcare Common Procedure Coding System Modifiers when Billing for Patient Care in Clinical Research Studies

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], Medicare administrative contractors (A/B MACs) and durable medical equipment Medicare administrative contractors [DME MACs]) for services provided to Medicare beneficiaries in clinical research studies.

What Providers Need to Know

This article is based on change request (CR) 5805. The Centers for Medicare & Medicaid Services (CMS) is discontinuing HCPCS modifiers QA (FDA Investigational Device Exemption), QR (Item or Service Provided in a Medicare Specified Study), and QV (Item or Service Provided as Routine Care in a Medicare Qualifying Clinical Trial) as of December 31, 2007, and creating two new modifiers that will be used solely to differentiate between routine and investigational clinical services.

These new modifiers will be included in the 2008 Annual HCPCS Update and are effective for dates of service on and after January 1, 2008:

Q0 Investigational clinical service provided in a clinical research study that is in an approved clinical research study. Q0 replaces QA and QR.

Q1 Routine clinical service provided in a clinical research study that is in an approved clinical research study. Q1 replaces QV.

Use these two new modifiers as follows:

- Investigational clinical services are defined as those items and services that are being investigated as an objective within the study. Investigational clinical services may include items or services that are approved, unapproved, or otherwise covered (or not covered) under Medicare.
- Routine clinical services are defined as those items and services that are covered for Medicare beneficiaries outside of the clinical research study; are used for the direct patient management within the study; and, do not meet the definition of investigational clinical services. Routine clinical services may include items or services required solely for the provision of the investigational clinical services (e.g., administration of a chemotherapeutic agent), clinically appropriate monitoring, whether or not required by the investigational clinical service (e.g., blood tests to measure tumor markers), and items or services required for the prevention, diagnosis, or treatment of research related adverse events (e.g., blood levels of various parameters to measure kidney function).

Medicare contractors will not search their files to adjust affected claims processed prior to implementation of this change, but they will adjust such claims that you bring to their attention.

Note: If a category A or B investigational device is used on the clinical trial, providers should continue to include the investigational device exemption (IDE) in item 23 of the CMS-1500 claim form or the electronic equivalent. Also, your Medicare contractor will validate the IDE number when it appears on the claim with modifier Q0 and if the IDE number does not meet validation criteria, the claim will be returned as unprocessable.

Additional Information

You may see the official instruction (CR 5805) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1418CP.pdf*.

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

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

MLN Matters Number: MM5805
Related Change Request (CR) Number: 5805
Related CR Release Date: January 18, 2008
Related CR Transmittal Number: R1418CP
Effective Date: January 1, 2008
Implementation Date: No later than April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1418, CR 5805

Individuals Authorized Access to CMS Computer Services—Provider Community

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

The Third in a Series of Articles

This article contains three steps to accessing the Centers for Medicare & Medicaid Services (CMS) enterprise provider application including how to request a provider application role in IACS-PC (see step 2).

Provider Types Affected

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

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

Provider Action Needed

CMS enterprise applications to be made available via the web soon include the Provider Enrollment, Chain and Ownership System (PECOS) and the Provider Statistical and Reimbursement Report (PS&R) System. Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider Community (IACS-PC).

What Providers Need to Know

In the near future, the CMS will be formally announcing new online enterprise applications that will allow Medicare fee-for-service (FFS) providers to access, update, and submit information over the Internet.

CMS enterprise applications are those hosted and managed by CMS and for the most part do not include Internet applications offered by FI/carrier/MAC. Details of these provider applications will be announced as they become available.

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

The second article addressed questions and gave remaining instructions for registering provider organizations including registering as a backup security official (BSO), user group administrator (UGA), and end user (EU). It also discussed approving user requests. This article may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf*.

Note: IACS – PC includes individual practitioners who will be working on their own accord and will not have any other company staff (they may have surrogates or "contractors" who are not their employees which they may contract with to work on their behalf) and also includes "Provider Organizations" defined in IACS as practices, groups, single and multi-specialty offices etc., where the provider may have additional staff in IACS and delegate IACS-PC work to staff as well as their staff using IACS-PC.

The Three Steps to Access a CMS Enterprise Application

Provider IACS-PC users must take three steps to access a CMS enterprise application:

Step 1: Be Approved for an IACS-PC Role.

The first two *MLN Matters Articles* in this series discussed how to register in IACS-PC.

The purpose of the IACS-PC registration process is to:

- Confirm the identity of the person requesting registration.
- Assure registrants have a legitimate business need to access CMS provider systems.
- Provide the registrant an IACS-PC role (e.g., SO, BSO, UGA, or end user) that defines their responsibilities (if any) for approving the registration requests of others in their organization.
- Provide the registrant a user ID and password for IACS-PC.

Step 2: Be Approved for an Application Role.

After receiving approval for an IACS-PC role, a registered user in a provider organization may then request to be an "Application Approver" or an "End User." (Note: Because individual practitioners do work in the application themselves, they do not designate "Application Approver" roles).

This role determines:

- Their responsibilities (if any) to approve application access requests from others in their organization.
- What CMS enterprise applications (if any) they have a legitimate need to access.
- The appropriate level of access to each application for their job function (which application "role" they require).

Users who received approval in IACS-PC in Step 1, may now request access to specific CMS enterprise applications using their IACS-PC account.

This can be done by requesting either an "Application Approver" or an application "User" role for each application needed to perform Medicare related job functions. For provider applications, there are specific roles within the application that define what the user can do. For example,

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

some application users may be limited to viewing information and printing reports, while others can enter, edit and submit information to CMS. These roles will be specific to each application.

Each user must request a specific application role in IACS-PC for each CMS enterprise provider application they wish to use.

The "Request Access to CMS Application Quick Reference Guide" provides instructions for requesting an application role. It may be found on the CMS website at *http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Request_Access_to_CMS_Application_QRG_111607.pdf*.

Application Approvers

Organizations must have designated persons that approve each end user's request for an application role. The person who performs this task is an "application approver" and as such cannot personally access applications for which they serve in this role.

Though the UGA may frequently be the appropriate persons to have this role, organizations have discretion in how they designate the application approvers so that it is appropriate for their particular organization. For example, the UGA may be designated by the SO or BSO to serve in this role for their user group, or an end user may be approved for this role by the SO or BSO for the user group with which they are associated.

Note: If a user group does not have an application approver for an application, the requests will, by default, be routed to the SO and BSO for a decision.

Application Approver Key Points

- An application approver must be a member of the user group(s) for which they serve as an application approver (this does not apply if the SOs/BSOs is the application approver).
- Providers have flexibility in assigning the application approver role.
- The UGA does not have to be the application approver within the user group.
- An end user within a user group may serve in the role of the application approver.
- A different person may serve as an application approver in a user group for each application.
- The same person can be the application approver for multiple applications in a user group.
- The same person can be the application approver for multiple user groups (though they must be a member of each group).
- There may be multiple application approvers for the same application within the same user group. In this situation, the first approver who approves or denies the request will serve as the decision authority. All of the application approvers within the user group do not need to act on each request.
- A person can be an application approver for one application, and an application user for a different application, just not for the same one.
- If an application approver does not exist for an application in a user group, the user group requests for that application will go to the SO and BSO for a decision.
- Organizations with a large number of IACS-PC users are encouraged to have application approvers in each user group for each application (may be the same person) so that all of the application requests are not routed to the SO and BSO as the default application approvers.

Note: System security requires a "separation of duties" – which means that those who approve user requests for CMS enterprise application roles will not have access to the applications for which they have an approver role. Therefore those in Application Approver roles will not have access to the application for which they are an approver. Security Officials and Backup Security Officials, by definition, can never access any applications as they serve as the default Application Approvers as noted above.

Instructions for approving application approver and application user role requests are the same as for approving IACS-PC registration requests. The *Approver Quick Reference Guide* may be found on the CMS Web site at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_approver_qrg_12_07_07.pdf*.

Step 3: Enter the application when it becomes available.

You will be notified as CMS enterprise applications become available. After you have been approved in steps 1 and 2, you will be able to access available CMS enterprise applications using your approved application specific roles via the CMS Web site.

Additional CMS Partner and Customer Communities will use IACS

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

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

Additional Help

CMS has established the end user services (EUS) help desk to support access to IACS-PC. The EUS help desk may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

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

Coming Soon

- CMS enterprise applications to be made available via the Web include the Provider Enrollment, Chain and Ownership System (PECOS) and the Provider Statistical and Reimbursement Report (PS&R).
- IACS Website.
- Instructions for modifying your user profile.
- What to do if you forget your user ID or password
- Tools for SOs, BSOs and UGAs to manage user accounts.

MLN Matters Number: SE0754
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0754

Notice of Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the current value of funds rate (five percent for calendar year 2008) or the private consumer rate (PCR) as fixed by the Department of the Treasury.

The Department of the Treasury has notified the Department of Health & Human Services that the PCR has been changed to 12.125 percent, effective January 18, 2008. The PCR will remain in effect until a new rate change is published.

Source: CMS Pub. 100-06, Transmittal 134, CR 5753

Individuals Authorized Access to CMS Computer Services—Provider Community

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

Note: CMS has revised this special edition *MLN Matters* article on January 15, 2008, to add another question and answer to emphasize that potential users should only register once in IACS. The *MLN Matters* article SE0753 was published in the January 2008 *Medicare A Bulletin* (pages 15-17).

The Second in a Series of Articles

This article contains:

- Four questions and answers about the registration process for provider organizations. (See Note below.)
- Links to the Quick Reference Guides available for completing the registration process for provider organizations. (See Note below.)

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

Provider Types Affected

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

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

Provider Action Needed

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

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

What Providers Need to Know

In the near future, CMS will be announcing new online enterprise applications that will allow Medicare FFS providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

Registering in IACS-PC

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

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

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

Four Questions and Answers about the Provider Organization Registration Process

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

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

2. I want to register as an SO. I do not have my organization's IRS CP-575. What else can I send?

In addition to the CP-575, SOs may also submit copies of other official Internal Revenue Service (IRS) documentation. An official IRS document should have the following information:

Required:

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

Optional:

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

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

- Copy of IRS CP-575
- Copy of IRS 147C letter; or
- Copy of federal tax deposit coupon.

All documents received must be legible.

3. I will work for more than one provider, or serve in multiple roles in the same organization. Do I need to register in IACS separately for each organization or role?

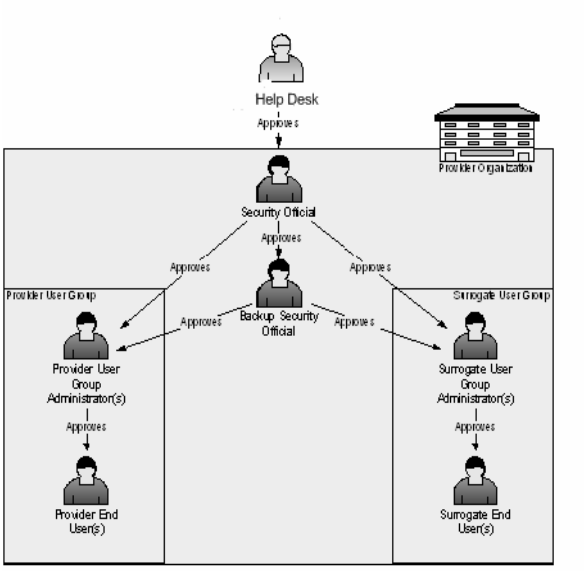
No. Each user will receive only one IACS-PC user ID and password. If you will work for more than one provider, or have multiple roles in the same provider, register in IACS for one role. Once you receive approval and your user ID and password, you can add additional roles to your account. Instructions for modifying your IACS profile will be released shortly. In the meantime, questions may be directed to the help desk as shown in the "Additional Help "section at the end of this article.

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

As few as two staff can be registered in IACS-PC for a provider organization to access CMS enterprise applications. The first person must register as a security official (SO), the second registers as a user group administrator (UGA). The UGA may access CMS applications as approved by the SO.
The backup security official is an optional role. End users are only required for provider organizations with 10 or more IACS-PC users.
If you are an individual practitioner who will be using IACS-PC personally, please refer to the first *MLN Matters* article, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

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

Quick Reference Guides for Completing the Provider Organization Registration Process



IACS-PC Registration Approval Process

1. Backup Security Official Guide

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

2. User Group Administrator Guide

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

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

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

Special note for UGAs of Surrogate User Groups

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

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

If the provider organization does appear in IACS-PC, each provider's SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS-PC.

In the future, CMS will explore options for simplifying this process for contractors which perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to individual practitioners within IACS.

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

3. **An End User Registration Quick Reference Guide** may be found on the CMS Web site at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_end_user_registration_qrg_12_06_07.pdf*.

4. **Approver Quick Reference Guide**

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

Next Steps in Accessing a CMS Enterprise Application

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

Additional Help

CMS has established an external user services (EUS) help desk to assist with your access to IACS-PC. The EUS help desk may be reached by E-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

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

MLN Matters Number: SE0753 – Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0753

NATIONAL PROVIDER IDENTIFIER

Compliance Date Enforcement and Clarification of Key NPI Implementation Dates

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

Industry-Wide Enforcement of the NPI Compliance Date

The compliance date for the national provider identifier (NPI) for all HIPAA covered entities except small health plans was May 23, 2007. (Small health plans have until May 23, 2008 to comply.) In guidance provided on April 2, 2007, the Centers for Medicare & Medicaid Centers (CMS) announced that, through May 23, 2008, it would not impose penalties on covered entities that deploy contingency plans to facilitate the compliance of their trading partners. **On May 24, 2008, CMS will lift its enforcement-leniency policy.** Complaints will be investigated as they are today, but penalties will be a legitimate resolution if the entity does not demonstrate compliance or corrective action. CMS will continue to employ a complaint-driven approach to enforcement. For example, if a complaint is received alleging a failure to comply with the NPI requirements, CMS will contact the entity to secure evidence of compliance and the contingency plan that had been in place. If violations are identified, enforcement actions will take place.

This notice does not prohibit covered entities from lifting contingency plans prior to May 24, 2008.

In sum, no later than May 24, 2008, all covered entities are expected to be using the NPI in a compliant manner, and all contingency plans should be lifted.

NPPES and the NPI Enumerator – Misconceptions and Facts

In conversations and correspondence with health care providers, health plans, and others within the health care industry, it is very clear that there are misconceptions concerning the National Plan and Provider Enumeration System (NPPES) and the NPI Enumerator. Below we have listed some common misconceptions and the facts that correct those misconceptions.

Misconception
NPPES sends data directly to the Medicare provider enrollment system.

Fact
NPPES **does not send** data to the Medicare provider enrollment system or to the provider enrollment system of any health plan. As explained in the NPI

Compliance Date Enforcement and Clarification of Key NPI Implementation Dates (continued)

final rule, applying for enrollment in a health plan is a completely separate process from the process of applying for an NPI.

Misconception

NPPES sends data directly to the Medicare claim system.

Fact

NPPES does not send data to the Medicare claims system or to the claim system of any health plan. Medicare extracts certain NPPES data and uses those data in its Medicare NPI crosswalk. That crosswalk is used in processing Medicare Part A and Part B claims. Other health plans are also free to use NPPES data to help process their claims.

Misconception

NPPES is part of the Medicare provider enrollment system.

Fact

Obtaining an NPI is required in order for a health care provider to enroll in Medicare; however, the NPPES does not function as a part of the Medicare provider enrollment system. Medicare requires a health care provider to have an NPI and to furnish that NPI on the Medicare provider enrollment application form (CMS-855). In addition, once a health care provider submits a CMS-855 to Medicare, Medicare compares the NPI and certain other information on the CMS-855 to certain information in that health care provider's record in NPPES. If the information being compared does not match, the health care provider must correct whichever information (NPPES or CMS-855) is incorrect in order for the enrollment process to continue.

Misconception

Obtaining an NPI guarantees payment to the health care provider by a health plan.

Fact

As explained in the NPI Final Rule, obtaining an NPI does not guarantee payment to the health care provider by Medicare or by any other health plan. NPI assignment simply establishes the uniqueness of an enumerated health care provider amongst all other enumerated health care providers. Most health plans will not pay a health care provider that is not enrolled in that health plan.

Misconception

NPPES verifies licenses and credentials that are reported by health care providers when applying for NPIs.

Fact

NPPES does not verify licenses or credentials. NPPES verifies only two things:

(1) It verifies a health care provider's social security number if the health care provider is an individual who furnished his/her SSN when applying for the NPI; and

(2) Using special software, it verifies that the health care provider's business mailing and practice location addresses are legitimate postal service addresses, but not that the health care provider is actually associated with or located at either of those addresses. Licensure and credentials must be verified by health plans as part of their enrollment processes. It is possible, under certain circumstances that the NPI Enumerator may contact health care providers who have submitted applications, updates, or deactivations to verify information that was furnished in order to properly process those actions. Health care providers are reminded that the information they send to NPPES must be true, correct, and complete, in accordance with the certification statement of the NPI Application/ Update Form (paper form and Web-based form).

Misconception

NPPES is a Medicare system.

Fact

NPPES is not a Medicare system; it belongs to no health plan. It is maintained by CMS for the health care industry in general, in accordance with the NPI final rule and as part of CMS' delegated HIPAA authority.

Health care providers who apply for NPIs are not required to furnish any information about their enrollment in any health plan. In an optional field, health care providers may report legacy identifiers that health plans have assigned to them in the past. This field, "Other Provider Identification Numbers," can capture the legacy identifiers and the issuers of those identifiers (i.e., the names of the health plans that assigned them). The information in this field is used by health plans to help them locate their enrolled providers in NPPES in order to know of their NPI assignments. For this reason, Medicare providers are urged to report their Medicare legacy identifiers in this field.

Misconception

The NPI Enumerator can update the Medicare claims and enrollment systems.

Fact

The NPI Enumerator cannot view, update, or interact with the Medicare claims or the Medicare enrollment systems, nor can it do so with any health plan's claims or enrollment systems.

Misconception

The NPI Enumerator can view and update/change the Medicare NPI crosswalk.

Fact

The NPI Enumerator cannot view or update/change the Medicare NPI crosswalk. The NPI Enumerator can assist providers with certain aspects of updating their NPPES records, and some of that information in those NPPES records could be used by Medicare in the Medicare NPI crosswalk.

Misconception

The NPI Enumerator serves Medicare providers and supports Medicare operations, not other providers or health plans.

Compliance Date Enforcement and Clarification of Key NPI Implementation Dates (continued)

Fact

The NPI Enumerator operates under contract to CMS in accordance with the NPI final rule and as part of CMS' delegated HIPAA authority. The NPI Enumerator serves the entire health care provider community for NPI purposes, not just Medicare providers. The functions of the NPI Enumerator are not specific to any health plan.

CMS has posted information that lists the specific duties and responsibilities of the NPI Enumerator in a recent *MLN Matters* article located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0751.pdf*.

An article that further clarifies the functions of NPPES and the NPI Enumerator is in development; this article will be announced once available.

Important Information for Medicare Providers

Medicare's Key Dates

There are two key dates remaining for 2008 in Medicare's NPI implementation plan. There is also some confusion as to the difference between the implementation steps for March 1st and May 23rd.

The chart below indicates the implementation steps for each date; as well a new column to help further clarify the difference between these two dates.

Date	Implementation Steps	Key Point
March 1, 2008	• Medicare FFS 837P and CMS-1500 claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to, and rendering provider fields). • You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary provider fields. • Failure to submit an NPI in the primary provider fields will result in your claim being rejected or returned as unprocessable. • Until further notice, you may continue to include legacy identifiers only for the secondary provider fields.	**Claims with only legacy identifiers in the primary provider fields will be rejected.**
May 23, 2008	• In keeping with the Contingency Guidance issued on April 2, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims and SPR remittance advice. (Note that this date is one day earlier than that mandated by the National Enforcement Policy) • This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction. • CMS will also stop sending legacy identifiers on COB crossover claims at this time.	**If the claim contains a legacy identifier in any field, it will be rejected.**

Only Four Months Until May 23, 2008 – Test NPI-only Claims NOW

While Medicare is receiving well over 90 percent of claims containing an NPI in primary provider fields, there is a very small percent of claims submitted with NPI only. **Until you submit claims with an NPI-only, you will not have a preview of what your experience will be on May 23.** The time for correcting problems, should there be any, is getting short. CMS urges that **all** Medicare providers test **now** so that problems can be resolved prior to May 23rd. For example, if there is a problem that requires a change in your Medicare enrollment information, you will need to act immediately.

How to Test

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

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

Remember, if you test and your claims are processed successfully, you can approach the May 23rd date with confidence. If you do not, you may face unanticipated cash flow problems.

Medicare DMEPOS Suppliers: If Your Claims Are Rejecting!

Medicare DMEPOS suppliers may be experiencing claims rejections if they did not obtain their NPIs properly, if they are not properly enrolled in Medicare, or both. For example, if a DMEPOS supplier who is a sole proprietorship enrolled

Compliance Date Enforcement and Clarification of Key NPI Implementation Dates (continued)

with the national supplier clearinghouse (NSC) as an organization and furnished an employer identification number (EIN) instead of a social security number (SSN), but obtained a national provider identifier (NPI) as an entity type 1 - Individual, the Medicare NPI crosswalk will be unable to link that DMEPOS supplier's Medicare legacy identifier (the NSC number) to its NPI. This is because the NSC number and the NPI identify different entity types—one identifies an organization and the other an individual. When a linkage between a Medicare legacy identifier and an NPI used in a claim does not exist in the Medicare NPI crosswalk, the claim will reject. DMEPOS suppliers should contact the DME MAC if they do not understand the error message they received.

If the rejection was due to the inability of the Medicare NPI crosswalk to link the NPI to the NSC number, the DMEPOS supplier should check the NPPES record to ensure the appropriate entity type (1 = Individual; or 2 = Organization) is reflected in that record. Individuals (including sole proprietorships) obtain NPIs as entity type 1. Organizations obtain NPIs as entity type 2. If the NPPES record shows the appropriate entity type, the DMEPOS supplier should contact the NSC to ensure the enrollment record is correct. If the NPPES record does not show the appropriate Entity type, the DMEPOS supplier needs to take action to ensure the appropriate entity type is selected. If assistance is necessary, the NPI Enumerator (1-800-465-3203) can explain to the DMEPOS supplier how this is done.

Once the NPPES record is correct, the DMEPOS supplier needs to ensure that it is properly enrolled in Medicare. The NSC, once contacted, will ask appropriate questions to determine if the DMEPOS supplier is, in fact, a sole proprietorship, and if so, properly reflected as such in the enrollment record.

The NSC will assist the DMEPOS suppliers in correcting their enrollment records.

DMEPOS suppliers who are sole proprietorships should be aware of the following:

- A DMEPOS supplier who is a sole proprietorship obtains an entity type 1 (Individual) NPI.
- When enrolling in Medicare (CMS-855S) with the NSC, a DMEPOS supplier who is a sole proprietorship furnishes his/her SSN as the taxpayer identification number (TIN).
- The legal name of the sole proprietorship business is the sole proprietor's name.
- It is possible for the sole proprietorship to have a "doing business as" (dba) name. The dba name can be reported on the CMS-855S and in the NPI application (in the "Other Name" field). A dba name, however, is not a legal name.
- It is possible that the sole proprietorship requested and received an EIN from the Internal Revenue Service (IRS) if the sole proprietorship has employees. This EIN will protect the sole proprietor's SSN from appearing in claims and on W-2s.
- Medicare will treat the EIN as the TIN for purposes of claims processing, but the SSN must still be reported on the CMS-855S.
- When Medicare reports tax information to the IRS for that EIN, the IRS will link that EIN to the sole proprietor's SSN.

Additional Information on Reporting a National Provider Identifier (NPI) for Ordering/ Referring and Attending/Operating/Other/ Service Facility for Medicare Claims

Visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5890.pdf* for a recently released *MLN Matters* article on the topic of reporting NPIs for order/ referring and attending/operating/other/service facility for Medicare claims.

CMS to Host National NPI Roundtable on February 6 2008

CMS will host a national NPI Roundtable on Wednesday, February 6, from 2:30 – 4:00 p.m. ET. This call will focus on the status of the Medicare implementation and a related question and answer session.

Registration details are available on the CMS Web site at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/listservwording2-6-08npicall.pdf*.

WEDI To Host NPI Audio Cast

The Workgroup for Electronic Data Interchange (WEDI) will host an audio cast to discuss NPI implementation from an industry-wide standpoint. The audio cast will be held on February 21, 2008.

Visit *http://www.wedi.org/npioi/index.shtml* for registration details. Please note there is a charge to participate in WEDI events.

Need More Information?

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

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

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

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

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

Source: CMS Provider Education Resource 200801-20

Additional Information on Reporting a National Provider Identifier for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

Effective with claims received on or after May 23, 2008, Medicare will not pay for referred or ordered services or items; unless the fields for the name and NPI of the ordering, referring and attending, operating, other, or service facility providers are completed on the claims.

CAUTION – What You Need to Know

Change request (CR) 5890, from which this article is taken, provides that it is the claim/bill submitter's responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers' national provider identifiers (NPIs) for claims. Further, it requires that the provider or supplier who is furnishing the services or items, after unsuccessfully attempting to obtain the NPI from these providers; report their own name and NPI in the ordering/referring/attending/operating/other/service facility provider/purchased service provider fields of the claims.

GO – What You Need to Do

Make sure that your billing staffs are aware of this requirement to place the "furnishing" provider or supplier's name and NPI in the appropriate fields and to use your name and NPI if those of the ordering/referring and attending/operating/other/service facility provider/purchased service providers are not obtainable.

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The NPI final rule (45 CFR Part 162, CMS-045-F), published on January 23, 2004, established the NPI as this standard; and mandates that all entities covered under HIPAA (including health care providers) comply with the requirements of this NPI final rule.

Medicare previously required a unique physician identification number (UPIN) be reported on claims for any ordering, referring/attending, operating, other, and service facility providers (i.e., or for any provider that is not a billing, pay-to, or rendering provider). Further, in accordance with the NPI final rule; effective May 23, 2008, when reported on a claim, the identifier for such a provider must be an NPI, regardless of whether the provider is a covered entity, or participates in the Medicare program. **Therefore, Medicare will not pay for referred or ordered services, or items, unless the name and NPI number of the ordering, referring and attending, operating, other, or service facility provider are on the claim.**

Note: Physicians (MD and DO) and the following nonphysician practitioners: 1) nurse practitioners (NP); 2) clinical nurse specialist (CNS); 3) physician assistants (PA); 4) and certified nurse midwives (CNM) are the only types of providers eligible to refer/order services or items for beneficiaries.

You should be aware that it is the claim/bill submitter's responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers' NPIs on the claim. If these providers do not directly furnish their NPIs to the billing provider at the time of the order, the billing provider must contact them to obtain their NPIs prior to delivery of the services or items.

If, after several unsuccessful attempts to obtain the NPI from the ordering, referring, attending, operating, other, service facility provider, or purchased service provider; CR 5890, from which this article is taken, requires that (effective May 23, 2008) the provider or supplier who is furnishing the services or items report their own name and NPI in the claim's ordering/referring/attending/operating/other/service facility provider/purchased service provider fields.

Additional Information

You may find more information about reporting an NPI for ordering, referring and attending, operating, other, service facility providers for Medicare Claims by going to CR 5890, located on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R235PI.pdf*.

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: MM5890
Related Change Request (CR) Number: 5890
Related CR Release Date: January 18, 2008
Related CR Transmittal Number: R235PI
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-08, Transmittal 235, CR 5890,

GENERAL COVERAGE

Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases

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

Provider Types Affected

Providers and suppliers who bill Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI), carriers, Medicare administrative contractors (A/B MAC), and durable medical equipment contractors (DME MAC) for nebulized beta adrenergic agonist therapy services for lung diseases.

What You Need to Know

Change request (CR) 5820, from which this article is taken, provides that (effective September 10, 2007) no national coverage determination (NCD) for nebulized beta adrenergic agonist therapy for lung diseases is appropriate. Therefore, you should make sure that your billing staffs are aware that local contractors will continue to make section 1862(a)(1)(A) reasonable and necessary decisions through a local coverage determination process or case-by-case adjudication.

Note: No changes to process or policy are being made with CR 5820.

Background

Lung diseases such as chronic obstructive pulmonary disease (COPD) and asthma are characterized by airflow limitation that may be partially or completely reversible. Pharmacologic treatment with bronchodilators (intended to improve the movement of air into and from the lungs by relaxing and dilating the bronchial passageways) is used to prevent and/or control daily symptoms that may cause disability for persons with these diseases.

Beta adrenergic agonists (which can be administered via nebulizer, metered dose inhaler, orally, or dry powdered inhaler) are a commonly prescribed class of bronchodilator drug. For example, nebulized beta adrenergic agonist with racemic albuterol has been used for many years, and more recently, levalbuterol, the (R) enantiomer of racemic albuterol, has been used in some patient populations.

Because of concerns regarding the appropriate use of nebulized beta adrenergic agonist therapy for lung disease, the Centers for Medicare & Medicaid Services (CMS) internally generated a formal request for a national coverage determination (NCD) to determine when treatment with a nebulized beta adrenergic agonist is reasonable and necessary for Medicare beneficiaries with COPD.

The examination of the published medical evidence did not provide sufficient information that would enable CMS to define, at this time, specific populations of patients who would benefit from a particular treatment with particular medications. Moreover, because an NCD is defined, in part, as including "whether or not a particular item or service is covered nationally" under title XVIII, sections 1862(l), 1869(f)(1)(B); CMS does not believe a national policy is possible or prudent at this time.

Therefore, effective with dates of service on and after September 10, 2007, Medicare contractors will continue to make 1862(a)(1)(A) reasonable and necessary decisions and process claims for nebulized beta adrenergic agonist therapy for lung disease through their local coverage determination process or case-by-case adjudication.

Note: No changes to process or policy are being made with CR 5820.

Additional Information

You can find the official instruction, CR 5820, issued to your FI, RHHI, Carrier, A/B MAC, or DME MAC by visiting the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R79NCD.pdf*.

You will find the *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determinations, Section 200.2 – Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases – (Effective September 10, 2007) as an attachment to that CR.

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

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

MLN Matters Number: MM5820
Related Change Request (CR) Number: 5820
Related CR Release Date: December 21, 2007
Related CR Transmittal Number: R79NCD
Effective Date: September 10, 2007
Implementation Date: January 22, 2008

Source: CMS Pub. 100-03, Transmittal 79, CR 5820

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

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

Provider Types Affected

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

Impact on Providers

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

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

Background

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

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

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

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

What you Need to Know

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

1. Effective January 1, 2008, all claims billing for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent hematocrit or hemoglobin reading.

   - For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Such claims for ESAs not reporting a value code 48 or 49 will be returned to the provider.
   - Effective for services on or after January 1, 2008, for professional paper claims, test results are reported in item 19 of the CMS-1500 claim form. For professional electronic claims (837P) billed to carriers or A/B MACs, providers report the hemoglobin or hematocrit readings in Loop 2400 MEA segment. The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results. The test results should be entered as follows: TR= test results, R1=hemoglobin or R2=hematocrit (a 2-position alpha-numeric element), and the most recent numeric test result (a 3-position numeric element, decimal implied [xx.x]). Results exceeding 3-position numeric elements (10.50) are reported as 10.5.

     Examples: If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter: TR/R2/32.3.
   - Effective for dates of service on and after January 1, 2008, contractors will return to provider paper and electronic professional claims, or return as unprocessable paper and electronic institutional claims for ESAs when the most recent hemoglobin or hematocrit test results are not reported.
   - When Medicare returns a claim as unprocessable for ESAs with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 for failure to report the most recent hemoglobin or hematocrit test results, it will include claim adjustment reason code 16 (Claim/service lacks information which is needed for adjudication.) and remittance advice code MA130 (Your claim contains incomplete and/or invalid

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

information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)

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

Additional Information

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

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

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

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

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

Payment for Pre-administration-Related Services Associated with Intravenous Immune Globulin Administration Extended

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

Provider Types Affected

Physicians or hospital outpatient facilities billing Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services related to the preadministration of intravenous immune globulin (IVIG) for Medicare beneficiaries.

Provider Action Needed
STOP – Impact to You

In 2006 and 2007, Medicare made a separate payment to physicians and hospital outpatient departments for pre-administration-related services associated with administration of IVIG, Healthcare Common Procedure Coding System (HCPCS) code G0332.

CAUTION – What You Need to Know

Change request (CR) 5713, from which this article was taken, states that the Centers for Medicare & Medicaid Services (CMS) is extending the temporary IVIG pre-administration-related services payment to hospital outpatient departments and physicians that administer IVIG through calendar year (CY) 2008. This IVIG pre-administration service may only be billed by the physician or outpatient hospital providing the IVIG infusion once per patient per day of IVIG administration. For services on or after January 1, 2008, the service must be billed on the same claim form as the IVIG product (HCPCS code J1566, J1568, J1569, J1561 and/or J1572) and have the same date of service as the IVIG product and a drug administration service.

Payment for Pre-administration-Related Services Associated with IVIG Administration Extended (continued)

GO – What You Need to Do

Make certain that your billing staff is aware of these billing requirements.

Background

Under Section 1861(s)(1) and 1861(s)(2), Medicare Part B covers IVIG administered by physicians in physician offices and by hospital outpatient departments. More specifically, when you administer IVIG to a Medicare beneficiary in the physician office or hospital outpatient department, Medicare makes separate payments to the physician or hospital for both the IVIG product itself and for its administration via intravenous infusion.

This payment is for the additional pre-administration-related services required to locate and acquire adequate IVIG product during this current period where there may be potential market issues.

As a reminder, here are some important details that you should know:

- The policy and billing requirements concerning the IVIG pre-administration-related services payment are the same in 2008 as they were in 2007 and 2006.
- This IVIG pre-administration service payment is in addition to Medicare's payments to the physician or hospital for the IVIG product itself and for its administration by intravenous infusion.
- Medicare carriers, FIs, or A/B MACs will pay for these services, that are provided in a physician office, under the physician fee schedule; and FIs or A/B MACs will pay for them under the outpatient prospective payment system (OPPS), for hospitals subject to OPPS (bill types: 12x, 13x) or under current payment methodologies for all non-OPPS hospitals (bill types: 12x, 13x, 85x).
- You need to use HCPCS code G0332, Pre-administration-Related Services for IVIG, to bill for this service.
- You can bill for only one IVIG pre-administration per patient per day of IVIG administration.
- For services on or after January 1, 2008, the service must be billed on the same claim form as the IVIG product (HCPCS codes J1566, J1568, J1569, J1561, and/or J1572) and have the same date of service as the IVIG product and a drug administration service. Physicians' claims will be rejected as unprocessable and hospital claims will be returned by your FI, carrier, or A/B MAC if one of the IVIG product HCPCS codes is not included with G0332 for that date of service. In doing so, the contractor will use one or both of the following codes:

  M67 – "Missing other procedure codes;" and/or

  16 – "Claim/service lacks information which is needed for adjudication."

- Physicians' claims will be rejected as unprocessable and hospital claims will be returned for pre-administration-related services by your FI, carrier, or A/B MAC if more than 1 unit of service of G0332 is indicated on the same claim for the same date of service. They will use the appropriate reason/remark code such as:

  M80 – "Not covered when performed during the same session/date as a previously processed service for the patient;" and/or

  B5 – "Payment adjusted because coverage/program guidelines were not met or were exceeded."

Note: The definition for J1566 is changed effective January 1, 2008. The new definition is "Injection, immune globulin, intravenous, lyophilized (e.g., powder), NOS, 500MG."

Additional Information

For complete details regarding this issue, please see the official instruction (CR 5713) issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1338CP.pdf*.

You may also want to view CR 5635, which implemented HCPCS Coding Changes for Immune Globulin, effective for services on or after July 1, 2007. For the article related to this CR, please visit the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5635.pdf*.

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

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

MLN Matters Number: MM5713
Related Change Request (CR) Number: 5713
Related CR Release Date: September 21, 2007
Related CR Transmittal Number: R1338CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1338, CR 5713

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

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

Note: CMS has revised this *MLN Matters* article on January 15, 2008, to correct the remittance advice (RA) reason code for carriers and Part B Medicare administrative contractors (MACs) for claims that contain a film mammography HCPCS code and the facility is certified for digital mammography only. The correct RA code is 171 and not B6 as previously stated. All other information remains unchanged. The *MLN Matters* article MM5577 was published in the January 2008 *Medicare A Bulletin* (pages 24-25).

Provider Types Affected

Providers who bill Medicare fiscal intermediaries, carriers, and Part A/B MACs for mammography services.

What You Need to Know

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

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

Background

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

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

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

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

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

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

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

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

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

Therefore, effective April 1, 2008:

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

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

  - Remittance advice (RA) reason code B7 (This provider was not certified/eligible to be paid for this procedure/service on this date of service).
  - RA remark code N110 (This facility is not certified for film mammography).

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

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

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

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

- MSN 16.2 (This service cannot be paid when provided in this location/facility);
- RA reason code B7 (This provider was not certified/ eligible to be paid for this procedure/service on this date of service), and
- Remark code N110 (This facility is not certified for film mammography).
- They will deny the claim if it contains a film mammography HCPCS code and the facility is certified for digital mammography only. In denying these claims because the facility is not certified to perform film mammography, they will use MSN message MSN 16.2. In this instance, carriers/B MACs will use RA reason code 171 (Payment is denied when performed/billed by this type of provider, in this type of facility) and remark code N110 and FIs/A MACs will use reason code B7.

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

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

Additional Information

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

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

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

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

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

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

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

Advance Beneficiary Notice

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

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

ADDITIONS/REVISIONS TO EXISTING LCDS

A93303: Transthoracic Echocardiography (TTE)—Revision to LCD

The local coverage determination (LCD) for transthoracic echocardiography (TTE) was last revised on January 1, 2008. Since that time, a revision was made to move the "Training Requirement" language from the coding guidelines and add the language to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, language was added pertaining to the grandfathering of technicians for consistency with other Part A LCDs.

Effective Date

This revision to the LCD is effective for services provided **on or after January 10, 2008.** The full text of this LCD (L1566) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

ATHERSVCS: Therapy and Rehabilitation Services—Revision to LCD

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on June 30, 2007. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to incorporate new, revised language surrounding the therapy cap limitations and the exception process for therapy caps. Change request (CR) 5871, dated January 10, 2008, outlines the new therapy cap limits and revises language for the therapy cap exception process. The limit for therapy caps for calendar year 2008 is $1,810 for physical therapy and speech-language pathology services combined and $1,810 for occupational therapy services. The exception process for therapy caps has been extended through June 30, 2008. For a complete discussion on the therapy caps and the exception process, please refer to the LCD and the Centers for Medicare & Medicaid Services (CMS) manual Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 5, Section 10.2.

This LCD revision is effective **January 14, 2008** for services provided **on or after January 1, 2008.**

In addition, the coding guideline has been revised to add *CPT* code *96125 (Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report)* to the table of "always therapy services", in accordance with CR 5810. Please see the coding guideline for a complete discussion of the "always therapy table".

This revision is effective **January 7, 2008** for services provided **on or after January 1, 2008**.

The full text of this LCD (L1125) is available on or after this effective date through our provider education Web site *http://www.fcso.com*. ❖

ADDITIONAL MEDICAL INFORMATION

AJ1440: G-CSF (Filgrastim, Neupogen®)—Clarification on Correct Administration of Neupogen

First Coast Service Options, Inc. (FCSO) has discovered, through medical review and subsequent data analysis that providers are inappropriately administering Neupogen (J1440 and J1441) to patients who are receiving a chemotherapeutic agent.

Neupogen is not a cancer chemotherapy agent. It is a class II hematopoietic growth factor that acts on progenitor cells. Because Neupogen acts only on progenitor cells that are already committed to one pathway, it increases only the neutrophil count. The local coverage determination (LCD) for Neupogen outlines the Food and Drug Administration (FDA) approved indications and the off-label indications FCSO will cover when the medical necessity criteria are met.

Under the "Limitations" section of the LCD, it is outlined that Neupogen should not be given within 24 hours before or after a dose of a chemotherapeutic agent, as rapidly dividing myeloid cells are potentially sensitive to these agents. This instruction is also outlined in the FDA-approved label. This rule applies to any indication in the LCD that requires the administration of a chemotherapeutic agent.

AJ1440: G-CSF (Filgrastim, Neupogen®)—Clarification on Correct Administration of Neupogen (continued)

An example of inappropriate administration found during medical review of claims shows that providers are administering Neupogen the day before, the day of and the day after chemotherapy administration. In the cases reviewed, patients received one injection of Neupogen less than 12 hours before chemotherapy, then received an injection immediately following chemotherapy infusion and received a Neupogen injection, the next day, less than 12 hours after the chemotherapy infusion. The documentation reviewed, also did not show a documented fever. For this example, the indication as outlined in the LCD for the chemotherapy patient, is to decrease the incidence of infection, as manifested by febrile neutropenia, for patients on myelosuppressive chemotherapy.

FSCO would like to reiterate to providers that the continued practice of inappropriate administration of Neupogen might lead to medical review of documentation. FCSO does not expect to see Neupogen billed the day before, the day of or the day after chemotherapy administration. If providers do bill Neupogen the day before or the day after chemotherapy administration, the medical record must show that Neupogen was not given less than 24 hours before and/or less than 24 hours after chemotherapy and that this requirement is documented in the medical record. Claims that cannot support this requirement may be denied as not medically necessary.

FCSO strongly encourages providers to review the current LCD for Neupogen to ensure their patients meet the coverage criteria outlined for each indication and that all other documentation and utilization requirements are met. The LCD is available through our Web site at *http://www.fcso.com*.

Questions regarding coverage or the appropriate administration of Neupogen may be forwarded to *medical.policy@fcso.com*. Providers who feel the language in the LCD is not appropriate may refer to FCSO's reconsideration process located on our Web site. ❖

WIDESPREAD MEDICAL REVIEW PROBE

CPT Code *99211*: Widespread Probe Review Results

Procedure code *99211* (*Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician*) was chosen for focused medical review for fiscal year 2005 based on July 1, 2004 to December 31, 2004, Medicare Part A data. Based on the conclusions of the findings with claim review indicating same and similar service groups billing without an *evaluation and management (E/M)* code, as well as with varying *E/M* codes (*99211, 99212, 99213*, etc.) on almost all providers, a recommendation was made to perform a widespread probe. Therefore, a widespread probe of one hundred claims, which encompassed one hundred and nineteen services from twenty providers for the time period from January 1, 2006 through June 30, 2006, was performed. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed, appropriately coded and medically reasonable and necessary.

Summary of the Findings

One hundred claims, which encompassed one hundred and nineteen services, were reviewed for twenty providers for *CPT* code *99211*. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services. The *Federal Register*, Volume 71, Number 163, dated Wednesday, August 23, 2006, proposed rules, page 49605 discusses the April 7, 2000, outpatient prospective payment system (OPPS) final rule (65 FR 18434) in which the Centers for Medicare & Medicaid Services (CMS) outlines instructions for hospitals to report facility resources for clinic and emergency room visits using *CPT E/M* codes and to develop internal hospital guidelines to determine what level of visit to report for each patient.

Of the one hundred and nineteen services reviewed, one hundred and five services were allowed as billed and fourteen services were denied for medical necessity. The services denied did not follow the facilities established guidelines for mapping procedures to *CPT* code *99211*. ❖

HOSPITAL SERVICES

Clarification of Patient Discharge Status Codes and Hospital Transfer Policies

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

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs).

Provider Action Needed

STOP – Impact to You

This special edition article is based on information from the Centers for Medicare & Medicaid Services (CMS) regulations and transmittals and the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual 2008 (Version 2.00 July 2007) Section Form Locator 17 (Patient Discharge Status) effective date: March 1, 2007 copyrighted by the American Hospital Association (AHA); NUBC UB-04 Version 2.00 Clarifications and Errata (as of 8/22/07). It provides clarifications and instructions on determining the correct patient discharge status code to use when completing your claims.

Important: The NUBC is responsible for the maintenance and dissemination of guidance for the UB-04 code set. The CMS has provided a subset of information below for Medicare-participating providers. For greater detail, providers should visit *http://www.nubc.org/* in order to purchase a UB-04 manual.

CAUTION – What You Need to Know

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter or at the end time of a billing cycle. It belongs in form locator 17 on a UB-04 claim form or its electronic equivalent in the HIPAA compliant 837 format.

GO – What You Need to Do

See the *Background* section of this article for more details regarding instructions and clarifications for patient discharge status coding.

Background

This special edition article is being provided to help you determine the right discharge status code to use with your claims. Assigning the correct patient discharge status code is just as important as any other coding used when filing a claim and the same processes should be applied for patient discharge status codes as with any other coding. Choosing the patient discharge status code correctly avoids claim errors and helps you receive payment for your claim sooner.

A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter (this could be a visit or an actual inpatient stay) or at the time end of a billing cycle (the 'through' date of a claim). CMS requires patient discharge status codes for:

- Hospital inpatient claims (type of bills [TOBs] 11x and 12x)
- Skilled nursing claims (TOBs 18x, 21x, 22x and 23x)
- Outpatient hospital services (TOBs 13x, 14x, 71x, 73x, 74x, 75x, 76x and 85x)
- All hospice and home health claims (TOBs 32x, 33x, 34x, 81x and 82x).

It is important to select the correct patient discharge status code, and in cases in which two or more patient discharge status codes apply, you should code the highest level of care known. Omitting a code or submitting a claim with an incorrect code is a claim billing error and could result in your claim being rejected or your claim being cancelled and payment being taken back. Applying the correct code will help assure that you receive prompt and correct payment.

Identifying the appropriate patient discharge status code can sometimes be confusing, so be sure to read the frequently asked questions (FAQ) section at the end of this article for further guidance.

Patient Discharge Status Codes and Their Appropriate Use

The following describes patient discharge status codes and provides details regarding their appropriate use:

01 – Discharge to Home or Self Care (Routine Discharge)
This code includes discharge to home; jail or law enforcement; home on oxygen if durable medical equipment (DME) only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

02 – Discharged/Transferred to a Short-term General Hospital for Inpatient Care
This patient discharge status code should be used when the patient is discharged or transferred to a short-term acute care hospital. Discharges or transfers to long-term care hospitals should be coded with patient discharge status code 63.

03 – Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care
This code indicates that the patient is discharged/transferred to a Medicare certified nursing facility in anticipation of skilled care. For hospitals with an

Clarification of Patient Discharge Status Codes and Hospital Transfer Policies (continued)

approved swing bed arrangement, use Code 61 – Swing bed. This code should be used regardless of whether or not the patient has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay will be covered by Medicare. For reporting other discharges/transfers to nursing facilities see codes 04 and 64. Code 03 should not be used if:

- The patient is admitted to a non-Medicare certified area.

04 – Discharged/Transferred to an intermediate care facility (ICF)
Patient discharge status code 04 is typically defined at the state level for specifically designated intermediate care facilities. It is also used:

- To designate patients that are discharged/ transferred to a nursing facility with neither Medicare nor Medicaid certification, or
- For discharges/transfers to state designated assisted living facilities.

05 – Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in This Code List
Cancer hospitals excluded from Medicare prospective payment system (PPS) and children's hospitals are examples of such other types of health care institutions.

New Definition for Patient Discharge Status Code 05 – Effective, per NUBC, on April 1, 2008

05 – Discharged/Transferred to a Designated Cancer Center or Children's Hospital
Usage Note: Transfers to non-designated cancer hospitals should use code 02. A list of (National Cancer Institute) designated cancer centers may be found on the Internet at *http://www3.cancer.gov/cancercenters/centerslist.html*.

06 – Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care
This code should be reported when a patient is:

- Discharged/transferred to home with a written plan of care for home care services (tailored to the patient's medical needs) – whether home attendant, nursing aides, certified attendants, etc.
- Discharged/transferred to a foster care facility with home care; and
- Discharged to home under a home health agency with DME.

This code should not be used for home health services provided by a:

- DME supplier or
- Home IV provider for home IV services.

07 – Left Against Medical Advice or Discontinued Care
The important thing to remember about this patient discharge status code is that it is to be used when a patient leaves against medical advice or the care is discontinued. According to the NUBC, discontinued services may include:

- Patients who leave before triage, or are triaged and leave without being seen by a physician; or
- Patients who move without notice, and the home health agency is unable to complete the plan of care.

08 – Reserved for National Assignment
This patient discharge status code is reserved for national assignment.

09 – Admitted as an Inpatient to this Hospital
This code is for use only on Medicare outpatient claims, and it applies only to those Medicare outpatient services that begin greater than three days prior to an admission.

10-19 – Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

20 – Expired
This code is used only when the patient dies.

21-29 – Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

30 – Still Patient or Expected to Return for Outpatient Services
This code is used when the patient is still within the same facility and is typically used when billing for leave of absence days or interim bills. It may be used for both inpatient or outpatient claims.

It is used for inpatient claims when billing for leave of absence days or interim billing (i.e., the length of stay is longer than 60 days).

On outpatient claims, the primary method to identify that the patient is still receiving care is the bill type frequency code (e.g., frequency code 3: interim - continuing claim).

31-39 – Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

Hospice Patient Discharge Status Codes – Hospice Claims Only (TOBs: 81x & 82x)
The following patient discharge status codes should only be used when submitting hospice claims:

40 – Expired at home –This code is for use only on Medicare and TRICARE claims for hospice care.

41 – Expired in a medical facility, such as a hospital, skilled nursing facility (SNF), intermediate care facility (ICF), or freestanding hospice.

42– Expired – Place unknown – This code is for use only on Medicare and TRICARE claims for hospice care.

Clarification of Patient Discharge Status Codes and Hospital Transfer Policies (continued)

43 – Discharged/Transferred to a Federal Hospital
This code applies to discharges and transfers to a government operated health care facility including:

- Department of Defense hospitals
- Veteran's Administration hospitals, or
- Veteran's Administration nursing facilities.

This patient discharge status code should be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.
The NUBC has also clarified that this code should also be used when a patient is transferred to an inpatient psychiatric unit of a Veterans Administration (VA) hospital.

44-49 Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

50 and 51 – Discharged/Transferred to a Hospice
These two patient discharge status codes are used to identify when a patient is discharged or transferred to hospice care.

The level of care that will be provided by the hospice upon discharge is essential to determining the proper code to use. NUBC clarified the following hospice levels of care:

- Routine or Continuous Home Care. Patient discharge status code "50: Hospice home" should be used if the patient went to his/her own home or an alternative setting that is the patient's "home," such as a nursing facility, and will receive in-home hospice services.
- General Inpatient Care. Patient discharge status code "51 Hospice medical facility" should be used if the patient went to an inpatient facility that is qualified and the patient is to receive the general inpatient hospice level of care.
- Inpatient Respite. Patient discharge status code "51 Hospice medical facility" should be used if the patient went to a facility that is qualified and the patient is receiving hospice inpatient respite level of care. Unless a patient has already been admitted to/accepted by a hospice, level of care cannot be determined. Therefore, it is recommended that, if a patient is going home or to an institutional setting with a hospice "referral only," (without having already been accepted for hospice care by a hospice organization) the patient discharge status code should simply reflect the site to which the patient was discharged, not hospice (i.e. 01: home or self care, or 04: an intermediate care nursing facility, assuming it is not a Medicare SNF admission).

Additional Guidance on Use of Patient discharge status Code 50 or 51:

- Patient discharge status code 50 should be used if the patient went to his/her own home or an alternative setting that is the patient's "home," such as a nursing facility, and will receive in-home hospice services.

Patient discharge status code 51 should be used when a patient is:

- Discharged from acute hospital care but remains at the same hospital under hospice care
- Transferred from an inpatient acute care hospital to a Medicare-certified SNF under the following conditions:
  - The patient has elected the hospice benefit and will be receiving hospice care under arrangement with a hospice organization; the patient is receiving residential care only.
  - The patient does not qualify for skilled level of care outside the hospice benefit for conditions unrelated to the terminal illness.
  - Admitted from home (a private residence) to an acute setting. Upon discharge, the patient is transferred as a new nursing home placement to a designated hospice unit/bed.

52-60 – Reserved for National Assignment
These patient discharge status codes are reserved for national assignment.

61 – Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed
This code is used for reporting patient discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.
When a patient is discharged from an acute hospital to a critical access hospital (CAH) swing bed, usepPatient discharge status code 61. Swing beds are not part of the post acute care transfer policy.

62 – Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital
Inpatient rehabilitation facilities (or designated units) are those facilities that meet a specific requirement that 75 percent of their patients require intensive rehabilitative services for the treatment of certain medical conditions. This code should be used when a patient is transferred to a facility or designated unit that meets this qualification.

63 – Discharged/Transferred to Long Term Care Hospitals
This code is for hospitals that meet the Medicare criteria for long-term care hospital (LTCH) certification as follows: LTCHs are facilities that provide acute inpatient care with an average length of stay of 25 days or greater. This code should be used when transferring a patient to a LTCH. If you are not sure whether a facility is a LTCH or a short-term care hospital, you should contact the facility to verify their facility type before assigning a patient discharge status code.

Clarification of Patient Discharge Status Codes and Hospital Transfer Policies (continued)

64 – Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare

Nursing facilities may elect to certify only a portion of their beds under Medicare, and some nursing facilities choose to certify all of their beds under Medicare. Still others elect not to certify any of their beds under Medicare. When a patient is transferred to a nursing facility that has no Medicare certified beds, this code should be used. If any beds at the facility are Medicare certified, then the provider should use either patient discharge status code 03 or 04, depending on:

- The level of care the patient is receiving; and
- Whether the bed is Medicare certified or not.

65 – Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital

This code should be used when a patient is transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit.

Note: This code should not be used when a patient is transferred to an inpatient psychiatric unit of a federal hospital (e.g. Veterans Administration Hospitals). In this case, see patient discharge status code 43.

66 – Discharged/Transferred to a Critical Access Hospital

Patient discharge status code 66 is used to identify a transfer to a critical access hospital (CAH) for inpatient care. Providers will need to establish a process for identifying whether a hospital is paid under the PPS or whether the facility is designated as a CAH.

Note: Discharges or transfers to a critical access hospital (CAH) swing bed should still be coded with patient discharge status code 61.

67-69 – Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

New Patient Discharge Status Code 70 – Per NUBC, Effective April 1, 2008

70 – Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

New patient discharge status code 70 was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for discharges/to dates on or after April 1, 2008. (See Code 05)

71-99 –- Reserved for National Assignment

These patient discharge status codes are reserved for national assignment.

Patient Discharge Status Codes Affected by the Hospital Transfer Policies for Inpatient PPS and IRF PPS

The IPPS Acute to Acute Transfer policy applies to transfers coded with patient discharge status code 02 and applies to all diagnosis-related groups (DRGs) and when the length of stay is less than the average length of stay for the DRG.

Under Medicare's **Post Acute Care Transfer policy** (42 CFR 412.4), a discharge of a hospital inpatient is considered to be a post acute care transfer when the patient's discharge is assigned to one of the qualifying DRGs, and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (IPPS) (includes: inpatient rehabilitation facilities, long term care hospitals, psychiatric hospitals, cancer hospitals and children's hospitals).
- To a skilled nursing facility (not swing beds)
- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within three days after the date of discharge.

Note: A list of the FY2008 DRGs is available in Table 5 of the IPPS final rule for 2008. That rule is available on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf*.

Based on the above, the IPPS post-acute care transfer policy applies to claims coded with patient discharge status codes 03, 05, 06, 62, 63, and 65.

Inpatient rehabilitation facilities (IRFs): 42 CFR 412.624(f) the following patient discharge status codes are applicable under the IRF transfer policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

NUBC Frequently Asked Questions (FAQs) and Answers

1) Q: A patient is discharged from our facility (disposition code 01) and is to go to a doctor's appointment the same day. The patient is then admitted to another hospital after seeing the doctor. What disposition code is appropriate, 01 or 02?

A: *Based on the information the hospital had at discharge, the patient was discharged to home (01). If your facility was unaware of the planned admission at the second facility, it is likely that you will have to provide support for your coding decision when the fiscal intermediary receives the claim for admission to another hospital on the same day you discharged the patient.*

2) Q: If a facility discharges a patient to a personal care home, which is similar to assisted living facilities, are they most appropriately coded as 01 or 04?

A: *If the personal care home is the person's place of residence, even temporarily, use code 01, discharged to home or self-care.*

3) Q: What discharge status code should be used when a patient is sent to another acute care facility for an outpatient procedure later in the day? This occurs when we do not have the equipment to perform the procedure and the intention is that the patient will not be returning to our facility after the procedure.

Clarification of Patient Discharge Status Codes and Hospital Transfer Policies (continued)

A: *Since this is a discharge to outpatient treatment, and it is expected that the patient will go home afterward, use discharge status 01, discharged to home or self-care.*

4) Q: We have a home health agency with DME. Often we find the orders reads "Home with walker". We do not see a physician order for home health care nor has there been an assessment documented by the receiving home health nurse. The nursing discharges instructions check "home". Is the Patient discharge status code still 06**?**

A: *No. "Home with walker" does not imply a discharge to home under care of organized home health service organization in anticipation of covered skilled care. Accordingly, code 01, discharged to home or self care (routine discharge) would be appropriate.*

5) Q: What is the difference between residential care and assisted living care?

A: *In terms of patient discharge status codes, there is no difference. Discharges to residential care and private (non-state designated/supported) assisted living facilities are coded alike (01).*

6) Q: An established nursing home patient (i.e. the nursing home is their permanent residence) is transferred to an acute setting. Upon discharge, they are sent back to the same nursing home with a hospice referral only. What patient discharge status code would be appropriate?

A: *If the patient has not made a hospice election, and has a referral only, use code 01, discharged to home.*

7) Q: A patient was discharged to home with home health services. Two days later the patient was readmitted to our hospital. We were notified by the discharge planner of the patient's readmission and the fact that home health services were not started for the patient and the discharge status code needed to be changed to 01. By the time of the discharge planner's notification, we had already submitted the patient's bill with the discharge status code of 06. In this instance what should the correct discharge status code be on this patient?

A: *To ensure accurate reimbursement and reporting, send a replacement claim with the correct discharge status code (01).*

8) Q: What status code should be used for a patient transferred to a SNF rehabilitation unit? This unit is within the SNF. Is this considered a transfer to a SNF or to a rehabilitation facility?

A: *A rehabilitation unit that is part of an SNF is paid under the SNF prospective payment system. Moving a patient from one unit to another does not constitute a transfer for billing purposes and should not result in separate claims. If a patient is discharged from an acute inpatient hospital to a Medicare-certified SNF in anticipation of skilled care, use 03. Status code 03 is also used if the patient moves from an acute inpatient hospital to a rehab unit in a SNF.*

9) Q: What is the appropriate patient discharge status code for a patient transferred from an acute care hospital to a nursing facility for a non-skilled/ custodial/residential level of care? For example:

The patient is discharged to a facility that is only certified with skilled beds but the patient does not qualify for a skilled level of care.
The Medicare certified nursing facility is licensed for both skilled and intermediate care beds, and the patient is transferred to intermediate care.
The patient resides at a Medicare certified SNF but only receives non-skilled services.

A: *Code 04, discharged/transferred to an intermediate care facility (ICF) would be the appropriate patient status discharge code for all of the examples above.*

10) Q: If a patient is discharged from a hospital based transitional care unit (i.e., skilled nursing unit) to the acute hospital under observation status, what is the discharge status for the TCU claim?

A: Use Code 05, discharged/transferred to another type of health care institution not defined elsewhere in this code list.

11) Q: If a patient is discharged to home for the provision of home health services, but, the continuing care is either 1) not related to the condition or diagnosis for which the individual received inpatient hospital services or 2) is related, but, not provided within the post-discharge window, what is the correct patient status code to use?

A: *Code 06 would be the appropriate patient discharge status code. In addition, the provider should append one of the following condition codes, as appropriate, to the claim:*

Condition Code 42 – Continuing care not related (i.e. condition or diagnosis) to inpatient admission or;

Condition Code 43 – Continuing care not provided within prescribed post-discharge window.

12) Q: If a patient is discharged from an acute care hospital and PT/OT is arranged to be done in the home by a rehabilitation agency that is not affiliated with the home health care agency that made the arrangements, what is the appropriate code to use — 01 or 06?

A: *If the therapy services are being provided under the home health benefit (e.g. Medicare Part A), use Code 06; if the therapy is provided under the outpatient therapy benefit (e.g., Medicare Part B), use Code 01.*

Clarification of Patient Discharge Status Codes and Hospital Transfer Policies (continued)

13) Q: If a patient is discharged from acute hospital care but remains at the same hospital under hospice care, what status code should be used for the acute stay discharge?

A: *Use Code 51 Hospice – medical facility.*

14) Q: What discharge status code should be used when a patient is discharged to a chemical dependency treatment facility that is not part of a hospital?

A: *If the chemical dependency treatment facility is not a psychiatric hospital or psychiatric distinct part unit of a hospital, and the patient is undergoing inpatient/residential treatment, use Code 05, discharged/transferred to another type of health care institution not defined elsewhere in this code list.*

Note: *The NUBC has approved the establishment of a new code (70) to take effect April 1, 2008 for other types of health care facilities not defined elsewhere in the code list.*

Additional Information

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: SE0801
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0801

Reprocessing of Certain Inpatient Hospital Prospective Payment Claims

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

Provider Types Affected

Hospitals that bill Medicare fiscal intermediaries (FI) or Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

What Providers Need to Know

Change request (CR) 5845, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) has corrected the incorrect listing of twenty five diagnostic related groups (DRG) in the regular post acute care transfer list, which had resulted in transfer claims for these DRGs receiving an incorrect payment.

Please note that FIs and A/B MACs will reprocess your claims that contain these 25 DRGs. **You need take no action to initiate the reprocessing of the claims.**

In addition, CR 5845 also contains revisions to the wage indices (WIs) for a few core based statistical areas (CBSA). You should make sure that your billing and reimbursement staffs are aware of these revisions and understand that they will necessitate the adjustment of a few hospital claims. **Providers impacted by these changes should note that your FI or A/B MAC will reprocess the affected claims**. **You need take no action to initiate the reprocessing of the claims.**

Background

The post-acute care transfer DRGs that should receive a special pay transfer payment have been receiving a payment error. CR 5845, from which this article is taken, announces CMS correction of this error within the inpatient hospital prospective payment (IPPS) PRICER.

These twenty-five DRGs (28, 29, 30, 40, 41, 42, 219, 220, 221, 477, 478, 479, 480, 481, 482, 492, 493, 494, 500, 501, 502, 515, 516, 517, and 956) are considered fiscal year 2008, "special pay" DRGs within the post-acute care (PAC) transfer policy. Further, you should note that in a PAC transfer situation, claims are paid 50 percent of the appropriatePPS rate for the first day of the stay and 50 percent of the graduated per diem rate for each day of the stay up to the full DRG.

You may want to refer to the regulations at 42 CFR 412.4(f)(2) for additional information.

CR 5845 also announces that CMS has made changes to a few core-based statistical areas (CBSAs) wage indices based on the October 10, 2007 correction notice to the fiscal year 2008 inpatient hospital PPS final rule (72 FR 57634), and a subsequent correction notice that will be published in the *Federal Register* in early November 2007. In accordance with the regulations at 42 CFR 412.64(k)(1), these corrections are retroactive to October 1, 2007.

Reprocessing of Certain Inpatient Hospital Prospective Payment Claims (continued)

These WI changes impact certain providers in CBSA 13820, 26620, 16180, 39900, 16974, 14484, and 53. The specific hospitals affected and their revised WIs and geographic adjustment factors (GAF) are listed in CR 5845, which may be seen at the Web address provided in the next section of this article.

Additional Information

You may find more information about the correction of post acute care transfer DRG payment errors and of the specific revised CBSA wage indices by going to CR 5845, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1405CP.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: MM5845
Related Change Request (CR) Number: 5845
Related CR Release Date: January 4, 2008
Related CR Transmittal Number: 1405CP
Effective Date: October 1, 2007
Implementation Date: February 4, 2008

Source: CMS Pub. 100-04, Transmittal 1405, CR 5845

April 2008 Update to the Medicare Code Editor and GROUPER

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

Provider Types Affected

Hospitals that bill Medicare fiscal intermediaries (FI) or Medicare administrative contractors (A/B MAC) for services they provide to Medicare beneficiaries.

What You Need to Know

Change request (CR) 5876, from which this article is taken, announces an April 2008 update to the Medicare code editor (MCE) and GROUPER to accommodate the addition of the new patient status discharge code 70: "Discharges or transfers to other types of health care institutions not defined elsewhere in the UB-04 (CMS-1450) manual code list."

Hospitals should make sure their billing staffs are aware of these MCE and GROUPER changes so that they can update their systems to incorporate them, as needed.

Background

Section 503(a) of Public Law 108-173, as part of the amendments related to recognizing new technology under the inpatient prospective payment system (IPPS), included a requirement to update ICD-9-CM codes twice a year instead of the single yearly (October 1) update. This section amended section 1886(d) (5) (K) of the Act by adding a clause (vii) which states that the "Secretary shall provide for the addition of new diagnosis and procedure codes on April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) until the fiscal year that begins after such date."

However, while coding updates for April releases of MCE/GROUPER will not adjust payment; for this April 2008 release, the Centers for Medicare & Medicaid Services (CMS) needs to update the diagnosis related group (DRG) software and other systems in order to recognize and accept the new patient status code of 70.

Additional Information

You may find more information about the April 2008 update to the MCE and Grouper by going to CR 5876, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1411CP.pdf*.

You might also want to read the implementing instructions for patient discharge status code 70, which are discussed in *MLN Matters* article MM5764 (**New Patient Status Discharge Code 70 to Define Discharges or Transfers to Other Types of Health Care Institutions not Defined Elsewhere in the UB-04 (CMS-1450) Manual Code List**) on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5764.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: MM5876
Related Change Request (CR) Number: 5876
Related CR Release Date: January 11, 2008
Related CR Transmittal Number: R1411CP
Effective Date: Discharges on or after April 1, 2008
Implementation Date: April 7, 2008

Source: CMS Pub. 100-04, Transmittal 1411, CR 5876

Revision to Certification for Hospital Services Covered by the Supplementary Medical Insurance Program as it Pertains to Ambulance Services

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

Note: Change request (CR) 5833 rescinds and fully replaces CR 5684. The *MLN Matters* article MM5684 that relates to CR 5684 was published in the September 2007 *Medicare A Bulletin* (page 34).

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 ambulance services provided to Medicare beneficiaries.

Provider Action Needed

The article is based on change request (CR) 5833, which updates the Section 20 of Chapter 4 of the *Medicare General Information, Eligibility, and Entitlement Manual* as it pertains to physician certification statement requirements for all ambulance providers. CR 5833 deletes from that manual section the paragraph that requires a physician certification of ambulance services provided by a hospital to transport a patient during an emergency situation, such as transport from the scene of an accident.

Background

The Centers for Medicare & Medicaid Services (CMS) discovered there was a problem with a paragraph in the *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 4, Section 20 regarding language not allowing the current exception under physician certification statement (PCS), i.e., that the PCS **is not required** during an emergency situation (such as the scene of an accident).

Therefore, CR 5833 deleted the following paragraph in Chapter 4 (Section 20) of the *Medicare General Information, Eligibility, and Entitlement Manual* (Pub 100-01) that pertained to physician certification and recertification of services and ambulance services because it conflicted with Title 42 of the Code of Federal Regulations (CFR), Sections 410.40(d) (2) and (3):

> *Certification by a physician in connection with ambulance services furnished by a participating hospital is required. In cases in which the hospital provides ambulance service to transport the patient from the scene of an accident and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify as to the medical need for the ambulance service.*

Deletion of this paragraph brings the manual into alignment with current regulations, which eliminate the PCS requirement in these emergency situations.

Additional Information

The official instruction, CR 5833, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R50GI.pdf*.

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

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

MLN Matters Number: MM5833
Related Change Request (CR) Number: 5833
Related CR Release Date: December 21, 2007
Related CR Transmittal Number: R50GI9
Effective Date: September 17, 2007
Implementation Date: January 7, 2008

Source: CMS Pub. 100-01, Transmittal 50, CR 5833

CRITICAL ACCESS HOSPITAL SERVICES

2008 Annual Update for the Health Professional Shortage Area Bonus Payment

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

Note: CMS has revised this *MLN Matters* article on December 31, 2007, to reflect that change request (CR) 5698 was revised. The CR release date, transmittal number and Web address for accessing CR 5698 were change. All other information remains the same. The *MLN Matters* article MM5698 was published in the November 2007 *Medicare A Bulletin* (page 23).

Provider Types Affected

Physicians and providers submitting claims to Medicare administrative contractors (A/B MACs), carriers, and fiscal intermediaries (FIs) for services provided in a health professional shortage areas (HPSAs).

Impact on Providers

This article is based on CR 5698, which alerts affected physicians, carriers, A/B MACs and FIs that the new HPSA bonus payment information for 2008 will be available soon. This article is informational only for physicians that the 2008 automated bonus payment applies to claims with dates of service on or after January 1, 2008 through December 31, 2008.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Section 413(b)) mandated an annual update to the automated HPSA bonus payment files, and the Centers for Medicare & Medicaid Services (CMS) creates these new automated HPSA bonus payment files annually. The 2008 HPSA bonus payment file will be used for the automated bonus payment for claims with dates of service on or after January 1, 2008, through December 31, 2008. Physicians and providers should review the CMS Web site to determine whether a HPSA bonus will automatically be paid for services provided in their ZIP code area or whether a modifier must be submitted.

In addition, physicians will find annual HPSA bonus payment files, as they become available, and other important HPSA information on the CMS Web site at *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/*.

Additional Information

The official instruction (CR 5698) issued to your Medicare A/B MAC, carrier, or FI is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1404CP.pdf*.

For the CMS information about HPSA/PSA (physician scarcity area) bonuses, you may visit the CMS Web site at *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/*.

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

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

MLN Matters Number: MM5698 – Revised
Related Change Request (CR) Number: 5698
Related CR Release Date: December 28, 2007
Related CR Transmittal Number: R1404CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1404, CR 5698

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ESRD SERVICES

Line Item Billing Requirement for End-Stage Renal Disease Claims

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

Note: CMS has revised this *MLN Matters* article on January 22, 2008, to add references to related change request (CR 5768 (*http://www.cms.hhs.gov/Transmittals/downloads/R1364CP.pdf*) and CR 5545 (*http://www.cms.hhs.gov/Transmittals/downloads/R1285CP.pdf*). These CRs added to the requirements initiated in CR 5039. The related MLN Matters articles may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5768.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5545.pdf*. All other information remains unchanged. The *MLN Matters* article MM5039 was published in the December 2006 *Medicare A Bulletin* (pages 29-30).

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for end-stage renal disease (ESRD) services

Provider Action Needed
STOP – Impact to You

This article is based on change request (CR) 5039, which provides updates to line-item billing requirements for ESRD claims (type of bill 72x).

CAUTION – What You Need to Know

CR 5039 instructs that line-item billing is required for all ESRD claims with dates of service on or after April 1, 2007. Renal dialysis facilities are then required to bill all services with line item date of service detail, except supplies and epoetin alfa (EPO).

GO – What You Need to Do

See the *Background* section of this article for further details regarding this change.

Background

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) Implementation Guide, the Centers for Medicare & Medicaid Services (CMS) **requires that all outpatient claims contain a line item date of service for each revenue code billed on the claim**. CMS has completed implementation of line-item billing for most institutional Part B claims and has encouraged renal dialysis facilities (RDFs) to begin line-item billing. CMS has permitted RDFs to continue to roll-up the services provided throughout the month; and choose one date of service within the billing period on the claim to report all instances of each revenue code on a single line.

As a result, ESRD claims are currently being received and processed using both methods: line-item billing; and services rolled-up for all instances of each revenue code.

The method of rolling up all instances of each revenue code on a single line does not provide the most accurate claims data since the claim is reporting that all of a given service is provided on the same date. **Inherent with this method of billing is an increase in the number of claims that cannot be processed to payment due to claims with overlapping dates of service**.

In these overlapping claim cases, RDFs must report service dates of other providers within the month they are billing using an occurrence span code 74 on the claim to prevent the overlap of the claims and allow both claims to be paid. RDFs have expressed to CMS that this is a difficult task because they are not always informed of the beneficiary receiving services performed by other providers.

The Medicare claims processing system has the ability to compare services on multiple claims to the line date that could prevent both the unnecessary suspension of claims for overlapping billing periods and the reporting of the occurrence span code 74 for the RDFs.

To apply this system functionality to the ESRD claims, the claim must provide the line item date of service detail for each service being billed on the claim. This is a substantial benefit that line item billing can provide for RDFs in submitting ESRD claims.

Benefits of Line Item Billing Include:

- More accurate and timely claim payments to providers.
- Less staff time needed to research dates of services performed by other providers.
- Clinical data will no longer need to be rolled up to accommodate the claims processing systems and therefore, will more closely match the claim record.
- More detailed claim data could be used to assist the CMS in future refinements to improve the accuracy and equity of ESRD payments.
- HIPAA compliance for submitting the appropriate line item date of service for both the CMS and its providers is ensured.

Line Item Details

CR 5039 instructs RDFs to:

- Bill a separate line item for each dialysis session performed.
- Report the appropriate line item date of service to conform with the date the service was provided to the beneficiary. The units reported on the line for each date dialysis was performed should not exceed one.
- The use of occurrence span code 74 will not be necessary for ESRD claims with dates of service on or after April 1, 2007.
- Reporting value code 67 will not be required for ESRD claims with dates of service on or after April 1, 2007.

Medicare FIs will return to the provider any claims with dates of service on or after April 1, 2007, when:

- The claim contains units exceeding 1 reported on lines containing revenue codes 0821, 0831, 0841, or 0851.

Line Item Billing Requirement for End-Stage Renal Disease Claims (continued)

Coding Adequacy for Hemodialysis

All claims billing for hemodialysis sessions must continue to report *CPT* code *90999* (unlisted dialysis procedure, inpatient or outpatient), and modifiers G1 through G6 used for reporting the urea reduction ratio (URR) for determining the adequacy of hemodialysis.

However, it is not required that *CPT* code *90999* and a G1-G6 modifier be reported on every line item that contains a hemodialysis session.

Home Dialysis Under Method One

For intermittent home dialysis under method one, providers should submit a separate line item for each dialysis session using the dates in the predetermined plan of care schedule provided to the beneficiary unless informed by the beneficiary that the schedule was changed.

In the event that the schedule was changed, the provider should note the changes in the medical record and bill according to the revised schedule.

For continuous ambulatory peritoneal dialysis (CAPD) and continuous cycling peritoneal dialysis (CCPD) under method one, providers should submit a separate line item for the dialysis for each day of the month.

If the provider is aware of an inpatient stay for the beneficiary within the month, the RDF may include the date of admission and date of discharge as a billable day for the dialysis but should omit the dates within the inpatient stay.

In the event that the RDF is unaware of an inpatient stay during the month, the Medicare system will detect the overlapping dates and reject only the line-item dates within the inpatient stay but pay the remainder of the claim for any dates that are not within the inpatient stay.

Implementation

The implementation date for the instruction is April 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1084CP.pdf*.

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

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

MLN Matters Number: MM5039 – Revised
Related Change Request (CR) Number: 5039
Related CR Release Date: October 27, 2006
Related CR Transmittal Number: R1084CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Source: CMS Pub. 100-04, Transmittal 1084, CR 5039

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CORF SERVICES

Outpatient Therapy Caps with Exceptions Start January 1, 2008

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

Provider Types Affected

Therapists and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MAC)) for therapy services for Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 5871, from which this article is taken announces the dollar amount of outpatient therapy caps for 2008, and clarifies the *Medicare Claims Processing Manual* regarding exceptions to outpatient therapy services.

On January 1, 2008, the financial limits on outpatient therapy services is $1,810 for combined physical therapy and speech-language pathology services; and $1,810 for occupational therapy services.

You should make sure that your billing staffs are aware of these new outpatient therapy caps. You might also want to refer to the updated *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation), for the complete documentation of the outpatient therapy services exceptions clarifications (which are summarized below). The complete revised manual sections are attached to CR 5871, which is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1414CP.pdf*.

Background

The Balanced Budget Act of 1997 enacted financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital services. The 2006 Deficit Reduction Act enacted exceptions to the limits, and the Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the cap exceptions process through June 30, 2008. The dollar amount of the cap is updated annually in accordance with the Medicare economic index.

CR 5871, from which this article is taken announces the dollar amount of outpatient therapy caps for 2008. Effective January 1, 2008, the financial limits on outpatient therapy services will be $1,810 for combined physical therapy and speech-language pathology services; and $1,810 for occupational therapy services. Exceptions are allowed for medically necessary outpatient therapy services.

The financial limits on outpatient therapy services over the last three years are displayed in Table 1.

Table 1 – Financial Limits on Outpatient Therapy Services*

Year	Physical Therapy and Speech Language Pathology Combined	Occupational Therapy
2008	$1,810	$1,810
2007	$1,780	$1,780
2006	$1,740	$1,740

Note: Medicare pays up to 80 percent of the limits after the deductible has been met.

The Medicare summary notice (MSN) message 38.18 has been updated to read:

> ALERT: Coverage by Medicare is limited to *$1,780 in 2007 and $1,810 in 2008* for outpatient physical therapy and speech-language pathology combined. Occupational therapy services have the same limits. Medicare pays up to 80 percent of the limits after the deductible has been met. Exceptions to these limits apply to therapy billed by hospital outpatient departments and may also apply to medically necessary services.

CR 5871 also clarifies the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation), regarding exceptions to outpatient therapy services (except when billed by outpatient hospitals). A summary of the major manual clarifications follows:

1. **Section 10.2, Subsection B. Moratoria and Exceptions for Therapy Claims Future Exceptions** language added as follows:
   The cap exception for therapy services billed by outpatient hospitals was part of the original legislation (Balanced Budget Act of 1997), and applies as long as caps are in effect. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions, as they did for 2007 and as they again extended through June 30, 2008, as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

2. **Section 10.2, Subsection C-1 Exceptions to Therapy Caps – General**
   When the exceptions process (as directed by legislation) is in effect the policies in this section apply. Further, with the exception of the use of modifier KX, the guidance in this section applies to all therapy services addressed by this section.
   The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps.

3. **Section 10.2, Subsection C-2 Automatic Process Exceptions**
   Beginning January 1, 2007, all exceptions are processed automatically. You should be aware that the term "automatic process exceptions" indicates that the claims processing for the exception is automatic, and not that the exception, itself, is automatic.

Outpatient Therapy Caps with Exceptions Start January 1, 2008 (continued)

In making a decision about whether to utilize the automatic process for exception, clinicians should consider, (among other considerations) whether services are appropriate to the patient's condition including the diagnosis, complexities and severity You should be aware that the list of the ICD-9 codes (for conditions and complexities that might qualify a beneficiary for exception to caps) that is found in the table in subsection 10.2 C-3 is only a guideline; and neither assures that services on the list will be excepted, nor limits the provision of covered and medically necessary services for conditions that are not on the list. Not all patients who have a condition or complexity on the ICD-9-CM code list are "automatically" excepted from therapy caps. You should see the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 230.3 (Practice of Speech-Language Pathology) for documenting the patient's condition and complexities. Note that Medicare contractors may scrutinize claims from providers whose services exceed caps more frequently than is typical. Further guidance on billing therapy services are found in the local coverage determinations of some contractors.

4. **Subsection C-3. ICD-9 Codes That are Likely to Qualify for the Automatic Process Therapy Cap Exception Based Upon Clinical Condition or Complexity**
   Some Medicare contractors' local coverage determinations do not allow the use of some of the codes on the list in this subsection to be in the primary diagnosis position on a claim. If your contractor has determined that these codes do not characterize patients who require medically necessary services, you may not use these codes. Rather, to describe the patient's condition, you must use a billable diagnosis code that your contractor allows.

   Medicare will apply therapy caps to services based on the medical necessity of the service for the patient's condition, not on the condition itself. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted.
   You may use the automatic process for exception for medically necessary services when the patient has a billable condition that is not on the list in this subsection. The diagnosis on this list may be put in a secondary position on the claim and/or in the medical records, as your contractor directs.

Additional Information

You may find more information about the outpatient therapy caps for 2008, and the *Medicare Claims Processing Manual* clarifications regarding exceptions to outpatient therapy services by going to CR 5871, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1414CP.pdf*.

The updated *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation) is 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: MM5871
Related Change Request (CR) Number: 5871
Related CR Release Date: January 10, 2008
Related CR Transmittal Number: R1414CP
Effective Date: January 1, 2008
Implementation Date: January 25, 2008

Source: CMS Pub. 100-04, Transmittal 1414, CR 5871

Outpatient Therapy Cap Financial Limitation Revision

Effective January 1, 2008, the financial limits on outpatient therapy services has been revised. The new amounts are:

- Combined physical therapy and speech-language pathology – $1,810
- Occupational therapy – $1,810.

Notice of Exclusion from Medicare Benefits Form

It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits, and that, where necessary, appropriate care above the limits may be obtained at a hospital outpatient therapy department. Although use of the Notice of Exclusion from Medicare Benefits (NEMB) form is not a Medicare requirement, it is encouraged. Providers may use the NEMB (No. CMS 20007 & Formulario No. CMS 20007) form, or a similar form of their own design to inform beneficiaries of the therapy financial limitation and the cap exclusion process. The NEMB form may be found on the CMS Web site at *http://www.cms.hhs.gov/BNI/11_FFSNEMBGeneral.asp#TopOfPage*. ❖

Source: CMS Pub. 100-04, Chapter 5, Section 10.2

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

January 2008 Update of the Hospital Outpatient Prospective Payment System

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

Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [Fis], Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries [RHHIs]) for outpatient services provided to Medicare beneficiaries and paid under the OPPS.

Impact on Providers

This article is based on change request (CR) 5912, which describes changes to the outpatient prospective payment system (OPPS) to be implemented in the January 2008 OPPS update. Be sure billing staffs are aware of these changes.

Background

CR 5912 describes changes to and billing instructions for various payment policies implemented in the January 2008 OPPS update. The January 2008 integrated outpatient code editor (I/OCE) software changes are discussed in CR 5865. *MLN Matters* article, MM5865, is available on the Centers for Medicare & Medicaid (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5865.pdf*.

The January 2008 I/OCE and OPPS PRICER will reflect January 2008 changes to:

- The Healthcare Common Procedure Coding System (HCPCS)
- Ambulatory payment classification (APC)
- HCPCS modifier
- Revenue code additions, changes, and deletions identified in this notification.

CR 5912 affects chapter 4, sections 10, 20, 30, 50, 61, 70, 130, 160, 190, 200, 230, and 290; chapter 16, section 40.3; and chapter 17, section 90.2 of the *Medicare Claims Processing Manual*. CMS is reorganizing or deleting information in these sections. These manual revisions will be released in a future CR.

Key Changes

The key changes according to CR 5912 are as follows:

- For calendar year (CY) 2008, Medicare has created two parallel Level II HCPCS G-codes (G0396 and G0397) to allow for proper reporting and payment of alcohol and substance abuse structured assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury. Medicare contractors will make payment under the OPPS for HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397, (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention greater than 30 minutes), only when appropriate, reasonable and necessary (i.e., when the service is provided to evaluate patients with signs/symptoms of illness or injury) as per section 1862(a)(1)(A) of the Social Security Act. For more information regarding this change, refer to CR 5912.
- The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires Medicare to pay for brachytherapy sources for the period of January 1, 2008 through June 30, 2008, at hospital charges, adjusted to the costs (with the exception of C2637, which is nonpayable). Therefore, the prospective payment rates for each source, which are listed in Addendum B of the VY2008 final rule for OPPS, will **not** be used for payment during that time period. Instead, the status indicators of brachytherapy source HCPCS codes (except C2637), which were previously paid at charges adjusted to cost, will remain "H" effective January 1, 2008 through June 30, 2008. Further instructions will be issued later for payment after June 30, 2008. CR 5912 also has a table (Table 5) containing a comprehensive list of brachytherapy sources payable as of January 1, 2008.
- Table 9 of CR 5912 contains updated payment rates for certain HCPCS codes (J0152, J0881, J1438, J1440, J1441, J2425, J2505, J0215, J0289, J1740, J7342, J8560, and J9268) that are effective January 1, 2007 through March 31, 2007. The Medicare contractors will adjust as appropriate claims you bring to their attention that:
  - Have dates of service that fall on or after January 1, 2007, but prior to April 1, 2007.
  - Contain HCPCS code listed in Table 9 which is included in the business requirements section of CR 5912.
  - Were originally processed prior to the installation of the January 2008 OPPS PRICER.
- Table 10 of CR 5912 contains updated payment rates for selected drugs and biologicals (HCPCS codes J0881, J1324, J1438, J1440, J1441, J2425, and J2502) that are effective from April 1, 2007 through June 30,

January 2008 Update of the Hospital Outpatient Prospective Payment System (continued)

2007. Medicare contractors will adjust as appropriate claims you bring to their attention that:

- Have dates of service that fall on or after April 1, 2007, but prior to July 1, 2007.
- Contain HCPCS code listed in Table 11.
- Were originally processed prior to the installation of the January 2008 OPPS PRICER.

- Table 11 of CR 5912 contains updated payment rates for selected drugs and biologicals (HCPCS codes J0881, J1438, J1440, J1441, J2505, Q3025, and Q4089) that are effective from July 1, 2007 through September 30, 2007. Medicare contractors will adjust as appropriate claims you bring to their attention that:
  - Have dates of service that fall on or after July 1, 2007, but prior to October 1, 2007.
  - Contain HCPCS code listed in Table 11.
  - Were originally processed prior to the installation of the January 2008 OPPS PRICER.
- The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires CMS to pay for therapeutic radiopharmaceuticals for the period of January 1, 2008 through June 30, 2008 at hospitals charges adjusted to the costs. Therefore, the prospective payment rates for each therapeutic radiopharmaceutical, which are listed in Addendum B of the CY2008 final rule from CMS dated November 27, 2007, will **not** be used for payment of therapeutic radiopharmaceuticals from January 1 through June 30, 2008. Instead, the status indicators of therapeutic radiopharmaceutical HCPCS codes that were previously paid at charges adjusted to costs will remain at "H" effective January 1, 2008 through June 30, 2008, for payment at hospital charges adjusted to costs. The codes for therapeutic radiopharmaceuticals, long descriptors, status indicators, and APCs for CY 2008 are listed in Table 12 of CR 5912.
- Effective January 1, 2008, Medicare contractors will return to the provider claims that report a nuclear medicine service but do not also report a diagnostic radiopharmaceutical.
- Providers who bill A/B MACs and RHHIs need to be aware that C-codes: C9237, C9240, C9354, and C9355 are included in the January 2008 I/OCE update. However, these codes are not on the 2008 HCPCS file. Contractors will manually add these codes to their systems. Status and payment indicators for these codes will be listed in the January 2008 update of the OPPS Addendum A and Addendum B on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage*.

CR 5912 is quite lengthy and also includes important changes regarding certain OPPS issues. Those details will not be repeated in this article, but are available in CR 5912 on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1417CP.pdf*.

The issues discussed in CR 5912 include:

- Payment for cardiac rehabilitation services and the medical evaluation which is required to meet the Medicare comprehensive program requirements.
- Payment for extended assessment and management composite APCs, including a table (Table 1 of CR 5912) that shows criteria for composite payment.
- Payment for direct admission to observation, including a discussion of HCPCS codes used for these services.
- Changes to packaged services for the 2008 OPPS, including a table (Table 2 of CR 5912) of composite APCs and criteria for composite payment.
- Billing for wound care services, including a list of revisions to revenue codes that may be reported with *CPT codes 97597, 97598, 97602, 97605,* and *97606*.
- Billing for bone marrow and stem cell processing services.
- Update billing for implantable cardioverter defibrillators (ICDs), which reports that the four Level II HCPCS codes (G0297, G0298, G0299, and G0300) are deleted effective January 1, 2008, and hospitals are required to bill the appropriate *CPT* codes, specifically *33240 or 33249*, as appropriate, along with the applicable device C-codes, for payment under the OPPS.
- Adjustment to payment in cases of devices replaced with partial credit for the replaced device, including two helpful tables (Tables 4.1 and 4.2) regarding the use of the FC modifier.
- Changes to device edits for 2008, including a reference that these edits are available under the "downloads" section on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.
- As previously mentioned, a discussion of payment for brachytherapy sources, including a table (Table 5) that lists brachytherapy sources payable as of January 1, 2008, along with associated APCs and payment rates.
- Billing for drugs and biologicals, including a table (Table 6) of new 2008 HCPCS codes (A9501, A0509, A9569, A9570, A9571, A9576,A9577, A9578, C9237, C9238, C9239, C9240, C9354, C9355, J0400, J1573, J2724, and J9226), a table (Table 7) of HCPCS code and dosage descriptor changes for 2008, a table (Table 8) of new drugs separately payable under OPPS in 2008 (C9237 – (Injection, lanreotide acetate, 1mg) and C9240 – (Injection, ixabepilone, 1mg); New Drug Administration codes for 2008 (*90769, 90770, 90771*, and *90776*).
- Billing for cardiac echocardiography services, including a table (Table 13) of HCPCS codes for echocardiograms with contrast (HCPCS codes C8921, C8922, C8923, C8924, C8925, C8926, C8927, and C8928).
- Modification of the methodology for calculating hospital overall cost-to-charge ratios for hospitals that have nursing and paramedical education programs.

January 2008 Update of the Hospital Outpatient Prospective Payment System (continued)

- Changes to the OPPS PRICER logic.
- OCE logic changes for the partial hospitalization program (PHP) services.

Additional Information

To see the official instruction (CR 5912) issued to your Medicare FI, RHHI or A/B MAC refer to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1417CP.pdf*.

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

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

MLN Matters Number: MM5912
Related Change Request (CR) Number: 5912
Related CR Release Date: January 18, 2008
Related CR Transmittal Number: R1417CP
Effective Date: January 1, 2008 (unless otherwise noted)
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1417, CR 5912

January 2008 Integrated Outpatient Code Editor Specifications Version 9.0

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

Provider Types Affected

All providers who submit institutional outpatient claims (including non-outpatient prospective payment system [non-OPPS] hospitals) to Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5865 and notifies providers that the integrated outpatient code editor (I/OCE) specifications version 9.0 is effective January 1, 2008. Note that claims with dates of service **prior to July 1, 2007,** are routed through the non-integrated versions of the OCE software that **coincide with the versions in effect for the date of service on the claim.**

Background

This article is based on CR 5865 and informs providers that the I/OCE routes all institutional outpatient claims (including non-OPPS hospital claims) through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis. **This integration does not change the current logic that is applied to outpatient bill types that already pass through the OPPS OCE software.** It expands the software usage to include non-OPPS hospitals.

There are numerous changes/additions/deletions to diagnosis codes, ambulatory payment classification (APC) codes, and Health Care Common Procedure Codes (HCPCS) in January 2008. All of the changes will not be detailed in this article. Instead, please see CR 5865 for those details. CR 5865 is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1419CP.pdf*.

The key changes for the January 2008 I/OCE are as follows: (Some I/OCE modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.)

January 2008 Integrated Outpatient Code Editor Specifications Version 9.0 (continued)

Effective Date	Modification
1/1/08	Modify appendix D to prevent double discounting: 1. Replace discount formula #6 with formula #3 in applicable rows, to prevent application of both multiple procedures & terminated procedure discounting to the same procedure. 2. Create new discount formula #9 to replace discount formula #7 (to pay 100 percent of the APC rate, 50 percent x2, for a bilateral T procedure that is not the highest).
1/1/08	Discontinue use of discount formulae #6 and #7
1/1/08	Create new payment adjustment flag (PAF) 8: Item provided with partial credit to provider. 1. Assign to procedures subject to 50 percent of offset, when modifier FC is present. 2. Reduce APC payment rate by 50 percent of offset amount before application of discounting logic.
1/1/08	Expand edit 75 to apply to modifier FC in addition to FB – to trigger if modifier FB or FC is appended to a code with status indicator (SI) other than S, T, X or V.
1/1/08	Expand use of SI of "Q" – to include other codes (not packaged services only) subject to SI change based on criteria.
1/1/08	Implement new 'composite' APC assignment logic as specified in appendix K and appendix H-c of the I/OCE specifications attached to CR 5865
1/1/08	Implement two-character payment adjustment flags, 91-99; use for composite APCs (see appendix G of CR 5865).
1/1/08	Deactivate observation logic that is based on payable G0378 (appendix H-a).
1/1/08	Remove criterion for 'payable G0378' from G0379 processing (appendix H-b).
1/1/08	Implement logic for assignment of new composite ambulatory payment classifications (APCs), which include observation (appendix K).
1/1/08	Bypass edit 48 for revenue code 0948.
1/1/08	Apply wound care logic to all revenue codes in the therapy series: 042x, 043x and 044x (not 04x0 only).
1/1/08	Modify PHP and MH per-diem logic (appendix C) • Replace APC numbers with specified lists of codes ◆ PH services = list of codes that count toward Partial Hospitalization APC ◆ MH services = list of codes that are included in the Daily Mental Health services cap • Assign SI of 'N' to all codes that are packaged into APC 33 & 34 • Count multiple occurrences of OT (G0129) as separate units in determining "three or more" for PHP
1/1/08	Modify the current special packaged codes logic to package only in the presence of codes with SI of S, T, V or X on the same date of service = "STVX-packaged" codes.
1/1/08	Expand special packaged codes logic to add codes that will be packaged in the presence of a code with SI of T on the same date of service = "T-packaged" codes.
8/1/00	Bypass edit 48 for revenue codes 099x. Assign edit 9 (SI-E) if submitted without a HCPCS.
10/1/07	Rescind previous program modification – re-apply edit 71 to bill type 12x.
1/1/07	Modify the program to exclude bill type 12x from edit 77 (change effective date from 10/1 to 1/1/07).
1/1/08	New edit 78 – Claim lacks required radiopharmaceutical (RTP). Assign to specified nuclear medicine procedure if no specified radiopharmaceutical on the claim.
1/1/08	Make non-OPPS bill type 83x invalid for the I/OCE – assign claim processed flag of "1" (claim could not be processed, invalid bill type).
7/1/07	Modify the program to bypass edit 17 for bill type 85x.

January 2008 Integrated Outpatient Code Editor Specifications Version 9.0 (continued)

Effective Date	Modification
7/1/07	Modify the processing flow such that no values are returned for the following OPPS-related flags on Non-OPPS claims (OPPS flag = 2). Return blank fields in the APC/ASC Return buffer. • status indicator • payment indicator • discounting formula number • line item denial or rejection • packaging • payment adjustment • payment method • line item action. Return "0" in the payment APC/ASC field.
	Make HCPCS/APC/SI changes as specified by CMS.
	Implement version 13.3 of the NCCI file, removing all code pairs, which include anesthesia (*00100-01999; 99143-99150*), *E&M* (*92002-92014, 99201-99499*), or MH (*90804-90911*).
	Add new modifiers (FC, EA, EB, EC, KG, KK, KU, KW, KY, Q0, Q1) and delete modifiers QA, QR, and QV as specified by CMS.
	Modify description for edit 75: Incorrect billing of modifier FB or FC.
10/1/07	Add new revenue code 0948 to the valid revenue code list, no pre-assigned SI.
	Modify description for SI 'M' (Service not billable to the FI/MAC) also modify descriptions for SI A, and K, and N, and Q, and V, and Y.
	Rename OCE Overview as appendix L; Rename Summary of Modifications as appendix M.

Readers should also read through the specifications attached to CR 5865 and note the yellow highlighted sections, which indicate change from the prior release of the I/OCE software.

Additional Information

For complete details regarding CR 5865, please see the official instruction (CR 5865) issued to your Medicare A/B MAC, RHHI, or FI. To view the instruction, visit the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1419CP.pdf*.

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

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

MLN Matters Number: MM5865
Related Change Request (CR) Number: 5865
Related CR Release Date: January 18, 2008
Related CR Transmittal Number: R1419CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Source: CMS Pub. 100-04, Transmittal 1419, CR 5865

EDUCATIONAL EVENTS

Upcoming Provider Outreach and Education Events

February 2008 – March 2008

Ask the Contractor – Topic: Recovery Audit Contractor (RAC)

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

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

Type of Event: **Teleconference/Webcast**

National Provider Identifier – Part A and B Providers

When: **Wednesday, February 20, 2008**

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

Type of Event: **Webcast**

Ask the Contractor – Skilled Nursing Facilities and Comprehensive Error Rate Testing (CERT)

When: **Thursday, February 21, 2008**

Time: **10:00a.m. – 11:30 a.m. Eastern Standard Time**

Type of Event: **Teleconference/Webcast**

Hot Topics – Medicare Updates

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

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

Type of Event: **Teleconference/Webcast**

Two Easy Ways To Register

Online – To register for this seminar, please visit our new training Web site at *www.fcsomedicaretraining.com*.

- If you are already a registered user of FCSO's Learning Management System (LMS), simply log on, select the specific session you are interested in, and click the "Register" button.
- If you are a **first-time user** of the LMS, you will need to set up an account. To do so, follow these steps:
  - From the welcome page, click on "I need to request an account" just above the log on button.
  - Complete the Request User Account form. (**Note**: Providers who do not yet have an NPI may use 9999.) You will receive your log on information within 72 hours of requesting an account.
  - Once your registration is complete, log on and select "Course Catalog," then select "Catalog." Select the specific session you are interested in, and then click the "Register" button.

Fax – If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to (904) 361-0407. Keep listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events. Providers without Internet access may leave a message on our FCSO Provider Education and Outreach Registration Hotline 1-904-791-8103 requesting a fax registration form.

Please Note:

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

Registrant's Name: _____
Registrant's Title: _____
Provider's Name: _____
Telephone Number: _____ Fax Number: _____
E-mail Address: _____
Provider Address: _____
City, State, ZIP Code: _____

More educational events (teleconferences, webcasts, etc.) will be planned to help providers with hot issues. Keep checking our Web site *http://www.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

January is National Glaucoma Awareness Month

Approximately three million Americans have glaucoma. Because the disease often progresses silently in the initial stages, with no symptoms, it is estimated that up to half of the approximately three million Americans with the disease don't know they have it. Vision loss from glaucoma is permanent and irreversible. While anyone can get glaucoma, certain groups of people are at higher risk for the disease. Glaucoma is more likely to occur in African Americans than in Caucasians and is a leading cause of blindness among African American and Hispanic populations in the United States. People with diabetes are nearly twice as likely to develop glaucoma as adults without diabetes. And people with a family history of glaucoma are more likely to get glaucoma too. Although glaucoma cannot be cured, early detection and treatment usually can stop further damage and prevent blindness. The benefit provided by Medicare offers a comprehensive glaucoma screening for seniors and others with Medicare at high risk for the disease.

Medicare Coverage

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high-risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older.

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure (IOP) measurement
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

What Can You Do?

The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that all eligible people with Medicare take full advantage of the annual glaucoma screening benefit. Your high-risk Medicare patients may not remember to schedule their annual glaucoma-screening exam. You can help remind them by talking with them about glaucoma and their risk for the disease, what can happen when glaucoma goes undetected/untreated, and how they can help protect themselves from severe consequences with early detection by getting an annual glaucoma screening exam. Your reminder and referral for a glaucoma-screening exam can help provide high-risk Medicare beneficiaries with peace of mind and safeguard their vision.

For More Information

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

The *MLN* Preventive Services Educational Products Web page – Provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

Glaucoma Screening Brochure – This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of glaucoma screening services. To view online go to the CMS Web site *http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma.pdf*.

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

The CMS Web site provides information for preventive service covered by Medicare. Go to *http://www.cms.hhs.gov*, select "Medicare", scroll down to the "Prevention" section.

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

For more information about glaucoma, visit The National Eye Institute *http://www.nei.nih.gov/index.asp*.

For more information about National Glaucoma Awareness Month, please visit *http://www.preventblindness.org/*. ❖

Source: CMS Provider Education Resource 200801-04

January Flu Shot Reminder

It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because flu viruses change each year.

Please encourage your Medicare patients who haven't already done so to get their annual flu shot. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends.

Get Your Flu Shot – Not the Flu!

Remember Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is not a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing the special edition *MLN Matters* article SE0748 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf*. ❖

Source: CMS Provider Education Resource 200801-03

Medicare Provides Coverage for Many Preventive Services and Screenings

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

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

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

Source: CMS Provider Education Resource 200801-02

OTHER EDUCATIONAL RESOURCES

Ambulatory Surgical Center Fee Schedule Fact Sheet

The Ambulatory Surgical Center Fee Schedule Fact Sheet, which provides general information about the ambulatory surgical center (ASC) fee schedule, ASC payments, and how ASC payment amounts are determined, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508.pdf*. ❖

Source: CMS Provider Education Resource 200801-08

The Home Health Prospective Payment System Fact Sheet

The Home Health Prospective Payment System Fact Sheet, which provides information about coverage of home health services and elements of the home health prospective payment system, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/downloads/HomeHlthProspPymtfctsht08-508.pdf*. ❖

Source: CMS Provider Education Resource 200801-07

Hospice Payment System Fact Sheet Available

The Hospice Payment System fact sheet, which offers providers information about the Medicare hospice benefit, is now available from the Centers for Medicare & Medicaid Services Medicare Learning Network in downloadable format at *http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf*.

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

Source: CMS Provider Education Resource 200801-19

ORDER FORM – PART A MATERIALS

The following materials are available for purchase. To order, please complete and submit this form along with your check/money order (PAYABLE TO: FCSO – account number 40-500-150).

NUMBER ORDERED	ITEM	ACCOUNT NUMBER	COST PER ITEM
_____	***Medicare A Bulletin* Subscriptions –** The *Medicare A Bulletin* is available free of charge online at *http://www.floridamedicare.com*. Hardcopy or CD-ROM distribution is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers that meet the above criteria must register with our office (see Third Quarter 2006 *Medicare A Bulletin* page 8-9) to receive the *Bulletin* in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason is giving indicating why the electronic publication available free-of-charge on the Internet cannot be used. Non-Medicare providers (e.g., billing agencies, consultants, software vendors, etc.) or providers that need additional copies at other office-facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published during October 2007 through September 2008 (back issues sent upon receipt of the order). Please check here if this will be a: [ ] Subscription Renewal or [ ] New Subscription	40-500-150	$250.00 (Hardcopy) $20.00 (CD-ROM)

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ALL ORDERS MUST BE PREPAID –

DO NOT FAX - PLEASE PRINT

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

Sign up to our *eNews* electronic mailing list

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

IMPORTANT ADDRESSES, TELEPHONE NUMBERS AND WEBSITES

Addresses

CLAIMS STATUS

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

PART A REDETERMINATION

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

MEDICARE SECONDARY PAYER (MSP)

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

General MSP Information
Completion of UB-04 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

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

PROVIDER EDUCATION

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

Seminar Registration Hotline
1-904-791-8103

Seminar Registration Fax Number
1-904-361-0407

ELECTRONIC CLAIM FILING

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

FRAUD AND ABUSE

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

PART A RECONSIDERATION

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

OVERPAYMENT COLLECTIONS

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

PROVIDER ENROLLMENT

American Diabetes Association Certificates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

Telephone Numbers

PROVIDERS

Customer Service Center Toll-Free
1-888-664-4112
Speech and Hearing Impaired
1-877-660-1759

BENEFICIARY

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

ELECTRONIC MEDIA CLAIMS

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

Electronic Eligibility
1-904-791-8131

Electronic Remittance Advice
1-904-791-6865

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

PC-ACE Support
1-904-355-0313

Testing
1-904-791-6865

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

Medicare Web sites

PROVIDERS

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

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

RAILROAD MEDICARE

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

MEDICARE A BULLETIN

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

* ATTENTION BILLING MANAGER *