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 *http://medicare.fcso.com*.

Routing Suggestions :

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

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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

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) noti cation parameters.

The Medicare Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. Important noti cations requiring communication in between publications will be posted to the FCSO Medicare provider education Web site *http://medicare.fcso.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 May 2008 *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 scal 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 speci c 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-speci c 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 speci c facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-speci c 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 noti cation of new nalized 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 scal 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 speci c 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 bene ciaries.

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

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

GENERAL INFORMATION

Change in the amount of controversy requirements

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 carriers, durable medical equipment Medicare administrative contractors (DME MACs), scal intermediaries (FIs), Part A/B MACs (A/B MACs), and/or regional home health intermediaries (RHHIs) for services provided to Medicare bene ciaries.

Provider action needed

This article is based on change request (CR) 6295, which noti es Medicare contractors of the amount in controversy (AIC) required to sustain administrative law judge (ALJ) and federal district court appeal rights beginning January 1, 2009.

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2009, is $120. The amount remaining in controversy requirement for requests made on or after January 1, 2009, is $120.

For federal district court review, the amount remaining in controversy goes from $1,180 for requests on or after January 1, 2008, to $1,220 for requests on or after January 1, 2009.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Bene ts Improvement and Protection Act of 2000 (BIPA). CR 6295 modi es the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 29, Section 330.1 and Section 345.1) to update the AIC required for an ALJ hearing or judicial court review.

Additional information

The of cial instruction (CR 6295) issued to your Medicare carrier, A/B MAC, DME MAC, FI, and/or RHHI is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1676CP.pdf*.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6295
Related Change Request (CR) Number: 6295
Related CR Release Date: January 30, 2009
Related CR Transmittal Number: R1676CP
Effective Date: May 4, 2009
Implementation Date: May 4, 2009

Source: CMS Pub. 100-04, Transmittal 1676, CR 6295

Flu shot reminder

It's not too late to give and get the u shot!

In the US, the peak of u season typically occurs anywhere from late December through March; however, u season can last as late as May. Each of ce visit presents an opportunity for you to talk with your patients about the importance of getting an annual u shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the u shot.

Don't get the fly. Don't give the flu

Remember: In uenza and pneumococcal vaccinations and their administration are covered Part B bene ts. Note that in u-enza and pneumococcal vaccines are not Part D covered drugs.

Health care professionals and their staff can learn more about Medicare's Part B coverage of adult immunizations and related provider education resources, by reviewing special edition *MLN Matters* article SE0838 located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf*. ❖

Source: CMS PERL 200901-55

Implementation of provider authentication requirements for contacting Medicare

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

Note: The Centers for Medicare & Medicaid Services (CMS) revised this article to re ect the revised change request (CR) 6139, which CMS re-issued on February 25, 2009. The effective and implementation dates for providers have been changed to April 6, 2009. Also, the CR release date, transmittal number, and the Web address of the CR have been changed. All other information remains the same. The special edition *MLN Matters* article MM6139 was published in the September 2008 *Medicare A Bulletin* (pages 14-15).

Provider types affected

CR 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, scal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [A/B MACs], or durable medical equipment Medicare administrative contractors [DME MACs]). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to interactive voice response (IVR) systems.

What you need to know

CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a customer service representative (CSR).

Effective April 6, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication:

1. Your national provider identi er (NPI)
2. Your provider transaction access number (PTAN)
3. The last ve-digits of your tax identi cation number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background

In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, bene ciary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last 5-digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor system will verify that the NPI, PTAN, and last ve-digits of the TIN are correct and belong to you before providing the information you request.

Note: You will only be allowed three attempts to correctly provide your NPI, PTAN, and last ve-digits of your TIN.

As a result of CR 6139, the *Disclosure Desk Reference* for provider contact centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the *Medicare Contractor Beneficiary and Provider Communications Manual,* Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to re ect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

Authentication of providers with no NPI

Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to nd the claim and return claims status information.

Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

Beneficiary authentication

Before disclosing bene ciary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four bene ciary data elements are required for authentication:

1. Last name
2. First name or initial
3. Health Insurance Claim Number (HICN)
4. Either date of birth (eligibility, next eligible date, durable medical equipment Medicare administrative contractor information form [DIF] [pre-claim]) **or** date of service (claim status, CMN/DIF [post-claim]).

Written Inquiries

In general, three data elements (NPI, PTAN, and last ve digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received

Implementation of provider authentication requirements for contacting Medicare (continued)

without letterhead including hardcopy, fax, e-mail, pre-formatted inquiry forms or inquiries written on remittance advice (RAs) or Medicare summary notices (MSNs),

The exception to this requirement is written inquiries received on the provider's of cial letterhead including emails with an attachment on letterhead. In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice location and name on the letterhead must match the contractor's le for this provider. (However, your Medicare contractor may use discretion if the le does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either the NPI, the PTAN, or last ve-digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last ve-digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

Overlapping Claims

When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last ve-digits of the TIN, bene ciary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional information

You may nd more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R24COM.pdf*.

If you have any questions, please contact your Medicare contractor (carrier, FI, RHHI, 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6139 – Revised
Related Change Request (CR) Number: 6139
Related CR Release Date: February 25, 2009
Related CR Transmittal Number: R24COM
Effective Date: April 6, 2009
Implementation Date: April 6, 2009 for providers

Source: CMS Pub. 100-02, Transmittal 24, CR 6139

Revised payment system fact sheets

The following revised payment system fact sheets are now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

Medicare Physician Fee Schedule (January 2009): Provides general information about the Medicare physician fee schedule. This fact sheet may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*.

Hospital Outpatient Prospective Payment System (January 2009): Provides general information about the hospital outpatient prospective payment system, ambulatory payment classi cations, and how payment rates are set. This fact sheet may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf*.

Hospice Payment System (January 2009): Provides general information about the Medicare hospice bene t including coverage of hospice services, certi cation requirements, election periods, and how payment rates are set. This fact sheet may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf*.

Note: If you are unable to access any of the hyperlinks in this message, please copy and paste the URLs into your Internet browser. ❖

Source: CMS PERL 200902-07

January 2009 Medicare Fraud & Abuse fact sheet

The January 2009 Medicare Fraud & Abuse fact sheet is now available at *http://www.cms.hhs.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf* on the *Medicare Learning Network (MLN)*. The Centers for Medicare & Medicaid Services (CMS) works with other government agencies and law enforcement organizations to protect the Medicare program from fraud and abuse. Together with CMS, providers can help identify and prevent fraud and abuse; the rst step for providers to protect themselves is to understand the legal de nitions and be able to identify fraudulent and abusive practices. This fact sheet provides information on many available resources to help you understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse. ❖

Source: CMS PERL 200902-30

Providers serving Medicare beneficiaries enrolled in private fee-for-service plans

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

Provider types affected

All Medicare physicians, providers, and suppliers who provide services to Medicare patients enrolled in a Medicare Advantage (MA) private fee-for-service (PFFS) organizations.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) has announced a new process for handling payment disputes raised by providers who serve Medicare patients enrolled in MA PFFS plans. Such disputes arise when the billing provider is not satis ed with the MA PFFS organizations payment and the provider has exhausted the dispute resolution process with that organization. Effective January 1, 2009, CMS has delegated the adjudication of PFFS provider payment disputes to an independent review entity, i.e., First Coast Service Options, Inc. (FCSO). Therefore, as of January 1, 2009, after having exhausted the appeals process with the PFFS plan; providers should begin submitting payment dispute decision requests directly to FCSO. This process applies to providers treating such patients, where the provider has not contracted with the MA PFFS organization. Providers rendering such services without contracting with the MA PFFS plan are "deemed" providers for that plan. Please see the *Background* section for more detail.

Background

Prior to January 1, 2009, CMS central and regional of ce staff adjudicated payment disputes between deemed and noncontracted PFFS providers and MA organizations offering PFFS plans. However, beginning January 1, 2009, after an MA PFFS plan informs a provider or supplier in writing that a payment dispute has been denied through the MA PFFS plan provider payment dispute process; those who disagree with the pricing decision have the right to request the decision be reviewed by an independent review entity under contract with CMS.

Further, on November 25, 2008, CMS released a health plan management system (HPMS) memorandum (Instructions for Model Private Fee-For-Service Terms and Conditions of Payment) announcing (effective January 1, 2009) that FCSO would be the independent review entity to which the adjudication of PFFS provider payment disputes would be delegated. In this role, FCSO directly adjudicates payment disputes between deemed and noncontracted private fee-for-service (PFFS) providers and MA organizations offering PFFS plans.

What decisions are subject to the payment dispute process?

Provider payment disputes include any decisions in which there is a dispute that the payment amount made by the MA PFFS plan to deemed providers is less than the payment amount that would have been paid under the MA PFFS plan terms and conditions, or the amount paid to noncontracted providers is less than would have been paid under original Medicare (including balance billing).

Note: A deemed provider is one who was aware that the patient was a private fee for service member at the time of service, and therefore had the ability to view the plan's terms and conditions of payment. A noncontracting provider is one that was not aware the patient was a private fee for service member at the time of service, e.g., an emergency situation.

Which decisions are not subject to the PFFS provider payment dispute process?

- Services denied for coverage issues such as local coverage determinations (LCDs)
- National coverage determinations (NCDs)
- Appeals of medical necessity determinations by the plan should rst be sent through the appeals process of the MA PFFS plan and that process should be on the plan's Web site along with the plan's terms and conditions of payment, and
- Disputes between a contracted network PFFS provider and the MA PFFS plan are also not reviewed by the IRE or CMS.

How do you file a request for independent review (payment dispute decision [PDD])?

If you have exhausted the PFFS organization's dispute resolution process and wish to escalate review, you must le a PDD request directly with FCSO within 180 days of written notice from the MA PFFS plan (all requests must be received within 180 days of the MA PFFS plan written decision).

You must submit the request in writing; preferably on a standard PDD form available at the FCSO's PFFS Web site. A written request that is not made on the standard PDD form will be accepted if it contains all the required elements, as follows:

- Provider or supplier contact information including name and address
- Pricing information, including the national provider identi er (NPI) of the provider (and CMS certi cation number (CCN) or OSCAR number for institutional providers), ZIP where services were rendered, physician specialty, the name of the MA PFFS plan that made the redetermination including the speci c PFFS plan name, and whether the provider/supplier is deemed or noncontracted
- The reason for dispute; a description of the speci c issue
- A copy of the provider's submitted claim with disputed portion identi ed
- A copy of the PFFS plan's original pricing determination
- A copy of the PFFS plan's redetermination (dispute) pricing decision

Providers serving Medicare beneficiaries enrolled in private fee-for-service plans (continued)

- A copy of the relevant portion of terms and conditions (which are on the plan's Web site and that Web site address should be listed on the bene ciary's membership card for the plan) or contract and any supporting documentation and correspondence that support the provider's position that the plan's reimbursement is not correct (this may include interim rate letters where appropriate)
- An appointment of provider or supplier representative authorization statement, if applicable, and
- The name and signature of the party or the representative of the party.

Mail your requests to:

First Coast Service Options Inc.
PFFS Payment Disputes
P.O. Box 44017
Jacksonville, Florida 32231-4017

Alternatively, if the submission and associated documents do not contain any personally identi able health information (PHI) (or any PHI has been redacted), you may submit the payment dispute decision request to a dedicated e-mail box at *IREPFFS@FCSO.com*. FCSO can also receive PDD requests (including associated documents such as claims forms that may contain PHI) via fax at 1-904-361-0551.

What is the timeframe for making a PDD?

Once you have requested a PDD, FCSO may request documentation from the MAPFFS plan that processed the redetermination. When that plan receives FCSO's request for the case le, they must send it within seven calendar days so that FCSO receives it on or before the eighth day. PFFS plans that do not respond timely to IRE requests will be considered out of compliance with their CMS contract and subject to compliance processes.

FCSO will issue a decision within 60 days after receiving a provider payment dispute appeal unless it grants itself an exception to the 60-day timeframe. In the issued payment dispute decision letter, FCSO will notify all parties of either its decision, or that it has dismissed the PDD request. The PDD letter will also include the facts of the appeal, arguments made for and against additional reimbursement, the adjudicator's decision and rationale, and noti cation to the parties of their right to request a debrie ng. Finally, when the IRE renders a decision on a case and noti es all parties of its decision, it considers the case closed. Please note again, however, that both parties have the right to request a debrie ng.

If you have questions regarding the adjudication process or individual disputes being reviewed by the IRE, you can contact FCSO at 1-904-791-6430. You will be able to leave messages at this number and should expect a return call within 48 hours of receipt. Additionally, you can mail correspondence associated with a dispute request to:

First Coast Service Options Inc.
PFFS Payment Disputes
P.O. Box 44035
Jacksonville, Florida 32231-4035

Additional information

The standard PDD form and other information regarding this independent review process are available on the FCSO Web site at *http://www.fcso.com/whatwedo/QIC/139297.asp*.

MLN Matters Number: SE0902
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 SE0902

Shipboard services billed to Medicare not provided within the United States

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

Note: The Centers for Medicare & Medicaid Services (CMS) has rescinded change request (CR) 6217 and replaced it with CR 6327 issued on February 13, 2009. The *MLN Matters* article MM6217 was published in the January 2009 *Medicare A Bulletin* (pages 16-17). The *MLN Matters* article MM6327 is being published in this in this edition February 2009 *Medicare A Bulletin*.

MLN Matters Number: MM6217 – Rescinded
Related Change Request (CR) Number: 6217
Related CR Release Date: October 3, 2008
Related CR Transmittal Number: R1609CP and R95BP
Effective Date: January 5, 2009
Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1609, CR 6217

Shipboard services billed to Medicare not provided within the United States

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, scal intermediaries [FIs], and/or Medicare administrative contractors [MACs]) for billed shipboard services provided to Medicare bene ciaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6327 which clari es payment for shipboard services billed to Medicare contractors and services not provided within the United States.

Caution – what you need to know

Change request (CR) 6327 revises the *Medicare Claims Processing Manual* and the *Medicare Benefit Policy Manual* to clarify that Medicare contractors will make payment for physician and ambulance services furnished in connection with a covered foreign hospitalization, including emergency physician and ambulance services furnished during the time period immediately preceding the covered foreign hospitalization. **CR 6327 rescinds and fully replaces CR 6217.**

Go – what you need to do

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

Background

Medicare law prohibits payment for items and services furnished outside the United States except for certain limited services (see the Social Security Act, Section 1814(f) at *http://www.ssa.gov/OP_Home/ssact/title18/1814.htm* and Section 1862(a)(4) at *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the Internet). The law speci es the following are exceptions to the "foreign" exclusion:

- Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
  - The emergency arose within the U.S, or
  - The emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay, between Alaska and another state.
- Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual's residence within the U.S. than the nearest U.S. hospital that is adequately equipped and available to treat the individual's condition, whether or not an emergency exists
- Physician and ambulance services in connection with a foreign inpatient hospital stay that is covered in accordance with (1) or (2) above.

Note: The term "United States" includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and, for purposes of services rendered on a ship, the territorial waters adjoining the land areas of the United States.

The *Medicare Claims Process Manual* (Chapter 1, Section 10.1.4.7; see *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site) currently states that:

- Services furnished by a physician or supplier in U.S. territorial waters must be furnished on board vessels of American registry, and
- The physician must be registered with the Coast Guard in order for Medicare to make payment.

However, that manual language is not consistent with Medicare law. Therefore, because Section 10.1.4.7 is not consistent with Medicare law, CMS is clarifying Section 10.1.4.7 in order to make it consistent with current Medicare law by removing the language that states:

- The vessels must be of American registry, and
- The physician must be registered with the Coast Guard.

CMS is also clarifying Chapter 1, Sections 10.1.4, and 10.1.4.1 and Chapter 3, Section 110.1 of the *Medicare Claims Processing Manual* and Chapter 16, Section 60 of the *Medicare Benefit Policy Manual* to show that physician and ambulance services furnished in connection with a covered foreign hospitalization are covered. The term "and during a period of" covered foreign hospitalization implies that only physician and ambulance services that are furnished during the period of the covered foreign hospitalization are covered (i.e., the period after the bene ciary has been admitted to the foreign hospital), when, in fact, the emergency physician and ambulance services are covered both:

- During the time period immediately before the bene ciary is actually admitted to the foreign hospital, and
- During the covered foreign hospitalization itself.

You may nd the revised chapters of two manuals referenced above as attachments to CR 6327.

Additional information

The of cial instruction, CR 6327, was issued to your carrier, FI, and MAC via two transmittals. The rst modi es the *Medicare Claims Processing Manual* and is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1677CP.pdf* and the second modi es the *Medicare Benefit Policy Manual* and that transmittal is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R102BP.pdf*.

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

Shipboard services billed to Medicare not provided within the United States (continued)

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6327
Related Change Request (CR) Number: 6327
Related CR Release Date: February 13, 2009
Related CR Transmittal Number: R1677CP and R102BP
Effective Date: March 13, 2009
Implementation Date: March 13, 2009

Source: CMS Pub. 100-04, Transmittal 1677, CR 6327

Physician signature requirements for diagnostic tests

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

Note: The Centers for Medicare & Medicaid Services (CMS) revised this article to remove a parenthetical statement under the *What you need to know* section of this article. All other information remains the same. The special edition *MLN Matters* article MM6100 was published in the September 2008 *Medicare A Bulletin* (page 16).

Provider types affected

Physicians and other providers who bill Medicare contractors (carriers, scal intermediaries (FI), or Medicare administrative contractors (A/B MAC)) for diagnostic laboratory services provided to Medicare bene ciaries.

What you need to know

CR 6100, from which this article is taken, updates the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests) Subsection 80.6.1 (De nitions); to incorporate language previously contained in Section 15021 of the *Medicare Carriers Manual*, but inadvertently omitted when the *Medicare Benefit Policy Manual* was published.

Speci cally, it notes that a physician's signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

Make sure that your of ce, billing, and/or laboratory staffs are aware of this updated guidance regarding the signature requirement for diagnostic tests.

Additional information

You may nd more information about physician signature requirements for diagnostic tests by going to CR 6100, located at *http://www.cms.hhs.gov/Transmittals/downloads/R94BP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. You will nd the updated *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests), Subsection 80.6.1 (De nitions) as an attachment to CR 6100.

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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6100 – Revised
Related Change Request (CR) Number: 6100
Related CR Release Date: August 29, 2008
Related CR Transmittal Number: R94BP
Effective Date: January 1, 2003
Implementation Date: September 30, 2008

Source: CMS Pub. 100-02, Transmittal 94, CR 6100

Revised Clinical Laboratory Fee Schedule Fact Sheet

The revised *Clinical Laboratory Fee Schedule Fact Sheet* (February 2009), which provides general information about the clinical laboratory fee schedule, coverage of clinical laboratory services, and how payment rates are set, is now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network* in downloadable format at *http://www.cms.hhs.gov/MLNProducts/downloads/clinical_lab_fee_schedule_fact_sheet.pdf*. ❖

Source: CMS PERL 200902-27

DMEPOS supplier accreditation – get it now

Deadline is September 30, 2009

The Centers for Medicare & Medicaid Services (CMS) wants to remind suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B that they must obtain accreditation by September 30, 2009. In order to retain or obtain a Medicare Part B billing number, all DMEPOS suppliers (except for exempted professionals and other persons as speci ed by the Secretary) must comply with Medicare's supplier and quality standards and become accredited. DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

DMEPOS suppliers who submitted a completed application to an accrediting organization, on or before January 31, 2009, will have an accreditation decision (either full accreditation or denied accreditation) on or before the September 30, 2009, deadline.

DMEPOS suppliers submitting applications to an accrediting organization, on or after February 1, 2009, may or may not have their accreditation decision by the September 30, 2009, deadline.

The accreditation requirement applies to suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine, and prosthetic devices, prosthetics, and orthotics. Pharmacies, pedorthists, mastectomy tters, orthopedic tters/technicians, and athletic trainers must also meet the September 30, 2009, deadline for DMEPOS accreditation.

Certain eligible professionals and other persons as speci ed by the Secretary are exempt from the accreditation requirement.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at *http://www.cms.hhs.gov/medicareprovidersupenroll*. ❖

Source: CMS PERL 200902-29

Medicare DMEPOS Competitive Bidding Program announcement

The Centers for Medicare & Medicaid Services (CMS) has delayed the effective date for the interim nal rule with comment period that implements certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) for the round one rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Acquisition Program. The effective date was originally February 17, 2009, and now is April 18, 2009.

The original comment period on the interim nal rule remains unchanged. The public has until March 17, 2009, to submit comments on the substantive policy issues discussed in the rule.
For additional information, visit the CMS Web site at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/*. ❖

Source: CMS PERL 200902-24

Internet-based enrollment available in all states and the District of Columbia

It's fast, secure, and easy

Now there's a better way for physicians and nonphysician practitioners (NPPs) to enroll or make a change in their Medicare enrollment information. The Internet-based Provider Enrollment, Chain and Ownership System (PECOS) will allow physicians and NPPs to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on le with Medicare, or check on the status of a Medicare enrollment application via the Internet.

The Centers for Medicare & Medicaid Services (CMS) will make Internet-based PECOS to all organizational providers and suppliers (except durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] suppliers) later this year.

Fast

By submitting the initial Medicare enrollment application through Internet-based PECOS, a physician or NPPs enrollment application can be processed as much as 50 percent faster than by paper. This means that it will take less time to enroll or make a change in an existing enrollment record. For additional information about the types of changes that must be reported, go to the Download section of *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Secure

Internet-based PECOS meets all required government security standards in terms of data entry, data transmission, and the electronic storage of Medicare enrollment information. Only authorized individuals can enter enrollment information into PECOS or view PECOS data from the Internet. Authorized individuals include physicians and NPPs. Their user IDs and passwords protect the access to their enrollment information. After physicians or NPPs create user IDs and passwords or change their passwords, they should keep this information secure and not share it with anyone. By safeguarding their user IDs and passwords, they are taking an important step in protecting their enrollment information. CMS does not disclose Medicare enrollment information to anyone except when we are authorized or required to do so by law.

Internet-based enrollment available in all states and the District of Columbia (continued)

Easy

Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The scenario-driven application process will ensure that physicians and NPPs complete and submit only the information necessary to enroll or make a change in their Medicare enrollment record.

There are three basic steps to completing an enrollment action using Internet-based PECOS. Physicians and NPPs must:

1. Have a national plan and provider enumeration system (NPPES) user ID and password to use Internet-based PECOS.

   For security reasons, physicians and NPPs should change passwords periodically, at least once a year. For information on how to change a password, go to the NPPES help page available at *https://nppes.cms.hhs.gov/NPPES/Welcome.do* and select the Reset Password Page.

2. Go to Internet-based PECOS at *https://pecos.cms.hhs.gov* and complete, review, and submit the electronic enrollment application via Internet-based PECOS.

3. Print, sign and date the certi cation statement (blue ink recommended) and mail the certi cation statement and all supporting paper documentation to the Medicare contractor.

Note: A Medicare contractor will not process an Internet enrollment application without the signed and dated certi cation statement and the required supporting documentation. In addition, the effective date of ling an enrollment application is the date the Medicare contractor receives the signed certi cation statement that is associated with the Internet submission.

Additional information

For information about Internet-based PECOS, including important information that physicians and NPPs should know before submitting a Medicare enrollment application via Internet-based PECOS, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll*. ❖

Source: CMS PERL 200901-43

Steps for completing Internet-based Medicare enrollment

Now there is a better way for physicians and nonphysician practitioners (NPPs) to enroll or make a change in their Medicare enrollment information. The Internet-based provider enrollment, chain and ownership system (PECOS) will allow physicians and NPPs to enroll, make a change in their Medicare enrollment, or view their Medicare enrollment information on le with Medicare.

Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The scenario-driven application process will ensure that physicians and NPPs complete and submit only the information necessary to enroll or make a change in their Medicare enrollment record.

There are three basic steps to completing an enrollment action using Internet-based PECOS. Physicians and NPPs must:

1. Have an NPPES User ID and password to use Internet-based PECOS.

   - For security reasons, physicians and NPPs should change passwords periodically, at least once a year. For information on how to change a password, go to the NPPES application help page available at *https://nppes.cms.hhs.gov/NPPES/Help.do?topic=* and select the Reset Password Page.

2. Access the Internet-based PECOS at *https://pecos.cms.hhs.gov* and complete, review, and submit the electronic enrollment application.

3. Print, sign and date the two-page certi cation statement and mail along with all supporting paper documentation to the Medicare contractor within seven days of electronic submission.

Note: A Medicare contractor will not process an Internet enrollment application without the signed and dated certi cation statement. In addition, the effective date of ling an enrollment application is the date the Medicare contractor receives the signed certi cation statement that is associated with the Internet submission.

Additional information

For information about Internet-based PECOS, including important information that physicians and NPPs should know before submitting a Medicare enrollment application via Internet-based PECOS, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

CMS will make Internet-based PECOS to all organizational providers and suppliers (except durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] suppliers) later this year. ❖

Source: CMS PERL 200902-25

AMBULANCE SERVICES

Clarification of date of service of ambulance services

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

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (carriers, scal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for ambulance services provided to Medicare bene ciaries.

Impact on providers

Providers of ambulance services should note the clari cations made by change request (CR) 6372, as noted in this article. Speci cally, CR 6372 clari es the proper date of service to use on claims, especially in situations where the bene ciary dies.

Background

CR 6372 provides clari cation of Centers for Medicare & Medicaid Services (CMS) policy towards dates of service (DOS) for ambulance services, especially in regard to a bene ciary's date of death.

The clari cations for providers of ambulance services are listed as follows:

- The date of service of an ambulance service is the date that the loaded ambulance vehicle (ground or air) departs the point of pickup, except in cases where the bene ciary is pronounced dead as noted below.
- In the case of a ground transport, if the bene ciary is pronounced dead after the vehicle is dispatched but before the (now deceased) bene ciary is loaded into the vehicle, the DOS is considered to be the date of the ambulance vehicle dispatch.
- In the case of an air transport, if the bene ciary is pronounced dead after the aircraft takes off to pick up the bene ciary, the DOS is considered to be the date of the ambulance vehicle takeoff.

Failure to code dates of service correctly in these situations could result in the denial of the claim.

Additional information

The of cial instruction, CR 6372, issued to your carrier, FI, or A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1682CP.pdf*.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6372
Related Change Request (CR) Number: 6372
Related CR Release Date: February 13, 2009
Related CR Transmittal Number: R1682CP
Effective Date: March 13, 2009
Implementation Date: March 13, 2009

Source: CMS Pub. 100-04, Transmittal 1682, CR 6372

Ambulance fee schedule fact sheet

The revised *Ambulance fee schedule fact sheet (January 2009)*, which provides general information about the ambulance fee schedule, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AmbulanceFeeSched_508-09.pdf*. ❖

Source: CMS PERL 200902-02

Sign up to our *eNews* electronic mailing list

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GENERAL COVERAGE

Heartsbreath test for heart transplant rejection

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

Provider types affected

Providers submitting claims to Medicare contractors (carriers, scal intermediaries [FIs], and/or Medicare administrative contractors [MACs]) for Heartsbreath testing services provided to Medicare bene ciaries.

Provider action needed

This article is based on change request (CR) 6366 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) determined that the Heartsbreath test is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act, and is noncovered for dates of service on or after December 8, 2008. See the *Background* and *Additional information* sections of this article for further details regarding this issue.

Background

On December 8, 2008, CMS issued a decision memorandum in response to a formal request for Menssana Research, Inc., to consider national coverage of the Heartsbreath test as an adjunct to the heart biopsy to detect grade 3 heart transplant rejection in patients who have had a heart transplant within the last year and an endomyocardial biopsy in the prior month. CMS determined that the evidence does not adequately de ne the technical characteristics of the test nor demonstrate that Heartsbreath testing to predict heart transplant rejection improves health outcomes in Medicare bene ciaries.

Key points

- Effective for claims with dates of service on and after December 8, 2008, the Heartsbreath test used to predict heart transplant rejection is nationally noncovered. This coverage change to *Current Procedural Terminology (CPT)* code *0085T*, *breath test for heart transplant rejection*, will be effective with the April 1, 2009, quarterly update of the Medicare physician fee schedule database.
- Effective with the April 1, 2009, quarterly update of the integrated outpatient code editor, *CPT* code *0085T*, *breath test for heart transplant rejection*, is no longer payable by Medicare.
- When denying claims for *CPT* code *0085T*, Medicare contractors will use:

  Medicare summary notice (MSN) message 16.10: Medicare does not pay for this item or service
  Claim adjustment reason code 50: These are noncovered services because this is not deemed a medical necessity by the payer
  Claim adjustment remark code MA 51: Missing/ incomplete/invalid procedure code(s)
  N386: This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp* on the CMS Web site. (If you do not have Web access, contact your Medicare contractor to request a copy of the NCD.)

- For bene ciaries who choose to have this procedure anyway, providers shall issue an advance bene ciary notice (ABN) indicating that Medicare issued an NCD at section 260.10 of the *NCD Manual* stating that the Heartsbreath test is not reasonable and necessary for Medicare bene ciaries. Medicare never pays for this test and the bene ciary would be held nancially liable. (Beginning March 1, 2009, the ABN-G will no longer be valid and providers must issue the revised ABN (CMS-R-131.)
  - Medicare contractors will include the group code CO (contractor obligation) or PR (provider responsibility) depending on liability.
- For claims already processed with dates of service between December 8, 2008, and April 1, 2009, contractors will not search their les, but may go back and adjust claims that are brought to their attention.

Additional information

The of cial instruction (CR 6366) was issued to your Medicare FI, carrier or MAC via two transmittals. The rst conveys the revised claims processing instructions and is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1683CP.pdf*.

The second transmittal conveys the change to the *National Coverage Determinations Manual* and that transmittal is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R99NCD.pdf*.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6366
Related Change Request (CR) Number: 6366
Related CR Release Date: February 13, 2009
Related CR Transmittal Number: R1683CP and R99NCD
Effective Date: December 8, 2008
Implementation Date: April 6, 2009
Source: CMS Pub. 100-04, Transmittal 1683, CR 6366

HOSPITAL SERVICES

Corrections to the inpatient prospective payment system wage index for fiscal year 2009

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

Provider types affected

Inpatient acute care hospitals who bill Medicare scal intermediaries (FIs) or Medicare administrative contractors (MACs) for services provided to Medicare bene ciaries. See below for the list of affected hospitals.

Provider action needed

This change only impacts hospitals which chose to notify CMS that they wished to revise the decision that CMS made on their behalf regarding their FY 2009 wage index. (See the *Background* section of this article for more details and a list of speci c hospitals affected.) Please note that FIs and MACs will reprocess any claims with discharge dates on or after October 1, 2008, that were previously processed using an incorrect wage index. You need take no action to initiate the reprocessing of the claims. You should notify your billing of ce staff that adjustments to payments will be made within the next 90 days.

Background

Due to the extension of section 508 in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), the Centers for Medicare & Medicaid Services (CMS) stated in its nal rule, published August 19, 2008, that due to the timing of the extension, CMS would be unable to recompute the FY 2009 wage index for any hospital reclassi ed under section 508 and special exception hospitals in time for inclusion in the FY 2009 wage index. Instead, CMS stated that we would publish the nal wage FY 2009 wage index in a separate notice and that it would analyze the data for hospitals in areas affected by the MIPPA extension and make decisions on behalf of hospitals that we believe would result in the highest FY 2009 wage index for which they are eligible. Hospitals were allowed 15 days from the date of the separate notice, published October 3, 2008, to notify CMS if they wished to revise the decision that CMS made on their behalf.

The following list shows the provider numbers of hospitals who requested a reversal of the decision that CMS made on its behalf and their new wage index and geographic adjustment factor (GAF):

050069, 050168, 050173, 050193, 050224, 050226, 050230, 050348, 050426, 050526, 050543, 050548, 050551, 050567, 050570, 050580, 050589, 050603, 050609, 050678, 050693, 050720, 050744, 050745, 050746 and 050747 have a new wage index of 1.2032 and a GAF of 1.1351. Hospital 250078 has a new wage index of 0.8418 and a GAF of 0.8888 and hospital 260110 has a corrected wage index of 0.8992 and a corrected GAF of 0.9298.

Additional information

The of cial instruction (CR6363) issued to your Medicare MAC and/or FI is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R447OTN.pdf*.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6363
Related Change Request (CR) Number: 6363
Related CR Release Date: February 13, 2009
Related CR Transmittal Number: R447OTN
Effective Date: October 1, 2008
Implementation Date: May 18, 2009

Source: CMS Pub. 100-20, Transmittal 447, CR 6363

Update to the inpatient prospective payment system PRICER for fiscal year 2009

The inpatient prospective payment system (IPPS) personal computer (PC) PRICER for scal year (FY) 2009 has been updated with the January 2009 provider data. To download the FY 2009 version 3 of the PC PRICER le (updated January 30, 2009), go to the "Inpatient PPS PC PRICER" Web page (*http://www.cms.hhs.gov/PCPricer/03_inpatient.asp*), under the "Downloads" section. ❖

Source: CMS PERL 200902-01

Payments to institutional providers with multiple service delivery locations

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

Provider types affected

Hospitals and other institutional providers who bill Medicare administrative contractors (MACs) or fiscal intermediaries (FIs) for providing services, which are paid under the Medicare physician fee schedule (MPFS), to Medicare beneficiaries.

What you need to know

Change request (CR) 6300, from which this article is taken, instructs your MAC or FI to assign payment localities based on the ZIP code of the actual service facility location, rather than the main provider address, when such services are paid under the MPFS. On such claims submitted via the 837 institutional claim to MACs or FIs, Medicare will use the nine-digit ZIP code reported in the 2310E loop, when present, to determine the payment locality to apply to payments for MPFS and anesthesia services. See the *Background* section, below, for details.

Background

Since institutional providers have historically operated from a single physical location, the provider files in Medicare fiscal intermediary shared system (FISS) contain only a provider's single master address. Where a nine-digit ZIP code is required, this master address has been used to determine the fee amount for services that are paid under the MPFS.

Increasingly, however, hospitals are operating off-site outpatient facilities and other institutional outpatient service providers are operating multiple satellite offices. Sometimes these facilities are in different payment locations than the parent provider. In order for MPFS and anesthesia payments to be accurate, the nine-digit ZIP code of the off-site or satellite facility should be used to determine the locality.

CR 5243 (released January 2007) instructed Medicare outpatient service providers to report the nine-digit ZIP code of the actual service facility location in the 2310E loop of the 837 Institutional claim transaction; however, because there is no corresponding field in its internal claim record to carry a service facility nine-digit ZIP code, FISS has not been able to implement this change.

CR 6300, from which this article is taken, instructs FISS to map the nine-digit service facility ZIP code reported in data element N403 of loop 2310E of an incoming 837 institutional claim to a payer-only value code in order to capture the ZIP code of the service facility when it differs from the main provider address. This will make the data available to the payment logic in FISS so proper payment can be made based on the MPFS.

Notes:

1. Medicare contractors will pay MPFS and anesthesia services using the nine-digit service facility ZIP code (described above) for claims that you submit electronically via the institutional 837, but will continue to use the ZIP code associated with your master address to determine the payment location on claims that you submit via direct data entry (DDE) or paper formats.
2. When you bring to your MAC or FI's attention timely claims that were paid inaccurately because the service facility ZIP code was lacking, your MAC or FI will adjust the claims by appending the value code and the service facility ZIP code that you specify.

Additional information

The official instruction, CR 6300, issued to your MAC or FI is located on the Centers for Medicare & Medicaid Services (CMS) Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1681CP.pdf*.

You might also want to review the MLN Matters article related to CR 3287, which you may find on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3287.pdf*.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6300
Related Change Request (CR) Number: 6300
Related CR Release Date: February 13, 2009
Related CR Transmittal Number: R1681CP
Effective Date: October 1, 2007
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1681, CR 6300

Payment for co-surgeons in a method II critical access hospital

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

Provider types affected

Method II critical access hospitals (CAHs) billing Medicare administrative contractors (A/B MACs) and/or scal intermediaries (FIs) for physicians that have reassigned their billing rights to the CAH on type of bill (TOB) 85x with revenue codes 96x, 97x, or 98x with modi er 62 for co-surgeon services rendered in a method II CAH to Medicare bene ciaries.

Provider action needed

This article is based on change request (CR) 6319 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR 6319 to highlight the revisions to the *Medicare Claims Processing Manual*, Chapter 4 dealing with payment for co-surgeons in a method II CAH.

Physicians billing on type of bill 85x for professional services rendered in a method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the method II CAH, payment is made to the CAH for professional services (revenue codes 96x, 97x or 98x). Medicare makes a payment for a co-surgeon when the procedure is authorized for a co-surgeon and the person performing the surgery is a physician. **CR 6319 implements the reduction in payment for co-surgeon services.** See the *Key Points* section for speci cs regarding the revisions and the impact on claims for co-surgeon services in a method II CAH.

Background

When the billing rights are reassigned to the method II CAH, payment is made to the CAH for professional services (revenue codes 96x, 97x or 98x). Under some circumstances, the skills of two surgeons (each in a different specialty) are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition.

Co-surgery refers to a single surgical procedure which requires the skill of two surgeons, each in a different specialty, performing parts of the same procedure simultaneously. It is not always co-surgery when two doctors perform surgery on the same patient during the same operative session. **Co-surgery has been performed if the procedure(s) performed is part of and would be billed under a single surgical procedure code.**
Medicare uses the payment policy indicators on the Medicare physician fee schedule database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a speci c Healthcare Common Procedure Coding System/*Current Procedural Terminology* (HCPCS/*CPT*) code. The MPFSDB is located on the CMS Web site at *http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp*.

The revised *Medicare Claims Processing Manual* Chapter 4 (attached to CR 6319) outlines changes that impact ve areas as follows:

1. Coding co-surgeon services rendered in a method II CAH
2. Use of payment policy indicators for determining procedures eligible for payment of co-surgeons
3. Payment of co-surgeon services rendered in a method II CAH
4. Co-surgeon medicare summary notice (MSN) and remittance advice (RA) messages
5. Review of supporting documentation for co-surgeon services in a method II CAH.

Key points regarding claims for co-surgeon services in a method II CAH

- Medicare will accept claims for co-surgeon services submitted on type of bill 85x with revenue code 96x, 97x, or 98x if it contains either one claim line with a surgical HCPCS/*CPT* code and has modi er 62 or two claim lines with the same surgical HCPCS/CPT code with the same line item date of service, and modi er 62 on each line.
- In the situation just described where co-surgeon services are reported on two claim lines within the same claim, both lines must have modi er 62. Where only one line has modi er 62, Medicare will deny the line without modi er 62 with the following messages:
  - Medicare summary notice (MSN) 16.10 indicating Medicare does not pay for this item or service
  - Remittance advice (RA) remark code M78, indicating Missing/incomplete/invalid HCPCS modi er
  - Group code of CO showing contractual obligation
  - Claim adjustment reason code (CARC) 4 denoting that the procedure code is inconsistent with the modi er used or a required modi er is missing.
- When billing for co-surgeon services, remember that Medicare will pay only when the services are rendered by two surgeons, each with a different specialty, and the claim carries modi er 62 to show there were two surgeons for co-surgery.
- The MPFSDB must re ect an acceptable payment policy indicator for the associated HCPCS/CPT code in order for the claim to be considered for payment. If the payment policy indicator is "0" indicating that co-surgeons are not permitted for that procedure, Medicare will deny the claim with the following:
  - MSN message 15.12, indicating Medicare does not pay for two surgeons for this procedure
  - RA Remark Code N431 to show "service is not covered with this procedure"
  - A group code of PR, showing patient responsibility
  - A CARC of 54 to show "Multiple physicians/assistants are not covered in this case."

Payment for co-surgeons in a method II critical access hospital (continued)

- Medicare contractors will develop co-surgeon services on TOB 85x with revenue code 96x, 97x or 98x and modi er 62 for the supporting documentation needed to establish medical necessity when the HCPCS/*CPT* code has a payment policy indicator of '1' showing that co-surgeons could be paid depending on supporting documentation.
- Medicare contractors will de ne the appropriate supporting documentation needed to establish medical necessity for co-surgeon services when the HCPCS/ CPT code has a payment policy indicator of '1'.
- Method II CAHs should remember that they will be liable for non-covered co-surgeon services unless they issue an appropriate advance bene ciary notice (ABN) when the payment policy indicator is '1'.
- Medicare contractors will deny co-surgeon services when the supporting documentation does not establish medical necessity when the payment policy indicator is '1'.
- Medicare contractors will use the following messages when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was issued:
  - **MSN message 36.1** – Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.
  - **RA Remark Code of M38** – The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
  - **Group code of PR** – Patient responsibility
  - **CARC code of 54** – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will use the following messages when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was not issued:
  - **MSN message 36.2** – It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this of ce three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must le your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.
  - **RA Remark Code M27** – The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be led within 120 days of the date you receive this notice. You must make the request through this of ce.
  - **Group code CO** – Contractual obligation
  - **CARC code 54** – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will develop co-surgeon services on type of bill (TOB) 85x with RC 96x, 97x or 98x and modi er 62 to establish that the two specialty requirement is met when the HCPCS/CPT code has a payment policy indicator of '2'.
- Medicare contractors will deny co-surgeon services when the two specialty requirement is not met, i.e., the two co-surgeons each have the same specialty. When denying such claims, Medicare will use the following messages:

MSN message 21.21 – This service was denied because Medicare only covers this service under certain circumstances.

RA Remark code N95 – The provider type/provider specialty may not bill this service.

Group code PR – Patient responsibility.

CARC code 54 – Multiple physicians/assistants are not covered in this case.

- Medicare contractors will return to provider (RTP) co-surgeon services submitted on TOB 85x with RC 96x, 97x or 98x when the HCPCS/*CPT* code billed with modi er 62 has a payment policy indicator of '9', indicating the co-surgeon concept does not apply.
- Medicare contractors will determine if a clinician or a non-clinician medical reviewer should review the supporting documentation submitted for co-surgeon services.
- Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date. However, they will adjust such claims that you bring to their attention.
- Finally, when Medicare pays for co-surgeon services, payment is the lesser of the actual charge or 62.5 percent of the MPFS payment minus deductible and coinsurance. Where payment rights are reassigned to a method II CAH, that CAH is paid 115 percent of that lesser payment amount.

Additional information

The of cial instruction (CR 6319) issued to your Medicare FI or A/B MAC is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1672CP.pdf*.

Payment for co-surgeons in a method II critical access hospital (continued)

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6319
Related Change Request (CR) Number: 6319
Related CR Release Date: January 30, 2009
Related CR Transmittal Number: R1672CP
Effective Date: January 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1672, CR 6319

Clarification on use of national drug codes in 837 I billing

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

Provider types affected

Hospitals, home health agencies, and other providers who bill Medicare contractors (scal intermediaries [FI], regional home health intermediaries [RHHI], or Medicare administrative contractors [MAC]) for drugs, especially new drugs provided under the outpatient prospective payment system (OPPS).

What you need to know

Change request (CR) 6330, from which this article is taken, speci es how quantities of drugs are to be reported and then processed by Medicare when the national drug codes (NDC) is used for institutional billing. Speci cally, it also requires Medicare contractors to accept decimal values for NDC quantities. CR 6330 also adds to prior instructions regarding the reporting of drugs that have not yet been approved by the Food and Drug Administration (FDA). Be sure your billing staff is aware of these changes.

Background

As provided by CR 3287 issued May 28, 2004, (MMA-Hospital Outpatient Billing and Payment under Outpatient Prospective Payment System for New Drugs or Biologicals After FDA Approval but Before Assignment of a Product-Speci c Drug/Biological HCPCS Code); Medicare hospitals, subject to the OPPS, may use Healthcare Common Procedure Coding System (HCPCS) code C9399 to report drugs that have been approved by the FDA, but that do not yet have a product-speci c drug/biological HCPCS code.

CR 6330, from which this article is taken, builds on those instructions and adds some additional requirements for providers. Effective July 1, 2009, hospitals billing for drugs/biologicals that have received FDA approval but which have not yet received product-speci c drug/biological HCPCS codes will not only specify the NDC of the drug/biological, but will also specify the quantity of that drug/biological using the CTP segment in the ANSI X-12 837 I (in Loop 2410 LIN 03).

In addition, CR 6330 provides that the use of the 'units eld,' while adequate to de ne quantities when HCPCS codes are used to describe drugs and biologicals, is not adequate to describe the quantities of a drug or biological identi ed only by an NDC. Thus, CR 6330 requires Medicare contractors to accept decimals to specify the quantity in this new quantity eld, and requires Medicare's systems to retain this information in the repository and forward it to a subsequent payer (although the decimals may be rounded to whole numbers for actual claims processing).

Additional information

For further information, see the instruction issued to your FI, RHHI, or MAC regarding this issue, which may be found by going to the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R446OTN.pdf*.

You might also want to review the *MLN Matters* article related to CR 3287, which you may nd on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3287.pdf*.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6330
Related Change Request (CR) Number: 6330
Related CR Release Date: February 13, 2009
Related CR Transmittal Number: R446OTN
Effective Date: July1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-20, Transmittal 446, CR 6330

Hospital-acquired conditions listening session transcript now available

The Centers for Medicare & Medicaid Services (CMS) has recently updated the educational resources section (*http://www.cms.hhs.gov/HospitalAcqCond/07_EducationalResources.asp*) of the Hospital-Acquired Conditions (HAC) & Present on Admission (POA) Indicator Reporting Web site to include the audio file and transcript from the hospital-acquired conditions and hospital outpatient healthcare-associated conditions listening session held on Thursday, December 18, 2008. ❖

Source: CMS PERL 200901-45

Inpatient Rehabilitation Facility Prospective Payment System fact sheet updated

The revised publication titled *Inpatient Rehabilitation Facility Prospective Payment System* fact sheet (October 2008), which provides information about the inpatient rehabilitation facility prospective payment system rates and classification criteria, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS PERL 200901-41

Inpatient rehabilitation facility prospective payment system PRICER update

The provider specific data for the fiscal year (FY) 2009 inpatient rehabilitation facility prospective payment system (IRF PPS) personal computer (PC) PRICER has been updated and is ready to be downloaded from the page, *http://www.cms.hhs.gov/PCPricer/06_IRF.asp*, under the Downloads section. If you use the IRF PPS PC PRICER, please go to the page above and download the latest version of the IRF PC PRICER, posted on February 5, 2009. ❖

Source: CMS PERL 200902-14

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 Medicare administrative contractor. 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://medicare.fcso.com*, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

ESRD SERVICES

Update to the end-stage renal disease PC PRICER

The Centers for Medicare & Medicaid Services (CMS) has updated the PC PRICER Web page at *http://www.cms.hhs.gov/PCPricer/02e_ESRD_Pricer.asp#TopOfPage* to include the updated end-stage renal disease (ESRD) PC PRICER with the rates for 2009.

The PC PRICER is located in the Downloads section of the Web page. ❖

Source: CMS PERL 200901-53

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SKILLED NURSING FACILITY SERVICES

Skilled nursing facility consolidated billing Web-based training course

The revised skilled nursing facility consolidated billing (SNF CB) Web-based training (WBT) course (October 2008), which provides general information about skilled nursing facilities (SNF), SNF consolidated billing, and under "arrangement agreements" between SNFs and other providers or suppliers, is now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network.* To access this course, visit *http://www.cms.hhs.gov/MLNProducts/01_Overview.asp* and select the "Web-based Training Modules" link from the "Related Links Inside CMS" section located at the bottom of the Web page. ❖

Source: CMS PERL 200902-08

Availability of Five-Star Preview reports

The Five-Star Preview reports became available on February 19. Please visit your quality improvement evaluation system (QIES) mailbox (available through your electronic connection to the state servers) for submission of Minimum Data Set (MDS) data to review your results. To access these reports, select the Certi cation and Survey Provider Enhanced Reports (CASPER) link located at the bottom of the login page.

Once in the CASPER system, click on the Folders button and access the ve star report in your "st LTC facid" folder. The "st" is the two-digit postal code of the state in which your facility is located, and "facid" is the state-assigned facility identi er of your facility.

A new version of the Five-Star Quality Rating Technical Users' Guide and an accompanying Summary of Updates to the Technical Users' Guide document are accessible on the Five-Star Quality Rating System Web page at *http://www.cms.hhs.gov/CertificationandComplianc/13_FSQRS.asp*. ❖

Source: CMS PERL 200902-26

Sign up to our *eNews* electronic mailing list

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HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

The outpatient code editor Web-based training revised in January 2009

The outpatient code editor (OCE) Web-based training (WBT), which is made available by the Centers for Medicare & Medicaid Services (CMS) Medicare *Learning Network* (MLN), may help health care professionals, and medical administrative staff, to understand the OCE utilized under the outpatient prospective payment system (OPPS), as well as other payment systems. This WBT addresses the OCE in the scal intermediary standard system (FISS). It may be accessed by going to *http://www.cms.hhs.gov/MLNGenInfo/*. Then, scroll to the "Related Links Inside CMS" section and select Web based training (WBT) modules. You will nd the "Outpatient Code Editor WBT" from the list provided. ❖

Source: CMS PERL 200902-06

Archiving and retrieving of the integrated outpatient code editor and the Medicare code editor for processing claims

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

Note: The Centers for Medicare & Medicaid Services (CMS) has rescinded change request (CR) 6177 issued on October 24, 2008. The implementation date of April 1, 2009, has been targeted for a later date. The *MLN Matters* article MM6177 was published in the November 2008 *Medicare A Bulletin* (page 47).

MLN Matters Number: MM6177 – Rescinded
Related Change Request (CR) Number: 6177
Related CR Release Date: October 24, 2008
Related CR Transmittal Number: R391OTN
Effective Date: N/A
Implementation Date: N/A

Source: CMS Pub. 100-20, Transmittal 391, CR 6177

ELECTRONIC DATA INTERCHANGE

A guide to assist with understanding the remittance advice

Understanding the Remittance Advice: A Guide for Medicare Providers, Physician, Suppliers and Billers (October 2008): This guide is now available to download from the CMS *Medicare Learning Network* (MLN). This publication is designed to help fee-for-service Medicare providers understand the remittance advice (RA), its applicable uses, and how to interpret RA elds and codes communicated by Medicare contractors. To view, download and print this guide, please go to the (*MLN*) at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

Note: Print copies will be available in approximately four to six weeks. ❖

Source: CMS PERL 200902-10

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 Medicare administrative contractor. By signing up, you will receive automatic e-mail noti cation 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://medicare.fcso.com*, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
March 2009 – April 2009

Topic: Introduction to the Provider Data Summary report

When: Tuesday, March 10, 2009

Time: 12:30 p.m. – 1:30 p.m. ET

Type of Event: Webcast

Hot topics – Medicare updates, coverage determinations, and tips to avoid claim denials and returns

When: Wednesday, March 11, 2009

Time: 11:30 a.m. – 12:30 p.m. ET

Type of Event: Webcast

Topics – Provider enrollment for new physicians, residents, and interns (Part A and B)

When: Wednesday, March 12, 2009

Time: 11:30 a.m. – 1:00 p.m. ET

Type of Event: Webcast

Topic – Community Mental Health Center – Psychiatric Partial Hospitalization Program

When: Thursday, April 23, 2009

Time: 11:30 a.m. – 1:00 p.m. ET

Type of Event: Webcast

Two easy ways to register

Online – Visit our provider training Web site at *www.fcsomedicaretraining.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time User?** Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identi er may enter "99999" in the NPI eld. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Tips for using the FCSO provider training Web site

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

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

Select **Register** in the Options column located next to the speci c course listed on the Instructor-Led Training (ILT) schedule page. For further assistance, contact FCSO Medicare training help desk at 1-866-756-9160 or send an e-mail to *fcsohelp@geolearning.com*.

Please Note:

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

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

Keep checking our Web site, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers. ❖

PREVENTIVE SERVICES

February is American Heart Month

In recognition of American Heart Month, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of cardiovascular screening blood tests and smoking and tobacco-use cessation counseling for eligible Medicare bene ciaries.

Quick facts

- Although heart disease is sometimes thought of as a "man's disease," it is the leading cause of death for both women and men in the United States, and women account for 52.8 percent of the total heart disease deaths.
- Heart disease is the leading cause of death among women aged 65 years and older.
- Major risk factors for heart disease include high blood pressure, high blood cholesterol, tobacco use, diabetes, physical inactivity, and poor nutrition.
- The average age of a rst heart attack for men is 66 years.
- Smoking causes coronary heart disease, the leading cause of death in the United States. Cigarette smokers are two-four times more likely to develop coronary heart disease than nonsmokers.
- Cigarette smoking approximately doubles a person's risk for stroke.
- Cigarette smoking causes reduced circulation by narrowing the blood vessels (arteries). Smokers are more than 10 times as likely as nonsmokers to develop peripheral vascular disease.

Cardiovascular screening blood tests

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

- Total cholesterol test
- Cholesterol test for high-density lipoproteins
- Triglycerides test

Coverage of cardiovascular screening blood tests is provided as a Medicare Part B bene t. The bene ciary will pay nothing for blood tests; there is no coinsurance or copayment and no deductible for this bene t.

Note: The cardiovascular screening bene t covered by Medicare is a stand alone billable service separate from the initial preventive physical examination or "Welcome to Medicare Visit" and does not have to be obtained within the rst six months of a bene ciary's Medicare Part B coverage

Smoking and tobacco-use cessation counseling

Medicare provides coverage of smoking and tobacco-use cessation counseling for people with Medicare who meet one of the following criteria:

- Use tobacco and have a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use, or
- Are taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on Food and Drug Administration-approved information.

Eligible bene ciaries are covered under Medicare Part B when certain conditions of coverage are met, subject to certain frequency and other limitations.

For more information

CMS has developed a variety of educational products and resources to help fee-for-service health care professionals 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 the *Medicare Learning Network* (MLN) preventive services education products and resources for fee-for-service health care professionals. The Web page is located on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

This Expanded Benefits Brochure: This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of the initial preventive physical exam (IPPE), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests. To view online go to the CMS Web site *http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf*.

February is American Heart Month (continued)

Smoking and Tobacco-use Cessation Counseling Services: This tri-fold brochure provides health care professionals with and overview of Medicare's smoking and tobacco-use counseling service benefit. To view online, go to the CMS Web site *http://www.cms.hhs.gov/MLNproducts/downloads/smoking.pdf*.

To order copies of these brochures, free of charge, visit the CMS *MLN* at *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to related Links inside CMS, and select MLN Product Ordering Page.

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

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

For information about American Heart Month, please visit the American Heart Association's Web site at *http://www.americanheart.org/presenter.jhtml?identifier=3063135* and the Centers for Disease Control and Prevention's Web site at *http://www.cdc.gov/dhdsp/announcements/american_heart_month.htm*. ❖

Source: CMS PERL 200902-05

OTHER EDUCATIONAL RESOURCES

Revised Medicare Learning Network publications

The following revised publications are now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place an order for these publications, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

- Facilitators, trainers, educators, and physicians: Medicare Resident, Practicing Physician, and Other Health Care Professional Training Facilitator's Kit (October 2008) provides all the information and instructions necessary to prepare for and present a Medicare resident, practicing physician, and other health care professional training program including instructions for facilitators, customization guide, a PowerPoint presentation with speaker notes, pre- and post-assessments, master assessment answer keys, and evaluation tools. The Facilitator's Kit contains the following materials:
  - *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*
  - Facilitator's Guide
  - Medicare Resident, Practicing Physician, and Other Health Care Professional Training: An introduction video.
- *Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program Bookmark* (November 2008) provides information about the Medicare resident, practicing physician, and other health care professional training program.
- *Rural Health Bookmark* (November 2008) offers Medicare providers, suppliers, and physicians information about rural educational resources. ❖

Source: CMS PERL 200902-18

The Expanded Benefits Brochure is now available for ordering

Now available for order: The *Expanded Benefits Brochure* (January 2009). This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of three preventive services: the initial preventive physical examination (IPPE), also known as the "Welcome to Medicare Physical Exam" or the "Welcome to Medicare" visit, ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests.

To view, download, and print this brochure, please go to the *Medicare Learning Network (MLN)* at *http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf*.

To order free of charge, visit *http://www.cms.hhs.gov/MLNProducts/*, scroll down to Related Links Inside CMS, and select MLN Product Ordering Page. ❖

Source: CMS PERL 200901-50

Rural Health Bookmark available in print

The *Rural Health Bookmark* (November 2008), which offers Medicare providers, suppliers, and physicians information about rural educational resources, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to *Related Links Inside CMS* and select MLN Product Ordering Page. ❖

Source: CMS PERL 200902-21

The New 2009 e-prescribing incentive program educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a new educational resource has been posted to the e-prescribing incentive program section on the CMS Web site.

The following item is available for download:

2009 Electronic Prescribing Incentive Program Made Simple – This fact sheet provides detailed information on how to participate in the 2009 e-prescribing incentive program by reporting the e-prescribing measure.

To access this new educational resource, visit *http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp#TopOfPage* on the CMS Web site and click on the *2009 Electronic Prescribing Incentive Program Made Simple* link. ❖

Source: CMS PERL 200901-52

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Order Form – Medicare 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://medicare.fcso.com*. Hardcopy or CD-ROM distribution is limited to one copy per medical facility that has billed at least one Part A claim for processing during the 12 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 of ce (see May 2008 *Medicare A Bulletin* page 4) 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 given 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 of ce-facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published from October 2008 through September 2009 (back issues sent upon receipt of the order). Please check here if this will be a: [ ] Subscription renewal or [ ] New subscription	40-500-150	$33.00 (Hardcopy) $55.00 (CD-ROM)

Subtotal $ _____

Tax **(add % for your area)** $ _____

Total $ _____

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Medicare Publications

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Atlanta, GA 30384-6443

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Mailing Address:_____

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Attention:_____ Area Code/Telephone Number:_____

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(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)

ALL ORDERS MUST BE PREPAID –

DO NOT FAX - PLEASE PRINT LEGIBLY

Note: *The Medicare A Bulletin is available* ***free of charge*** *online at* ***medicare.fcso.com****.*

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Addresses

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

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

MEDICARE SECONDARY PAYER (MSP)
Information on Hospital Protocols
Admission Questionnaires
Audits
Medicare Secondary Payer
Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

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

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

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

OVERPAYMENT COLLECTIONS
Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and Skilled Nursing Facility Routine Cost Limit Exceptions
Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
Attn: FOIA PARD – 16T
P.O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

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

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

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 DATA INTERCHANGE
1-888-670-0940

Option 1
Transaction Support

Option 2
PC-ACE Support

Option 3
Direct Data Entry (DDE) Support

Option 4
Enrollment Support

Option 5
Electronic Funds
(check return assistance only)

Option 6
Automated Response Line

Medicare Web sites

PROVIDERS
Florida Medicare Contractor
medicare.fcso.com
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARIES
Centers for Medicare & Medicaid Services
www.medicare.gov

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦