Medicare B Update!
A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue…

Features

To receive quick, automatic notification when new publications and other items of interest are posted to our provider education Web sites, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com*, click on the "Join our Electronic Mailing List FCSO eNews" link and follow the prompts. The *FCSO eNews* is sent at least every other week, more frequently as required.

The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider education Web sites: *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*.

Routing Suggestions:

- ❑ Physician/Provider
- ❑ Office Manager
- ❑ Billing/Vendor
- ❑ Nursing Staff
- ❑ Other _____

_____

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FIRST COAST SERVICE OPTIONS, INC.
A CMS Contracted Intermediary & Carrier

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The *Medicare B Update!* is published quarterly by the Medicare Communication and Education department of First Coast Service Options, Inc. (FCSO), to provide timely and useful information to Medicare Part B providers in Connecticut and Florida.

Questions concerning this publication or its contents may be directed in writing to:

Medicare Part B
MCE-Publications
P.O. Box 45270
Jacksonville, FL
32232-5270

A PHYSICIAN'S FOCUS

Medical Record Review Request—From Whom and Why

We have received questions from physicians regarding medical record review or, more specifically, requests from Medicare for medical records. A standard statement in the medical policies notes that medical record documentation maintained by the performing physician or allied provider must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be included in the patient's medical record. This information is normally found in the history and physical examination notes, office/progress notes, hospital notes, and/or procedure report.

There are currently medical record reviews conducted by different entities contracted by the Centers for Medicare & Medicaid Services (CMS) and other government offices, and each has distinct program goals. Under the Medicare Integrity Program enacted by Congress, entities such as FCSO, a carrier (pays Part B provider claims in Florida and Connecticut) and a fiscal intermediary (pays Part A provider claims in Florida), are known as the affiliated contractor (AC) as distinct from a program safeguards contractor (PSC). As a general rule, PSC is accountable for reducing fraud and abuse in the Medicare program, and AC is responsible for reducing the Medicare fee-for-service claim payment error rate. Of course, there may be overlap in responsibilities and programs. Other Medicare contractors that pay claims and may request records for medical review include the durable medical equipment regional carrier (DMERC) and the regional home health intermediary (RHHI). Though they do not pay claims directly, the quality improvement organizations (QIO) in each state have inpatient acute care hospital claim review responsibility, as well as other initiatives that may entail medical review. Two special PSC contractors administer the Comprehensive Error-Rate Testing (CERT) program, and systematically request records for medical review. Also, the Office of the Inspector General (OIG), in the Department of Health & Human Services (which governs the Medicare program), conducts surveys or assessments that involve the claim payment process and necessitates medical review. Medical records for these reviews, and subsequent follow-up reviews, will be requested by the entity contracted by the OIG for this purpose.

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

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

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

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

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

CERT program – The CERT documentation contractor will request records for review by the CERT review contractor, AdvanceMed of Richmond, Virginia. The CERT program randomly samples 200 claims per month per contractor nationally.

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

PSC and OIG – Programs to prevent fraud and abuse.

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

Finally, although limited to three states, a new medical review initiative has generated national provider interest. The Medicare Modernization Act directs the secretary of the Department of Health & Human Services to demonstrate the use of recovery audit contractors (RACs) under the Medicare Integrity Program in identifying underpayments and overpayments, and recouping overpayments under the Medicare program. As the states with the largest Medicare expenditure amounts, California, Florida, and New York have been selected for pilot RACs that began in May 2005 and last for three years. Public Consulting Group (Medicare secondary payer [MSP] claim reviews) and Health Data Insight (non-MSP claim reviews) were awarded the Florida contracts.

Medical Record Review Request—From Whom and Why, continued

RAC pilot program

- RACs will perform data analysis to identify areas of investigation.
- Claims reviewed by RACs will have been submitted to the carriers/intermediaries at least a year before to ensure that the ordinary processing will have been completed. All reviews are post payment.
- RACs will apply national coverage policies and local coverage determinations (LCDs) that have been published by the Medicare contractors.
- The collection policies to be applied by this pilot will be the same as those currently in effect for the carriers/ intermediaries, including assessment of interest on the portion of any debt that is unpaid 30 days after issuance of the demand letter.
- If underpayments are determined, the information will be forwarded to the ACs for processing and payment. Providers will be permitted to appeal any negative determinations to their contractor.

FCSO paid over 90 million claims in fiscal year 2005 for Part A and B providers in FL and CT. Fortunately, only a small percentage of these claims require the submission of medical records for review. If you receive a request for medical records on a Medicare beneficiary and are not sure of your responsibilities, please contact the Medicare Part B Customer Service Center at 1-866-454-9007 (FL) or 1-866-419-9455 (CT) for clarification or call the number on the requesting letter for more details. Your prompt response to a legitimate request will benefit you and the Medicare program.

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THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

The *Medicare B Update!* is a comprehensive magazine published quarterly by First Coast Service Options, Inc. (FCSO) for Part B providers in Connecticut and Florida. In accordance with notification requirements established by the Centers for Medicare & Medicaid Services, approximate delivery dates for fiscal year 2006 are:

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2006	**Mid-November 2005**	**January 1, 2006**
Second Quarter 2006	Mid-February 2006	April 1, 2006
Third Quarter 2006	Mid-May 2006	July 1, 2006
Fourth Quarter 2006	Mid-August 2006	October 1, 2006

Important notifications that require communication in between these dates will be posted to the FCSO Medicare provider education websites, *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. In some cases, additional unscheduled special issues may be posted.

Who Receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education website(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM

Distribution of the *Update!* in hardcopy or CD-ROM format is limited to individual providers and professional association (PA) groups who have billed at least one Part B claim to either Connecticut or Florida Medicare for processing 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 registration form to us*.

For additional copies, providers may purchase a separate annual subscription in hardcopy or CD-ROM format (see order form on the inside back cover of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

We use the same mailing address for *all* correspondence, and cannot designate that the *Update!* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Registration department. Please remember that address changes must be done using the appropriate Form CMS-855.

Clear Identification of State-Specific Content

A blue header bar preceding articles clearly indicates whether the topic is applicable to both Connecticut and Florida, Connecticut only, or Florida only. Articles common to both states appear at the beginning of the publication. Within common articles, references to phone numbers, addresses, reimbursement amounts, past publications, etc., are state-specific as appropriate. Content specific to Connecticut is next, followed by content specific to Florida. Connecticut and Florida local medical review policy (LMRP/LCD) summaries are maintained in separate sections.

Publication Format

The *Update!* is arranged into distinct sections.

Following the table of contents, a letter from the Carrier Medical Director, and an administrative information section, the *Update!* provides content applicable to both states, as noted previously. Within this section, information is categorized as follows.

- The **claims** section provides claim submission requirements and tips, plus correspondence (appeals and hearings) information.
- The **coverage/reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by specialty *categories* (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **electronic media claim** (EMC) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **general information** section includes fraud and abuse, provider registration, and Medicare Secondary Payer topics, plus additional topics not included elsewhere.

Medical review and **comprehensive data analysis** will *always* be in state-specific sections, as will **educational resources**. Important **addresses, phone numbers**, and **websites** are also listed for each state

An **Index** to the year's previous issues of the *Update!* and a Part B Materials order form are included in the back of the publication.

The *Medicare B Update!* Represents Formal Notice of Coverage Policies

Articles included in each *Update!* represent formal notice that specific coverage policies either have or will take effect on the date given. Providers who receive each issue are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines. **The date the *Update!* is posted to the website is considered the notice date**, in the event there is a dispute over whether a provider received advance notice regarding coverage of a specific service and the financial liability for it.

Advance Beneficiary Notices (ABNs)

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. ABNs advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment. ABNs allow beneficiaries to make informed consumer decisions about receiving items or services for which they may have to pay out-of-pocket, and to be more active participants in their own health care treatment decisions. An ABN must meet the following requirements:

- The ABN must be on an approved Form CMS-R-131 (see "New Patient Liability Notice" below).
- The ABN must be given in writing, in advance of furnishing the service or item.
- The ABN must include the patient's name, date(s) and description of the service or item, and the reason(s) why the service or item may not be considered medically reasonable and necessary (e.g., the service is not covered based on the patient's diagnosis, the frequency of the service was in excess of accepted standards of medical practice, etc.).
- The notice must be signed and dated by the patient, indicating the patient assumes financial responsibility for the service if payment is denied as being not medically reasonable and necessary for reason(s) indicated on the advance notice. The signature of the provider of service is not required.
- The ABN should be maintained with the patient's medical record.

New Patient Liability Notice

Form CMS-R-131 is the new approved ABN, ***required for services provided on or after January 1, 2003***. Form CMS-R-131 was developed as part of the Centers for Medicare & Medicaid Services' (CMS) Beneficiary Notices Initiative (BNI), and was approved by OMB (Office of Management and Budget) on June 18, 2002. The new ABNs are designed to be more beneficiary-friendly, more readable and understandable, with patient options more clearly defined.

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users, following the guidance in CMS Program Memoranda (PM) AB-02-114 and AB-02-168, which may be found on the CMS website at *http://cms.hhs.gov/manuals/pm_trans/AB02114.pdf* and *http://cms.hhs.gov/manuals/pm_trans/AB02168.pdf*.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found on CMS's BNI website at *http://www.cms.hhs.gov/medicare/bni*.

ABN Modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier **GA** (waiver of liability statement on file) or **GZ** (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier **GZ** may be used in cases where a signed ABN is *not* obtained from the patient; however, when modifier **GZ** is billed, the provider assumes financial responsibility if the service or item is denied.

"GA" Modifier and Appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier **GA** (wavier of liability statement on file).

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable **must** have the patient's ***written consent*** for an appeal. Written appeals requests should be sent to:

Connecticut
Attention: Medical Review
Medicare Part B CT
PO Box 45010
Jacksonville, FL 32232-5010

OR

Florida
Attention: Medical Review
Medicare Part B Claims Review
PO Box 2360
Jacksonville, FL 32231-0018

Distribution of the *Medicare B Update!*

Use of the Internet has become an accepted standard of communication throughout the world. Publications produced by First Coast Service Options, Inc. (FCSO) for our Connecticut Medicare Part B and Florida Part A and B customers are available on our provider education websites (*http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*). Our Medicare publications are posted to the websites in PDF (portable document format) and may be viewed, printed, or downloaded free of charge.

Hardcopy publications, by contrast, nationally cost Medicare a substantial amount of money for printing and postage. Reducing the number of hardcopies produced is one way Medicare contractors can reduce costs that may be better utilized elsewhere. In addition, enhancements to online publications can be made that are not possible in print.

Providers Must Qualify and Register to Receive the *Medicare B Update!* in Hardcopy or CD-ROM Format

Hardcopy or CD-ROM distribution of the *Medicare B Update!* is limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Medicare providers who meet these criteria have to register with us to receive the *Update!* in hardcopy or CD-ROM format.** Qualifying providers will be eligible to receive one hardcopy or CD-ROM of that issue, *if* a valid reason can be shown why the electronic publication available on the Internet cannot be utilized. "I just prefer hardcopy" is an invalid reason – a valid reason might be lack of a personal computer with Internet access, lack of a CD-ROM drive, or another technical or other barrier.

If you believe you meet these criteria and wish to receive hardcopies or CD-ROMs, you must complete and return the registration form that follows. You will be required to re-register annually. If you registered previously and no longer need a hardcopy, please indicate this on the form.

If you are willing and able to receive the *Update!* electronically from the Internet, you do not need to reply to us. Providers and other entities that do not meet the criteria and desire a hardcopy or CD-ROM may purchase an annual subscription to the *Update!* (please see the "2006 Part B Materials" order form on the inside back cover of this issue).

Note: If you have a paid subscription, you will receive hardcopies or CD-ROMs of the *Medicare B Update!* through your subscription period.

Features of the Electronic Publication

There are advantages to accessing the *Update!* online: the electronic version is posted to the Web before print copies are distributed, and you can view, print, or download only those articles important to your practice.

In addition, we have enhanced the format of electronic and CD-ROM newsletters to provide helpful features that do not appear in the current hardcopy format, including hyperlinks. A hyperlink is an element in an electronic document that links the user to another place in the same document, to an entirely different document, or to a Web site. This feature will provide users instant access to the following items:

- *Articles of Interest* – The newsletters' table of contents includes hyperlinks to each article, therefore a provider can choose an article(s) of particular interest to his/her medical practice.
- *Third-Party Websites* – All third-party websites referenced within articles include hyperlinks to the applicable information on that website. (*Online publications only*.)
- *References within the Contractor Websites* – All additional resources or reference materials mentioned in the newsletter include hyperlinks to that information within the FCSO Medicare websites (e.g., full-text versions of local medical review policies, prior publications, forms, online registration, etc.). Additionally, links to unique Web pages allow access to information applicable to the user's specialty classification. (*Online publications only*.)

The enhanced electronic publications are available at no charge through the FCSO Medicare websites and on CD-ROM at a minimal cost. In addition, you may sign up for the *FCSO eNews*, our free electronic mailing list. Subscribers receive an email notice when new publications are posted to our websites, plus frequent notification of other items of interest. Anyone with an email address may sign up for *eNews*; you don't have to be at the office.

NOTE: Providers not sending back the form will be changed back to online if previous getting a hardcopy version.

Medicare B Update! Hardcopy/CD-ROM Registration Form

To receive the *Medicare B Update!* in hardcopy or CD-ROM format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form.

Please note that you are not obligated to complete this form to obtain information published in the *Medicare B Update!* – issues published beginning in 1997 are available free of charge on our provider education websites *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*.

Provider/Professional Association Name:

Medicare Provider Identification Number (PIN):

Address:

City, State, ZIP Code:

Contact Person/Title:

Telephone Number:

Rationale for needing a hardcopy:

Does your office have Internet access? YES ❑ NO ❑

Do you have a PC with a CD-ROM drive? YES ❑ NO ❑

Other technical barrier or reason for needing publications hardcopy or on CD-ROM:

Mail your completed form to:

Medicare Communication and Education - Publications
P.O. Box 45270
Jacksonville, FL 32232-5270

or fax to 1 (904) 791-6292

Please let us know your concerns or questions regarding this initiative:

Please do not contact our customer service call center regarding this initiative. Additional questions or concerns may be submitted via the website in the "contact us" section.

CLAIMS

Correct Coding Initiative Edits to Apply to ALL Therapy Providers

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Outpatient Physical Therapy and Speech-Language Pathology Providers (OPTs), and Home Health Agencies (HHAs)

Provider Action Needed

STOP – Impact to You

Effective January 1, 2006, the Medicare Correct Coding Initiative (CCI) edits will be applied to **ALL** outpatient services furnished by the above mentioned providers.

CAUTION – What You Need to Know

Be aware that application of CCI edits under the Physician Fee Schedule (PFS) will make uniform the manner in which all outpatient rehabilitation therapy services - including physical therapy, occupational therapy, and speech-language pathology services - are paid. To review the CCI edits that apply to Medicare Part B services paid by Medicare fiscal intermediaries (FIs) see *http://www.cms.hhs.gov/providers/hopps/cciedits/* on the CMS website.

GO – What You Need to Do

Affected providers should begin immediately to prepare their systems with any necessary software, educate their staff and management about the 2006 CCI application to their claims, and watch for forthcoming information from CMS and their local contractor (carrier or fiscal intermediary), after October 1, 2005, **although the CCI concept should not be unfamiliar- just its application .**

Background

This Special Edition, SE0545, is published by the Centers for Medicare & Medicaid Services (CMS) as a 'heads-up' to institutional therapy providers to make certain that they are aware of the changes in Medicare's payment processes that are to begin January 1, 2006. **It is important to note that the CCI edits are applied to services billed by the same provider for the same beneficiary on the same date of service.**

Medicare's National Correct Coding Initiative (NCCI) is an edit system that was developed to promote national correct coding methodologies and eliminate improper coding. These edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices.

Carriers currently apply the CCI edits to all practitioners filing claims for rehabilitation therapy services, including the services of physicians (and their incident-to services) and the services provided by physical therapists and occupational therapists in private practices. Additionally, CCI edits are applied in the outpatient hospital setting by the intermediaries, including rehabilitation therapy services. However, until now, CCI edits have not been applied to other institutional therapy providers of outpatient rehabilitation therapy services, including physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. These institutional therapy providers include:

- SNFs,
- CORFs,
- OPTs, and
- (HHAs.

In January 1999, the institutional therapy providers were changed, via the 1997 Balanced Budget Act (BBA) requirements, from cost-based reimbursement to payment under the Medicare physician fee schedule (MPFS). At that time, these entities were granted a temporary postponement from the CCI edits because there was no Outpatient Code Editor (OCE) CCI mechanism in place.

Congressional concerns about rising utilization of therapy services and the fact that these facilities have had 5-plus years to adjust to the billing requirements of the MPFS, CMS has determined that this is the appropriate time to apply the CCI edits in these settings. Application of the CCI edits ensures that all therapy providers are subject to the same billing and coding rules and requirements. It is believed that these changes will have a positive budgetary effect as it incorporates safeguards against improper coding and over-payment of therapy services.

Billing Instructions

SNFs, CORFs, OPTs (sometimes referred to as rehabilitation agencies), and HHAs (home health services not under a home health plan of treatment) will see the CCI edits applied to types of bills (TOB) as follows:

Skilled Nursing Facilities (SNFs): • Skilled Nursing Facility Inpatient Part B • Skilled Nursing Facility Outpatient	 TOB 22x TOB 23x
Comprehensive Outpatient Rehabilitation Facilities (CORFs)	TOB 75x
Rehabilitation Agencies/Outpatient Physical Therapy and Speech-Language Pathology Providers (OPTs)	TOB 74x
Home Health Agency (HHAs) (home health services not under a home health plan of treatment)	TOB 34X

The CCI edits will be applied to the above bill types as of January 1, 2006. Since calendar year 2000, the edits have been applied to all services, including outpatient therapy services, provided by OPPS hospitals.

Please also note the following billing pointers:

- A therapy billing web page, developed specifically for PTs and OTs, contains billing information and includes the requirements that are necessary pre-conditions to the service delivery framework that CMS assumes is in place when Part B therapy services are delivered. This site outlines the "assumptions" for payment of outpatient Part B PT and OT therapy services and lists some references to help underscore that all of these services are subject to the payment rules of the MPFS. This information can be found or accessed at *http://www.cms.hhs.gov/providers/therapy/billing.asp* on the CMS website.
- Physical and occupational therapists (PTs and OTs) and their therapy assistants - physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) - and speech-language pathologists (SLPs) must all meet Medicare personnel qualifications at 42 CFR 484.4 to provide outpatient therapy services in these therapy providers. The standards that apply to therapists are detailed in our manual at Pub. 100-02, chapter 15, sections 220 and 230.
- Affected providers should pay special note to modifier -59 that permits a distinct procedural service to be billed for the same patient on the same day by the same provider. These distinct services are identified as independent of other services provided that day by using the modifier -59. At the *http://www.cms.hhs.gov/providers/therapy/billing.asp* website, scenario #6 (of 11 scenarios) contains the following example of the use of modifier -59:
- Billing for both individual (one-on-one) and group services provided to the same patient in the same day is allowed, provided the CMS and coding rules for one-on-one and group therapy are both met, and that the group therapy session be clearly distinct or independent from other services and billed using a -59 modifier.
- The group therapy CPT code (*97150*) and the direct one-on-one 15-minute CPT code for therapeutic exercises (*97110*), are a mutually exclusive CCI code pair: *97150* is the column one code, *97110* is the column two code, and the -59 modifier is permitted to be used.
- This requires the group therapy and the one-on-one exercise therapy to occur in different sessions, separate encounters, or different timeframes – occurring sequentially, not concurrently - that are distinct or independent from each other.
- The therapist would bill for both group therapy and therapeutic exercises, appending the –59 modifier to the column two code, *97110*. Without the -59 modifier, payment would be made for the column one group therapy CPT Code, *97150*. The CCI edits are based upon interpretation of coding rules.
- Review the FAQs explaining two kinds of Edits: FAQ 3373 (Column1/Column2) and FAQ 3372 (Mutually Exclusive). Click on the following link and enter NCCI in the search box—the CMS FAQ site. 3373 is on page one and 3372 page two.

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php

- The preceding bullet point refers to the code pairs that are a crucial underpinning of the CCI edits. Keep in mind that whether you bill a carrier or an intermediary, the CCI principles and logic are the same. However, a few code-pair edits and the -59 modifier applicability may vary from the two versions: OPPS and physician. Remember that the NCCI edits are updated quarterly and the hospital version is one calendar quarter behind the carrier "physician" version. Review the background information regarding the NCCI edits for the Hospital Outpatient Prospective Payment (OPPS) at: *http://www.cms.hhs.gov/providers/hopps/cciedits/background.asp* on the CMS website.

Additional Information

There is Medlearn information on the web written about the CCI edits. The Medlearn Matters article numbers are: MM3244, MM3995, MM3823, MM3349, and MM3688 and can be viewed by going to: *http://www.cms.hhs.gov/medlearn/matters/* then clicking on the appropriate number.

Another Medlearn product is a CCI Reference Guide published in 2002. The Guide is comprehensive and helpful in terms of acquainting the reader with the entire CCI edit process. Keep in mind that the latest edits will always be available on the web—this Guide is excellent background information and available at *http://www.cms.hhs.gov/contractors/customerserv/ccirefgde.pdf* on the CMS website.

Another version of this guide focused on the viewpoint of interest to hospitals may be found at *http://www.cms.hhs.gov/providers/hopps/cciedits/* on the CMS website. A version of the CCI guide for physicians may be found at *http://www.cms.hhs.gov/physicians/cciedits/* on the CMS website.

The following site describes eleven therapy-billing scenarios and scenario number six explains CCI edits with modifier 59, an excellent reference for all types of billing: *http://www.cms.hhs.gov/providers/therapy/billing.asp.*

The following AMA site is a primer on CCI edits and presents a history of the CCI initiative, column one and two codes and the rationale behind modifier -59: *http://www.ama-assn.org/ama/pub/category/3233.html.*

Further information on these CCI edit applications will be made available via future Medlearn Matters articles as well. Watch the Medlearn Matters site and information made available from your carrier/intermediary for further developments. As always, if you have questions, please contact your carrier or intermediary at their toll free number available at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0545
Effective Date: January 1, 2006 *Revised*

Quarterly Update to Correct Coding Initiative (CCI) edits, Version 11.3, Effective October 1, 2005

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians billing Medicare carriers

Provider Action Needed

This is a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of CCI edits will be effective on October 1, 2005. Physicians may view the current CCI edits and the current mutually exclusive code (MEC) edits at *http://www.cms.hhs.gov/physicians/cciedits* on the Centers for Medicare & Medicaid (CMS) website. The website will be updated with the Version 11.3 edits as soon as they are effective.

Background

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of CCI edits, Version 11.3, is effective on October 1, 2005. This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables: Column 1/Column 2 Correct Coding Edits table and MEC Edits table.

Additional Information

The CCI and MEC files shall maintain the file formats in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 20.9, which can be found at *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp* on the CMS website.

Related Change Request (CR) #: 3995
Medlearn Matters Number: MM3995
Related CR Release Date: August 26, 2005
Related CR Transmittal #: 657
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

Annual ICD-9-CM Update – Supplemental to MM3888

The annual ICD-9-CM update (change request 3888) that is effective for dates of service on and after October 1, 2005, expands the diagnosis code of 585 for chronic kidney disease to include a fourth digit to allow for a higher degree of specificity in reporting the stage of kidney disease. Medlearn Matters article MM3888 was published in the Fourth Quarter 2005 *Medicare B Update!* pages 8-9.

The new codes for chronic kidney disease are defined as follows:

585.1	*Chronic kidney disease, Stage I*
585.2	*Chronic kidney disease, Stage II (mild)*
585.3	*Chronic kidney disease, Stage III (moderate)*
585.4	*Chronic kidney disease, Stage IV(severe)*
585.5	*Chronic kidney disease, Stage V*
585.6	*End stage renal disease*
585.9	*Chronic kidney disease, unspecified*

Note: Claims submitted with ICD-9-CM 585 with dates of service on or after October 1, 2005 will be denied as unprocessable.

Source: Pub 100-04, Transmittal 591, Change Request 3888

Fragmented Billing

Fragmented billing occurs when providers submit claims for services that are furnished on the same date of service on separate bills. This can potentially cause an erroneous payment to occur. The carrier must make an overpayment request as well as correct history in these situations.

To alleviate the unnecessary steps to recoup/adjust previously processed claims, submit related services rendered on the same date of service on the same claim.

Global surgery procedures are an example of the types of service that should be billed on the same claim when rendered by the same provider on the same day. Since the Medicare fee schedule amount for surgical procedures includes all services that are part of the global surgery package, carriers do not pay more than that amount when a bill is fragmented. When total charges for fragmented services exceed the global fee, process the claim as a fee schedule reduction (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global surgery allowed amount). Carriers do not attribute such reductions to medical review savings except where the usual medical review process results in recoding of a service, and the recoded service is included in the global surgery package.

Source: Medicare Claims Processing Manual Chapter 12, Section 40.5

2006 Annual Update for the Health Professional Shortage Area Bonus Payments

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians who provide services in designated (Health Professional Shortage Area (HPSAs).

Provider Action Needed

STOP – Impact to You

New information on the new automated HPSA bonus payments for 2006 is posted on the Centers for Medicare & Medicaid Services (CMS) website.

CAUTION – What You Need to Know

Section 413(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment files. This CR provides those files for claims with dates of service on or after January 1, 2006, through December 31, 2006.

GO – What You Need to Do

You should review the information on the CMS website to determine if you qualify for the HPSA bonus payment for 2006.

Background

Section 1833(m) of the Social Security Act provides a 10 percent bonus payment for physicians who furnish medical care services in geographic areas that the Health Resources and Services Administration (HRSA) designates as primary medical care HPSAs.

MMA Section 413(b) required CMS to annually update the bonus payment files, and CR4113 provides the names of those updated files for 2006. To find details regarding the HPSA bonus payments, please visit *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0449.pdf* on the CMS website.

The updated list of HPSA zip codes for calendar year (CY) 2006 can be found at *http://www.cms.hhs.gov/providers/bonuspayment* on the CMS website.

Additional Information

You can find more information about the HPSA bonus payment by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that web page, look for CR4113 in the CR NUM column on the right, and click on the file for that CR.

You can also go to the Medlearn Matters Provider Education Web page at *http://www.cms.hhs.gov/medlearn/matters/* to find other Medlearn Matters articles that address the bonus payments.

Special Edition articles SE0449, SE0453, and SE0450 and Medlearn Matters articles MM3108, MM3827, MM3822, MM3336, and MM3800 all address HPSA issues. From this website, you can also look at the CRs from which the articles were derived by clicking on the respective CR number.

You might also want to look at the *Medicare Claims Processing Manual* (Publication 100.04), Chapter 12 (Physician/Practitioner Billing), Section 90.4 (Billing and Payment in Health Professional Shortage Areas (HPSAs).

You can find this manual at *http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf* on the CMS website.

Finally, if you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Medlearn Matters Number: MM4113
Related Change Request (CR) #: 4113
Related CR Release Date: October 14, 2005
Effective Date: January 1, 2006
Related CR Transmittal #: 722
Implementation Date: January 3, 2006

Instructions to Forego HPSA/PSA Incentive

Effective January 1, 2005, the Centers for Medicare & Medicaid Services (CMS) implemented a new health professional shortage area (HPSA) and physician scarcity area (PSA) automated payment file that lists ZIP codes that will receive the bonus payment.

Effective October 1, 2005, for claims with dates of services **on or after January 1, 2005,** Medicare will allow payment of a bonus on just the professional components of services that have a professional component/technical component of 1 (diagnostic services or radiology services), even when the global service code is submitted. Services that have a PC/TC of 4 will continue to reject as unprocessable services. Providers need to resubmit the services with the appropriate code to receive the bonus payments.

Note: Physicians can access database indicators/tags via CMS website *http://www.cms.hhs.gov/physicians/mpfsapp/step1.asp*.

In addition, physicians can choose to not receive any HPSA or PSA bonus payment on services that would otherwise be eligible need to notify their carriers. This notification will be in effect until the physician directs otherwise.

Action Required by Providers Choosing to Forego HPSA/PSA Bonus Payment

Effective for claims received **on or after October 1, 2005,** providers choosing not to receive the HPSA/PSA bonus payment on eligible services must contact the Medicare carrier. **The preferred method to contact the carrier is by telephone.** The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is:

For Florida providers 1-866-454-9007
For Connecticut providers 1-866-419-9455

FCSO representatives will request the name of the provider and the name and the professional title of the caller.

If by mail, send your request to:

Florida providers

Medicare Part B Inquiries
P. O. Box 2360
Jacksonville, FL 32231-0018

Connecticut providers

Attention: Correspondence
Medicare Part B
P. O. Box 45010
Jacksonville, FL 32232-5010

Physicians need to notify FCSO when reversing the decision to forego the HPSA/PSA bonus payment.

Source: CMS Pub. 100-4, Transmittal 556, CR 3822

Medicare's Common Working File Expansion of Duplicate Claim Edit for Clinical Diagnostic Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Clinical laboratories billing Medicare carriers for laboratory services.

Provider Action Needed

STOP – Impact to You

Effective January 1, 2006, the Medicare system will edit to check for duplicate claims for referred clinical diagnostic laboratory services to more than one carrier will be modified to include all claims, with or without the modifier 90.

CAUTION – What You Need to Know

Claims submitted, with or without the modifier 90, for referred clinical diagnostic laboratory services will be identified as "duplicate claims" when the involved claims contain different carrier numbers and all of the following data matches in the claim fields: (a) Beneficiary Name; (b) Beneficiary Health Insurance Claim Number (HICN); (c) Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code; and (d) Date of Service.

GO – What You Need to Do

Affected providers should be aware of this change.

Background

The Centers for Medicare & Medicaid Services (CMS) issued CR 3551, Transmittal 124, on October 29, 2004, to implement a new edit in Medicare's systems, effective April 1, 2005, to check for duplicate claims for referred clinical diagnostic laboratory services and purchased diagnostic services submitted by physicians/supplier to more than one carrier.

This edit for clinical diagnostic laboratory services and purchased diagnostic claims, which was implemented on April 4, 2005, did not edit line items that contained the modifier 90. When performing the data matching, the Medicare duplicate claim edit for referred clinical diagnostic laboratory performed the matching on the claim fields: (a) Beneficiary Name; (b) HICN; (c) CPT/ HCPCS code; (d) Date of Service; and (e) CPT/HCPCS Code Modifier. That edit was not applied to claims with a modifier 90.

Medicare will modify the duplicate claim edit to reject all clinical laboratory services submitted to carriers when it has been determined that another carrier has already paid for the same service on the same date of service, **with the exception of those claims containing the modifier 91. This modified edit will apply to all laboratory claims** with dates of service on or after January 1, 2006.

When claims are denied as a result of this edit, Medicare carriers will use remark code N347 on the remittance advice to show "Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer."

Note: Repeat clinical laboratory services for the same beneficiary on the same date of service are identified by the modifier 91. When performing the data matching, the CWF duplicate claim edit for referred clinical diagnostic laboratory service will not include the modifier 91 on referred laboratory claims in the matching criteria, but will perform matching on all others as specified above.

The CWF duplicate claim edit will only apply to claims containing a CPT code that is included on the clinical laboratory fee schedule (available on the CMS clinical laboratory website at *http://www.cms.hhs.gov/suppliers/clinlab/default.asp*), or a HCPCS code that is included on the Abstract File for Purchased Diagnostic Tests/Interpretations implemented in April 2005.

Implementation Date

The implementation date for this instruction is January 3, 2006.

Additional Information

CR 3551, Transmittal 124, Common Working File (CWF) Duplicate Claim Edit for Referred Clinical Diagnostic/Purchased Service may be viewed at *http://www.cms.hhs.gov/manuals/pm_trans/R124OTN.pdf* on the CMS website. The related Medlearn Matters article may be viewed at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3551.pdf* on the CMS website.

For complete details on this change, please see the official instruction issued to your carrier. That instruction may be viewed by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3946 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3946
Medlearn Matters Number: MM3946
Related CR Release Date: July 29, 2005
Related CR Transmittal #: 626
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

National Modifier and Condition Code To Be Used To Identify Disaster-Related Claims

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)) for services rendered to beneficiaries affected by Hurricane Katrina.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4106, which establishes a new condition code and modifier for providers to use to indicate claims for victims of Hurricanes Katrina and Rita and other disasters.

CAUTION – What You Need to Know

To accommodate the emergency health care needs of Medicare beneficiaries and providers affected by Hurricanes Katrina and Rita and any future disasters, the Centers for Medicare & Medicaid Services (CMS) has created the following new condition code and modifier, effective for dates of service on and after August 21, 2005. The new condition code is **"DR (Disaster Related)"** and the new modifier is "**CR (Catastrophe/Disaster Related)**."

GO – What You Need to Do

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

Background

CMS has acted to ensure that the Medicare program will be flexible enough to accommodate the emergency health care needs of beneficiaries and medical providers in the states devastated by Hurricanes Katrina and Rita. Many of the programs' normal operating procedures have been relaxed to speed the provision of health care services to the elderly and persons with disabilities who depend on Medicare services.

Because of hurricane damage to local health care facilities, many Medicare beneficiaries have been evacuated to neighboring states where receiving hospitals and nursing homes have no access to patients':

- Health care records;
- Current health status; or
- Verification of status as Medicare beneficiaries.

Note: CMS is assuring facilities and medical providers receiving Medicare beneficiaries affected by Hurricanes Katrina and Rita that *the normal requirements for documentation will be waived and the presumption of eligibility should be made.*

Health care providers that furnish medical services in good faith, but who cannot comply with normal program requirements because of Hurricanes Katrina and Rita, will be:

- Paid for services provided; and
- Exempt from sanctions for noncompliance (unless it is discovered that fraud or abuse occurred).

New Condition Code and Modifier

To facilitate Medicare claims processing and track services and items provided to victims of Hurricanes Katrina and Rita and any future disasters, CMS has established a new condition code and modifier for providers to use on disaster-related claims. The new condition code and modifier are for use by providers submitting claims for Medicare beneficiaries who are Katrina disaster patients in any part of the country and are effective for dates of service on and after August 21, 2005. The new codes are the following:

- The new condition code is **DR - Disaster Related**
- The new modifier is **CR - Catastrophe/Disaster Related**

For physicians or suppliers billing their local carrier or DMERC, only the modifier (CR) should be reported and not the condition code. A condition code is used in FI billing.

For institutional billing, either the condition code or modifier may be reported. The condition code would identify claims that are impacted or may be impacted by specific payor policies related to a national or regional disaster. The modifier would indicate a specific Part B service that may be impacted by policy related to the disaster.

CR4106 instructs Medicare contractors to recognize the new condition code and modifier on October 3, 2005, if possible, but no later than October 31, 2005.

In addition to this Medlearn Matters Article, CMS regional offices will help facilitate contractor outreach regarding provider education on the use of the new modifier and condition code.

Implementation

The targeted implementation date is October 3, 2005, but no later than October 31, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/FI regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR4106 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/DMERC/FI at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 4106
Medlearn Matters Number: MM4106
Related CR Release Date: October 14, 2005
Related CR Transmittal #: 184
Effective Date: August 21, 2005
Implementation Date: October 3, 2005, but no later than October 31, 2005

Nonparticipating Physicians and Suppliers Billing Vaccinations

The purpose of this article is to clarify information published in the Fourth Quarter 2005 Medicare B Update! (pages 10-14) in regard to mandatory assignment rules as they apply to vaccinations.

Pneumococcal, hepatitis B, and influenza virus vaccines fall into the category of drugs and biologicals, therefore, effective for services provided on or after February 1, 2001, the mandatory assignment provision of section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA) applies.

All drugs and biologicals must be paid based on mandatory assignment. Therefore, regardless of whether the physician and supplier usually accept assignment, they must accept assignment for the vaccines, may not collect any fee up front, and must submit the claim for the beneficiary.

Nonparticipating physicians and suppliers (including local health facilities) may collect payment from the beneficiary for the administration codes, but must submit an unassigned claim on the beneficiary's behalf.

Source: Pub 100-04, Transmittal 525, Change Request 3733

Re-review of Previously Denied Claims Prohibited—CR3622

Effective for claims processed on or after July 5, 2005, the Medicare claims processing system will not allow the re-review of medical review denials.

This requirement is based on the Medicare Program Integrity Manual, Chapter 11, Fiscal Administration, Section 1.3 Prepay Review for MR purposes which requires that contractors deny as duplicate a newly submitted line that duplicates a line that a contractor has:

- Already denied for MR reasons;
- Medically reviewed; or
- Requested but did not receive documentation.

Duplicate means that both the original and resubmitted line has the same beneficiary, services, service dates and provider (billing and/or rendering).

Providers may not appeal duplicate denials unless the provider documents that the service was not a duplicate because it was performed more often than indicated in the original line.

By July 5, 2005, contractors will begin using a "Duplicate non-paid" denial message as follows: "We denied this service because it is a duplicate of a service denied on a previous claim. This denial is not appealable unless the provider can document that the service was not a duplicate because it was performed more often than indicated in the original line."

Source: Transmittal 104, Change Request 3622, dated February 11, 2005.

COVERAGE/REIMBURSEMENT

AMBULANCE

Enforcement of Hospital Inpatient Bundling: Carrier Denial of Ambulance Claims During an Inpatient Stay

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Independent ambulance services suppliers billing Medicare carriers

Provider Action Needed

STOP – Impact to You

Independent ambulance services suppliers cannot bill Medicare carriers for ambulance services that they provide to hospital inpatients (on or after 12/31/04), unless the services are provided either:

- On the dates of hospital admission and/or discharge, or
- Through a prior arrangement with the hospital.

If services other than these two scenarios are billed separately as Part B, the bills will be rejected. (There are exceptions for patients of long-term care hospitals, inpatient psychiatric facilities, or inpatient rehabilitation facilities as discussed later in this article.)

CAUTION – What You Need to Know

If an ambulance supplier bills Medicare and is paid prior to Medicare's receipt of the hospital inpatient claim, Medicare will recover the improper payment from the ambulance supplier.

GO – What You Need to Do

Make sure that your billing staffs are aware of these ambulance service-billing requirements.

Background

The Centers for Medicare & Medicaid Services (CMS) is strengthening its claims processing edits to detect incorrect payments to detect and prevent (or correct) improper payments to ambulance suppliers for transporting hospital inpatients. In CR 3933 (on which this article is based), CMS wants to make you aware of the rules that govern payment for the ambulance services that such suppliers provide to hospital inpatients.

Sections 1882(a)(14), 1886(d) and (g) of the Social Security Act, and Code of Federal Regulations (CFR) 411.15(m) disallow payment for ambulance services furnished to hospital inpatients on dates that fall between the patients' admission and discharge dates, unless the hospitals bills for services directly or makes special arrangements for the services with the independent ambulance supplier.

As a result, the independent supplier of ambulance services must look to the hospital for payment for these services, rather than to the Medicare beneficiary or carrier. More specifically, with the exception of services on the admission and discharge dates, all ambulance transportation provided to hospital inpatients must be bundled into the hospital bill. Medicare carriers will reject any bill for ambulance services that are provided to a hospital inpatient on a date that falls between their admission and discharge dates.

In summary, here is how this process works. Effective for dates of service on or after December 31, 2004, Medicare's systems search the paid claim histories of independent suppliers of ambulance services and compares the line item service dates (line items with specialty codes of "59") on the ambulance claims to the admission and discharge dates on hospital inpatient stays. Medicare then rejects the line items when an ambulance line item service date falls between the admission and discharge dates on a hospital inpatient bill.

And, if Medicare receives the ambulance claim prior to receiving the hospital inpatient bill, it performs the same search and if the ambulance claim falls within the admission and discharge dates, the ambulance claim is adjusted and the incorrect payment for the ambulance service will be recovered from the ambulance supplier.

Note: There is a special group of ambulance transportation payment situations that are permitted for inpatients of certain facilities. Specifically, these payments are permitted when the beneficiary is an inpatient of a long term care facility (LTCH), inpatient psychiatric facility (IPF), or inpatient rehabilitation facility (IRF), and is transported by ambulance to an acute care hospital to receive specialized services and the service date falls within the occurrence span code 74 (non-covered level of care) from and through dates, plus one day, on a LTCH, IPF, or IRF bill.

Finally, when Medicare rejects/adjusts an ambulance claim, the carrier will indicate, by using remittance advice remark code M2: "Not paid separately when the patient is an inpatient;" that:

1. The ambulance transportation occurred during a hospital inpatient stay (on a date that falls within the admission and discharge dates of a covered hospital inpatient stay), and is not separately payable, or
2. The service date falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a LTCH, IPF or IRF, and is not separately payable.

In addition, the carrier will also indicate the adjustment using remittance advice (RA) adjustment reason code 97 "Payment is included in the allowance for another service/procedure."

Additional Information

You can find more information about the payment of ambulance claims during an inpatient stay by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page, look for CR 3933 in the CR NUM column on the right, and click on the file for that CR.

You might also want to look at the Medicare Claims Processing Manual, Chapter 3 (Inpatient Part A Hospital) Section 10.5 (Hospital Inpatient Bundling). You can find this manual chapter as an attachment to CR3933.

Finally, if you have any questions, please contact your carrier at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3933
Medlearn Matters Number: MM3933
Related CR Release Date: July 29, 2005
Related CR Transmittal #: 622
Effective Date: Ambulance claims received on or after January 3, 2006 and 4 years after initial determination for adjustments
Implementation Date: January 3, 2006

AMBULATORY SURGICAL CENTERS

Fiscal Year 2006 Payment for Services Furnished in Ambulatory Surgical Centers

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Ambulatory Surgical Centers (ASCs) billing Medicare carriers or intermediaries

Provider Action Needed

This instruction advises that the **current** ACS payment rates and wage index values **remain** in effect for FY 2006.

Background

Section 626(a) of the Medicare Modernization Act (MMA) mandates, for ASC payment rates, a zero percent increase for inflation in FY 2005, the last quarter of Calendar Year (CY) 2005, and each calendar year from CY 2006 through CY 2009.

Wage Index Values

The implementation of new wage index values for FY 2006 is deferred until the Centers for Medicare & Medicaid Services (CMS) has had an opportunity to determine the impact of changes in the FY 2006 inpatient hospital wage index on payment amounts for individual ASCs. Therefore, ***payments to ASCs for services furnished on or after October 1, 2005, will not change.***

Until further notice, Medicare carriers will continue to use the FY 2004 wage index to calculate payments to ASCs and continue to use the payment rates that were effective for services furnished on or after April 1, 2004.

The labor-related portion of ASC payment rates is defined currently as 34.45 percent of the payment rate.

Carriers are currently using the FY 2004 hospital inpatient wage index to calculate payments for ASC services.

Transmittal AB-03-116 (CR2871), issued August 8, 2003, updated ASC facility payment rates for inflation and updated the wage index values used to adjust ASC payments for geographic wage differences effective for services furnished on or after October 1, 2003. CR2871 may be found at *http://www.cms.hhs.gov/manuals/pm_trans/AB03116.pdf* on the CMS website.

Transmittal 51 (CR3082), issued February 4, 2004, notified contractors about a change in ASC payment rates effective April 1, 2004, resulting from enactment of Section 626(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). CR3082 may be found at *http://www.cms.hhs.gov/manuals/pm_trans/R51OTN.pdf* on the CMS website.

ASC Payment Group Rates

The ASC payment group rates will remain as follows:

Group 1	$333	Group 6	$826 ($676 + $150 for intraocular lenses (IOLs))
Group 2	$446	Group 7	$995
Group 3	$510	Group 8	$973 ($823 + $150 for IOLs)
Group 4	$630	Group 9	$1339
Group 5	$717		

Additional Information

The CMS website for ASC information can be found at *http://www.cms.hhs.gov/suppliers/asc* on the CMS website.

The official instruction issued to your carrier/intermediary regarding this change may be found at *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR4075 in the CR NUM column on the right, and click on the file for that CR.

If you have questions regarding this issue, please contact your carrier/intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 4075
Related CR Release Date: September 30, 2005
Effective Date: October 1, 2005
Medlearn Matters Number: MM4075
Related CR Transmittal #: 690
Implementation Date: October 3, 2005

CONSOLIDATED BILLING

2006 Annual Update of Healthcare Common Procedure Coding System Codes for Skilled Nursing Facility Consolidated Billing

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and fiscal intermediaries (FIs) for services supplied to Medicare patients in a skilled nursing facility (SNF)

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4086 regarding the annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF Consolidated Billing (CB) and how the updates affect edits in Medicare claims processing systems, especially the Common Working File (CWF).

CAUTION – What You Need to Know

CR4086 provides updates to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with the policy for SNF consolidated billing that is detailed in Chapter 6 (Section 110.4.1) for carriers, and Chapter 6 (Section 20.6) for FIs.

GO – What You Need to Do

Physicians, suppliers, and providers should review the new coding files that will be posted on the CMS website.

Background

The Common Working File (CWF)

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered Skilled Nursing Facility (SNF) stay as well as for beneficiaries in a non-covered stay. These edits allow only those services excluded from consolidated billing to be separately paid by the carrier and\or FI.

For physicians and providers billing carriers: By the first week of December 2005, new code files will be posted to *http://www.cms.hhs.gov/medlearn/snfcode.asp* on the CMS website.

For those providers billing FIs: By the first week of December 2005, new Excel and PDF files will be posted to *http://www.cms.hhs.gov/providers/snfpps/snffi/* on the CMS website, under the "2006 Annual and Quarterly Updates" section.

Note: It is important and necessary for the provider community billing the FIs to view the "General Explanation of the Major Categories" bullet located under each Annual update bullet, at the *http://www.cms.hhs.gov/providers/snfpps/snffi/* link, to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Implementation

The implementation date for the instruction is January 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change, which may be viewed at *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR4086 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 4086
Related CR Release Date: October 7, 2005
Effective Date: January 1, 2006
Medlearn Matters Number: MM4086
Related CR Transmittal #: 696
Implementation Date: January 3, 2006

Financial Liability for Services Subject to Home Health Consolidated Billing

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Home Health Agencies (HHAs) and providers and suppliers of services to Medicare patients in a home health episode of care

Provider Action Needed

This instruction is intended mostly as an informational refresher. However, the article and CR3948 clarify guidance regarding Home Health Services (HHS) consolidated billing, particularly the guidance that addresses potential provider and beneficiary liability for payment. **Providers/suppliers treating Medicare patients in an episode of home health care are encouraged to review the entire CR3948.** Instructions for accessing CR3948 are provided at the end of this article.

The Centers for Medicare & Medicaid Services (CMS) is providing this information because questions about payment liability have persisted since the home health prospective payment system (HH PPS) was implemented in October 2000. CMS believes that providing clear answers in the *Medicare Claims Processing Manual* will help you better understand HH PPS.

Background

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing for all home health services that are included under a physician-authorized home health care plan. Earlier guidance and information about HH PPS consolidated billing was primarily published in articles attached to Program Memoranda. CR3948 (from which this article is taken) improves the organization of and clarifies instructions about HH PPS. In particular, it identifies circumstances in which providers or beneficiaries may be liable for payment for services subject to HH PPS consolidated billing.

A Short Summary of the Guidance

Under HHS consolidated billing, only the primary HHA can bill for services included in a beneficiary's home health benefit during the beneficiary's HHA episode of care. With the exception of durable medical equipment (DME) and physician-provided therapy services (discussed below), Medicare will not separately pay other providers or suppliers for any home health services that they render. Therefore, providers and suppliers of home health services should be aware that, under certain circumstances, they, or the beneficiary, could potentially bear the cost of these services.

The Guidance in More Detail

HH PPS consolidated billing provides that the Medicare payment for all of a beneficiary's home health items and services is to be made to a single (known as "primary") HHA that oversees that beneficiary's physician-authorized home health plan. This primary HHA is the **only** agency that may bill Medicare for home care for a given homebound beneficiary at a specific time. Further, the payment Medicare makes is to the primary HHA, regardless of who actually furnishes the service (including services furnished by others under arrangement to the primary HHA, by any other contracting or consulting arrangements existing with the primary HHA, or by any other mechanism).

However, while the primary HHA is responsible for providing all of a patient's home health services, they would not be responsible for payment to another provider if they were unaware of the physician's orders for that service. Therefore, if an independent provider/supplier were to provide the beneficiary a home health service that was already consolidated into the HHA's payment, their claim would be denied by Medicare and they would not receive payment.

Types of Services Subject to Home Health Billing

The following types of services are subject to this home health consolidated billing provision, and are included in the primary HHA's payment:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and non-routine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

Two types of services, however, are an exception to this guidance, and are therefore not subject to the home health consolidated billing methodology. These services are:

- Physician-performed therapy services (which means that although the procedure code would be subject to HH consolidated billing, the specialty code which indicates that it was provided by a physician removes it); and
- Durable medical equipment (DME).

Billing of Durable Medical Equipment

DME warrants some further discussion. DME may be billed by a supplier to a durable medical equipment regional carrier (DMERC) or billed by an HHA (including HHAs other than the primary HHA) to a Regional Home Health Intermediary (RHHI). To prevent duplicate RHHI and DMERC billing (the same dates of service for the same beneficiary), Medicare system edits ensure that all DME items billed by HHAs have a line-item date of service and HCPCS code, even though, by law, HH consolidated billing does not apply to DME. If the RHHI and the DMERC receive duplicate bills (for either purchase or rental), the first claim received will be processed and paid, and the subsequent duplicate claims will be denied.

How Do You Protect Yourself and the Beneficiaries?

In general, all providers and suppliers serving a home health patient should attempt to protect the beneficiary from unexpected liability by notifying them of the possibility that they can be responsible for payment.

Primary HHAs

Let's first discuss your responsibilities if you are the primary HHA. When a homebound beneficiary seeks care from you, you need to determine if they are already being

served by a primary HHA. You can ask the beneficiary or his/her representative, if they are already being served by an HHA. Or, you can send an inquiry to your RHHI.

If the response indicates that the beneficiary is not already under the care of another HHA, you may admit them and you will become primary. The HHA that submits a successfully processed request for anticipated payment (RAP) or No-RAP Low Utilization Payment Adjustment (LUPA) will be recorded as the primary HHA for a given episode in the Common Working File (CWF).

You may also admit them, even if an episode is already open at another HHA, if the patient has chosen to transfer. If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for that patient's consolidating billing.

At the time of their initial home health care admission, you, as the primary HHA, must advise the patient that you will be providing all of their home health services, including therapies and supplies. You must also explain the disciplines (e.g., skilled nursing, physical therapy, home health aide, etc.) that will be furnishing their care, and the proposed visit frequency.

In addition, you must advise the patient, in advance (both orally and in writing), about possible payment sources, including what Medicare is expected to cover, as well as other payment sources, including payment from the patient. This discussion should help alert the beneficiary to the possibility of payment liability if they were to obtain services from anyone other than their primary HHA.

Independent Providers/Suppliers

Since Medicare payment for services that fall under home health consolidated billing is made to the primary HHA, independent providers or suppliers of these services need to understand that Medicare will not pay you separately. Therefore, before you provide a homebound beneficiary any services, you need to first determine if they are being served by a primary HHA.

To get this information you can, first, ask the beneficiary (or their authorized representative) if they are currently receiving home health services under a home health plan of care. In fact, beneficiaries and their representatives should have the most complete information as to whether or not they are receiving home health care. But, beneficiary-derived HH information, in and of itself, does not shift liability to either the beneficiary or to Medicare. Additionally, you can ask your intermediary or carrier.

Institutional providers who bill Fiscal Intermediaries (FIs) can access this information electronically through the home health Common Working File (CWF) inquiry process (See Chapter 10, Section 30.1, Health Insurance Eligibility Query to Determine Episode Status attached to CR3948.) Independent therapists who bill carriers or suppliers who bill DMERCs can call the provider toll free line to request home health eligibility information available on the CWF. (Those toll free numbers are available at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.) But remember that the carrier's or DMERC's information is based only on claims Medicare has received from HHAs by the day of the contact.

If you are concerned about the reliability of any of this information, you should advise the HH beneficiary that if they decide to accept your services rather than those provided by the primary HHA, they can be liable for the payment.

Finally, if you learn of a home health episode and contact the primary HHA, you might inquire about the possibility of making a payment arrangement with them for the service. Such contacts may foster relationships between therapy providers, suppliers and HHAs that are beneficial both to the providers involved and to Medicare beneficiaries.

Hospitals

Hospitals are responsible for making Medicare beneficiaries and caregivers aware of Medicare home health coverage policies in order to:

- Help ensure that those services are provided appropriately; and
- Alert the beneficiary to their potential liability under home health consolidated billing.

Under the Medicare Conditions of Participation (COP) for Hospitals: Discharge planning, (42 CFR, section 482.43 (b) (3) and (6)), your discharge planning process must include an evaluation of the likelihood that a patient will require post-hospital services and an evaluation of their availability. Hospitals need to counsel those beneficiaries who are to receive HH services after discharge that their primary HHA will provide all of their home health services. You should also provide them with a list of HHAs from which to choose, and notify the agency that you are referring the patient to and provide the agency with any counseling notes. This should serve as a reminder to the HHA to notify the beneficiary that they will be providing all of their HH services.

Other Important Information

Institutionalizing an HH patient

Under HH PPS, claims for inpatient hospital and Skilled Nursing Facility (SNF) services have priority over claims for home health services. Because institutionalized beneficiaries cannot receive home care, if Medicare detects dates of service on an HH PPS claim that fall within the dates of an inpatient or SNF claim (not including the dates of admission and discharge), the RHHI will reject the HH claim. This will be the outcome even if the HH PPS claim were received first and the SNF or inpatient hospital claims came in later.

Edits and Denials

Claims subject to consolidated billing may be identified either prepayment or postpayment. HH consolidated billing editing is applied when Medicare has received and processed the episode claim. Any line item services within the episode start, and end, or last billable service dates, will be edited.

Medicare sends information to the FIs and carriers that enable them to reject or deny line items on claims subject to consolidated billing. This rejection or denial may take place either prior to, or after, payment. If it occurs after payment, Medicare notifies the FI or carrier to make a postpayment rejection or denial. FI post-payment recoveries will be made automatically in the claims process, and carriers follow their routine overpayment identification and recovery procedures.

Important editing issues include the following:

- If Medicare receives only a Request for Anticipated Payment (RAP) from an HHA for an episode and an incoming claim from another provider contains dates of service within the 60-day home health episode period, Medicare alerts the FI or carrier that the incoming claim may be subject to consolidated billing. The FI or carrier

will process the claim for payment, but also alerts the provider on the remittance advice with remark code N88: *"This payment is being made conditionally. An HHA episode of care notice has been filed for this patient...This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."*

- If an independent provider/supplier submits a claim for services (subject to home health consolidated billing) for a beneficiary under a home health care plan (place of service on the claim is "12 home"), but Medicare does not yet have a record of either a RAP or a home health claim for the episode of care, your carrier will alert you on the remittance advice with remark code N116: *"This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care…This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."*
- In HH PPS consolidated billing, non-routine medical supplies are identified as a list of discrete items by HCPCS code. Medicare periodically publishes Routine Update Notifications that contain updated lists of non-routine supply codes and therapy codes that must be included in home health consolidated billing. The lists are updated annually, effective January 1, as a result of the annual changes in HCPCS codes, and also as frequently as quarterly if required by the creation of new, mid-year HCPCS codes. (Medlearn Matters articles are prepared to inform providers of these periodic updates.)
- Any claim submitted to a DMERC, with dates of service that overlap the dates of an open HH PPS episode and containing a non-routine supply HCPCS code, will be denied.
- Non-routine supply HCPCS codes, which may be claimed as part of providing certain emergency, surgical, diagnostic, and end stage renal disease (ESRD) services, are either bundled into the rate paid for the primary service, or are otherwise incident to the primary service(s) being rendered. They do not fall within the bundling provisions of HH PPS, and are not subject to CWF consolidated billing edits.
- Medicare enforces consolidated billing for outpatient therapies on claims submitted to FIs, recognizing as therapies all services billed under revenue codes 042X, 043X, 044X. These revenue codes have been cross-referenced to a list of HCPCS codes that represent the same services for use in editing against carrier claims. This list will also be updated periodically by Routine Update Notification.
- Remember, however, as mentioned earlier, physician-performed therapy services are not subject to home health consolidated billing.
- **Osteoporosis drugs** are subject to home health consolidated billing, even though they continue to be paid on a cost basis. Only a primary HHA can bill for their use by Medicare patients in an episode of care. For more detailed information, refer to Section 90.1 of Chapter 10 of the *Medicare Claims Processing Manual*, which is available at *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp* on the CMS website.

Additional Information

This article summarizes the information made available in CR3948. Providers treating Medicare patients in a home health episode of care are encouraged to be familiar with all the details of CR3948. You can find CR3948 at *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website.

From that web page, look for CR3948 in the CR NUM column on the right, and click on the file for that CR.

CR3948 includes revised portions of the *Medicare Claims Processing Manual* related to the HH PPS.

Finally, if you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3948
Medlearn Matters Number: MM3948
Related CR Release Date: August 5, 2005
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Effective Date: October 1, 2000
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October 2005 Quarterly Update to Skilled Nursing Facility Consolidated Billing

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians providing positron emission tomography (PET) scan professional component services to SNF patients affected by skilled nursing facility (SNF) consolidated billing (CB).

Provider Action Needed

STOP – Impact to You

Medicare established HCPCS codes, *78459, 78491, 78492, 78608, 78609, 78811, 78812, 78813, 78814, 78815*, and *78816* for PET scans effective for dates of service on or after January 28, 2005. The physician professional component (modifier 26) of these services may be paid separately outside of SNF CB. These codes will be added to editing on October 3, 2005.

CAUTION – What You Need to Know

Your Medicare carrier may not have paid you correctly for these services on or after October 3, 2005 if you bring such claim(s) to your carrier's attention.

GO – What You Need to Do

Should you have received a denial for these services for claims of dates of service or another 1/18/05 through 10/2/05, contact your carrier to have these claim adjusted.

Background

The affected HCPCS codes are as follows:

- *78459 Myocardial imaging, positron emission tomography (PET), metabolic evaluation*
- *78491 Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress*
- *78492 Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress*
- *78608 Brain imaging, positron emission tomography (PET); metabolic evaluation*
- *78609 Brain imaging, positron emission tomography (PET); perfusion evaluation*
- *78811 Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck)*
- *78812 Tumor imaging, positron emission tomography (PET); skull base to mid thigh*
- *78813 Tumor imaging, positron emission tomography (PET); whole body*
- *78814 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck)*
- *78815 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh*
- *78816 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT)* for attenuation correction and anatomical localization; whole body

Implementation Date

This change will be made to Medicare systems on October 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website.

From that web page, look for CR 4010 in the CR NUM column on the right, and click on the file for that CR.

For more information on SNF CB, see Medlearn Matter Special Edition SE0431, Skilled Nursing Consolidated Billing, available at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf* on the CMS website.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

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DIABETIC SERVICES

Manual Update on Medical Nutrition Therapy - Manual Update

Change request 3955 has manualizes sections in the current Internet Only Manual (IOM) for Medical Nutrition Therapy (MNT) Services (Pub 100-04, Chapter 4, Sections 300 through 300.6). The definition for diabetes mellitus has been changed based on the 2003 Medicare Physician Fee Schedule Regulation. Also, material that was excluded from the new IOM has been added. Update sections include:

300.1 – General Conditions and Limitations on Coverage
300.2 – Referrals for MNT Services
300.3 – Dietitians and Nutritionists Performing MNT Services
300.4 – Payment for MNT Services
300.5 – General Claims Processing Information
300.6 – Common Working File (CWF) Edits

300 - Medical Nutrition Therapy (MNT) Services

(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

Section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permits Medicare coverage of Medical Nutrition Therapy (MNT) services when furnished by a registered dietitian or nutrition

professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when referral is made by a physician as defined in section 1861(r)(l) of the Act. It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time. The effective date of this provision is January 1, 2002.

The benefit consists of an initial visit for an assessment; follow-up visits for interventions; and reassessments as necessary during the 12-month period beginning with the initial assessment ("episode of care") to assure compliance with the dietary plan. Effective October 1, 2002, basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes as defined at 42 CFR, 410.130 is 3 hours. Also effective October 1, 2002, basic coverage in subsequent years for renal disease is 2 hours.

For the purposes of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 6 months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate (GFR) 13-50 ml/min/1.73m^2). Effective Janaury 1, 2004, CMS updated the definition of diabetes to be as follows: Diabetes is defined as diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

The MNT benefit is a completely separate benefit from the diabetes self-management training (DSMT) benefit. CMS had originally planned to limit how much of both benefits a beneficiary might receive in the same time period. However, the national coverage decision, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full 3 hours of MNT. However, providers are not allowed to bill for both DSMT and MNT on the same date of service for the same beneficiary.

300.1 General Conditions and Limitations on Coverage

(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

A. General Conditions on Coverage

The following are the general conditions of coverage:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease. As described above, a treating physician means the primary care physician or specialist coordinating care for beneficiary with diabetes or renal disease.
- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician;
- Services may be provided either on an individual or group basis without restrictions and;
- For a beneficiary with a diagnosis of diabetes, Diabetes Self Management Training (DSMT) and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary. For a beneficiary with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the beneficiary may receive MNT services based on a change in medical condition, diagnosis or treatment as stated in 42 CFR 410.132(b)(5).

B – Limitations on Coverage

The following limitations apply:

- MNT services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under Section 1881 of the Act.
- A beneficiary may not receive MNT and DSMT on the same day.

300.2 Referrals for MNT Services

(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

Medicare covers 3 hours of MNT in the beneficiary' s initial calendar year. No initial hours can be carried over to the next calendar year. For example, if a physician gives a referral to a beneficiary for 3 hours of MNT but a beneficiary only uses 2 hours in November, the calendar year ends in December and if the third hour is not used, it cannot be carried over into the following year. The following year a beneficiary is eligible for 2 follow-up hours (with a physician referral). Every calendar year a beneficiary must have a new referral for follow-up hours. Referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease .

Documentation must be maintained by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care and reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. The UPIN number of the referring physician must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. The Carrier or FI shall return claims that do not contain the referring UPIN of the referring physician.

Note: Additional covered hours of MNT services may be covered beyond the number of hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132 (a).

300.3 Dietitians and Nutritionists Performing MNT Services

(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

A – Professional Standards for Dietitians and Nutritionists

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means a dietitian or nutritionist licensed or certified in a State as of December 21, 2000 (they are not required to meet any other requirements); or an individual whom, on or after December 22, 2000:

- Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose. The academic requirements of a nutrition or dietetics program may be completed after the completion of the degree;
- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual; and
- Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements stated above.

B – Enrollment of Dietitians and Nutritionists

- In order to file claims for MNT, a registered dietitian/nutrition professional must be enrolled as a provider in the Medicare program and meet the requirements outlined above. MNT services can be billed with the effective date of the provider's license and the establishment of the practice location.
- The carrier shall establish a permanent UPIN for any new registered dietitian or nutrition professional who is applying to become a Medicare provider for MNT.
- Registered dietitians and nutrition professionals must accept assignment. Since these new providers must accept assignment, the limiting charge does not apply.

300.4 Payment for MNT Services

(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

The contractor shall pay for MNT services under the physician fee schedule for dates of service on or after January 1, 2002, to a registered dietitian or nutrition professional that meets the above requirements. Deductible and coinsurance apply. As with the diabetes self management training (DSMT) benefit, payment is only made for MNT services actually attended by the beneficiary and documented by the provider, and for beneficiaries that are not inpatients of a hospital or skilled nursing facility.

The contractor shall pay the lesser of the actual charge, or 85 percent of the physician fee schedule amount when rendered by a registered dietitian or nutrition professional. Coinsurance is based on 20 percent of the lesser of these two amounts. As required by statute, use this same methodology for services provided in the hospital outpatient department.

A – Payable Codes for MNT with Applicable Instructions

- *97802 – Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes*. (NOTE: This HCPCS code must only be used for the initial visit.)
  This code is to be used only once for the initial assessment of a new patient. The provider shall bill all subsequent individual visits (including reassessments and interventions) as *97803*. The provider shall bill all subsequent group visits as *97804*.
- *97803 – Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes*
  The provider shall bill this code for all reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient (see the heading, Additional Covered Hours for Reassessments and Interventions).
- *97804 – Group (2 or more individual(s)), each 30 minutes* - The provider shall bill this code for group visits, initial and subsequent. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group.

Note: The above codes can be paid if submitted by a registered dietitian or nutrition professional who meet the specified requirements; or a hospital that has received reassigned benefits from a registered dietitian or nutritionist. These services cannot be paid "incident to" physician services.

B – HCPCS Codes for MNT When There is a Change in the Beneficiaries Condition (for services effective on or after January 1, 2003)

The following HCPCS codes shall be used when there is a change in the beneficiary's condition:

- G0270 – Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes.

- G0271 – Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group (2 or more individuals), each 30 minutes.

Note: These G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered, (3 hours in the initial calendar year, and 2 follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132(a).

300.5 General Claims Processing Information

(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

This benefit is payable for beneficiaries who have diabetes or renal disease. Contractors are urged to perform data analysis of these services in your jurisdiction. If you determine that a potential problem exists, you should verify the cause of the potential error by conducting an error validation review as described in the Program Integrity Manual (PIM), Chapter 3, Section 2A. Where errors are verified, initiate appropriate corrective actions found in the PIM, Chapter 3, Sections 3 through 6. If no diagnosis is on the claim, return the claim as unprocessable. If the claim does not contain a diagnosis of diabetes or renal disease, then deny the claim under Section 1862(a)(1)(A) of the Act.

A. Special Requirements for Carriers

- Registered dietitians and nutrition professionals can be part of a group practice in which case the provider identification number of the registered dietitian or nutrition professional that performed the service must be entered in on the claim form. - The specialty code for "dietitians/nutritionists" is 71

B. Medicare Summary Notices (MSNs)

- Use the following MNT messages where appropriate. If you locate a more appropriate message, then you should use it.
- If a claim for MNT is submitted with dates of service before January 1, 2002, use MSN 21.11 (This service was not covered by Medicare at the time you received it). The Spanish version is 'Este servicio no estaba cubierto por Medicare cuando usted lo recibio.'
- If a claim for MNT is submitted by a provider that does not meet the criteria use MSN 21.18 (This item or service is not covered when performed or ordered by this provider). The Spanish version is 'Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor.'

C. FI Special Billing Instructions

MNT Services can be billed to FIs when performed in an outpatient hospital setting. The Hospital outpatient departments can bill for the MNT services through the local FI if the nutritionists or registered dietitians reassign their benefits to the hospital. If the hospitals do not get the reassignments the nutritionists and the registered dietitians will have to bill the local Medicare carrier under their own provider number or the hospital will have to bill the local Medicare carrier.

Note: Nutritionists and registered dietitians must obtain a Medicare provider number before they can reassign their benefits.

The only applicable bill types are 13X, 14X, 23X, 32X, and 85X.

300.6 Common Working File (CWF) Edits

(Rev.673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

The CWF edit will allow 3 hours of therapy for MNT in the initial calendar year. The edit will allow more than 3 hours of therapy if there is a change in the beneficiary's medical condition, diagnosis, or treatment regimen, and this change must be documented in the beneficiary's medical record. Two new G codes have been created for use when a beneficiary receives a second referral in a calendar year that allows the beneficiary to receive more than 3 hours of therapy. Another edit will allow 2 hours of follow up MNT with another referral in subsequent years.

Advance Beneficiary Notice (ABN)

The beneficiary is liable for services denied over the limited number of hours with referrals for MNT. An ABN should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable.

An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professions who are qualified to render the service in their state but who have not obtained Medicare provider numbers.

Source: Pub 100-4, Chapter 4, Sections 300 – 300.6, Change Request 3955, Transmittal 673

DRUGS AND BIOLOGICALS

October 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective October 1, 2005, and Revisions to April 2005 and July 2005 Quarterly ASP Medicare Part B Drug Pricing Files

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare providers who bill Medicare contractors: carriers, including durable medical equipment regional carriers (DMERCs), fiscal Intermediaries (FIs), and regional home health intermediaries (RHHIs)

Provider Action Needed

STOP – Impact to You

CR3992 provides the payment allowance limits in the April 2005, July 2005, and October 2005 average sales price (ASP) drug pricing files. The revised payment limits for the codes listed in this article supersede the payment limits for these codes in any publication published prior to this document.

CAUTION – What You Need to Know

Be aware that certain Medicare Part B drug payment limits were revised for dates of service on or after April 1, 2005; on or before June 30, 2005; on or after July 1, 2005, and on or before September 30, 2005.

GO – What You Need to Do

Make certain your billing staff is aware of these changes. Downloads for the April 2005, July 2005, and October 2005 ASP drug pricing files are available after September 19, 2005. See the *Additional Information* section in this article for the website address.

Background

According to Section 303 (c) of the Medicare Modernization Act (MMA), the Centers for Medicare & Medicaid Services (CMS) will update the payment allowances for Medicare Part B drugs on a quarterly basis. Beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the ASP.

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis. Each quarter, CMS will update your carrier/FI payment allowance limits with the ASP files.

Exceptions

There are, however, exceptions to the general rule and they were summarized in MM3846 effective April 1, 2005. This article may be found at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3846.pdf* on the CMS website.

The **one new exception** listed in this CR states that the payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors (carriers, DMERCs, FIs, and RHHIs) will determine payment limits for radiopharmaceuticals based on invoice pricing or the methodology in place in November 2003.

Implementation

The implementation date for the instruction is October 3, 2005.

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be found at *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR3992 in the CR NUM column on the right and click on the file for that CR.

CMS will also update the Microsoft Excel files on the CMS website to reflect these revised payment limits.

Those files are at *http://www.cms.hhs.gov/providers/drugs/asp.asp* on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3992
Medlearn Matters Number: MM3992
Related CR Release Date: August 19, 2005
Related CR Transmittal #: 653
Effective Date: April 1, 2005, July 1, 2005, and October 1, 2005, respectively
Implementation Date: October 3, 2005

DURABLE MEDICAL EQUIPMENT

October 2005 Quarterly Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services paid under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

Provider Action Needed

This article is based on Change Request (CR) 4026 and provides specific information regarding the October quarterly update of the 2005 DMEPOS fee schedule.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to:

- Implement fee schedule amounts for new codes; and
- Revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for:

- Durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)); and
- Parenteral and enteral nutrition (PEN) by regulations contained in the Code of Federal Regulations (42CFR 414.102).

Note: **There are no changes to the PEN fee schedule file for October 2005.**

The following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) on October 1, 2005, and are effective for claims with dates of service on or after October 1, 2005:

Code	Description of Code
Q0480	Driver for use with pneumatic ventricular assist device, replacement only
Q0481	Microprocessor control unit for use with electric ventricular assist device, replacement only
Q0482	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only
Q0483	Monitor/display module for use with electric ventricular assist device, replacement only
Q0484	Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0485	Monitor control cable for use with electric ventricular assist device, replacement only
Q0486	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only
Q0488	Power pack base for use with electric ventricular assist device, replacement only
Q0489	Power pack base for use with electric/pneumatic ventricular assist device, replacement only
Q0490	Emergency power source for use with electric ventricular assist device, replacement only
Q0491	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only
Q0492	Emergency power supply cable for use with electric ventricular assist device, replacement only
Q0493	Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only
Q0494	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0495	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0496	Battery for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0497	Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0498	Holster for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0499	Belt/vest for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0500*	Filters for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0501	Shower covers for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0502	Mobility cart for pneumatic ventricular assist device, replacement only
Q0503	Battery for pneumatic ventricular assist device, replacement only, each
Q0504	Power adapter for pneumatic ventricular assist device, replacement only, vehicle type
Q0505	Miscellaneous supply or accessory for use with ventricular assist device

*** Replacement filters** described by code Q0500 are furnished in boxes of varying quantities by different manufacturers. Therefore, the base unit for code Q0500 for billing purposes is per each filter.

Note: Instructions regarding the implementation of the above codes were furnished in CR3931.

October 2005 Quarterly Fee Schedule Update for DMEPOS, continued

The following table describes upcoming changes in certain HCPCS codes for wheelchairs beginning October 1, 2005.

HCPCS CODE	New Information
E0971 (anti-tipping device for wheelchairs)	The fee schedule amount for code E0971 is being revised to reflect a base-billing unit of "EACH." Up to this point E0971 represented "each" or a "pair" of devices. In October the fee schedule will be standardized to represent fees per each unit.
E1038 & E1039 (transport chairs)	The fee schedule amounts for E1038 are being revised to correct errors in the fee calculations and reflect changes in billing for items under these codes. The fees erroneously included elevating leg rests and those should be billed separately using code K0195. The updated schedule will no longer include prices for the leg rests.
K0195 (elevating leg rests)	Suppliers should be billing these leg rests under this code.
E1039 (transport chairs with patient weight capacity over 300 pounds)	Claims dated on/after October 1, 2005 should contain E1039 for chairs with weight capacity OVER 300 pounds.
E1038 (transport chairs with patient weight capacity under 300 pounds)	Claims dated on/after October 1, 2005 should contain E1038 for chairs with weight capacity of 300 pounds or less.
E1238 (Pediatric size, folding, adjustable wheelchair without seating system)	The fee schedule is being revised for E1238 to correct fee schedule calculation errors.

HCPCS codes L3000 through L3649 were added to the fee schedule file effective July 1, 2005, for use in paying claims for shoes that are an integral part of an orthoses.

L5685 was added to the HCPCS effective January 1, 2005. The fee schedules are being established as part of this report.

Implementation

The implementation date for this instruction is October 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website.

From that Web page, look for CR4026 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

Also, the quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual (Pub 100-04, Chapter 23, Section 60)*. This manual can be accessed at *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 4026
Medlearn Matters Number: MM4026
Related CR Release Date: September 2, 2005
Related CR Transmittal #: 665
Effective Date: January 1, 2005 for implementation of revised fee schedule amounts for codes in effect on January 1, 2005; October 1, 2005 for all other changes
Implementation Date: October 3, 2005

END STAGE RENAL DISEASE

Implementation of Carrier Guidelines for End-Stage Renal Disease Reimbursement for Automated Multi-Channel Chemistry Tests (Supplemental to Change Request 2813)

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers billing automated multi-channel chemistry tests to Medicare carriers.

Provider Action Needed

STOP – Impact to You

This article is based on information from Change Request (CR) 3890, which supplements CR2813 by implementing carrier procedures for enforcing compliance with the payment policy for end-stage renal disease (ESRD)-related laboratory services (i.e., the ESRD 50/50 rule).

CAUTION – What You Need to Know

The ESRD 50/50 rule requires the billing laboratory to identify automated multi-channel chemistry AMCC tests ordered and to classify them according to the following categories:

1. AMCC test ordered by an ESRD facility (or MCP physician) that is part of the composite rate and is not separately billable,
2. AMCC test ordered by an ESRD facility (or MCP physician) that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity; and
3. AMCC test ordered by an ESRD facility (or MCP physician) that is not part of the composite rate and is separately billable.

This proportion (or percentage) of composite tests to non-composite tests is used to determine whether separate payment may be made for all tests performed on the same day for the same beneficiary.

GO – What You Need to Do

When billing Medicare for ESRD-related AMCC tests, laboratories must identify which tests, if any, are not included within the ESRD facility composite rate payment. Ensure the tests are properly identified. When billing for AMCC tests, the laboratory must identify the appropriate modifier for each test, as follows:

- **Modifier "CD"** – AMCC test has been ordered by an ESRD facility (or MCP physician) that is part of the composite rate and is not separately billable.
- **Modifier "CE"** – AMCC test has been ordered by an ESRD facility (or MCP physician) that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.
- **Modifier "CF"** – AMCC test has been ordered by an ESRD facility (or MCP physician) that is not part of the composite rate and is separately billable.

Background

This instruction supplements change request (CR) 2813 (transmittal 198, dated June 4, 2004, subject: ESRD Reimbursement for Automated Multi-Channel Chemistry (AMCC) Tests) by implementing Medicare carrier procedures to enforce compliance with the payment policy for ESRD-related laboratory services. The Centers for Medicare & Medicaid Services (CMS) is implementing these new procedures in response to payment vulnerabilities identified by the Office of the Inspector General (OIG) in the Department of Health and Human Services.

The ESRD 50/50 Rule

The ESRD 50/50 rule requires the billing laboratory to determine (for the same beneficiary on the same date-of-service):

- The number of AMCC tests (ordered and performed) that are included in the composite payment rate paid to the ESRD facility (or the monthly capitation payment made to the furnishing physician); and
- The number of covered non-composite tests paid.

The proportion of composite versus non-composite tests calculated by the billing laboratory is then used to determine whether separate payment may be made for all tests performed on that day. Medicare's composite rate payment to an ESRD facility (or monthly capitation payment [MCP] to a physician) includes reimbursement for certain routine clinical laboratory tests furnished to an ESRD beneficiary. However, separate payment for such clinical laboratory tests may be made when more than 50 percent of all Medicare-covered laboratory services (furnished to the same beneficiary on the same date of service) are AMCC tests that are not included in the composite payment rate.

In other words (for the same beneficiary on the same date of service):

When…	Then…
The 50 percent threshold is met [i.e., more than 50 percent of the covered tests are non-composite payment rate tests]	All laboratory tests (composite payment rate and non-composite payment rate tests) furnished on that date are separately payable.
The 50 percent threshold is not met [i.e., 50 percent or more of the covered tests are included under the composite payment rate]	No laboratory tests (including non-composite payment rate tests) furnished on that date are separately payable.

Note: A non-composite payment rate test is defined as any test separately reimbursable outside of the composite payment rate or beyond the normal frequency covered under the composite payment rate that is reasonable and necessary.

Laboratory Tests Subject to ESRD 50/50 Rule
The laboratory tests subject to the ESRD 50/50 rule are those tests:

- Included within AMCC tests, and
- Furnished to an ESRD beneficiary based upon an order by:
- A doctor rendering care in the dialysis facility; or
- A monthly capitation payment (MCP) physician at the dialysis facility for the diagnosis and treatment of the beneficiary's ESRD.

Note: Tests ordered by the MCP physician outside of the dialysis clinic are not subject to the ESRD 50/50 rule.

Payment Policy for AMCC Tests for ESRD Beneficiaries
With respect to the application of the payment policy for AMCC tests for ESRD beneficiaries, the following applies:

- Payment is at the lowest rate even if those automated tests were submitted as separate claims for tests performed by the same provider, for the same beneficiary, for the same date of service.
- For a particular date of service, the laboratory identifies the AMCC tests ordered that are included in the composite rate and those that are not included. The composite rate tests are defined in attachments to CR3890. Attachment 1 shows tests for hemodialysis, intermittent peritoneal fialysis (IPD), continuous cycling peritoneal dialysis (CCPD), and hemofiltration. Attachment 2 covers continuous ambulatory peritoneal dialysis (CAPD). Instructions for accessing CR3890 are provided in the Additional Information section of this article.
- All tests ordered for beneficiaries with chronic dialysis for ESRD must be billed individually. Carriers must reject claims for these tests when billed as a panel.
- When billing Medicare for ESRD-related AMCC tests, laboratories must identify which tests, if any, are not included within the ESRD facility composite rate payment. Three pricing modifiers discreetly identify the different payment situations for ESRD AMCC services. When billing for AMCC tests, the laboratory must identify the appropriate modifier for each test, as follows:

- **Modifier "CD"** – AMCC test has been ordered by an ESRD facility (or MCP physician) that is part of the composite rate **and** is not separately billable.
- **Modifier "CE"** – AMCC test has been ordered by an ESRD facility (or MCP physician) that is a composite rate test but is beyond the normal frequency covered under the rate **and** is separately reimbursable based on medical necessity.
- **Modifier "CF"** – AMCC test has been ordered by an ESRD facility (or MCP physician) that is **not** part of the composite rate **and** is separately billable.

Note: ESRD clinical laboratory tests identified with modifiers "CD", "CE" or "CF" may not be billed as organ or disease panels. Upon the effective date of CR3890, all ESRD clinical laboratory tests must be billed individually.

Implementation

The implementation date for this instruction is January 1, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR3890 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3890 Medlearn Matters Number: MM3890
Related CR Release Date: June 27, 2005 Related CR Transmittal #: 598
Effective Date: January 1, 2006 Implementation Date: January 1, 2006

Billing Procedure Code Q9952 – Supplemental to MM3748

Effective April 1, 2005, new "Q" codes (Q9951-Q9957) were added to the HCPCS for contrast agents. Procedure code A4643 was replaced with procedure code Q9952 (*injection gadolinium-based magnetic resonance contrast agent, per ml).* Procedure code A4643 has specific coverage guidelines outlined in the Medicare Claims Processing Manual, Chapter 13-Radiology Services and Other Diagnostic Procedures, Section 40-Magnetic Resonance Imaging (MRI) procedures.

Since procedure code A4643 was replaced with Q9952, then the same guidelines apply to procedure code Q9952. Therefore, Q9952 must be billed in conjunction with one of the following MRI CPT codes: *70553, 72156, 72157,* and *72158.* If not billed with one of the previously mentioned codes, the service will be denied.

Payment for Q9952 is based on the average sales price (ASP) plus 6 percent.

Source: Pub 100-04, Transmittal 502, Change Request 3748

EVALUATION AND MANAGEMENT SERVICES

New G Code for Power Mobility Devices

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services related to Power Mobility Devices (PMDs).

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4121 which announces that a new G Code (G0372) has been established to recognize the additional physician service and resources required to establish and document the need for PMDs.

CAUTION – What You Need to Know

The new G code is only payable if all of the information necessary to document the PMD prescription is included in the medical record after a face-to-face examination of the beneficiary, and the PMD supplier receives the prescription within 30 days after the face-to-face examination.

GO – What You Need to Do

Please see the *Background* section of this article for further details.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 302(a)(2)(E)(iv)) details the revised conditions for Medicare payment of Power Mobility Devices (PMDs). It states that payment for motorized or power wheelchairs may not be made unless a face-to-face examination of the beneficiary has been conducted, and a written prescription (order) for the PMD has been provided by a:

- Physician (as defined in Section 1861(r)(1) of the Social Security Act);
- Physician assistant;
- Nurse practitioner; or
- Clinical nurse specialist (as those terms are defined in Section 1861(aa)(5) of the Social Security Act).

Note: Payment for the history and physical examination will be made through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient.

New G Code

Due to the MMA requirement that the physician or treating practitioner create a written prescription and a regulatory requirement that the physician or treating practitioner prepare pertinent parts of the medical record for submission to the durable medical equipment supplier, the Centers for Medicare & Medicaid Services (CMS) has established the new G Code (G0372), to recognize additional physician services and resources required to establish and document the need for a PMD.

CMS believes that the typical amount of additional physician services and resources involved is equivalent to the physician fee schedule relative values established for a level 1 office visit for an established patient (Current Procedural Terminology (CPT) code 99211).

The payment amount for such a visit is $21.60; therefore, the payment amount for G0372 for 2005 will be $21.60, adjusted by the geographic area where the services is provided, and based on the physician fee schedule values for a level 1 established patient office visit (CPT 99211).

Code G0372 indicates that:

- All of the information necessary to document the PMD prescription is included in the medical record; and
- The PMD supplier has received the prescription, along with the supporting documentation, within 30 days after the face-to-face examination.

Effective October 25, 2005, G0372 will be used to recognize additional physician services and resources required to establish and document the need for the PMD, and it will be added to the Medicare physician fee schedule.

New G Code for Power Mobility Devices, continued

G Code & Payment Information	Short Descriptor	Long Descriptor
G0372 Procedure Status = A WRVU = 0.17 Non-Facility PE RVU = 0.39 Facility PE RVU = 0.06 Malpractice RVU = 0.01 PC/TC = 0 Site of Service = 1 Global Surgery = XXX Multiple Procedure Indicator = 0 Bilateral Procedure Indicator = 0 Assistant at Surgery Indicator = 0 Co-Surgery Indicator = 0 Team Surgery Indicator = 0 Diagnostic Supervision = 0 Type of Service = 1	MD service required for PMD	Physician service required to establish and document the need for a power mobility device

Pricing

Connecticut

Par	Non-Par	Limiting charge
24.26	23.05	26.50
9.71	9.22	10.61*

*=These amounts apply when service is performed in a facility setting.

Florida

PARTICIPATING			NONPARTICIPATING			LIMITING CHARGE		
LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
20.82	21.91	22.86	19.78	20.81	21.72	22.75	23.94	24.97
9.06	9.37	9.74	8.61	8.90	9.25	9.90	10.24	10.64*

*=These amounts apply when service is performed in a facility setting

Implementation

The implementation date for the instruction is October 25, 2005.

Additional Information

For full details regarding wheelchair coverage, visit the CMS page for wheelchairs at *https://www.cms.hhs.gov/coverage/wheelchairs.asp* on the CMS website.

For complete details on the new G code, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that web page, look for CR4121 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Medlearn Matters Number: MM4121
Related Change Request (CR) #: 4121
Related CR Release Date: October 18, 2005
Effective Date: October 25, 2005
Related CR Transmittal #: 713
Implementation Date: October 25, 2005

Updates to Home and Domiciliary Care Visits

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Providers billing carriers for medically necessary evaluation and management (E/M) home and domiciliary care visits and carriers processing these claims

Provider Action Needed

This article and related CR3922 provide information on place of service (POS) codes to be included with the Current Procedural Terminology (CPT) codes for home and domiciliary care visits. Specifically, POS code 13 should be used where the POS is an assisted living facility and code 14 should be used for group homes, effective for services on or after April 1, 2004. Use of the correct codes will help Medicare make prompt and correct payments for these services.

Background

CPT Codes 99321 – 99333: Domiciliary, Rest Home, or Custodial Care Services

CPT codes *99321* through *99333*: Domiciliary, Rest Home (e.g. Boarding Home), or Custodial Care Services, are used to report E/M services to individuals residing in a facility which provides room, board, and other personal assistance services, generally on a long-term basis. CR3922 updates the place of service (POS) codes that can be used with CPT codes *99321* through *99333* to include: 13 (assisted living facility) and 14 (group home).

Assisted living facilities may be known as adult living facilities. Previously, POS codes 33 (custodial care facility) and 55 (residential substance abuse facility) were the sites of service for CPT codes *99321* through *99333*.

CPT Codes *99341 – 99350*: Home Services Codes

CPT codes *99341* through *99350*: Home Services codes, are used to report E/M services furnished to a patient residing in his or her own private residence. Related CR3922 instructs carriers to interpret the term "private residence" as a private home, an apartment, town home, or other non-congregate/shared facility living arrangement.

A congregate/shared facility living arrangement includes assisted living facilities, adult living facilities, and group homes. These updates to home and domiciliary care visits specify that "home service codes do not apply to an individual residing in any type of congregate/shared facility living arrangement." home services CPT codes *99341* through *99350* should not be used with POS codes 13 or 14.

Skilled Nursing Facility (SNF) or Nursing Facility (NF) Services

Home Services codes should not be used for E/M services provided to patients residing in a skilled nursing facility (SNF) or a nursing facility (NF). E/M services provided to patients residing in an SNF or an NF must be reported using the appropriate level of service code within the range identified for comprehensive nursing facility assessments (CPT codes *99301 – 99303*) and subsequent nursing facility care services (CPT codes *99311 – 99313*). Use CPT codes *99315 – 99316* for SNF/NF discharge services.

Related Instructions

New POS codes were published in Transmittal 121 (CR 3087), dated March 19, 2004, available at: *http://www.cms.hhs.gov/manuals/pm_trans/R121CP.pdf* on the CMS website.

Additionally, CR3087 revised the description of the Group Home code to read: "A residence, with shared living areas, where clients receive supervision and other services, such as social and/or behavioral services, custodial services, and minimal services (e.g. medical administration)."

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR 3922 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3922
Medlearn Matters Number: MM3922
Related CR Release Date: September 2, 2005
Related CR Transmittal #: 667
Effective Date: April 1, 2004
Implementation Date: December 5, 2005

Changes to the Laboratory National Coverage Determination Edit Software for October 2005

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Laboratories billing Medicare carriers or intermediaries for clinical diagnostic laboratory services

Provider Action Needed

CR4005 announces changes to the list of codes included in the October 2005 release of the Medicare laboratory national coverage determination (NCD) edit module for clinical diagnostic laboratory services.

These changes are a result of new ICD-9-CM code changes that become effective October 1, 2005.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as final rule, 66 FR, 58788, on November 23, 2001. Nationally uniform software was developed by Computer Sciences Corporation and incorporated into the Medicare claim processing systems so that laboratory claims subject to any of the 23 NCDs are processed uniformly throughout the nation, effective January 1, 2003.

In addition, the laboratory edit module for the NCDs is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCDs process. (See the *Medicare Claims Processing Manual, Pub. 100-4, Chapter 16, Section, 120.2*. This manual may be found at *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp* on the CMS website.)

CR4005 announces the changes that will be included in the October 2005 release of the edit module for clinical diagnostic laboratory services. Those changes, which become effective October 1, 2005, include the following:

Urine Culture

In accordance with the coding analysis, CMS is adding new ICD-9-CM code ***585.6, End Stage Renal Disease,*** to the list of ICD-9-CM Codes Covered by Medicare for Urine Culture. CMS is deleting ICD-9-CM code ***585, Chronic Renal Failure***, from the same list for this NCD.

Immunodeficiency Virus (HIV) Testing (Diagnosis)

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Human Immunodeficiency Virus (HIV) Testing (Diagnosis). Those codes are as follows:

287.30 - Primary thrombocytopenia, unspecified	***287.33 - Congenital and hereditary thrombocytopenic purpura***
287.31 - Immune thrombocytopenic purpura	***287.39 - Other primary thrombocytopenia***
287.32 - Evans' syndrome	

CMS is deleting ICD-9-CM code ***287.3, PrimaryThrombocytopenia***, from the same list for this NCD.

Blood Counts

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes That Do Not Support Medical Necessity for Medicare for Blood Counts. Those codes are as follows:

443.82 – Erythromelalgia	***V26.31 - Testing for genetic disease carrier status***
525.40 - Complete edentulism, unspecified	***V26.32 - Other genetic testing***
525.41- Complete edentulism, class I	***V26.33 - Genetic counseling***
525.42 - Complete edentulism, class II	***V49.84 - Bed confinement status***
525.43 - Complete edentulism, class III	***V59.70 – Egg (oocyte) (ovum) donor, unspecified***
525.44 - Complete edentulism, class IV	***V59.71 - Egg (oocyte) (ovum) donor, under age 35,anonymous recipient***
525.50 - Partial edentulism, unspecified	***V59.72 - Egg (oocyte) (ovum) donor, under age 35,designated recipient***
525.51 - Partial edentulism, class I	***V59.73 - Egg (oocyte) (ovum) donor, age 35 and over,anonymous***
recipient	
525.52 - Partial edentulism, class II	***V59.74 - Egg (oocyte) (ovum) donor, age 35 and over,designated recipient***
525.53 - Partial edentulism, class III	***V62.84 - Suicidal ideation***
525.54 - Partial edentulism, class IV	

CMS is deleting ICD-9-CM code ***V26.3, Genetic Counseling and Testing,*** from the same list for this NCD.

Partial Thromboplastin Time (PTT)

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Partial Thromboplastin Time (PTT). Those codes are as follows:

287.30 - Primary thrombocytopenia, unspecified	***585.4 Chronic kidney disease, Stage IV (severe)***
287.31 - Immune thrombocytopenic purpura	***585.5 Chronic kidney disease, Stage V***
287.32 - Evans' syndrome	***585.6 - End stage renal disease***
287.33 - Congenital and hereditary thrombocytopenic purpura	***585.9 Chronic kidney disease, unspecified***
287.39 - Other primary thrombocytopenia	

CMS is deleting ICD-9-CM codes, ***287.3, Primary Thrombocytopenia,*** and ***585, Chronic Renal Failure,*** from the same list for this NCD.

Prothrombin Time (PT)

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Prothrombin Time (PT). Those codes are as follows:

287.30 - 287.39 as defined in the section on Partial Thromboplastin Time (PTT) above	***585.4 – 585.9 as defined in the section on Partial Thromboplastin Time (PTT) above.***
443.82 Erythromelalgia	

CMS is deleting ICD-9-CM code, ***287.3, PrimaryThrombocytopenia***, and ***585, Chronic Renal Failure,*** from the same list for this NCD.

Serum Iron Studies

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Serum Iron Studies. Those codes are as follows:

287.30 – 287.39 as defined in the section on Partial Thromboplastin Time (PTT) above.
585.4 – 585.9 as defined in the section on Partial Thromboplastin Time (PTT) above.

CMS is deleting ICD-9-CM codes ***287.3, PrimaryThrombocytopenia,*** and ***585, Chronic Renal Failure,*** from the same list for this NCD.

Blood Glucose Testing

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Blood Glucose Testing. Those codes as follows:

276.50 Volume depletion, unspecified 276.52 Hypovolemia 276.51 Dehydration

CMS is deleting ICD-9-CM code ***276.5, Volume Depletion,*** from the same list for this NCD.

Thyroid Testing

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Thyroid Testing. Those codes are as follows:

327.00 - Organic insomnia, unspecified	***327.29 - Other organic sleep apnea***
327.01 - Insomnia due to medical condition classified elsewhere	***327.52 - Sleep related leg cramp***
327.09 - Other organic insomnia	***327.8 - Other organic sleep disorders***

Lipid Testing

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Lipid Testing. Those codes are as follows:

278.02 – Overweight 585.4 – 585.9 as defined in Partial Thromboplastin Time (PTT) above.

CMS is deleting ICD-9-CM code ***585, Chronic Renal Failure,*** from the same list for this NCD.

Digoxin Therapeutic Drug Assay

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Digoxin Therapeutic Drug Assay. Those codes are as follows:

276.50 - Volume depletion, unspecified
276.51 - Dehydration
276.52 - Hypovolemia
426.82 - Long QT syndrome
585.1 - Chronic kidney disease, StageI
585.2 - Chronic kidney disease, Stage II (mild)
585.3 - Chronic kidney disease, Stage III (moderate)
585.4 - Chronic kidney disease, Stage IV (severe)
585.5 - Chronic kidney disease, Stage V
585.6 - End stage renal disease
585.9 - Chronic kidney disease, unspecified

CMS is deleting ICD-9-CM codes ***276.5, Volume Depletion,*** and ***585, Chronic Renal Failure,*** from the same list for this NCD.

Prostate Specific Antigen Testing

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Prostate Specific Antigen Testing. Those codes are as follows:

599.60 - Urinary obstruction, unspecified ***599.69 - Urinary obstruction, not elsewhere classified***

CMS is deleting ICD-9-CM codes, ***599.6, Urinary Obstruction,*** from the same list for this NCD.

Gamma Glutamyl Transferase Testing

CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Covered by Medicare for Gamma Glutamyl Transferase Testing. Those codes are as follows:

291.82 - Alcohol induced sleep disorder
567.21 - Peritonitis (acute) generalized
567.22 - Peritoneal abscess
567.23 - Spontaneous bacterial peritonitis
567.29 - Other suppurative peritonitis
567.38 - Other retroperitoneal abscess
567.39 - Other retroperitoneal infections
567.81 - Choleperitonitis
567.82 - Sclerosing mesenteritis
567.89 - Other specified peritonitis
585.6 - End Stage Renal Disease

CMS is deleting ICD-9-CM codes, 567.2, Suppurat Peritonitis NEC, 567.8, Peritonitis NEC, and 585, Chronic Renal Failure, from the same list for this NCD.

Fecal Occult Blood Testing

CMS is adding ICD-9-CM codes ***287.30 – 287.39*** (as defined in Partial Thromboplastin Time (PTT) above) to the list of ICD-9-CM Codes Covered by Medicare for Fecal Occult Blood Testing. CMS is deleting ICD-9- CM code, ***287.3, PrimaryThrombocytopenia,*** from the same list for this NCD.

Negotiated Laboratory NCDs

In accordance with the coding analysis, CMS is adding new ICD-9-CM codes to the list of ICD-9-CM Codes Not Covered by Medicare for the Negotiated Laboratory NCDs. Those codes are as follows:

V17.81 - Family history, Osteoporosis ***V18.9 - Family history, Genetic disease carrier***
V17.89 - Family history, Other musculoskeletal diseases

CMS is deleting ICD-9-CM code, V17.8, Family history of certain chronic disabling diseases, from the same list.

Implementation Date

The implementation date for this instruction is October 3, 2005.

Additional Information

To see the official instruction issued to your carrier/intermediary regarding this change may be found by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website.

From that Web page, look for CR 4005 in the CR NUM column on the right, and then click on the file for that CR.

If you have questions regarding this issue, contact your carrier/intermediary on their toll free number which is available at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 4005 Medlearn Matters Number: MM4005
Related CR Release Date: August 19, 2005 Related CR Transmittal #: 651
Effective Date: October 1, 2005 Implementation Date: October 3, 2005

New Waived Tests Approved by the Food and Drug Administration Under Clinical Laboratory Improvement Amendments of 1988

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Providers/suppliers billing services to Medicare carriers

Provider Action Needed

STOP – Impact to You

This article includes information from change request (CR) 3984 which informs Medicare carriers of new tests granted waived status under Clinical Laboratory Improvement Amendments (CLIA) by the Food and Drug Administration (FDA).

CAUTION – What You Need to Know

Since these tests are marketed immediately after their approval, Medicare carriers need to be aware of these new tests and update their files so your claims can be accurately processed.

GO – What You Need to Do

See the Background Section of this article for more details regarding these new waived tests.

Background

The CLIA of 1988 regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid pay only for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

CR 3984 notifies Medicare carriers of the new waived CLIA covered tests, which were approved by the FDA. Medicare carriers will update their files to include the new tests granted waived status under CLIA, and CR 3984 includes the complete list of these tests as an attachment. To review the attachment to CR 3984, please see the official instruction issued to your carrier by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*. From that Web page, look for CR 3984 in the CR column on the right, and click on the file for that CR.

The latest tests approved by the FDA as waived tests under the CLIA are listed below. The current procedural terminology (CPT) codes for the new tests in the following table must have the modifier QW to be recognized as a waived test.

CPT Code/Modifier	Effective Date	Description
86318QW	December 9, 2004	Germaine Laboratories, Aimstep H. pylori {whole blood}
87807QW	January 28, 2005	Binax Now RSV Test (K032166/A005)
81003QW	February 18, 2005	Physician Sales & Service, Inc. PSS Select Urine Analyzer
87880QW	March 8, 2005	McKesson Medi-Lab Performance Strep A Test Dipstick
86308QW	March 8, 2005	Clearview Mono-Plus II
86318QW	March 8, 2005	Wampole Laboratories Clearview H. pylori II (finger stick or whole blood)
87899QW	March 16, 2005	Genzyme OSOM Trichomonas Rapid Test
86308QW	March 16, 2005	McKesson Medi-lab Performance Infectious Mononucleosis Test
83721QW	March 25, 2005	Polymer Technology Systems Cardiochek PA Analyzer
87880QW	April 21, 2005	Biotechnostix Rapid Response Strep A Rapid Test Strip
87880QW	April 21, 2005	Biotechnostix Rapid Response Strep A Rapid Test Device
87880QW	April 21, 2005	RAC Medical Clarity Strep A Rapid Test Strips
80101QW	June 3, 2005	Acon One Step Multi-Drug, Multi-Line Screen Test Device (Professional Use)

Note: The tests mentioned on the first page of the Attachment included with CR3984 (i.e., CPT codes: *81002, 81025, 82270, G0107, 82962, 83026, 84830, 85013,* and *85651*) do not require a QW modifier to be recognized as a waived test. Also note the following:

- New waived code ***83721QW*** has been assigned for LDL cholesterol testing performed using the Polymer Technology Systems Cardiochek PA Analyzer as of March 25, 2005, and
- New waived code ***87899QW*** has been assigned for Trichomonas testing performed using the Genzyme OSOM Trichomonas Rapid Test as of March 16, 2005.

For these two tests, your carrier will not search their files to 1) either retract payment or 2) retroactively pay claims. However, your carriers should adjust claims if you bring the claims to their attention.

Implementation

The implementation date for this instruction is October 3, 2005.

Additional Information

For complete details, please see the official instruction issued by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website.

From that Web page look for CR 3984 in the CR column on the right, then click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3984
Related CR Release Date: August 5, 2005
Effective Date: October 1, 2005
Medlearn Matters Number: MM3984
Related CR Transmittal #: 642
Implementation Date: October 3, 2005

MEDICARE PHYSICIAN FEE SCHEDULE

October Update to the 2005 Medicare Physician Fee Schedule Database

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the September 2005 Medicare B Update! Special Issue - October 2005 to the MPFSDB

Note: This article was revised because CR4031 was revised on September 9, 2005. The CR release date and transmittal number (see above) were changed in the article to coincide with the revised CR. All other information in the article remains the same.

Provider Types Affected

Physicians and providers billing Medicare carriers or intermediaries for services paid under the Medicare Physician Fee Schedule

Provider Action Needed

Physicians, suppliers, and providers should be aware of the changes to the Medicare Physician Fee Schedule Database (MPFSDB) and identify those changes that affect their practice.

Background

CR4031 amends payment files issued to Medicare carriers and intermediaries based upon the November 15, 2004, Final Rules for the 2005 MPFSDB.

Additional Information

The changes to the fee schedule involve numerous CPT/HCPCS codes. While many of these changes are effective retroactive to January 1, 2005, please note that your carrier/FI will not reprocess claims already processed, unless you request them to do so.

The complete details of these changes to the October update to the 2005 MPFSDB are described in an attachment to CR4031, which is the official instruction issued to your carrier/intermediary. That instruction may be viewed by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR4031 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare carrier/intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 4031
Medlearn Matters Number: MM4031
Related CR Release Date: September 9, 2005 *Revised*
Related CR Transmittal #: 672
Effective Date: January 1, 2005
Implementation Date: October 3, 2005

RADIOLOGY

Low Osmolar Contrast Media (LOCM): Payment Criteria and Payment Level

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare carriers for LOCM.

Provider Action Needed

STOP – Impact to You

CMS has eliminated the restrictive criteria (see Background section) for the payment of LOCM for non-hospital patients, effective January 1, 2005. CMS has additionally established new codes and a new payment methodology for LOCM. The payment methodology is effective as of April 4, 2005.

CAUTION – What You Need to Know

HCPCS code replacement

- Use HCPCS codes Q9945 - Q9951 instead of A4644 - A4646, respectively, when billing Medicare carriers for LOCM.
- Refer to Medlearn Matters article MM3748, page 2, for a description of these new HCPCS codes (see Additional Information section).

GO – What You Need to Do

Be sure billing staff are aware of these changes to ensure prompt and accurate payment of your claims for LOCM.

Background

Effective January 1, 2005, payment for LOCM furnished as part of medically necessary imaging procedures for intrathecal procedures and in intraarterial and intravenous injections will be made regardless of whether any of the five medical conditions listed in previous instructions are present. These previously restrictive criteria included:

- History of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting.
- History of asthma or allergy.
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension Generalized severe debilitation.
- Sickle cell disease.

Medicare carriers will use status indicator "E" for HCPCS codes Q9945-Q9951 and these codes are being updated on the Medicare physician fee schedule effective for services on or after April 1, 2005.

Effective April 4, 2005, payment by carriers for LOCM is based on the average sales price (ASP) plus six percent, in accordance with the standard method for drug pricing established by the Medicare Modernization Act (MMA) for other than hospital outpatient claims. For services during the period of January 1, 2005 to April 3, 2005, inclusive, payment is made in accordance with the established payment for calendar year 2004.

Additional Information

Medicare Part B drug pricing files are available at: *http://www.cms.hhs.gov/providers/drugs/default.asp* on the CMS website.

Medlearn Matters article MM3748 is available at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3748.pdf.*

The official instruction (CR3902) issued to your carrier regarding this change can be found by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that website, look for CR3902 in the CR NUM column on the right, and click on the file for that CR.

For additional information relating to this issue, please refer to your local carrier at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3902	Medlearn Matters Number: MM3902
Related CR Release Date: July 29, 2005	Related CR Transmittal #: 627
Effective Date: January 1, 2005	Implementation Date: October 31, 2005

Modification to Reporting of Diagnosis Codes for Screening Mammography Claims

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the Second Quarter 2005 Medicare B Update! page 43.

Note: This article was revised on October 11, 2005, to reflect changes made to CR3562 on October 7, 2005. The CR release date and transmittal date (see above) were revised and the effective date was changed from July 1, 2005, to January 1, 1998. All other information remains the same.

Provider Types Affected

All providers billing Medicare carriers or Fiscal Intermediaries (FIs) for screening mammography claims

Provider Action Needed

This article modifies instructions to allow reporting of either diagnosis code V76.11 or V76.12. Providers should note that to ensure proper coding, one of the following diagnosis codes should be reported on screening mammography claims:

- ***V76.11*** *– "Special screening for malignant neoplasm, screening mammogram for high-risk patients" or;*
- ***V76.12*** *– "Special screening for malignant neoplasm, other screening mammography."*

Background

Effective January 1, 1998, providers only reported diagnosis code V76.12 on screening mammography claims. Effective July 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will allow reporting of either V76.11 or V76.12, as appropriate.

Implementation

Implementation date is July 5, 2005.

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found at: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR3562 in the CR NUM column on the right and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3562	Medlearn Matters Number: MM3562
Related CR Release Date: October 7, 2005 *Revised*	Related CR Transmittal #: 705
Effective Date: January 1, 1998	Implementation Date: July 5, 2005

PET Scan Billing Requirements – Change Request 3945

Change request 3945 revised Publication 100-4, chapter 13, section 60 to include the applicable HCPCS codes for radiopharmaceutical diagnostic imaging agents (tracers) when billing for PET scan services performed on or after January 28, 2005.

The allowances for myocardial perfusion imaging PET scans (CPT codes 78491 and 78492) ***do not* include** the radiotracer as several products may be utilized. Providers are required to separately bill the ammonia N-13 or rubidium per the guidelines listed in the local coverage determination *78460* – Myocardial Perfusion Imaging.

Note: Change request 3945 makes no changes to the current policy, but simply reflects current policy more accurately.

You can obtain additional information about the billing requirements for FDG PET scans by going to *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3741.pdf*.

Section 60 has been revised as follows:

60.3.1 - Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005

(Rev. 628, Issued: 07-29-05; Effective: 10-31-05; Implementation: 10-31-05)

Note: All PET scan services require the use of a radiopharmaceutical diagnostic imaging agent (tracer). The applicable tracer code should be billed when billing for a PET scan service. See section 60.3.2 below for applicable tracer codes.

CPT	Description
78459	*Myocardial imaging, positron emission tomography (PET), metabolic evaluation*
78491	*Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress*
78492	*Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress*

PET Scan Billing Requirements – Change Request 3945, continued

78608 Brain imaging, positron emission tomography (PET); metabolic evaluation
78609 Brain imaging, positron emission tomography (PET); perfusion evaluation
78811 Tumor imaging, positron emission tomography (PET); limited area (eg, chest, head/neck)
78812 Tumor imaging, positron emission tomography (PET); skull base to mid thigh
78813 Tumor imaging, positron emission tomography (PET); whole body
78814 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck)
78815 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh
78816 Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body

60.3.2 Tracer Codes Required for PET Scans

Tracer codes applicable to CPT 78491 and 78492:

Institutional providers billing the fiscal intermediary

HCPCS	Description
Q3000	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium RB-82
A9526	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13

Physicians / practitioners billing the carrier:

HCPCS	Description
A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified
A9526	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13

Tracer codes applicable to CPT 78459, 78608, 78609, 78811-78816:

Institutional providers billing the fiscal intermediary:

HCPCS	Description
C1775 (OPPS Only)	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18
A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified

Physicians / practitioners billing the carrier:

HCPCS	Description
A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified

Source: Pub 100-4, Chapter 13, Section 60, Transmittal 628, Change Request 3945

VISION

Cessation of Additional $50 Payment for New Technology Intraocular Lenses

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Ambulatory Surgical Centers (ASC) that bill Medicare carriers for Intraocular Lenses (IOL)

Provider Action Needed

Effective for dates of service on or after May 19, 2005, HCPCS codes Q1001 and Q1002 expire for services performed in ASC settings. Previously, Medicare paid an additional $50 payment to ASCs for new technology intraocular lenses (NTIOL) billed with Q1001 and Q1002, but the five-year payment adjustment period for these codes expires on May 19, 2005.

Background

In 1999, Section 1833 (i)(2)(A)(iii) of the Social Security Act (the Act) required that the Centers for Medicare & Medicaid Services (CMS) establish a process that designated particular intraocular lenses (IOLs) as "new technology" and these IOLs became eligible for an additional $50 adjustment for NTIOLs (codes Q1001 and Q1002). This payment was effective from May 18, 2000, to May 18, 2005, and could be billed only by the ASC.

For dates of service on or after May 19, 2005, Medicare carriers will no longer pay the $50 additional payment to ASCs on claims for NTIOLs billed with HCPCS codes:

- **Q1001**(Category 1, AMO Array Multifocal lens: Model # SA40N); and
- **Q1002** (Category 2, Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Lens).

Cessation of Additional $50 Payment for New Technology Intraocular Lenses, continued

Implementation

The implementation date of CR3901 is October 3, 2005.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website.

From that Web page, look for CR3901 in the CR NUM column on the right, and click on the file for that CR.

CR3901 also includes the portions of the *Medicare Claims Processing Manual* that were revised to reflect this change.

For additional information relating to this issue, please refer to your carrier. To find their toll free phone number, go to *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3901
Medlearn Matters Number: MM3901
Related CR Release Date: August 5, 2005
Related CR Transmittal #: 639
Effective Date: May 19, 2005
Implementation Date: October 3, 2005

Implementation of Ruling 05-01 Regarding Presbyopia-Correcting Intraocular Lenses for Medicare Beneficiaries

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers or Fiscal Intermediaries (FIs) for IOLs

Provider Action Needed

STOP – Impact to You

In a recent ruling, the Centers for Medicare & Medicaid Services (CMS) clarified payment rules that enable Medicare beneficiaries to have the choice of receiving presbyopia-correcting intraocular lenses (IOLs). A beneficiary may request insertion of a presbyopia-correcting IOL in place of a conventional IOL following cataract surgery.

CAUTION – What You Need to Know

The beneficiary is responsible for payment of that portion of the charge for the presbyopia-correcting IOL and associated services that exceed the charge for insertion of a conventional IOL following cataract surgery.

GO – What You Need to Do

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

Background

The CMS recently announced a ruling (CMS Ruling 05-01 dated May 2005) that clarified its payment rules to present beneficiaries with the choice to receive presbyopia-correcting IOLs. Prior to this ruling, limitations on Medicare payment prevented beneficiaries from receiving these lenses. Now beneficiaries who choose to purchase this additional feature will be able to do so, provided they assume liability for the additional expense of that feature.

Note: CMS Ruling 05-01 is included below in the *Additional Information* section of this Special Edition article.

Presbyopia-Correcting IOL

Presbyopia is a type of age-associated refractive error that results in progressive loss of the focusing power of the lens of the eye, causing difficulty seeing objects at near distance, or close-up. Presbyopia occurs as the natural lens of the eye becomes thicker and less flexible with age.

A single presbyopia-correcting IOL can provide what would otherwise be achieved by two separate items:

- An implantable conventional IOL that restores far vision; and
- Eyeglasses or contact lenses that correct for presbyopia.

Note: The statute specifically excludes correction of common refractive errors from Medicare coverage.

Coverage Ruling

Payment for conventional IOLs furnished in an outpatient setting is covered by Medicare. However, providers have generally not offered beneficiaries presbyopia-correcting IOLs because the costs for this advanced technology substantially exceed Medicare's payment.

This ruling by CMS clarifies that a beneficiary may request insertion of a presbyopia-correcting IOL in place of a conventional IOL following cataract surgery.

The beneficiary is responsible for payment of that portion of the charge for the presbyopia-correcting IOL and associated services that exceed the charge for insertion of a conventional IOL following cataract surgery.

Effective for services furnished on or after May 3, 2005, the following are considered "presbyopia-correcting IOLs" by CMS:

Implementation of Ruling 05-01 Regarding Presbyopia-Correcting Intraocular Lenses for Medicare Beneficiaries, continued

- Crystalens™, manufactured by Eyeonics, Inc.
- AcrySof RESTOR™, manufactured by Alcon Laboratories, Inc.
- ReZoom™, manufactured by Advanced Medical Optics, Inc.

As a result of CMS ruling 05-01, the following policies may be stated:

Payment Policy for Facility Services and Supplies

- For an IOL inserted **following removal of a cataract** in a hospital, on either an outpatient or inpatient basis, that is paid under the hospital outpatient prospective payment system (OPPS) or the inpatient prospective payment system (IPPS), respectively; or in a Medicare-approved ambulatory surgical center (ASC) that is paid under the ASC fee schedule:
- Payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure. Medicare does not make separate payment to the hospital or the ASC for an IOL inserted following removal of a cataract.
- Any person or ASC, who presents or causes to be presented a bill or request for payment for an IOL inserted following removal of a cataract for which payment is made under the ASC fee schedule, is subject to a civil money penalty.
- For a presbyopia-correcting IOL inserted **following removal of a cataract** in a hospital, on either an outpatient or inpatient basis, that is paid under the OPPS or the IPPS, respectively; or in a Medicare approved ASC that is paid under the ASC fee schedule:
- The facility will bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional or presbyopia-correcting IOL is inserted. When a beneficiary receives a presbyopia-correcting IOL **following removal of a cataract,** hospitals and ASCs shall report the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL (see "Coding" below).
- There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust a presbyopia-correcting IOL **following removal of a cataract** that exceed the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL.
- There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services and supplies required to examine and monitor the beneficiary who receives a presbyopia-correcting IOL **following removal of a cataract** that exceed the facility charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary **after cataract surgery** followed by insertion of a conventional IOL.

Payment Policy for Physician Services and Supplies

- For an IOL inserted following removal of a cataract in a physician's office:
- Medicare makes separate payment, based on reasonable charges, for an IOL inserted following removal of a cataract that is performed at a physician's office.
- For a presbyopia-correcting IOL inserted following removal of a cataract in a physician's office:
- A physician shall bill for a conventional IOL, regardless of whether a conventional or presbyopia correcting IOL is inserted (see "Coding," below).
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a presbyopia-correcting IOL **following removal of a cataract** that exceed the physician charges for services and supplies for the insertion and adjustment of a conventional IOL.
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary **following removal of a cataract** with insertion of a presbyopia-correcting IOL that exceed the physician charges for services and supplies to examine and monitor a beneficiary **following removal of a cataract** with insertion of a conventional IOL.
- For a presbyopia-correcting IOL inserted **following removal of a cataract** in a hospital or ASC:
- A physician may not bill Medicare for a presbyopia-correcting IOL inserted during a cataract procedure performed in those settings because payment for the lens is included in the payment made to the facility for the entire procedure.
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a presbyopia-correcting IOL **following removal of a cataract** that exceed physician charges for services and supplies required for the insertion of a conventional IOL.
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary **following removal of a cataract** with insertion of a presbyopia-correcting IOL that exceed the physician charges for services and supplies required to examine and monitor a beneficiary **following cataract surgery** with insertion of a conventional IOL.

Implementation of Ruling 05-01 Regarding Presbyopia-Correcting Intraocular Lenses for Medicare Beneficiaries, continued

Coding Requirements

- No new codes are being established at this time to identify a presbyopia-correcting IOL or procedures and services related to a presbyopia-correcting IOL.
- Hospitals, ASCs, and physicians should use one of the following CPT codes to bill Medicare for removal of a cataract with IOL insertion:
- ***66982*** *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage*
- ***66983*** *Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)*
- ***66984*** *Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)*
- Physicians inserting an IOL or a presbyopia-correcting IOL in **a physician's office setting only**, may bill code V2632 (posterior chamber intraocular lens) for the IOL or the presbyopia-correcting IOL, which is paid on a reasonable charge basis. **Physicians must remember that they may only bill for professional services and not the lens itself when performing cataract surgery in an ASC or outpatient setting. In these settings, payment for the lens is packaged into the facility payment for the cataract extraction.**
- Hospitals, ASCs, and physicians should use the following CPT codes to bill Medicare for evaluation and management services usually associated with services following cataract extraction surgery:
- ***92002*** *Ophthalmological services; medical examination and evaluation with initiation of diagnostic an treatment program; intermediate, new patient*
- ***92004*** *Ophthalmological services; medical examination and evaluation with initiation of diagnostic an treatment program; comprehensive, new patient, one or more visits*
- ***92012*** *Ophthalmological services; medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established patient*
- ***92014*** *Ophthalmological services; medical examination and evaluation with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more services*
- Hospital outpatient claims should be submitted on type of bill (TOB) 12x, 13x, 83x, or 85x, as appropriate.

Beneficiary Liability

- When the beneficiary requests and receives a presbyopia-correcting IOL instead of a conventional IOL **following removal of a cataract**, the beneficiary is responsible for payment of facility and physician charges for services and supplies attributable to the presbyopia-correcting functionality of the presbyopia-correcting IOL:
- In determining the beneficiary's liability, the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the presbyopia-correcting IOL that exceeds the work and resources attributable to insertion of a conventional IOL.
- The physician and the facility may not charge for cataract extraction with insertion of a presbyopia-correcting IOL unless the beneficiary requests this service.
- The physician and the facility may not require the beneficiary to request a presbyopia-correcting IOL as a condition of performing a cataract extraction with IOL insertion.

Provider Notification Requirements

- When a beneficiary requests insertion of a presbyopia-correcting IOL instead of a conventional IOL following removal of a cataract:
- Prior to the procedure to remove a cataractous lens and insert a presbyopia-correcting IOL, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment or other subsequent treatments related to the presbyopia-correcting functionality of the IOL.
- The presbyopia-correcting functionality of a presbyopia-correcting IOL does not fall into a Medicare benefit category, and therefore, is not covered. Therefore, the facility and physician are not required to provide an advanced beneficiary notice (ABN) to beneficiaries who request a presbyopia-correcting IOL.
- Although not required, CMS strongly encourages facilities and physicians to issue a Notice of Exclusion from Medicare Benefits to beneficiaries in order to clearly identify the non-payable aspects of a presbyopia-correcting IOL insertion. This notice may be found in english language at *http://cms.hhs.gov/medicare/bni/20007_English.pdf* and in Spanish at *http://cms.hhs.gov/medicare/bni/20007_Spanish.pdf* on the CMS website.

Implementation of Ruling 05-01 Regarding Presbyopia-Correcting Intraocular Lenses for Medicare Beneficiaries, continued

Additional Information

The actual CMS ruling may be viewed at *http://www.cms.hhs.gov/rulings/CMSR0501.pdf* on the CMS website.

For complete details, please see the official instruction issued to your carrier or intermediary regarding this change, which may be found by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website.

From that web page, look for CR 3927 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare carrier or intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3927
Related CR Release Date: August 5, 2005
Effective Date: May 3, 2005
Medlearn Matters Number: MM3927
Related CR Transmittal #: 636
Implementation Date: September 6, 2005

GENERAL COVERAGE

Smoking and Tobacco-Use Cessation Counseling Services: Common Working File Inquiry for Providers

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Affected

Providers billing Medicare carriers or fiscal intermediaries (FIs) for smoking and tobacco-use cessation counseling.

Provider Action Needed

CR4104 announces the implementation of the capability for providers to access the common working file (CWF) (part of Medicare's claims processing systems) for viewing the number of smoking and tobacco-use cessation counseling sessions a beneficiary has received.

Background

CR3929, issued July 15, 2005, implements a frequency of service limitations edit in the CWF for smoking and tobacco-use cessation counseling, for dates of service on or after October 1, 2005. The implementation date for this CWF edit is October 3, 2005.

Effective April, 1, 2006, Medicare providers will be given the capability to view the number of smoking and tobacco-use cessation counseling sessions provided to a beneficiary. Providers will be able to access this file through the CWF, by entering the beneficiary's health insurance claim number (HICN).

Ultimately, the capability to view the number of smoking and tobacco-use cessation counseling sessions provided to a beneficiary gives providers the ability to determine a beneficiary's available coverage for this service.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be found by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website.

From that Web page, look for CR 4104 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Medlearn Matters Number: MM4104
Related CR Release Date: October 21, 2005
Related CR Transmittal #: 726
Related Change Request (CR) #: 4104
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

HIPAA - The Health Insurance Portability and Accountability Act

Claim Status Code/Claim Status Category Code Update

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All providers submitting Health Care Claim Status Transactions to Medicare carriers, including durable medical equipment carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs).

Provider Action Needed

This is a reminder item regarding the periodic update of certain code sets used as a result of the Health Insurance Portability and Accountability Act (HIPAA). Effective January 1, 2006, the Medicare Claims processing system will update its lists of Health Care Claims Status Codes and Health Care Claims Status Category Codes with all applicable code changes posted online with the "new as of 10/05" and prior date designations.

Background

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets.

Claim Status Category Codes and Claim Status Codes are used in the Health Care Claim Status Inquiry and Response (276/277) transactions:

- Claim Status Category Codes indicate the general payment status of the claim.
- Claim Status Codes provide more detail about the status communicated in the general Claim Status Category Codes.

These codes are available online at: http://www.wpc-edi.com/codes/Codes.asp.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/FI/RHHI regarding this change. That instruction may be viewed by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.*

From that web page, look for CR 3960 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare carrier/DMERC/FI/RHHI at their toll-free number, which may be found at: *http://www.cms.hhs.gov/medlearn/tollnums.asp*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3960	Medlearn Matters Number: MM3960
Related CR Release Date: July 29, 2005	Related CR Transmittal #: 631
Effective Date: January 1, 2006	Implementation Date: January 3, 2006

Clarification on Termination of the Incoming Claim Health Insurance Portability and Accountability Act Contingency Plan

The Centers for Medicare & Medicaid Services (CMS) has received a number of inquiries about the impact of termination of the contingency plan for incoming claims on October 1, 2005, on submission of Medicare Secondary Payer (MSP) claims. The Health Insurance Portability and Accountability Act (HIPAA) is furnishing the following information to clarify the Medicare requirements for submission of compliant MSP claims as required.

On August 4, 2005, CMS announced that the HIPAA contingency period for claims sent to Medicare would end on October 1, 2005. This termination does not apply to claims that Medicare sends outbound to other payers that have signed a coordination of benefits (COB) trading partner agreement for the transfer of claims by Medicare. It does apply to claims sent to Medicare for secondary payment following processing by a primary payer, however. Therefore, effective October 1, 2005, electronic MSP claims must comply with all X12 837 version 4010A1 implementation guide requirements, and include standard claim adjustment reason (CAS) codes to describe adjustments that a primary payer made during adjudication, or they will be rejected.

CMS is aware of provider concerns that primary payers frequently send paper explanations of benefits or 835 transactions that contain local messages or codes rather than standard CAS codes. HIPAA does not require that standard CAS codes be reported in paper explanations of benefits, and payers that still have an X12 835 HIPAA contingency plan in effect may not yet be able to report standard CAS codes. HIPAA does require health care benefit payers to send providers X12 835 version 4010A1 transactions if requested by providers, and those 835 transactions must contain standard CAS codes by the end of each payer's 835 contingency period.

CMS is working with the HIPAA standards committee that maintains the CAS codes to develop a simplified means to translate non-standard messages and codes into standard CAS codes. We expect this process to be approved and implemented quickly. However, until an alternate solution is approved for use, electronic MSP claims sent to Medicare are required to contain standard CAS codes, along with other loops, segments, and data elements that apply. It is the provider's responsibility to convert local adjustment reason codes or messages into the appropriate standard CAS codes prior to transmission of an 837 version 4010A1 claim to Medicare for secondary payment.

Source: Joint Signature Memorandum 05512, dated September 13, 2005

Mandatory Electronic Submission of Medicare Claims Questions & Answers

1Q. Must I submit Medicare claims electronically?
1A. Yes. All initial claims for reimbursement under Medicare must be submitted electronically, with limited exceptions.

2Q. When must I begin submitting Medicare claims electronically?
2A. The Administrative Simplification Compliance Act (ASCA) provision was effective for initial claims submitted on or after October 16, 2003. Submission of a paper claim constitutes an attestation by the provider that at least one of the paper claim exception criteria apply at the time of submission.

3Q. What are the exceptions to the electronic claim submission requirement?
3A. The electronic claim submission exceptions include:

- Intermediary (Part A) small providers - To qualify, a provider required to submit claims to Medicare must have fewer than 25 full-time equivalent employees (FTEs).
- Carrier (Part B) small providers - To qualify, a physician, practitioner, or supplier that bills Medicare must have fewer than 10 FTEs,
- Dentists,
- Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;
- Providers that conduct mass inoculations, such as flu injections, that may be permitted to submit paper roster bills and who do not have a contract in place for submission of claims for more than one state to a single Medicare contractor that commits them to electronic submission of flu shot claims;
- Providers that submit claims for secondary payment by Medicare when an agreement is in place with the primary payer that permitted that payer to issue a lower than normal payment for one or more services in that claim. Medicare calls these "Obligated to Accept as payment in Full" or OTAF adjustment claims;
- Providers that only furnish services outside of the United States;
- Providers experiencing a disruption in their electricity and communication connection that is outside of their control; and
- Providers that can establish that an "unusual circumstance" exists that preclude submission of claims electronically.

4Q. Who determines if a provider meets the electronic claim submission exception criteria?
4A. Providers are to self-assess to determine if they meet the exception criteria. If the provider determines he/she meets an exception that qualifies for submission of paper claims, no further action is needed at that time. If a provider is selected for enforcement review, the provider will receive a 'Review of Paper Claims Submission Practices' letter and will need to follow the instructions in that letter.

5Q. What is considered an "unusual circumstance"?
5A. The Centers for Medicare & Medicaid Services (CMS) interprets an "unusual circumstance" to be a temporary or long-term situation outside of a provider's control that precludes submission of claims electronically and therefore, it would be against equity and good conscience for CMS to require claims affected by the circumstance to be submitted electronically. Examples of "unusual circumstances" include:

a) Limited temporary situations when a Medicare contractor's claim system would reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);
b) Providers that submit fewer than 10 claims a month to a Medicare contractor on average;
c) Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;
d) Entities that can demonstrate that information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and
e) Other circumstances documented by a provider, generally in rare cases, where a provider can establish that, due to conditions outside of the provider's control, it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

6Q. Can I request a waiver of the electronic claim submission requirement?
6A. A provider may submit a waiver request if an "unusual circumstance" applies under c, d, or e above. Such requests are subject to Medicare contractor and CMS approval. If provider self-assessment indicates that an exception condition, other than c, d, or e is met, the provider is automatically waived from the electronic claim submission requirement for either the indicated claim type or the period when an "unusual circumstance" exists.

7Q. Where do I submit an "unusual circumstance" waiver?
7A. "Unusual Circumstance" wavier requests related to condition c, d, or e above should be submitted to:

Attention: ASCA Waiver
Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-44071

Be sure to include documentation appropriate to establish the validity of the waiver request. A waiver request should include the organizational name of the provider, address, contact person, the reason for the waiver, and why the provider considers enforcement of the electronic billing requirement to be against equity and good conscience.

8Q. Can I submit an "unusual circumstance" waiver to CMS?
8A. No. Providers are not to submit such requests directly to CMS. CMS has directed Medicare contractors to review such requests and if they agree the waiver request has merit, they will forward it to CMS with an explanation as to why contractor staff recommends CMS approval of the waiver request. If the contractor does not consider an "unusual circumstance" to be met, they will issue a "denial of an unusual circumstance waiver request" letter.

9Q. How do I submit a claim that for adjudication purposes requires a medical record or other claim attachment?
9A. Submit the initial claim electronically. If documentation is required, a development letter request will be sent to you requesting the needed documentation. Return the letter with the documentation attached by the specified timeframe and the claim will be adjudicated based on the claim and documentation submitted. Remember, the existence of an attachment is not an approved exception to the ASCA requirement for electronic submission of claims.

10Q. What if I do not have software to submit claims electronically?
10A. You have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. Information regarding this free billing software, PC-ACE Pro32®, and the necessary forms to obtain the software can be found on our website at *http://www.fcso.com/customers/providers.shtml* (for Florida providers) or *http://www.connecticutmedicare.com* (for Connecticut providers).

There is also commercial billing software, billing agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs. A list of HIPAA vendors, as well as information to assist providers in choosing a software vendor, is available in the EDI section of our website at: *http://www.floridamedicare.com* or *http://www.connecticutmedicare.com*.

If you have questions about electronic claim submission, you may contact us at:

Connecticut: (203) 639-3160, option 4
Florida: (904) 791-8767, option 1.

Source: CMS Online Manual – Publication 100-04, Chapter 24, Section 90

Medicare Announces End of HIPAA Contingency Plan for Claims Submissions

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare physicians, providers, and suppliers who continue to submit electronic claims in non-compliant HIPAA formats.

Impact on Providers

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is ending its contingency plan that allowed providers to submit claims formats electronically that were not in the format required by the Health Insurance Portability and Accountability Act (HIPAA). As of October 1, 2005, all providers must use the HIPAA compliant format for claims submitted to Medicare. **In June 2005, over 99% of claims submitted to Medicare were in HIPAA compliant formats.**

CAUTION – What You Need to Know

Non-compliant claims submitted to Medicare on or after October 1, 2005, will be rejected and returned to the provider.

GO – What You Need to Do

To assure that your claims are processed timely and that your cash flow is not interrupted, be sure to submit HIPAA compliant claims as of October 1, 2005.

Background

The Health Insurance Portability and Accountability Act (HIPAA) regulation required claims be submitted electronically effective October 16, 2003, in a format adopted for national use. To allow additional time for entities to become compliant, CMS established a contingency plan to continue Medicare fee-for-service (FFS) payments beyond October 16, 2003 based on non-compliant formats.

In a measured step toward full compliance, CMS announced that effective July 1, 2004, non-compliant electronic claims would be paid after 27 days (the same as paper claims). Further information on the contingency plan may be found in Medlearn Matters articles MM2981 and SE0414 at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2981.pdf* and *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0414.pdf* respectively. These articles also provided important information to assist those few remaining providers who need to begin sending HIPAA compliant claims.

Note: Through provider outreach activities, CMS has seen a steady decrease in the number of non-HIPAA compliant providers. In June 2005, fewer than 4% of Medicare FFS billing providers submitted electronic non-HIPAA compliant claims.

Considering the number of all active Medicare providers, it is clear that the Medicare provider community at large has done an outstanding job of adopting the HIPAA claims formats.

CMS believes that the industry has surpassed critical mass in both the total number of compliant claims and number of providers capable of sending compliant claims. Therefore, Medicare will end its HIPAA contingency Plan for claims submission on October 1, 2005.

Claims that are not compliant as of October 1, 2005 will be returned to the provider for submission as a compliant claim. But, prior to October 1, if you are not submitting HIPAA compliant claims your Medicare carrier, durable medical equipment regional carrier (DMERC), or intermediary will contact you directly regarding the need to become compliant to offer further assistance.

CMS expects to end the contingency plan for other transactions in the near future. The remittance advice (835) is our next target to end the full contingency. We will continue to monitor progress toward use of the HIPAA standards to guide in that decision.

Additional Information

As previously mentioned, further information on the contingency plan and on help in becoming compliant may be found in Medlearn Matters articles MM2981 and SE0414 at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2981.pdf* and *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0414.pdf* respectively.

As Medlearn Matters article MM2981 indicates Medicare carriers and intermediaries can provide free/low cost software that will enable submission of HIPAA compliant claims electronically. If you need such software, contact your carrier or intermediary at their special EDI telephone number. Your carrier/intermediary will also have a list of vendors who may assist you in submitting compliant claims.

For those billing Medicare Part B, you may find those numbers listed by state at: *http://www.cms.hhs.gov/providers/edi/bnum.asp.*

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

For additional information on HIPAA, visit the CMS website at: *http://www.cms.hhs.gov/hipaa/hipaa2/default.asp.*

To view the revised manual chapter for the claims receipt rules, see Chapter 1, Section 80.2.1.2, which can be found in Pub 100-04, the Medicare Claims Processing Manual. This can be found at: *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp.*

Related Change Request (CR) #: 3956	Medlearn Matters Number: MM3956
Related CR Release Date: August 4, 2005	Related CR Transmittal #: 171
Effective Date: October 1, 2005	Implementation Date: October 3, 2005

National Provider Identification Submission Instructions for Medicare Part B Electronic Transactions

Effective January 1, 2006, First Coast Service Options will begin acceptance of the National Provider Identification (NPI) when submitted on anASC X12N ANSI 837 or 276 version 4010A1 transaction.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique National Provider Identifier (NPI) to each physician, supplier and other provider of health care. CMS began to accept applications for NPI's via Internet and by mail on May 23,2005. A number of articles have been issued in recent months to educate and remind physicians, suppliers and other providers on the NPI and the application process. If you have not applied for an NPI, you may do so via the Internet at *https://nppes.cms.hhs.gov*.

One of the articles indicated that providers should not begin to submit their NPIs on claims or other health care transactions until notified by particular payers that they have completed system changes as needed to eliminate the possibility that transactions with NPIs could be rejected. Medicare, as well as other health benefit payers, needs to make system changes to

accept and process transactions using the NPI in lieu of those identifiers previously used to identify providers. Those prior identifiers are frequently referred to as "legacy identifiers."

Impacts

The NPI will not be accepted on pre-HIPAA transactions, such as the X12 270 version 3051 or any proprietary electronic eligibility format currently supported.

The following requirements must be met if you choose to submit an NPI between January 1, 2006 and October 1, 2006 on either the ASC X12N ANSI 837 (electronic claim) or the ASC X12N ANSI 276 (claim status).

Please Note: When submitting an NPI in either the ASC X12N ANSI 837 or the 276 transaction, the provider's legacy number (Medicare provider number) must be submitted for the same provider in the same loop or else the transaction will be rejected.

X12 837 Version 4010A1 NPI Edits

- The NPI may be submitted on the X12 837 version 4010A1 claim in the following provider loops: 2010AA, 2010AB, 2310A, B, C, D or E, or 2420A, B, C, D, E or F.
- When submitting an NPI, the NM108 must contain the XX qualifier and the NM109 of that same segment must contain a 10-byte numeric identifier (containing no special or alpha characters).
- When the NPI is submitted in either the billing loop (2010AA) or pay-to-provider loop (2010AB), two REF segments must be submitted. One to indicate the legacy provider identifier and one to indicate the Employee Identification Number (EIN) or Social Security Number (SSN.)
- When submitting the legacy provider number, the REF01 must contain either the 1C or 1G qualifier (depending on the loop) and the REF02 must contain the legacy provider identifier.
- When indicating the EIN or the SSN, the REF01 must contain the E1 qualifier (for the EIN) or SY (for the SSN) and the REF02 must contain the actual EIN or the SSN.
- If the NPI is submitted in any loops other than 2010AA or 2010AB, then only one REF segment is required for the reporting of the legacy provider identifier.
- REF01 must contain either the 1C or 1G qualifier (depending on the loop) and the REF02 must contain the legacy provider identifier.

Any 837-version 4010A1 claim submitted on or after January 1, 2006 not meeting the above specified requirements will be rejected by the standard system.

X12 276 Version 4010A1 NPI Edits

- The NPI must be submitted on the X12 276 version 4010A1 claim status request in the 2100C loop.
- When submitting an NPI, the 276 must contain two iterations of the 2100C loop. One to house the NPI and one to house the Medicare legacy number (Medicare provider number)
- Within the first 2100C loop, NM108 must contain the XX qualifier and the NM109 of that same segment must contain a 10-byte numeric identifier (containing no special or alpha characters).
- Within the second 2100C loop, NM108 must contain the SV qualifier and NM109 must contain the Medicare legacy number.
- Both the NPI and the provider legacy identifier submitted in a 276 version 4010A1 claim status request transaction will be reported back on the 277 version 4010A1 response transaction.

Any 276 version 4010A1 claim status request submitted on or after January 1, 2006 not meeting the above specified requirements will be rejected. Additionally, if a 276 is submitted with more than two iterations of the 2100C loop, or entry of the same qualifier (XX, SV or FI) more than once in NM108 of the 2100C loop iterations, it will be rejected by the standard system.

If you have additional questions please contact Medicare Part B EDI at:

Connecticut: (203) 639-3160, option 6.
Florida: (904) 354-5977, option 4.

Office hours are 8:00am to 4:30pm Monday through Thursday and 12:30pm to 4:30pm on Friday.

Source: Pub. 100-20 Transmittal:180 Change Request 4004

Update to the Healthcare Provider Taxonomy Codes Version 5.1

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs)

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4072, which includes details regarding the version 5.1 healthcare provider taxonomy code (HPTC) update.

CAUTION – What You Need to Know

CR4072 advises your carrier and/or DMERC to obtain the healthcare provider taxonomy code list version 5.1 and use it to update their internal HPTC tables to process your claim(s) correctly.

GO – What You Need to Do

Please see the *Background* section of this article for further details regarding this update.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that submitted data, which is part of a named code set, be valid data from that code set. Claims with invalid data are noncompliant.

Because healthcare provider taxonomy is a named code set in the American National Standards Institute (ANSI) X12N 837 Professional Implementation Guide, Medicare carriers, including DMERCs, must validate the inbound taxonomy codes against their internal HPTC tables.

The HPTC is an external non-medical data code set designed for use in classifying healthcare providers in an electronic environment according to provider type, or practitioner specialty. HPTCs are scheduled to be updated twice per year (April and October).

The updated code list is available from the Washington Publishing Company at *http://wwwwpcedi.com/codes/taxonomy* in two forms:

- Free Adobe PDF download; and
- Available for purchase, an electronic representation of the list, which will facilitate the automatic loading of the code set.

CR4072 advises your carrier and/or DMERC to use the most cost effective means to obtain the version 5.1 HPTC list and update their HPTC tables as necessary.

Implementation

The implementation date for the instruction is October 3, 2005.

Additional Information

To summarize the changes in Version 5.1, the following taxonomy codes are added:

- 170300000X
- 171000000X
- 1710I1002X
- 1710I1003X

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change at *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR 4072 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 4072
Related CR Release Date: September 30, 2005
Effective Date: October 30, 2005

Medlearn Matters Number: MM4072
Related CR Transmittal #: 694
Implementation Date: October 30, 2005

Completion of Attestation for All 270/271 Transactions

The Centers for Medicare and Medicaid Services (CMS) is making changes to its information technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response in real-time.

Providers are reminded that an attestation form must be completed prior to accessing the real-time eligibility application. This attestation form is available online on the CMS website at *hppt://www.cms.hhs.gov/it*.

Source: CMS Pub. 100-04, Transmittal 700, CR 4093

NATURAL DISASTERS

FCSO Offers Help to Address Potential Medicare Billing and Payment Impacts Due to a Natural Disaster - FLORIDA ONLY

The 2004 hurricane season severely impacted many of First Coast Service Options' (FCSO) Medicare customers. In response to the devastating impacts and potential damage, and in keeping our promise to provide superior customer service, FCSO has established a team to proactively assist providers. Here are some helpful tips related to communication, benefit payments and operational processes that may warrant special consideration:

1. First, we encourage impacted health care providers and suppliers to communicate billing and payment concerns by calling our Medicare Part B Customer Service Center at 1-866-454-9007.
2. Health care facilities whose cash flow may be adversely impacted by a natural disaster may be granted an accelerated payment. FCSO and the Centers for Medicare & Medicaid Services (CMS) have implemented a process to expedite these requests. Medicare Part A impacted providers who need to pursue an accelerated payment should contact Provider Audit and Reimbursement Specialist, Jeff Guy at 904-791-6695.
3. Part B providers whose cash flow may be adversely impacted by a natural disaster may fax a request including the reason for the advance payment and an authorization to offset the advance payment from pending claims. Information may be faxed to the attention of "Critical Inquiries" at 1-904-791-8316.
4. In filing an appeal request, natural disaster is an example of "good cause" in asking for a time extension.
5. If you cannot receive mail at your present location and you have a CMS-855 on file, you may set up a temporary "pay to" address, practice location and/or telephone number. Submit the request to the specially designated natural disaster fax line at (904) 301-1827. NOTE: Telephone requests will not be allowed.

- The fax request should include the following:
- The provider's Legal Business Name;
- Tax Identification Number/Social Security Number;
- Signature of either the provider or the authorized representative/designated official

If you don't have an CMS-855 on file and for more information, refer to the article titled "Temporary Provider Enrollment Procedures due to Hurricanes" posted on the Florida Medicare website.

1. Impacted providers and suppliers may use another physician's computer to transmit claims; however, someone from FCSO Medicare Electronic Data Interchange (EDI) must be involved in order to maintain the security of the records. If you are an impacted provider who needs to explore the feasibility of this option, please contact Medicare EDI Manager, Shelly Marsh at 1-904-791-8240.
2. If you were under a mandatory evacuation notice and had to transport patients by ambulance, Medicare will consider payment under certain conditions. Additional information will be made available as needed.
3. For guidelines regarding CMS' instructions for hospital dialysis due to natural disasters, see Change Request 2503, transmittal A-02-129. For complete details, please see the official instruction issued by going to *http://www.cms.hhs.gov/manuals/pm_trans/A02129.pdf* on the CMS website. Information related to this change request was also published in the January 2003 *Medicare A Bulletin* - Special Issue (page 31).
4. Points of interest for additional documentation requests:
    - In the event your records are destroyed due to a natural disaster, it is imperative that you clearly document "patients' files/records destroyed due to disaster" (or similar verbiage) and include the date(s) of occurrence.
    - Clearly indicate when the patient was "transported/relocated due to mandatory evacuation."

Additional information will be posted to *http://wwwfloridamedicare.com* as it becomes available. If you have additional questions, please contact our Medicare Part B Customer Service Center at 1-866-454-9007, as we have designated points-of-contact for various types of issues related to natural disasters.

Temporary Provider Enrollment Procedures due to Hurricanes

Hurricane Katrina has severely impacted the states of Louisiana, Mississippi, Alabama, and Florida. Therefore, the Centers for Medicare & Medicaid Services (CMS) requests that carriers in these States develop an easier process for providers/suppliers to change their pay-to-address, practice location, and/or telephone information.

Pay-to-Address, Practice Location, Telephone Number Requests

Any provider that requests a change to a pay-to-address, practice location and/or telephone number may do so by submitting the request to the specially designated natural disaster fax line at (904) 301-1827.

***NOTE**: Telephone requests will not be allowed.*

For those providers who already have a CMS-855 on file, the fax request should include the following:

- The provider's Legal Business Name;
- Tax Identification Number/Social Security Number;
- Signature of either the provider or the authorized representative/designated official.

***NOTE:** The faxed signature will be compared to the signature the CMS-855 signature.*

For those providers that do not have a CMS-855 on file, additional identifying information must be submitted with the provider's faxed request:

- Legal Business Name;
- Tax Identification Number/Social Security Number;
- Previous Practice and Pay-to-Address Information;
- Previous Telephone Number;
- Signatures;
- Any other identifying data the contractor deems necessary.

For those providers that are unable to reach their authorized representative or delegated official to sign the change request, carriers shall treat the request as being from a provider that does not have a CMS-855 on file; the additional identifying data outlined above shall be requested. ***If for any reason we are unable to verify/validate this information, the request shall be denied.***

Once the situation in the affected states has stabilized, carriers shall contact those providers that did not have an authorized representative/delegated official on file and ask them to resubmit their requests using the CMS-855 application.

Initial Enrollments

Carriers that have initial enrollment applications in-house that show practice locations that are located in disaster areas (identified by zip codes for the affected counties), will contact applicants in an attempt to obtain additional information.

In situations where the carrier can process the application, we will continue to do so.

In situations where the area will remain unstable, the carrier will request the applicant to resubmit his/her application at a later date. This notification will be made via U.S. mail if the applicant cannot be reach by phone.

Independent Diagnostic Testing Facility (IDTF)

If an IDTF is temporarily relocating due to this emergency, and it has an active provider identification number (PIN), the site visit requirement may be waived provided there is no change in modality. After this emergency has ended, if a provider decides to make this a permanent location; a site visit will be required.

Source: CMS Joint Signature Memorandum (JSM) 05510, dated September 10, 2005

Hurricanes Katrina and Rita – Frequently Asked Questions – Medicare Issues

Provider Types Affected

All providers who are affected by Hurricanes Katrina and Rita or serving Medicare patients affected by those hurricanes

Key Points

This article contains important information about Medicare issues resulting from Hurricanes Katrina and Rita. The Centers for Medicare & Medicaid Services (CMS) has posted pertinent information on its website at *http://www.cms.hhs.gov/hki*. This website is updated on a daily basis.

The information on this site includes the following:

Question and Answer Document

This document was created to answer frequently asked questions about Medicare issues resulting from Hurricanes Katrina and Rita. Please review each question and answer and take appropriate action to implement into your claims process. Account and document all activities associated with implementing these instructions. (To view this information, scroll down to the *Question and Answer* section on the page (*http://www.cms.hhs.gov/hki*) and select the category desired (e.g., Section 1135, General, Ambulance, etc.).

Hurricane Katrina Electronic Mailing List

This is an electronic mailing list service for those interested in receiving news automatically via e-mail from the CMS.

Hurricane Katrina: What Government Is Doing

This Department of Homeland Security website focuses on the government's response to Hurricane Katrina - including links to:

- How to Get Help;
- Donations and Volunteering;
- Finding Friends and Information;
- Health and Safety; and
- A link to Hurricane Katrina-related information in Spanish.

Fact Sheet: CMS Actions to Help Beneficiaries, Providers in Katrina Stricken Areas

This link leads to specific Medicare-related hurricane relief information for healthcare providers who furnish medical services related to Hurricane Katrina.

Phone Numbers for State Medical Assistance Offices

This Web page contains contact information for all states; related websites; and resources (a download of the Helpful Contacts tool).

State Health Officials Letter and 1115 Model Waiver Template

This links to state Medicaid directors' information, including:

- A Letter to State Medicaid Directors and State Children's Health Insurance Program Directors;
- An Application Template – Medicaid and SCHIP Coverage for Evacuees of Hurricane Katrina;
- Information on Evacuee Eligibility Simplification Based on Home State Eligibility Rules; and
- Medicaid Eligibility Groups – Income and Resource Limits.

Approved Katrina 1115 Waiver Information

This Web page contains approved Katrina 1115 Waiver documents for the states of Alabama, Arkansas, District of Columbia, Florida, Georgia, Idaho, Mississippi, and Texas, including an Approval Letter, the Terms and Conditions, and the Attachments for each of the states.

Hurricane Information from the Department of Health and Human Services

Topics on this page include:

- What HHS is Doing;
- Health and Safety;
- How to Get Help;
- Donate and Volunteer;
- Finding Friends and Information;
- What Other Federal Agencies are Doing; and
- Key State Government Agencies in the Region.

Hurricane Katrina Medicare Contractor and CMS Regional Office Contacts

This Web page informs Medicare providers about relevant contact points for those in the affected areas; and notifies providers about a list of Questions and Answers available online at *http://www.cms.gov* in the "Spotlight" section.

Signed Waiver Under Section 1135 of the Social Security Act 9/4/2005

Section 1135 of the Social Security Act allows the Secretary of Health and Human Services to waive or modify certain Medicare, Medicaid, or State Children's Health Insurance Program requirements in order to protect the public health and welfare in times of national crisis. On Wednesday August 31, 2005, Secretary Michael Leavitt notified the Congress that he was invoking this authority, as a consequence of Hurricane Katrina, in order to protect the health and welfare of the public in areas impacted by this crisis. CMS is taking action consistent with this authority to ensure that the people in these areas receive all necessary health care services.

Hurricane Katrina Recovery Information from FirstGov.gov

Links on this page include:

- Find Family and Friends;
- How to Get Help;
- Shelter and Housing for Survivors;
- Donate and Volunteer;
- Health and Safety;
- What Government is Doing; and
- Frequently Asked Questions.

Katrina Information Resources

Links on this page include:

- National Voluntary OrganizationsActive in Disaster (NVOAD) Resources; and
- CCD information related to Tetanus Prevention, non-01 and non-0139 Vibro cholerae; and
- Cancer Patient Resources for Hurricane Katrina.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0563
Related CR Release Date: N/A

NATIONAL PROVIDER IDENTIFIER

CMS National Provider Identifier Web Page

The Centers for Medicare & Medicaid Services is pleased to announce the new CMS Web page dedicated to providing all the latest National Provider Identifier (NPI) news for fee-for-service (FFS) Medicare providers. Visit *http://www.cms.hhs.gov/providers/npi/default.asp* on the website.

As a reminder, all health care providers are required by law to apply for an NPI. To apply online, visit *https://nppes.cms.hhs.gov*.

Source: Provider Education Resources Listserv, Message 200510-07

Medicare's Implementation of the National Provider Identifier: The Second in the Series of Special Edition Medlearn Matters Articles on NPI-Related Activities

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Providers and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries. In addition, organizations or associations that represent providers and plan to obtain NPIs for those providers should take note of this article.

Part 1: Information That Applies to All Providers

Background

All healthcare providers are eligible to receive NPIs. All HIPAA covered healthcare providers, whether they are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions.

Once enumerated, a provider's NPI will not change. The NPI remains with the provider regardless of job or location changes.

HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use **only** the NPI to identify covered healthcare providers in standard transactions by **May 23, 2007**. Small health plans must use **only** the NPI by **May 23, 2008**.

Obtaining and Sharing Your NPI

Providers and suppliers may now apply for their NPI on the National Plan and Provider Enumeration System (NPPES) website, *https://nppes.cms.hhs.gov*. The NPPES is the only source for NPI assignment.

The NPI will replace healthcare provider identifiers in use today in standard healthcare transactions by the above dates. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

Healthcare providers should apply for their NPIs as soon as it is practicable for them to do so. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment.

Providers may apply for an NPI in one of three ways:

- An easy web-based application process is available at *https://nppes.cms.hhs.gov*.
- A paper application may be submitted to an entity that assigns the NPI (the Enumerator). A copy of the application, including the Enumerator's mailing address, is available at *https://nppes.cms.hhs.gov*. A copy of the paper application may also be obtained by calling the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

Knowing the NPI Schedule of Your Health Plans and Practice Management System Companies

Providers should be aware of the NPI readiness schedule for each of the health plans with which they do business, as well as any practice management system companies or billing companies (if used). They should determine when each health plan intends to implement the NPI in standard transactions and keep in mind that each health plan will have its own schedule for this implementation. Your other health plans may provide guidance to you regarding the need to submit both legacy numbers and NPIs.

Providers should submit their NPI(s) on standard transactions only when the health plan has indicated that they are ready to accept the NPI. Providers should also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date.

Sharing Your NPI

Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are:

- Any provider with which they do business (e.g., pharmacies);
- Health plans with which they conduct business; and
- Organizations where they have staff privileges.

We understand that providers have many questions related to EFI or bulk enumeration, NPPES Data Dissemination, and the Medicare subparts policy. We have included information currently available on these key topics in this article and will continue to provide updates, as more information becomes available.

Electronic File Interchange (EFI) - Formerly Known as Bulk Enumeration

The Centers for Medicare & Medicaid Services (CMS) is in the process of putting into place a mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many healthcare providers, with provider approval, to the NPPES within a single electronic file. For example, a large group practice may want to have its staff handle the NPI applications for all its members.

If an organization/provider employs all or a majority of its physicians and is willing to be considered an EFI submitter, EFI enumeration may be a good solution for that group of providers.

The EFI Steps

Once EFI is available, concerned entities will follow these steps:

- An organization that is interested in being an EFI organization will log on to an EFI home page (currently under construction) on the NPPES web site (*https://nppes.cms.hhs.gov*) and download a certification form.
- The organization will send the completed certification form to the Enumerator to be considered for approval as an EFI organization (EFIO).
- Once notified of approval as an EFIO, the entity will send files in a specified format, containing NPI application data, to the NPPES.
- Providers who wish to apply for their NPI(s) through EFI must give the EFIO permission to submit their data for purposes of applying for an NPI.
- Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.
- The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s).

An EFIO may also be used for updates and deactivations, if the providers agree to do so.

National Plan and Provider Enrollment System (NPPES) Data Dissemination Policy

CMS expects to publish a notice regarding its approach to NPI data dissemination in the coming months.

The notice will propose the data dissemination strategy and processes. The approach will describe the data that CMS expects to be available from the NPPES, in compliance with the provisions of the Privacy Act, the Freedom of Information Act, the Electronic FOIA Amendments of 1996, the NPPES System of Records Notice, and other applicable regulations and authorities.

Crosswalks

Each health plan may create its own crosswalk, to cross check NPI and legacy identifiers. To that end, CMS stresses the importance of healthcare providers entering all of their current identification numbers onto their NPI application to facilitate the building of the crosswalks.

Subparts of a Covered Organization

Covered-organization healthcare providers (e.g., hospitals, suppliers of durable medical equipment, pharmacies, etc.) may be made up of components (e.g., an acute care hospital with an ESRD program) or have separate physical locations (e.g., chain pharmacies) that furnish health care, but are not themselves legal entities. The Final NPI rule calls these entities ***"subparts"*** to avoid confusion with the term healthcare "components" used in HIPAA privacy and security rules. Subparts cannot be individuals such as physicians, e.g., group practices may have more than one NPI, but individual members of that group practice by definition are not and cannot be "subparts."

The NPI was mandated to identify each healthcare provider, not each service address at which health care is furnished. Covered organization providers must designate as subparts (according to the guidance given in the NPI Final Rule) any component(s) of themselves or separate physical locations that are not legal entities and that conduct their own standard transactions. Covered organizations/providers must obtain NPI(s) for their subparts, or instruct the subparts to obtain their own NPIs. The subparts would use their NPIs to identify themselves in the standard transactions they conduct.

The NPI Final Rule also gives covered organizations/providers the ability to designate subparts should there be other reasons for doing so. Federal regulations or statutes may require healthcare providers to have unique billing numbers in order to be identified in claims sent to federal health programs, such as Medicare.

In some cases, healthcare providers who need billing numbers for federal health programs are actually components of covered healthcare providers. They may be located at the same address as the covered organization provider or they may have a different address.

In situations where such federal regulations or statutes are applicable, the covered organization providers would designate the components as subparts and ensure that they obtain NPI(s) in order to use them in standard transactions. The NPI will eventually replace the billing numbers in use today.

What Providers Can Do to Prepare for NPI Implementation

- Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.
- Check with your billing services, vendors, and clearinghouses about NPI compliance and what you need to do to facilitate the process.
- Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.
- Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

Part 2: Information that Applies to Medicare Fee-For-Service (FFS) Providers Only

All Medicare providers are reminded that they will be required to use the NPI *in Medicare claims transactions.*

NPI Transition Plans for Medicare FFS Providers

Medicare's implementation involving acceptance and processing of transactions with the NPI will occur in separate stages, as shown in the table below:

Stage	Medicare Implementation
May 23, 2005 - January 2, 2006:	Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.
January 3, 2006 -October 1, 2006:	Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.
October 2, 2006 - May 22, 2007:	CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.* Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.
May 23, 2007 – Forward:	CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

Crosswalk

The Medicare health plan is preparing a crosswalk to link NPI and Medicare legacy identifiers exclusively for Medicare business, which should enable Medicare to continue claims processing activities without interruption. NPI(s) will be verified to make sure that they were actually issued to the providers for which reported. Medicare will use the check digit to ensure the NPI(s) are valid.

Subparts Policy

CMS is currently developing policy on how Medicare providers should identify Medicare subparts. Further details will be provided when this policy is finalized.

Resources for Additional Information

Coming Soon—CMS is developing a Medlearn web page on NPI for Medicare FFS providers, which will house all Medicare fee for service educational resources on NPI, including links to all Medlearn Matters articles, frequently-asked-questions, and other information. CMS will widely publicize the launch of this Web page in the coming weeks.

You may wish to visit *http://www.cms.hhs.gov/hipaa/hipaa2/* regularly for the latest information about the NPI, including Frequently Asked Questions, announcements of Roundtables, conferences, and guidance documents regarding the NPI.

Go to *http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/CoveredEntityFlowcharts.pdf* to access a tool to help establish whether one is a covered entity under the administrative simplifications of HIPAA.

A helpful tool that provides an overview of the NPI and the application process for obtaining an NPI is available at *http://www.cms.hhs.gov/medlearn/npi/npiviewlet.asp*.

The Federal Register notice containing the NPI Final Rule is available at *http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf*.

There are some non-CMS Web sites that have information on NPI-related issues. While CMS does not necessarily endorse those materials, there may be information and tools available that might be of value to you.

You may also find some industry implementation recommendations and white papers on the NPI at *http://www.wedi.org*, which is the site of the Workgroup for Electronic Data Interchange (WEDI).

Medlearn Matters Number: SE0555
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

GENERAL INFORMATION

Announcing the New Booklet: Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians who have dialysis patients

Provider Action Needed

STOP – Impact to You

If you are a physician who has patients with permanent kidney failure, the new *Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* is for you.

CAUTION – What You Need to Know

The new Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services will tell you:

- How your patients can get Medicare if their kidneys fail;
- How Medicare helps to pay for kidney dialysis and kidney transplants; and
- Where to get additional help and information.

GO – What You Need to Do

See the *Background* section of this article to find out further details regarding this important new Medicare booklet for physicians.

Background

The new *Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* explains how Medicare helps pay for kidney dialysis and kidney transplant services in the *Original Medicare Plan*, also known as "fee-for-service." If your patients are in a *Medicare Advantage Plan* (the new name for Medicare + Choice), which includes *Medicare Managed Care Plans, Medicare Private Fee-for-Service Plans*, and *Medicare Preferred Provider Organization Plans*, their plan must give them at least the same coverage as the *Original Medicare Plan*, but it may have different rules.

The costs, rights, protections, and/or choices of where your patients get their care may be different if they are in one of these plans, and should be considered on a case-by-case basis.

A similar booklet has been made available to patients, but this booklet is written for you, their physician. It contains detailed information about relevant kidney-related Medicare information, including:

- Medicare Basics for People with Kidney Failure
- Coverage
- Impact of Provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
- Dialysis treatment Options
- Kidney Transplants
- Medicare Payment for Blood
- Impact of Other Kinds of Health Insurance
- Helpful Coverage Charts
- Key Definitions and other information.

Be sure to get your copy of the Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services. The Centers for Medicare & Medicaid Services has posted the booklet at http://www.cms.hhs.gov/medlearn/Book_Kidney_Dialysis-Final.pdf on the CMS website.

In addition, you can order printed copies of the Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services by going to http://www.cms.hhs.gov/medlearn/default.asp?link=products and from that page, scroll down and click on the Medlearn Product Ordering Page and follow the instructions to place an order.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0532
Related CR Release Date: N/A

Change in Address for Administrative Law Judge Hearing Requests

This information was previously published in the Fourth Quarter 2005 Medicare B Update! page 77.

Section 931 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Secretary of Health & Human Services (HHS) and the Commissioner of the Social Security Administration (SSA) to effectuate transfer of the administrative law judge (ALJ) function from SSA to the Secretary by October 1, 2005.

The Center for Medicare & Medicaid Services (CMS) has rescinded previous instruction to file ALJ requests with the specific Office of Medicare Hearing and Appeals (OMHA) office.

Action Required by Providers

Effective August 15, 2005, providers must submit all ALJ hearing request and appropriate documentation to the following address, consistent with the practice that was in effect prior to June 24, 2005:

Connecticut
Medicare ALJ Hearings
P. O. Box 45041
Jacksonville, FL 32231-5001

Florida
Medicare ALJ Hearings
P. O. Box 45001
Jacksonville, FL 32231-5001

Upon receipt of a request for an ALJ hearing, contractors will assemble the case file and forward the case file and request to the OMHA field office with jurisdiction, consistent with the timeframes established in Chapter 29 of the Medicare Claims Processing Manual.

Note: The HHS/OMHA will handle routinely all ALJ hearing requests submitted to that office between June 24, 2005, and August 14, 2005. No resubmission of the ALJ hearing request is required.

Source: CMS Joint Signature Memorandum 05448, August 5, 2005

Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Date May 1, 2005)

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare for services.

Provider Action Needed

STOP – Impact to You

The new second level in the administrative appeals process is called a **"reconsideration."** It is different from the previous first level of appeal for Part A claims performed by Medicare Fiscal Intermediaries (FIs). Reconsiderations will be processed by Qualified Independent Contractors (QICs).

CAUTION – What You Need to Know

Medicare contractors (FIs, including regional home health intermediaries (RHHIs), or carriers, including durable medical equipment regional carriers (DMERCs)) may consider as **good cause for late filing,** written redetermination requests that are:

- Mailed or personally delivered to CMS, SSA, RRB office or another government agency; and
- Mailed in good faith and within the time limit, **but**
- Do not reach the appropriate Medicare contractor until after the time period to file a request expired.

In this case, the Medicare contractor may extend the period for filing.

GO – What You Need to Do

Please refer to the *Background* section of this article for additional new policy information about the time limit for filing a request for redetermination.

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, now requires a new second level in the administrative appeals process called a reconsideration.

Requests for redeterminations of appeal decisions (determinations) should go either to the qualified independent contractor (QIC), the administrative law judge (ALJ), or the hearing officer (HO), depending on whether the claim is a Part A or Part B claim; whether the Medicare contractor who issued the initial claim decision is an FI or a carrier; and the date the claim was issued.

Time Limit for Filing a Request for Redetermination

A request for redetermination must be filed within 120 days of the date of receipt of the notice of initial determination (either the medicare summary notice [MSN] supplied to the beneficiary or the remittance advice [RA] supplied to the provider).

- For requests filed in writing - the date received is defined as the date received by the Medicare contractor in the corporate mailroom.
- For requests filed in person - the date received is defined as the date of the office's date stamp on the request.

Please refer to the following table for clarification.

Appeal Rights for Requests for Redeterminations The First Level of Appeal

Medicare Claims	Medicare Contractor Issuing Redetermination	Date Redetermination Issued and Mailed	Where to Appeal the Redetermination*
Part A/Part B	FI	On or after May 1, 2005	QIC
Part B	Carrier	On or after January 1, 2006	QIC
Part A	FI	Before May 1, 2005	ALJ
Part B	FI	Before May 1, 2005	HO
Part B	Carrier	Before January 1, 2006	HO

*Qualified Independent Contractor (QIC); Administrative Law Judge (ALJ); Hearing Officer (HO)

Additional Information

Medicare Claims Processing Manual, Chapter 29 - Appeals of Claims Decisions, 310.2, 310.3 can be found at *http://www.cms.hhs.gov/manuals/104_claims/clm104c29.pdf* on the CMS website.

Medlearn Matters article MM3530 - "MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title - Appeals Transition - BIPA 521 Appeals) **Revised: 4/12/2005** can be found at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3530.pdf* on the CMS website.

Change Request CR3530 "Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title- Appeals Transition – BIPA 521 Appeals) **Revised: 4/12/2005** can be found at *http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf* on the CMS website.

The official instruction issued to your FI, DMERC, or carrier regarding this change may be found by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS web site. From that Web page, look for CR3942 in the CR NUM column on the right, and click on the file for that CR. The new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR3942.

Please refer to your local carrier/DMERC/FI for more information about this issue. To find the toll free phone number, go to *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3942
Related CR Release Date: October 7, 2005
Effective Date: May 1, 2005
Medlearn Matters Number: MM3942
Related CR Transmittal #: 697
Implementation Date: January 9, 2006

General Appeals Process in Initial Determinations

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. It is different from the previous first level of appeal for Part A claims performed by fiscal intermediaries (FIs). Reconsiderations will be processed by qualified independent contractors (QICs).

CR4019 focuses on the general appeals process in Initial Determinations. CR4019 contains a considerable amount of information that is pertinent to the entire process of Medicare claims appeals, and focuses specifically on the additions of Sections 200 to 260 to Chapter 29 of the *Medicare Claims Processing Manual.*

Key Points

Centers for Medicare & Medicaid Services (CMS) Decisions Subject to the Administrative Appeals Process

The Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. These decisions are subject to appeal with the SSA.

Minor Errors and Omissions

Providers should be aware that there is no need to appeal a claim if the provider has made a minor error or omission in filing the claim, which, in turn, caused the claim to be denied. In the case where a minor error or omission is involved, the provider can request that the Medicare contractor reopen the claim so the error or omission can be corrected, rather than having to go through the appeals process.

Who May Appeal

CR4019 (Additions to Chapter 29) defines and describes the individuals and entities who have the right to appeal a Medicare contractor's initial determination. (Medicare contractors are carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including

regional home health intermediaries (RHHIs).) An individual who has a right to appeal is referred to as a "party."

Provider or Supplier Appeals When the Beneficiary Is Deceased

When a provider or supplier appeals on behalf of a deceased beneficiary, and the provider or supplier otherwise does not have the right to appeal, it is the contractor's responsibility to determine whether another party is available to appeal. CR4019 describes what must be done in this situation.

Parties to an Appeal

Any of the persons/entities who may appeal Medicare's decision to deny or reduce payment are parties to an appeal of a claim for items or services payable under Part A or Part B.

Steps in the Appeals Process: Overview

The process of appeal described in CR4019 is effective for all redeterminations issued on or after May 1, 2005, by Medicare FIs and all redeterminations issued on or after January 1, 2006, by carriers. The appeals process consists of five levels. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal. No appeal can be accepted until an initial determination has been made for the claim. The following chart outlines the steps in the Medicare appeal process:

The Medicare Fee-for-Service Appeals Process

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold to be Met or Amount in Controversy (AIC)
1. Redetermination			
Performed by the Medicare Contractor	120 days from date of receipt of the notice initial determination (MSN or RA). (The notice of initial determination is presumed to be received five days from the date of the notice unless there is evidence to the contrary.)	**Part A** – FI (MAC) **Part B** – Carrier (MAC)	None
2. Reconsideration			
• Performed by QIC\ • Case file prepared by the Medicare contractor and forwarded to the QIC.** • Medicare contractor may have effectuation responsibilities for decisions made by the QIC.	180 days from date of receipt of the redetermination	**Part A** and **B**– QIC	None
3. Administrative Law Judge (ALJ) Hearing			
• Case file prepared by the QIC and forwarded to the HHS Office of Medicare Hearings and Appeals (OMHA). • Medicare contractor may have effectuation responsibilities for decisions made at the ALJ level.	60 days from the date of receipt of the reconsideration notice	**Part A** and **B**– HHS OMHA Field Office	At least $100 remains in controversy*** *For requests made on or after January 1, 2006, at least $110 remains in controversy*

Continued on next page

The Medicare Fee-for-Service Appeals Process, continued

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold to be Met or Amount in Controversy (AIC)
4. Departmental Appeals Board (DAB) Review			
Contractor may have effectuation responsibilities for decisions made at the DAB level.	60 days from the date of receipt of the ALJ hearing decision/dismissal	**Part A** and **B** – DAB or ALJ Hearing Office	None
5. Federal Court (Judicial) Review			
Medicare contractor may have effectuation responsibilities for decisions made at the Federal Court level.	60 days from date of receipt of DAB decision or declination of review by DAB		At least $1,050 remains in controversy*** *For requests made on or after January 1, 2006, at least $1,090 remains in controversy*

*Where to Appeal - Part A includes Part B claims filed with the FI.
** In accordance with the appropriate manual section and the Joint Operating Agreement (JOA).
***Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar Amount in Controversy (AIC) requirement will increase by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Where to Appeal

Where a party must file an appeal depends on the level of appeal. The above chart indicates where appellants should file appeal requests for each level of appeal.

When to Appeal – Time Limits for Filing Appeals and Good Cause for Extension of the Time Limit for Filing Appeals

The time limits for filing appeals vary according to the type of appeal. The table above indicates the time limits for filing appeal requests for each level of appeal. These time limits may be extended if good cause for late filing is shown.

Good Cause - General Procedure to Establish Good Cause for Late Filing

Procedures to establish good cause are effective for all requests for redeterminations received by FIs on or after May 1, 2005, and all requests for redeterminations received by the carrier on or after January 1, 2006.

The new Section 240 of Chapter 29 of the *Medicare Claims Processing Manual* lists the general procedure for establishing good cause for late filing; when a favorable decision for good cause is made; and when an unfavorable decision for good cause is made. A listing of conditions and examples that may establish good cause for late filing by beneficiaries, **or** by providers, physicians, and suppliers, can be found in Section 240, which is attached to CR4019.

Amount in Controversy (AIC) Requirements

The amount in controversy requirements applies only to the ALJ and Federal Court Levels. The chart above indicates the amount in controversy (AIC) as well as the method of calculating the AIC, for the Medicare appeals process.

Additional Information

The official instruction issued to your FI or carrier regarding this change may be found by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR4019 in the CR NUM column on the right, and click on the file for that CR. All of the new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR4019. These sections provide excellent detail that explains the revised appeals process.

Please refer to your local FI or carrier for more information about this issue. To find their toll-free phone number, go to *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 4019
Medlearn Matters Number: MM4019
Related CR Release Date: October 7, 2005
Related CR Transmittal #: 695
Effective Date: May 1, 2005
Implementation Date: January 9, 2006

The Comprehensive Error Rate Testing Process for Handling a Provider's Allegation of Medical Record Destruction

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare providers

Provider Action Needed

STOP – Impact to You

This instruction outlines the process Medicare providers should follow when medical records requested by Medicare's comprehensive error rate testing (CERT) documentation contractor (CDC) and/or Medicare's CERT review contractor (CRC) are destroyed by disaster.

CAUTION – What You Need to Know

For CERT purposes, a "disaster" is defined as any natural or man-made catastrophe, which causes damages of sufficient severity and magnitude to partially or completely destroy or delay access to medical records and associated documentation.

- Natural disasters would include hurricanes, tornadoes, earthquakes, volcanic eruptions, fires, mudslides, snowstorms, and tsunamis.
- Man-made disasters would include terrorist attacks, bombings, floods caused by manmade actions, civil disorders, and explosions. A disaster may be widespread or impact multiple structures or be isolated and impact a single site only.

GO – What You Need to Do

If you cannot submit the requested medical records because they were destroyed by a disaster, the CDC/CRC will ask you to attest, under penalty of perjury, to the destruction of the medical records. The **Attestation Form** is available to providers at *http://www.certprovider.org*.

Providers who need to use this form can print and fax the form to the CDC who will either retain the form or send it to the CRC depending on which contractor sent the initial request letter for medical record documentation to the provider.

Background

The Centers for Medicare & Medicaid Services (CMS) recognizes that there are circumstances in which destruction of medical record documentation because of unforeseen events should not count as a "no documentation error." Therefore, CMS has established the following process and procedures to corroborate allegations that CERT-requested medical records were destroyed by a disaster.

The **corroboration process is comprised of two steps: 1) qualification and 2) accuracy**. In the first step, the CDC/CRC will review the attestation statement to determine if the event qualifies as a disaster.

Provider induced disasters and disasters caused by negligence on the part of providers will be counted as "no documentation errors."

The following are examples of provider induced disasters and **disasters caused by negligence** on the part of providers that **would NOT qualify** as a natural or man-made disaster:

- My dog ate the medical record
- My computer lost or destroyed the medical record

If the event does not qualify as a natural or man-made disaster defined in the Provider Action Needed section of this article, the claim associated with that medical record is documented as a "no documentation error." The following are examples of events that **WOULD qualify** as a natural or man-made disaster:

- The medical record was destroyed by a flood.
- Office fire consumed the medical record.

If the event does qualify as a natural or man-made disaster, the CDC/CRC will move to the **second step in the corroboration** process: confirming the accuracy of the attestation. The CDC will confirm the attestation statement through any or all of the following means:

The CDC **checks the following database records for evidence** of natural, man-made, and/or provider induced disasters: Pacer (civil and criminal searches), crimetime.com, news searches, internet search, HHS OIG sanctioned providers ,Merlin, state record searches (courthouse records, insurance carriers or *http://www.insurancefraud.org/* choicepoint /autotrak, argyli, tracer, and the National Crime Insurance Bureau).

The **CDC interviews the provider** who reported the destruction of medical records. The CDC determines the events leading up to the destruction of medical records, such as: what caused the destruction (weather, fire, etc.), were back-up records maintained (electronic or otherwise), what else might have been destroyed, were fire, police, insurance adjusters called to review the damage? The CDC will identify the magnitude of the destruction to medical records, determine if the Medicare carrier/DMERC/FI has copies, interview other third parties as necessary, and determine if medical records were retained elsewhere and how were they maintained.

The **CDC validates additional supporting evidence** for the event, which may include but not be limited to the following sources:

- Weather related events, such as, rain, floods, hurricanes, tornadoes, etc., that can be confirmed by NOAA on a state and county geographical basis.
- Fire that can be confirmed by checking with the local fire marshal.
- Explosions, such as, natural gas that can be confirmed by the local fire marshal or local gas company.
- Explosions, such as, chemical explosions that can be confirmed by the local fire marshal and the Bureau of Alcohol, Tobacco, and Firearms.
- Local, state, and federal investigative officials can confirm explosions.
- State insurance officials can confirm whether doctors, hospitals, and DME suppliers applied for insurance coverage under their insurance policies.
- FEMA can confirm if doctors, hospitals, and DME suppliers applied for disaster recovery loans.
- Local and state investigative agencies may be able to confirm events leading to the destruction of medical records.

- Employees or non-employees of doctors, hospitals, and DME suppliers may have contributed to the destruction of medical records and there should be records disclosing charges against that individual(s).

Where the CDC is unable to verify the accuracy of the explanation provided in the attestation statement, the claim will be counted as a "no documentation error."

Please note that this could eventually lead to a determination that an overpayment has occurred and overpayment recovery action could result.

Additional Information

Medlearn Matters article MM2976 describes the CERT program and MM3812 provides additional information on CERT. Those articles can be viewed at: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2976.pdf* and *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3812.pdf*, respectively on the CMS website.

To review copies of the letters CERT contractors use to request medical record documentation from Medicare Physicians/Providers go to *http://www.cms.hhs.gov/CERT/letters.asp* on the CMS website.

Also on this site are CERT Newsletters that provide information about the entire CERT process.

If you have questions, please contact your carrier or intermediary at their toll free number, which is available at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0547
Related CR Release Date: N/A

Medical Review Additional Documentation Requests

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare providers and suppliers

Provider Action Needed

STOP – Impact to You

Through the use of the additional documentation request (ADR), your carrier, including durable medical equipment regional carriers (DMERCs), or intermediary may ask you for additional documentation regarding a particular Medicare claim.

CAUTION – What You Need to Know

To get a more complete picture of a patient's clinical condition, CR4022 allows carriers, DMERCs, and intermediaries to request additional documentation about the patient's condition before and after a specific service to gain a more complete picture of the patient's clinical condition.

GO – What You Need to Do

Your staffs should be aware of ADRs and should be prepared to respond to them within 30 days.

Background

When a carrier, DMERC, or intermediary (also referred to as Medicare contractor[s], cannot make a coverage or coding determination from the information that has been provided on a claim and its attachments, they may ask for additional documentation by issuing an (ADR). The Medicare contractor must request records related to the claim(s) being reviewed. The Medicare contractor may collect documentation related to the patient's condition before and after a service in order to get a more complete picture of the patient's clinical condition. Your Medicare contractor will not deny other claims related to the documentation of the patient's condition before and after the claim in question unless they review and give appropriate consideration to the actual additional claims and associated documentation.

Additional Information

For more information about ADRs during prepayment or postpayment medical review, go to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR4022 in the CR NUM column on the right and click on the file for that CR.

Also useful is the *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.2 (Additional Documentation Requests (ADR) During Prepayment or Postpayment MR), which is an attachment to CR4022.

Finally, if you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 4022
Medlearn Matters Number: MM4022
Related CR Release Date: September 30, 2005
Related CR Transmittal #: 125
Effective Date: December 30, 2005
Implementation Date: December 30, 2005

Medicare Care Management for High Cost Beneficiaries Demonstration

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Provider types affected by CR4100 include physicians and providers who bill any Medicare contractor (carrier, durable medical equipment regional carrier (DMERC), fiscal intermediary (FI), or regional home health intermediary (RHHI)) for services provided to Medicare Fee-for-Service (FFS) beneficiaries (i.e., those in the traditional FFS Medicare program) who reside in any one of the geographic areas described below and who have enrolled in a CMHCB program.

The CMHCB programs in these geographic areas are operated by one of six organizations, known as Care Management Organizations (CMOs), that will deliver provider-based intensive care management services to certain FFS Medicare beneficiaries with one or more chronic conditions. Beneficiaries eligible for participation in the demonstration will be designated by the Centers for Medicare & Medicaid Services (CMS). If you submit claims to the Medicare contractors listed in the following charts, for Medicare patients who reside in the geographic areas shown in the charts, this article is of special interest to you:

Carrier, FI, DMERC, RHHI	Geographic Areas to be Served
1. Anthem Health Plans of Maine, Inc.	Massachusetts
2. Blue Cross and Blue Shield of South Carolina, also known as Palmetto GBA	Florida, Texas
3. Connecticut General Life Insurance Company	California, Nevada, Oregon, Washington
4. Empire HealthChoice Assurance, Inc.	New York
5. First Coast Service Options, Inc.	Florida
6. Group Health Incorporated	New York
7. HealthNow New York, Inc.	Massachusetts, New York
8. National Heritage Insurance Company	California, Massachusetts
9. Noridian Mutual Insurance Company	Nevada, Oregon, Washington
10. Regence BlueCross BlueShield of Oregon	Oregon
11. Trailblazer Health Enterprises, LLC	Texas
12. United Government Services, LLC	Nevada, Oregon, Washington, California, New York

Provider Action Needed

STOP – Impact to You

This article contains information from CR4100 that describes the CMS CMHCB Demonstration project and the associated Care Management Organizations (CMOs') programs. These programs are being implemented under the demonstration project to test whether supplemental care management services can improve quality of care and health results, and reduce unnecessary hospital stays and emergency room visits for Fee-for-Service (FFS) beneficiaries who have one or more chronic diseases. Care management services provided by the CMOs may include facilitating collaboration among beneficiaries' primary and specialist providers, and enhanced communication of relevant clinical information to providers for the beneficiaries enrolled in a CMHCB program.

CAUTION – What You Need to Know

A beneficiary's participation in this demonstration program will not change his or her FFS Medicare benefits. The beneficiary is **not** enrolled in an HMO, Medicare Advantage Plan, or other non-FFS plan. The beneficiary remains entitled to all FFS benefits. You may be contacted by one of the CMOs in your geographic area.

GO – What You Need to Do

Make sure that your office and billing staffs are aware that these beneficiaries remain eligible for FFS services. **There are no changes to Medicare FFS billing instructions or claims processing as a result of this CMHCB program.** Provider participation in care plans developed by, and other collaboration with, the CMO is voluntary and at provider discretion.

Background

This article provides information on CMS's implementation of the CMHCB project to conduct a three-year study of various care management models for certain beneficiaries in the traditional Medicare FFS program. These programs will be administered by the CMOs.

The CMO programs will support collaboration among demonstration participants' primary and specialist providers and enhance communication of relevant clinical information. The programs are intended to:

- Help increase adherence to evidence-based care;
- Reduce unnecessary hospital stays and emergency room visits; and
- Help participants avoid costly and debilitating complications.

FFS Medicare benefits will continue to be covered, administered, and paid under the traditional FFS Medicare program. Demonstration programs will be offered at no additional charge to the participating beneficiaries beyond their normal original Medicare plan premiums, co-payments, and/or deductibles. The CMOs will not be able to restrict beneficiary access to care, or restrict beneficiary provider choice.

Since the CMO services may include collaboration with the physician on the beneficiary's plan of care, you may be contacted by the CMO regarding any of your patients who enroll in the CMHCB demonstration. It is up to each physician to determine whether he or she wishes to collaborate with the CMO.

Note: Beneficiaries enrolled in these demonstrations remain eligible for FFS services, and physicians and providers of those services should continue to bill as they normally would.

There are no changes to Medicare FFS billing instructions or claims processing as a result of this demonstration.

CMO Program Features and Geographic Areas

The following table describes the name, target population, special features, scheduled launch date, and designated geographical areas of each program.

Name of Program	Population Focus and Program Features	Geographic Area
Health Buddy Program	Serves beneficiaries with congestive heart failure, diabetes, and or chronic obstructive pulmonary disease. Uses a technology platform. Patients receive a Health Buddy appliance that coaches them about their health, collects vital signs and symptoms, and transmits results back to multi-specialty medical groups. Physicians and nurses will use information provided through the Health Buddy program to spot problems early and ensure patients stay healthy **Launch date:** Early CY 2006	**Oregon**: Deschutes, Jefferson, Crook, Lake, Malheur, and Harney **Washington**: Chelan, Grant, Okanogan, and Douglas **Nevada:** Clark, Nye
Care Level Management	Serves beneficiaries who are seniors suffering from advanced, progressive chronic disease(s) and comorbidities with two or more condition-related hospital admissions in the past year. Care management via a distributed network of Personal Visiting Physicians (PVPs) who see patients in their homes and nursing facilities and who are available 24 hours a day, 7 days a week. PVPs are supported by Personal Care Advocate Nurses who are based in nearby regional offices and who provide care coordination and maintain regular phone contact with beneficiaries. Utilizes a web-based electronic medical record. **Launch date:** October 1, 2005	**California:** Alameda, San Francisco, Marin, San Mateo, Contra Costa, Sacramento, Santa Clara, Sonoma, Solano, San Joaquin, Fresno, Stanislaus, Monterey, Tulare, Madera, Merced, Santa Cruz, San Benito, Los Angeles, Ventura, Santa Barbara, San Luis Obispo, Riverside, San Bernardino, Kern, Kings, Orange, San Diego **Texas:** Bexar, Atascosa, Bandera, Comal, Guadalupe, Kendall, Medina, Wilson **Florida:** Brevard, Indian River, Osceola, Seminole, Orange
Mass General Care Management	Serves beneficiaries who seek care from Massachusetts General healthcare system. Comprehensive care management by a dedicated team of doctors and nurses. Specialized programs for patients with chronic conditions. Home visits and home telemonitoring as needed. Electronic medical record system assures coordination, continuity, and adherence to physician-approved care management plan. Launch date: Early CY 2006	Massachusetts: Norfolk, Suffolk, Middlesex, Essex, and Plymouth

CMO Program Features and Geographic Areas, continued

Name of Program	Population Focus and Program Features	Geographic Area
Montefiore Care Guidance	Serves beneficiaries with multiple chronic conditions, residing in naturally-occurring retirement communities regardless of where they currently receive care, and FFS beneficiaries cared for within the Montefiore healthcare network. Offers enhanced home-based services to participants using telemonitoring equipment and home visit programs. Also offers medication management, falls prevention, palliative care, and disease management programs. Launch date: Early CY 2006	New York: Bronx
RMS KEY to Better Health	Serves beneficiaries with chronic kidney disease. Provides intensive disease management directed by nephrologists in supplementary clinics to identify potential problems and avoid complications, coordinate early intervention plans and prevent acute hospitalization. Launch date: November 1, 2005	New York: Nassau, Suffolk, Queens
Texas Senior Trails	Serves beneficiaries who receive care from the Texas Tech Physician Associates primary care and specialist physicians and who are at greatest risk for readmission and adverse events in largely underserved, rural areas Team coordinates a home and office based program Launch date: Early CY 2006	Texas: Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Stonewall, Swisher, Terry, Wheeler, and Yoakum

Additional Information

Additional information on the demonstration project may be found at *http://www.cms.hhs.gov/researchers/demos/cmhcb.asp* on the CMS website.

For complete details, please see the official instruction issued to your Carrier/FI/DMERC/RHHI regarding this change, which can be viewed at *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR4100 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 4100
Medlearn Matters Number: MM4100
Related CR Release Date: September 23, 2005
Related CR Transmittal #: 28
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

Medicare Chronic Care Improvement—Medicare Health Support Program

CMS has *issued the following "Medlearn Matters... Information for Medicare Providers" article.*
This information was previously published in the Fourth Quarter 2005 Medicare B Update! pages 85-88.

Note: This article was revised on August 23, 2005, due to a revision to CR3953. The changes to the article are the new CR release date and transmittal number shown above, and updates to the information below. Also, please note that the implementation date of CR3953 is not tied to the implementation dates for Medicare Health Support Organizations (MHSOs).

Provider Types Affected

Physicians and providers in any one of the nine Chronic Care Improvement Organization (CCIO) areas as follows: (Each area specified shows the name of the CCIO with which Medicare has contracted followed by the geographic area served by that CCIO.)

1. AETNA, Inc. Chicago, Illinois counties; **2. American Healthways,** Maryland and the District of Columbia; **3.CIGNA,** Northwest Georgia; **4. Health Dialog,** Western Pennsylvania; **5. Humana,** Central and South Florida; **6. Lifemasters,** Oklahoma; **7. McKesson,** Mississippi; **8. Visiting Nurse Service EverCare/United,** Brooklyn and Queens, New York; **9. XL Health**, selected counties in Tennessee

Provider Action Needed

STOP – Impact to You

This article includes information from Change Request (CR) 3953 that describes the new Medicare Chronic Care Improvement program also known as "Medicare Health Support program" and identifies the nine selected CCIOs that contract with the Centers for Medicare & Medicaid Services (CMS) to provide chronic care services to certain beneficiaries enrolled in the traditional fee-for-service (FFS) Medicare program.

CAUTION – What You Need to Know

This is phase I of the Medicare Health Support program and will serve approximately 180,000 Medicare beneficiaries who have congestive heart failure and complex diabetes among their chronic conditions. Eligible beneficiaries do not have to change plans or providers to participate, and participation is totally voluntary. CCI programs will not restrict access to other Medicare services and will be provided at no extra cost to beneficiaries.

GO – What You Need to Do

See the Background and Additional Information sections for more information on this new program.

Background

This article provides information on the CMS' implementation of the Chronic Care Improvement program now known as "Medicare Health Support". Section 721 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) adds a new section 1807, "Voluntary Chronic Care Improvement Under Traditional Fee-for-Service (FFS) Medicare" to the Social Security Act. This requires Medicare to provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs, and to expand the implementation of the chronic care improvement (CCI) programs to additional geographic areas.

This initiative also represents one of the multiple strategies developed by the Department of Health & Human Services (DHHS) to improve chronic care, accelerate the adoption of health information technology, reduce avoidable costs, and diminish health disparities among Medicare beneficiaries nationally.

Some key points of "Medicare Health Support" are as follows:

- The program will test whether providing disease management services to Medicare beneficiaries who are in traditional FFS programs leads to improved outcomes and lower total costs to Medicare.
- CCIOs contract with CMS to provide disease management to targeted Medicare FFS beneficiaries (about 20,000 beneficiaries serviced by each CCIO) who suffer from congestive heart failure and diabetes.
- The first CCI program will be phased in during 2005, operate for 3 years and be tested through randomized controlled trials. The hope is that the program or components of the program prove successful and can be expanded regionally and/or nationally.
- The programs will offer add-on services—such as self-care guidance and support—to chronically ill beneficiaries. The goal is to help them adhere to their physician's plans of care and assure that they seek the medical care needed to reduce their health risks. Coordination and collaboration with the participants' providers to enhance communication of relevant clinical information is also a key component of the CCI program.
- CCI programs will not restrict access to care and will be provided at no cost to eligible beneficiaries. Such beneficiaries do not have to change from their existing plans, nor do they have to change physicians or providers in order to participate. Further, they may stop participating at any time.
- Each of the contracted CCIOs are paid separately by CMS, outside of the Medicare FFS claims payment system, a fixed "per member per month" (PMPM) payment.
- The CCIOs will not focus on any single disease, but will help participants manage all their health care problems.
- The CCIOs will **not** pay any claims on behalf of enrolled beneficiaries and a beneficiary's participation will not at all affect how claims from their physicians/providers are processed by Medicare.

The following chart identifies the CCIOs, details the specific program features of these CCIOs and delineates the geographic areas served by the CCIO:

CCIO	Program Features	Geographic Area
Lifemasters	• Single nurse as primary contact for beneficiary • Supported self-care model including education, medication compliance, behavior change • Home visits as appropriate • Team of local and call center-based nurses, physicians, pharmacists, and health educators • Digital weight scale and blood pressure monitors • Physician communication including customized care plans, alerts, decision support applications; access to patient care record and biometric monitoring data • Physician outreach includes in-person orientation for high volume physician practices • Physician web access to clinical information • Active involvement of other community agencies • 24-hour nurse line	Oklahoma
McKesson	• Extensive physician involvement, including on-site staff support • Data exchange with physicians, • Physician web access to clinical information • Telephonic outreach • Mail, fax, workbooks • Remote monitoring and biometric equipment for selected high risk participants • Pharmacist review of medications and collaboration with physicians • Management of long-term care residents and intensive case management, including end-of-life • 24-hour nurse line	Mississippi
Visiting Nurse Service EverCare/ United	• Home health agency leading outreach in community • Management of high-risk participants who require extensive in home management • Telephonic outreach and health risk assessments • Use of Smart Cards to use at physician visits and hospital admissions to track service use and convey embedded information to providers • Physician web access to clinical information • Active involvement of other community agencies • 24-hour nurse line	Brooklyn and Queens, New York
XL Health	• Biometric monitoring including glucometers and weight scales as necessary • RNs, social workers, and pharmacists in the field, interacting with providers and beneficiaries with complex needs • Medication counseling sessions by pharmacists at retail pharmacies • Specialized program for higher risk patients • Medication management and compliance • Data exchange with physicians, • Physician Web access to clinical information • 24-hour nurse line	Selected counties in Tennessee

Physicians and providers with questions regarding the program can find additional information at *http://www.cms.hhs.gov/medicarereform/ccip/* on the CMS website, or they may direct their inquiries directly to the following CCIO contacts:

AETNA: Kathleen Giblin Aetna Health Management, LLC 151 Farmington Avenue, RT11 Hartford, CT 06156 **Or call 888-713-2836 or visit** *http://www.aetna.com*	**LifeMasters:** Ron Lau, c/o Mel Lewis LifeMasters Supported Care 5000 Shoreline Court S#300 South San Francisco, CA 94080 **Or call 888-713-2837 or visit** *http://www.lifemasters.com*
American Healthways: Michael Montijo, M.D., American Healthways American Healthways, Inc. 3841 Green Hills Village Drive Nashville, TN 37215 **Or call 866-807-4486 or visit** *http://www.medicarehealthsupport.com*	**McKesson:** Sandeep Wadhwa McKesson Health Solutions 335 Interlocken Parkway Broomfield, CO 80021 **Or call 800-919-9110 or visit** *http://www.mckesson.com*
Health Dialog: Molly Doyle Health Dialog Services Corporation 60 State Street, Suite 1100 Boston, MA 02109 **Or call 800-574-8475 or visit** *http://www.myhealthsupport.com* (available August 2005)	**XL Health:** Paul Serini XLHealth 351 West Camden Street, Suite 100 Baltimore, Maryland 21201 **Or call 877-717-2247**
Humana: Heidi Margulis Humana, Inc. 500 West Main Street, 6th Floor Louisville, KY 40202 **Or call 800-372-8931 or visit** *http://www.greenribbonhealth.com*	**VNS/Evercare:** Paul Roth VNS CHOICE 5 Penn Plaza, 19th Floor New York, NY 10001-1810
CIGNA HealthCare: David Post CIGNA 900 Cottage Grove, B227 Bloomfield, CT 06002 **Or call 866-563-4551 or visit** *http://www.mhsgeorgia.com* (available August 2005)	

Implementation

The implementation date for this instruction is October 20, 2005.

Additional Information

For complete details of CR 3953, please see the official instruction issued by going to: *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*.

From that Web page look for CR 3953 in the CR column on the right and click on the file for that CR.

The Medicare fact sheet that describes the Medicare Chronic Care Improvement, "Medicare Health Support," program may be found on the Web at: *http://www.cms.hhs.gov/medicarereform/ccip/*.

This document is an excellent overview of the program.

Medlearn Matters Article MM3410 provides some background information on the "Use of Group Health Plan Payment System to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries Under Section 721 of the MMA" and may be viewed by going to: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3410.pdf*.

Related Change Request (CR) #: 3953
Medlearn Matters Number: MM3953
Related CR Release Date: August 12, 2005 *Revised*
Related CR Transmittal #: 27
Effective Date: October 20, 2005
Implementation Date: October 20, 2005

Nonphysician Practitioner Questions and Answers

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the 4th Quarter 2005 Medicare B Update! pages 80-83.

Note: This article was revised on August 16, 2005. The only change was the answer (A14) to question 14 (Q14) on page 4. All other information remains the same.

Provider Types Affected

Nonphysician practitioners (NPPs), physicians, suppliers, and providers.

Provider Action Needed

Be sure to understand the policies related to services for skilled nursing facilities (SNF) and nursing facilities (NF) as they relate to NPPs.

Background

The Balanced Budget Act of 1997 (BBA) modified the way the Medicare program pays for NPP services. Prior to January 1, 1998, these services were reimbursed by Medicare Part B only in certain geographical areas and health care settings. The BBA removed the restrictions on settings and effective January 1998, payment is allowed for non-physician practitioner services in all geographic areas and health care settings permitted under State licensing laws.

On November 13, 2003, CMS issued the Survey & Certification letter (S&C-04-08), which addresses the differences in requirements concerning the delegation of physician tasks in SNFs and NFs from a survey and certification perspective. Please note that reimbursement requirements for NPPs may differ from the survey and certification requirements. The following questions (Q1 through Q17) have been asked by NPPs, and each question has been answered (A1 through A17) by the Centers for Medicare & Medicaid Services (CMS).

Q1. Why do new regulations from CMS governing physician delegation of services differ between SNFs and NFs?

A1. The requirements addressing physician delegation of services are not new. The distinction made between the delegation of physician visits and tasks between SNFs and NFs is mandated by Congress in the law.

The original authority for 42 Code of Federal Regulations (CFR) § 483.40 was the sentence in section 1819(b)(6)(A) of the Social Security Act requiring that every SNF resident's medical care be under the supervision of a physician (the same sentence appeared in section 1919(b)(6)(A) of the Social Security Act for NFs). The requirements contained in 42 CFR, § 483.40, include a prescribed visit schedule and the requirement for the physician to perform the initial visit personally. Section 483.40 of the CFR originally applied these same standards uniformly in both SNFs and NFs. However, in section 4801(d) of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress subsequently amended the Medicaid provisions of the law (section 1919(b)(6)(A) of the Social Security Act) to allow, at the option of the State, all physician tasks (including the initial visit) to be delegated to physician extenders who are not employed by the facility but who are working in collaboration with the physician. In response, CMS amended the regulations to reflect this broader authority for delegating physician tasks in NFs (see § 483.40(f)). Since Congress declined to make a similar change in the statutory requirements for SNFs at section 1819(b)(6)(A) of the Social Security Act, the corresponding SNF requirements in § 483.40(c) and (e) remain unchanged.

Q2 When may NPPs begin to bill for medically necessary visits that occur prior to the initial comprehensive visit in a SNF and in a NF?

A2. CMS defined "initial comprehensive visit" in the November 13, 2003 S&C-04-08 and stated that NPPs may perform any medically necessary visits even if they occur prior to the initial comprehensive visits in both SNFs and NFs. Medically necessary visits that NPPs perform on or after November 13, 2003, may be billed to the carrier when collaboration and billing requirements are met in the SNF and NF setting. The Survey & Certification letter S&C-04-08, may be found at: *http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp*.

Q3 If state regulations require a physician co-signature for orders and/or notes written by an NPP, may the physician bill for this action?

A3 No. CMS only pays for medically necessary face-to-face visits by the physician or NPP with the resident. Since the NPP is performing the medically necessary visit, the NPP would bill for the visit.

Q4 If state regulations require more frequent visits than those that are federally mandated, are NPPs able to bill for those visits?

A4 CMS only reimburses physicians and NPPs for medically necessary visits and federally prescribed visits. Visits required to fulfill or meet state requirements are considered administrative requirements and are not medically necessary for the resident. Medicare pays for services that are reasonable and medically necessary for the treatment of illness or injury only, as stated in the Social Security Act, section 1862(a)(1)(A).

Q5 May NPPs who are employed by the facility bill for medically necessary visits?

A5. Payment may be made for the services of nurse practitioners (NPs) and clinical nurse specialists (CNSs) who are employed by a SNF or NF when their services are rendered to facility residents. If NPs and CNSs employed by a facility opt to reassign payment for their professional services to the facility, the facility can bill the appropriate Medicare Part B carrier under the NPs' or CNSs' UPINs for their professional services. Otherwise, the NPs or CNSs who are employed by a SNF or NF bill the carrier directly for their services to facility residents.

On the other hand, physician assistants (PAs) who are employed by a SNF or NF cannot reassign payment for their professional services to the facility because Medicare law requires the employer of a PA to bill for the PA's services. Hence, the facility must always bill the Part B carrier under the PA's UPIN for the PA's professional services to facility residents.

Q6. May NPPs employed by the NF perform the initial comprehensive visit, sign initial orders, or perform other federally required visits in NFs?

A6. No. The statute specifies that the NPPs are prohibited from providing these services when employed by the facility. The Social Security Act states at section 1919(b)(6)(A) that the health care of every resident must be provided under the supervision of a physician or under the supervision of an NPP not employed by the facility who is working in collaboration with a physician.

Q7. May NPPs perform the initial comprehensive visit in SNFs?

A7. No. The Social Security Act states at Section 1819(b)(6)(A) "that the medical care of every resident must be provided under the supervision of a physician." Congress did not extend this benefit to NPPs in an SNF as was done under 1919(b)(6)(A).

Q8. When may NPPs sign the initial orders for a SNF resident?

A8. NPPs may not sign initial orders for an SNF resident. However, they may write initial orders for a resident (only) when they review those orders with the attending physician in person or via telephone conversation and have the orders signed by the physician.

Q9 Must a physician verify and sign orders written by an NPP who is employed by the NF?

A9. Yes. The regulation at 42 CFR, § 483.40(b)(3) states, the physician must "Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."

In accordance with 42 CFR, Section 483.40(f), required physician tasks, such as verifying and signing orders in an NF, can be delegated under certain circumstances to a physician assistant, nurse practitioner, or clinical nurse specialist who is not an employee of the facility but who is working in collaboration with a physician. Therefore, in order to comply with survey and certification requirements, the physician must sign all orders written by an NPP who is employed by the NF.

Q10. Why must a physician verify and sign orders written by an NPP in the SNF?

A10. 42 CFR, Section 483.40(e)(2), which applies to physician delegation of tasks in SNFs, states "A physician may not delegate a task when regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies." Therefore, in accordance with 42 CFR, § 483.40(b)(3), the physician must "Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."

Q11. Referring to S&C –04-08 issued on November 13, 2003, the chart under the "Other Medically Necessary Visits and Orders" column, it specifies the ability of the NPP to perform AND sign but in the column for "Other Required Visits" it does not address signing. Does CMS require a physician's signature in such cases?

A11. 'Other Required Visits' refers to the federally required visits. During these required visits, it is not always necessary to write orders. However, during a "Medically Necessary Visit," which is when the resident's condition may have changed, thus, warranting a visit outside the federally required schedule, the resident is exhibiting signs and/or symptoms that require medical attention. In these cases, CMS believes orders will often be required and, thus, expect orders to address the resident's change in condition. Therefore, an NPP may sign the medically required orders. Please remain mindful that the survey and certification requirement that the physician must sign and date all orders remains in effect. (See Q&As 9 &10.)

Q12. Why can't a PA, regardless of employment, sign certifications/re-certifications for SNF residents?

A12. Congress amended section 1814(a)(2) of the Social Security Act in 1989. The Social Security Act specifies that NPs and CNSs who are not employed by the facility may certify (and recertify) that the services the beneficiary requires may only be performed in the SNF. They did not extend this benefit to PAs. Therefore, by statute, PAs may not sign SNF certifications/re-certifications.

Q13. If a physician extender is not employed by the NF but is employed by an organization related to the NF, may he/she still provide services in the nursing home?

A13. The requirement in 42 CFR, § 483.40(f), is specific in that the physician tasks may be performed by a NP, PA, or CNS "who is not an employee of the facility." In this case, the NPP is not an employee of the NF and, thus, can perform physician tasks as long as they work in collaboration with the physician.

Q14. If an NP or CNS is not employed by the SNF but is employed by an organization related to the SNF, may he/she sign the certification and re-certifications?

A14 The requirement in 42 CFR Section 424.20(e) is specific in that an NP or CNS "neither of whom has a direct or indirect employment relationship with the facility" may sign the certifications and re-certifications. Under 42 CFR 424.20(e)(2)(ii), when an NP or CNS has a direct employment relationship (as defined under common law) with an entity other than the SNF itself, he or she is also considered to have an indirect employment relationship with the SNF in any instance where the employing entity has an agreement with the SNF for the provision of general nursing services. For further explanation of this provision, please refer to the FY 2006 SNF prospective payment system final rule, 70 FR 45035 - 36, August 4, 2005. (Social Security Act section 1814(a)(2))

Q15. If physician delegation responsibilities are based on payment source, what are the physician delegation responsibilities for private pay resident, VA contracts or managed care?

A15. If the resident's stay is being paid for by a source other than Medicare or Medicaid AND the resident is residing in a Medicare/Medicaid dually certified facility, follow the most stringent requirement. If the resident is residing in a Medicare only or a Medicaid only certified facility, then follow the requirements for that specific certified facility.

Q16. Are NPPs allowed to certify/recertify therapy plans of care under Medicare Part B?

A16. 42 CFR § 424.24(c)(3) states that if a physician or NPP establishes the plan of care, he/she must also certify the plan of care. If a physical or occupational therapist or speech language pathologist establishes the plan of care, a physician or NPP who has knowledge of the case must sign the plan of care. (This Q&A was not addressed in the November 13, 2003, Survey & Certification letter, S&C-04-08.)

Should you have any questions concerning this article, please submit your inquiry via the CMS website as follows:

1) Click on Feedback in top tool bar of *www.cms.hhs.gov* (from home page or any page on *cms.hhs.gov*).
2) Select and click "Site Feedback" in last paragraph.
3) User should:
   a. Enter his/her email address,
   b. At Category, select "Providers" from the drop down menu,
   c. At the sub-category, select Nursing Home Quality Initiative,
   d. Enter feedback in space provided; and
   e. Submit feedback.

Related Instructions

The CMS website contains considerable information regarding SNF billing procedures and NPP billing processes. Some of the specific sites are as follows:

The *Medicare Claims Processing Manual, Pub. 100-04, Chapter 7 (SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule))* can be found at the following CMS website:
http://www.cms.hhs.gov/manuals/104_claims/clm104c07.pdf.

The *Skilled Nursing Facility Manual, Chapter V (Billing Procedures)* is located at the following CMS website:
http://www.cms.hhs.gov/manuals/12_snf/sn500.asp.

The Home Health Agency Manual, Chapter IV (Billing Procedures) website is located at:
http://www.cms.hhs.gov/manuals/11_hha/hh400.asp.

Additional Information

The CMS Quarterly Provider Update websites for Non-Physician Practitioners (NPPs) for 2004 can be found at:
http://www.cms.hhs.gov/providerupdate/january2004/nonphys.asp.

In addition, the CMS Quarterly Provider Update websites for NPPs for 2003 can be found at:
http://www.cms.hhs.gov/providerupdate/january2003/nonphys.asp
http://www.cms.hhs.gov/provider update/april2003/nonphys.asp
http://www.cms.hhs.gov/providerupdate/july2003/nonphys.asp
http://www.cms.hhs.gov/providerupdate/october2003/nonphys.asp.

Acronyms

CFR = Code of Federal Regulations
CMS = Centers for Medicare & Medicaid Services
CNS = Clinical Nurse Specialist
NF = Nursing Facility
NP = Nurse Practitioner
NPP = Nonphysician Practitioner (NPs, CNSs, & Pas are considered NPPs)
OBRA '90 = Omnibus Budget Reconciliation Act of 1990
PA = Physician Assistant
S&C = Survey & Certification
SNF = Skilled Nursing Facility
VA = Veterans Administration

Related Change Request (CR) #: N/A
Related CR Release Date: N/A ***Revised***
Medlearn Matters Number: SE0418
Effective Date: N/A- This is informational only.

Nature and Effect of Assignment on Carrier Claims

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians and suppliers who are Medicare participating physicians/suppliers and nonparticipating physicians/suppliers who are required by law to accept assignment (direct payment) from Medicare carriers, including durable medical equipment regional carriers (DMERCs) for covered Part B services, equipment, and supplies.

Provider Action Needed

Providers need to be aware that on January 1, 2005, Medicare regulations at 42 C.F.R. 424.55 were amended to eliminate the requirement that beneficiaries formally assign claims to suppliers when suppliers are **required by law** to accept assignment. In other words, the beneficiary is not required to assign the claim to the physician or supplier in order for an assignment to be effective in "mandatory assignment" situations.

Background

This action affirms the pattern that has emerged over time as the Social Security Act was amended in various sections to require suppliers to accept assignment for Medicare covered services whether or not the beneficiary actually assigned the claim to the supplier. The following is a synopsis of the CR3897 and the revised Medicare Claims Processing instructions (Chapter 1, Section 30.3.2) that are attached to CR3897:

- Physicians and suppliers who accept assignment from Medicare, by choice or by law, may not attempt to collect more than the appropriate Medicare deductible and coinsurance amounts from the beneficiary, his/her other insurance, or anyone else. .
- If the physician/supplier is not satisfied with the amount allowed by Medicare, procedures are in place for appeal of the contractor initial determination.
- If an enrollee has private insurance in addition to Medicare the physician/supplier is in violation of his/her assignment if he/she collects from the enrollee or the private insurance an amount that when added to the Medicare benefit exceeds the Medicare allowed amount.
- The beneficiary must continue to authorize the release of medical or other information necessary to process the claim.
- A nonparticipating physician/supplier who accepts assignment for some Medicare covered services is not prohibited from billing the patient for services for which he/she does not accept assignment. Also, the nonparticipating physician/supplier is not precluded from billing a patient for services that are not covered by Medicare.
- Physicians/suppliers should remember they may not attempt to "fragment" their bills.

Fragmenting is defined as accepting assignment for some services and then billing the enrollee for other services performed at the same place and on the same occasion. When Medicare carriers become aware that services are being "fragmented" they will inform the physician/supplier that the practice is unacceptable and that he/she must either accept assignment or bill the enrollee for all services performed at the same place on the same occasion. There is an **EXCEPTION**. In situations where assignment is mandatory, i.e., where a physician/supplier must accept assignment for certain services as a condition for any payment or for full payment to be made (e.g., clinical diagnostic laboratory tests, physician assistants), he/she may accept assignment for those conditional services without accepting assignment for other services furnished by him/her for the same enrollee at the same place and on the same occasion.

Implementation

The implementation date for CR 3897 is November 14, 2005.

Related Instructions

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website.

From that web page, look for CR3897 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please refer to your carrier/DMERC. To find their toll free phone numbers go to *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #3897
Medlearn Matters Number: MM3897
Related CR Release Date: August 12, 2005
Related CR Transmittal #: 643
Effective Date: January 1, 2005
Implementation Date: November 14, 2005

The Centers for Medicare & Medicaid Services Recovery Audit Contract Initiative

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers, especially in California, Florida, and New York

Provider Action Needed

Physicians, providers, and suppliers should note that this initiative is designed to determine whether the use of Recovery Audit Contracts (RACs) will be a cost-effective means of ensuring that you receive correct payments and to ensure that taxpayer funds are used for their intended purpose.

As the states with the largest Medicare expenditure amounts, California, Florida, and New York were selected for pilot RACs that began earlier this year and that will last for three years. Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the Medicare Affiliated Contractors (MACs), which include carriers, fiscal intermediaries (FIs), and durable medical equipment regional carriers (DMERCs).

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 306) directs the secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

Update

On January 11, 2005, the Center for Medicare & Medicaid Service (CMS) announced the recovery audit contractor demonstration project. (See MedLearn Matters article SE0469 which is available at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0469.pdf* on the CMS website.)

The demonstration, mandated by the MMA, will evaluate the use of recovery audit contractors in identifying Medicare underpayments and overpayments and recouping overpayments.

On March 28, 2005, the CMS awarded five RACs and officially announced the beginning of the recovery audit contractor demonstration. Three of the five recovery audit contractors will perform post-payment medical review in the states of California, Florida, and New York. Those firms and the state they are responsible for are as follows:

- Connolly Consulting will perform claim reviews for providers who are serviced by a FI or carrier in New York. Connolly Consulting will also perform reviews for durable medical equipment claims for Medicare beneficiaries who reside in New York.
- PRG Schultz and its subcontractor, Concentra Preferred Systems, will perform claim reviews for providers who are serviced by a FI or carrier in California. PRG Schultz will also perform reviews for durable medical equipment claims for beneficiaries who reside in California.
- HealthData Insights will perform claim reviews for providers who are serviced by a FI or carrier in Florida. Connolly Consulting will also perform reviews for durable medical equipment claims for beneficiaries who reside in Florida.

CMS is committed to alerting the provider community regarding the focus of the recovery audit contractor demonstration. The recovery auditors have at least three years of claims they may review.

Three-Tiered Review Process

The recovery audit contractors have a three-tiered process that is explained below:

- The first level involves Part A Diagnosis Related Group (DRG) reviews. These reviews normally involve making a request for medical records. Providers located in Florida began seeing medical record requests in August. Providers located in New York began seeing medical record requests in September. California providers will see medical record requests some time after October.
- The second level involves overpayments determined by the recovery audit contractor's proprietary data mining systems. These are overpayments that clearly do not meet the requirements of Medicare policies. These overpayments do not require a medical record request because it is very clear that an overpayment has occurred. These overpayments may be for a Part A or Part B service.

  However, CMS is approving a sample of these overpayments before the demand letters are released. In October 2005, physicians and/or providers in Florida may receive overpayment demand letters resulting from these automated reviews. Beginning in October, physicians and/or providers in California and New York may also see overpayment demand letters resulting from these reviews.
- The last level involves the actual request of medical records for Part B services. All of the recovery companies have indicated that physicians may see medical record requests for Part B services in October or November of 2005. In a future Medlearn Matters article, CMS will update the provider community when medical record requests could be made.

Note: Questions concerning the recovery audit contractor demonstration may be directed to an email address CMS has established for the demonstration. That email address is *http://cmsrecoveryauditdemo@cms.hhs.gov*.

Additional Information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Find out more about the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) at *http://www.cms.hhs.gov/medicarereform/* on the CMS website.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0565
Related CR Release Date: N/A

Announcing Medicare Part B FREE Medicare Remit Easy Print

Are you still using the Standard Paper Remittance (SPR)? Save TIME and MONEY by taking advantage of FREE Medicare Remit Easy Print (MREP) software now available for viewing and printing the HIPAA compliant Electronic Remittance Advice (ERA)! The MREP software gives providers and suppliers the following abilities:

- Easy navigation and viewing of the ERA using your personal computer;
- Print the ERA in the Standard Paper Remittance (SPR) format;
- Search capability that allows providers and suppliers the ability to find claims information easily;
- Print and export reports about ERAs including denied, adjusted and deductible applied claims;
- Easy-to-use method to archive, restore, and delete imported ERAs

Providers and suppliers can view and print as many or as few claims as needed. This will be especially helpful when you need to print only one claim from the remittance advice when forwarding the claim to a secondary payer. This FREE software can save you time resolving Medicare claim issues. Take advantage of the MREP features unavailable with the SPR.

In order to utilize the MREP software, you will need to receive a HIPAA compliant ERA. Contact Medicare EDI at (904) 354-5977 (Florida) or (203) 639-3160 (Connecticut), option 7 to find out more about MREP and/or for information on how to receive a HIPAA compliant ERA. Take advantage of this new software.

Begin using MREP today!

Source: CMS Joint Signature Memorandum 05522, dated September 19, 2005
CMS Joint Signature Memorandum 05562, dated October 3, 2005

Requirements for Voided, Canceled, and Deleted Claims

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All Medicare physicians, providers, and suppliers billing Medicare carriers, durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs)

Provider Action Needed

This Medlearn Matters article is based on information contained in Change Request (CR) 3627, which describes new CMS procedures and specific instructions to Medicare Contractors (Medicare carriers, intermediaries, and DMERCs) for voiding, canceling, and deleting claims.

As a result of these changes, providers should note that some claims they were able to delete in the past will no longer be deleted from Medicare's systems, but will instead become denied claims.

Background

The Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) has verified instances in which Medicare claims have been voided, cancelled, or deleted by Medicare carriers, DMERCs, and FIs. Further, the Medicare contractors have not traditionally maintained an audit trail for the voided, cancelled, or deleted claims. The OIG has indicated that Medicare must maintain an audit trail for voided, cancelled, and deleted claims.

The Centers for Medicare & Medicaid Services (CMS) is therefore implementing requirements for Medicare contractors (carriers/FIs, including DMERCs and Regional Home Health Intermediaries (RHHIs)) to:

- Deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons;
- Cancel, void, or delete claims that are unprocessable for acceptable reasons;
- Return as unprocessable claims that meet conditions mentioned below for the return of unprocessable claims; and
- Maintain an audit trail for all cancelled, voided, or deleted claims that Medicare systems have processed far enough to have assigned a claim control number (CCN) or document control number (DCN).

Note: CR3627 requires that Medicare carriers, intermediaries, and DMERCs keep an audit trail on these claims once a CCN or DCN has been assigned to the claim.

Acceptable Claims Deletions

Below is a list of acceptable reasons a Medicare contractor may cancel, delete, or void a claim:

1. The current CMS 1500 form or the current CMS 1450 form is not used.
2. The front and back of the CMS 1500 (12/90) claim form are required on the same sheet and are not (claims submitted to carriers only).
3. A breakdown of charges is not provided, i.e., an itemized receipt is missing.
4. Only six line items have been submitted on each CMS 1500 claim form (Part B only).
5. The patient's address is missing.
6. An internal clerical error was made.
7. The certificate of medical necessity (CMN) was not with the claim (Part B only).
8. The CMN form is incomplete or invalid (Part B only).
9. The name of the store is not on the receipt that includes the price of the item (Part B only).

Note: The Medicare contractor must keep an audit trail for all claims in the above

"Acceptable Claims Deletions" category if a CCN or a DCN was assigned to the claim.

Unacceptable Claims Deletions

The following are unacceptable reasons for Medicare contractors to void, cancel, or delete claims:

1. A provider notifies the Medicare contractor that claim(s) were billed in error and requests the claim be deleted (carrier claims only).
2. The provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (type of bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review. (FI claims only)
3. The patient's name does not match any Health Insurance Claim Number (HICN).
4. A claim meets the criteria to be returned as unprocessable under the incomplete or invalid claims instructions in the *Medicare Claims Processing Manual*, Chapter 1, Section 80.3.2.ff, which is available at *http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp* on the CMS website. Medicare contractors must deny or reject claims in the above "Unacceptable Claims Deletions" category.

Return as Unprocessable Claims

Medicare contractors may return a claim as unprocessable for the following reasons:

1. Valid procedure codes were not used and/or services are not described (e.g., block 24D of the CMS 1500) (Part B only).
2. The patient's HICN is missing, incomplete, or invalid (e.g., block 1A of the CMS 1500).
3. The provider number is missing or incomplete.
4. No services are identified on the claim.
5. Block 11 (insured policy group or FECA Number) of the CMS 1500 is not completed to indicate whether an insurer primary to Medicare exists (Part B only).
6. The beneficiary's signature information is missing (Part B only).
7. The ordering physician's name and/or UPIN is missing/invalid (blocks 17 and 17A of the CMS 1500).
8. The place of service code is missing or invalid (block 24B of the CMS 1500 – Part B only).
9. A charge for each listed service is missing (e.g., block 24F of the CMS 1500).
10. The days or units are missing (e.g., block 24G of the CMS 1500).
11. The signature is missing from block 31 of the CMS 1500 (Part B only).
12. Dates of service are missing or incomplete (block 24A of the CMS 1500).
13. A valid HICN is on the claim, but the patient's name does not match the name of the person assigned that HICN.

Summary

In summary, CMS believes the following:

- The problems listed under the "Acceptable Claims Deletions" heading are valid reasons to void/delete/cancel a claim if the Medicare contractor maintains an audit trail; and
- Claims with problems listed under the "Unacceptable Claims Deletions" heading should be denied or rejected by Medicare, and the decision to deny/reject the claim should be recorded in the Medicare contractor's claims processing system history file.

If a Medicare contractor determines that a claim is unprocessable before the claim enters that contractor's claims processing system (i.e., the claim processing system **did not assign a CCN or DCN** to the claim):

- The claim may be denied; and
- The contractor does not have to keep a record of the claim or the deletion.

If a Medicare contractor determines that a claim is unprocessable after the claim enters their claims processing system (i.e., the claim processing system **did assign a CCN or DCN** to the claim):

- The denied or rejected claim will not be totally deleted from Medicare's claims processing system. The Medicare contractor must maintain an audit trail for all deleted claims that have entered the claims processing system (i.e., the system assigned a CCN or DCN to the claim).

Implementation

The implementation date for the instruction is October 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR3627 in the CR NUM column on the right, and click on the file for that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3627 Medlearn Matters Number: MM3627
Related CR Release Date: June 17, 2005 Related CR Transmittal #: 159
Effective Date: October 1, 2005 Implementation Date: October 3, 2005

Medicare Guide to Rural Health Services Now Available

The Division of Provider Information Planning & Development at the Centers for Medicare & Medicaid Services (CMS) recently developed the "*Medicare Guide to Rural Health Services Information for Providers, Suppliers and Physicians*" which offers rural health information and resources in a single source. The guide is available to download on the CMS website at *http://www.cms.hhs.gov/medlearn/MedRuralGuide.pdf*.

Print and CD-ROM versions of the guide will be available on the CMS website in late November free of charge from the Medicare Learning Network's Web page at *http://www.cms.hhs.gov/medlearn/default.asp?link=products*.

Source: Provider Education Resources Listserv, Message 200510-03

Services Not Provided Within the United States

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians and providers billing Medicare carriers and intermediaries

Provider Action Needed

STOP – Impact to You

Physicians, providers, and suppliers should note that this article is based on information contained in Change Request (CR) 3781, which informs Medicare carriers and Fiscal Intermediaries (FIs) to permit payment to be made to a foreign hospital for emergency inpatient services in certain circumstances.

CAUTION – What You Need to Know

CR3781 instructs Medicare carriers and FIs to permit payment to be made to a foreign hospital for emergency inpatient services provided to a beneficiary where 1) the beneficiary was present in the United States at the time the emergency occurred which necessitated the inpatient hospital services, and 2) the hospital outside the U.S. that provided the emergency inpatient services was closer to the place where the emergency arose (or substantially more accessible) than the nearest adequately equipped hospital within the United States.

GO – What You Need to Do

Please see the *Background* and *Additional Information* sections of this instruction for further details.

Background

Although the typical exceptions to Medicare's "foreign exclusion" involve services that are furnished in Canada and Mexico, it is possible for Medicare to make payment to foreign hospitals besides those located in Canada and Mexico.

For example, if an emergency necessitated that inpatient hospital services be furnished to a Medicare beneficiary who is living in Guam and the nearest adequately equipped hospital to treat that beneficiary was located in the Philippines, Medicare payment would not be prohibited under Medicare's "foreign exclusion" because Medicare payment may be permitted for the services under the Social Security Act (Section 1814(f); 42 U.S.C. 1395f(f)) in such instances.

Therefore, CR3781 directs Medicare carriers and FIs to permit payment to be made to a foreign hospital for emergency inpatient services provided to a beneficiary where:

- The beneficiary was present in the United States at the time the emergency occurred that necessitated the inpatient hospital services; and
- The hospital outside the United States that provided the emergency inpatient services was closer to the place where the emergency arose (or substantially more accessible) than the nearest adequately equipped hospital within the United States.

Definition of "United States"

For purposes of the Social Security Act (Section 1814(f)), the term "United States" means:

- The 50 States;
- The District of Columbia;
- The Commonwealth of Puerto Rico;
- The Virgin Islands;
- Guam;
- American Samoa;
- The Northern Mariana Islands; and
- The territorial waters adjoining the land areas of the United States (for purposes of services rendered on board a ship).

Implementation

The implementation date for the instruction is November 17, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website.

From that Web page, look for CR3781 in the CR NUM column on the right, and click on the file(s) for that CR. You will note two CRs with 3781, one with a transmittal number of 38 (*Medicare Benefit Policy Manual* changes) and the other with a transmittal number of 654 *(Medicare Claims Processing Manual* changes).

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Related Change Request (CR) #: 3781
Related CR Release Date: August 19, 2005
Effective Date: November 17, 2005
Medlearn Matters Number: MM3781
Related CR Transmittal #: 38 and 654
Implementation Date: November 17, 2005

Modification to the Online Medicare Secondary Payer Questionnaire—Full Replacement of Change Request 3504

The Centers for Medicare & Medicaid Services (CMS) has rescinded change request (CR) 3504, which was to have made several changes to the "Medicare Secondary Payer Questionnaire." However, only one of the changes was specifically mentioned in CR 3504. In addition, none of the changes were incorporated in the CMS Internet Only Manual (IOM). CR 4098 will identify all *changes* that were made as part of CR 3504 and will make additional changes to the model questionnaire. These additional changes will assist providers in identifying other payers that may be primary to Medicare. Instruction related to CR 3504 were published in the Second Quarter 2005 *Medicare A Bulletin* (pages 18-21)

Modification to Online Medicare Secondary Payer Questionnaire may be found on the CMS Internet Only Manual, Pub. 100-05, Medicare Secondary Payer, Chapter 3 – MSP Provider, Physician, and Other Supplier Billing Requirements, Section 20.2.1. – Admission Questions to Ask Medicare Beneficiaries.

Implementation Date

The effective and implementation date for this modification is for services provider January 21, 2006.

Admission Questions to Ask Medicare Beneficiaries

The following *questionnaire contains* lists questions *that can be used* to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers *may use this* as a guide to help identify other payers that may be primary to Medicare. *This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.*

Part I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: *MM/DD/CCYY*

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

___ No.

2. Are the services to be paid by a government program such as a research grant?

___ Yes; Government Program will pay primary benefits for these services

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

___ Yes.

DVA IS PRIMARY FOR THESE SERVICES.

___ No.

4. Was the illness/injury due to a work related accident/condition?

___ Yes; Date of injury/illness: *MM/DD/CCYY*

Name and address of WC plan:

_____

Modification to the Online Medicare Secondary Payer Questionnaire, continued

Policy or identification number: _____
Name and address of your employer:
_____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.

___ No. **GO TO PART II.**

Part II

1. Was illness/injury due to a non-work related accident?
___ Yes; Date of accident: MM/DD/CCYY
___ No. **GO TO PART III**

2. What type of accident caused the illness/injury?
___ Automobile.
___ Non-automobile.

Name and address of no-fault or liability insurer:
_____
_____
_____
Insurance claim number: _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ Other

3. Was another party responsible for this accident?
___ Yes;

Name and address of any liability insurer:
_____
_____
_____
Insurance claim number: _____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ No. **GO TO PART III**

Part III

1. Are you entitled to Medicare based on:
___ Age. **Go to Part IV.**
___ Disability. **Go to Part V.**
___ ESRD. **Go to Part VI.**

Part IV – Age

1. Are you currently employed?
___ Yes.

Name and address of your employer:
_____
_____
_____
___ No. Date of retirement: *MM/DD/CCYY*
___ *No. Never Employed*

2. Is your spouse currently employed?
___ Yes.

Name and address of spouse's employer:
_____
_____
_____
___ No. Date of retirement: *MM/DD/CCYY*
___ *No. Never Employed*

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?
___ Yes.
___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN**

Modification to the Online Medicare Secondary Payer Questionnaire, continued

PART I OR II.

4. Does the employer that sponsors your GHP employ 20 or more employees?
___ Yes. **STOP. *GHP* IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____
_____
_____

Policy identification number *(this number is sometimes referred to as the health insurance benefit package number)*:

_____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient):

_____

Name of policyholder/*namedinsured*: _____
Relationship to patient: _____
___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Part V – Disability

1. Are you currently employed?
___ Yes.

Name and address of your employer:

_____
_____
_____

___ No. Date of retirement: *MM/DD/CCYY*
___ *No. Never employed.*

2. *If married, is your spouse* currently employed?
___Yes.

Name and address of your employer:

_____
_____
_____

___ *No. Date of retirement: MM/DD/CCYY*
___ *No. Never employed.*

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?
___ Yes.
___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART I OR II.**

4. Are you covered under the group health plan of a family member other than your spouse?
___ *Yes*

Name and address of your family member's employer:

_____
_____
_____

___ *No*

5. Does the employer that sponsors your GHP employ 100 or more employees?
___Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____
_____
_____

Policy identification number *(this number is sometimes referred to as the health insurance benefit package number)*:

_____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Modification to the Online Medicare Secondary Payer Questionnaire, continued

Name of policyholder/*named insured*: _____
Relationship to patient: _____
___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

*If yes, n*ame and address of GHP:

_____
_____
_____

Policy identification number *(this number is sometimes referred to as the health insurance benefit package number)*:

_____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient):

_____

Name of policyholder/*named insured*: _____
Relationship to patient: _____
Name and address of employer, if any, from which you receive GHP coverage:

_____
_____
_____

___ No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

___ Yes. Date of transplant: *MM/DD/CCYY*
___ No.

3. Have you received maintenance dialysis treatments?

___ Yes. Date dialysis began: MM/DD/CCYY

If you participated in a self-dialysis training program, provide date training started:
MM/DD/CCYY

___ No

4. Are you within the 30-month coordination period *that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)*

___ Yes
___ No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ Yes.
___ No. **STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

6. *Was your initial entitlement to Medicare (including simultaneous entitlement or dual entitlement) based on ESRD?*

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
___ No. **INITIAL ENTITLEMENT BASED ONAGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement?

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
___ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in *the Common Working File* (CWF) for the beneficiary, the provider still asks the *types of* questions *above* and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

Source: CMS Pub. 100-5, Transmittal 41 CR 4098 PCM #0529701

CONNECTICUT MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies/coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local medical review policies (LMRPs)/local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LMRPs are provided instead. Providers may obtain full-text LMRPs/LCDs on our provider education website, *http://www.connecticutmedicare.com*. Final LMRPs/LCDs, draft LMRPs/LCDs available for comment, LMRP/LCD statuses, and LMRP/LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs/LCDs; the date the LMRP/LCD is posted to the website is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new LMRPs/LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *http://www.connecticutmedicare.com* , click on the "eNews" link on the navigational menu and follow the prompts.

More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LMRP/LCD, contact Medical Policy at:

Attention: Medical Policy
First Coast Service Options, Inc.
P.O. Box 9000
Meriden, CT 06450-9000

Phone: 1-866-419-9455

Medical Review Table of Contents

Advance Notice Statement

Advance beneficiary notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

NEW LCDS

0067T: Computed Tomographic Colonography – New Policy

Computed tomographic colonography (CT colonography) also known as virtual colonoscopy utilizes helical computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2-D or 3-D reconstruction. The test requires colonic preparation similar to that required for standard colonoscopy (instrument colonoscopy), and air insufflation to achieve colonic distention. CT colonography has desirable features for a screening test. It does not require sedation. It is minimally invasive, rarely has complications and less expensive than conventional colonoscopy. Diagnosis and staging of colon cancer can be accomplished in one examination and detection of extracolonic abnormalities can be observed. However, gas insufflation of the intestine, which may be uncomfortable to the patient, is required and interpretation of the images is described as difficult and time consuming. When polyps are detected with CT colonography, patients could presumably undergo subsequent endoscopic colonography, which may require another bowel preparation. CT colonography is not endorsed for screening by the American Cancer Society, the U.S. Preventive Services Task Force, or any professional body and is non-covered by the Centers for Medicare and Medicaid Services (CMS).

Medicare will consider CT colonography medically reasonable and necessary for failure of conventional colonoscopy due to the inability to pass the colonoscope proximally. CT colonography will not be covered when used for routine screening.

This local coverage determination (LCD) is being developed to identify indications and limitations of medical necessity for coverage and documentation requirements.

This LCD is effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

17304: Mohs Micrographic Surgery – New Policy

Mohs Micrographic Surgery (MMS) is a precise tissue-sparing surgical technique used in the removal and treatment of selected malignant neoplasms of the skin. This surgery requires a single surgeon to act in two distinct roles as surgeon and pathologist. MMS is the removal of the tumor followed by marking of margins, immediate frozen section histopathologic examination of margins with subsequent re-excision of tumor-positive areas, and final closure of the defect.

A referral was received from the Program Safeguards Contractor (PSC) to develop a local coverage determination (LCD) for Mohs surgery. PSC data analysis identified potential program savings based on the utilization parameters defined by First Coast Service Options (FCSO) in the Florida local medical review policy (LMRP). Therefore, based on this referral, an LCD has been developed to define indications and limitations of coverage and coding guidelines for Mohs Surgery (*17304*).

This LCD is effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

92548: Computerized Dynamic Posturography – New Policy

Computerized dynamic posturography (CDP) is a means of assessing a patient's ability to use vestibular system information. The equipment for dynamic posturography consists of a moveable platform surrounded by a moveable screen that is computer-controlled. Both can move separately or simultaneously. CDP includes three protocols: 1). The Sensory Organization Test (SOT) assesses the patient's ability to balance using visual, vestibular, and proprioceptive information and to appropriately suppress disruptive visual and/or proprioceptive information under sensory conflict conditions. 2). The Motor Control Test (MCT) measures the ability to reflexively recover from unexpected external provocations. 3). Adaptation Test (ADT) measures the ability to modify automatic reactions when the support surface is irregular or unstable.

Posturographic methods that do not satisfy the American Academy of Otolaryngology-Head and Neck Surgery (AA)-HNS and the American Academy of Neurology (ANN) criteria cannot be considered equivalent to those that do comply with the AAO-HNS and AAN guidelines.

Computerized Dynamic Posturography (*92548*) is currently locally non-covered and is in the List of Noncovered Services LCD. A reconsideration request was received for evaluation of coverage. It was determined to develop a combined FL/CT LCD to define the indications and limitations of coverage and to remove from the Noncovered Services LCD.

This LCD was developed to define the indications and limitations of coverage and define ICD-9-CM codes that Support Medical Necessity and Documentation Requirements. . The ICD-9-CM codes include: 334.0-334.9, 386.00-386.9, 438.84, 438.85, 719.7, 780.4, 781.2, 781.3, 850.11, 850.12, 850.2, 850.3, 850.4, 850.5, 850.9, and 951.5.

This LCD is effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

J0128: Abarelix for the Treatment of Prostate Cancer – New Policy

Abarelix also called Plenaxis™ is a drug used to reduce the amount of testosterone made in patients with advanced symptomatic prostate cancer for which no other treatment options are available. It belongs to the family of drugs called gonadotropin-releasing hormone (GnRH) antagonists. Abarelix has received FDA approval for palliative treatment of men with advanced symptomatic prostate cancer, in whom GnRH agonist therapy is not appropriate and who refuse surgical castration, and have one or more of the following: (1) risk of neurological compromise due to metastases, (2) ureteral or bladder outlet obstruction due to local encroachment or metastatic disease, or (3) severe bone pain from skeletal metastases persisting on narcotic analgesia.

Effective March 15, 2005, the Centers for Medicare & Medicaid Services (CMS) has extended national coverage for the use of abarelix/(Plenaxis™) as a palliative treatment in patients with advanced symptomatic prostrate cancer.

This local coverage determination (LCD) is being developed to identify the ICD-9-CM code to be used by providers when billing abarelix. Providers should use ICD-9-CM code 185 – malignant neoplasm of the prostate when billing abarelix. The entire text of coverage guidelines is located in the Medicare National Coverage Determinations Manual, Chapter 1, Part 2, Section 110.19.

This LCD is effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

J2324: Draft LCD for Nesiritide (Natrecor®) Infusion for Chronic Congestive Heart Failure Not Finalized – New Policy Draft

Local coverage determination (LCD) draft for J2324, Nesiritide (Natrecor®) Infusion for Chronic Congestive Heart Failure, was developed for Medicare and presented to the Connecticut Carrier Advisory Committee on June 14, 2005. This LCD outlined entrance criteria for intravenous infusion of Nesiritide for the treatment of patients diagnosed with acutely decompensated congestive heart failure in the outpatient setting.

Due to controversy about the safety of giving Nesiritide (Natrecor®) Infusion for Chronic Congestive Heart Failure in this setting, and the fact that a request for a National Coverage Determination has been submitted to the Centers for Medicare & Medicaid Services (CMS) and is under consideration, First Coast Service Options, Inc. (FCSO) has elected not to finalize this policy. In addition, information was published from a panel of cardiology experts with recommendations to the manufacturer of this drug that its' use should be strictly limited to patients presenting to the hospital with acutely decompensated congestive heart failure.

J9041: Bortezomib (Velcade®) – New Policy

Bortezomib (Velcade®) is an antineoplastic agent which inhibits the activity of the 26S proteasome. It exhibits cytotoxicity to various malignant cells, including myeloma and lymphoma cells. Bortezomib is given by intravenous injection.

Based on documentation submitted to the Antineoplastic Drugs Workgroup meeting, a decision was made to develop a local coverage determination (LCD) to include indications and limitations of coverage, and ICD-9-CM codes that support medical necessity.

The following FDA approved indication is covered:

- Treatment of multiple myeloma patients who have received at least one prior therapy.

The following off-labeled indications are covered:

- Treatment of relapsed or refactory B-Cell Non-Hodgkin's lymphoma specifically; mantle-cell lymphoma (MCL) and follicular lymphoma (FL).

The following ICD-9-CM codes are covered:

202.00 – 202.08	Nodular lymphoma
202.80 – 202.88	Other lymphomas
203.00	Multiple myeloma without mention of remission

This LCD was presented to the Carriers Advisory Committee June 14, 2005. It will be effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

Macugen® (pegaptanib sodium injection) – New Policy

Age-related macular degeneration (AMD) is the leading cause of irreversible severe vision loss in Americans over 55 years of age. While the non-neovascular or dry form of the disease is more prevalent, neovascular or wet AMD is responsible for the majority of cases of vision loss. Neovascular (wet) AMD is characterized by choroidal neovascularization (CNV) beneath the retina. The neovascular tissue often leaks blood and fluid, and, when untreated, eventually progresses to scarring with destruction of the macula and loss of vision.

Macugen ® (pegaptanib sodium injection) is an FDA-approved, treatment for neovascular (wet) age-related macular degeneration. Macugen ® is a sterile, aqueous solution, containing pegaptanib sodium, which is an aptamer consisting of a covalent conjugate of twenty-eight modified oligonucleotides. Pegylation has been added to increase the half-life of pegaptanib sodium in the vitreous.

Pegaptanib sodium binds selectively and with high affinity to extracellular VEGF165, the pathogenic VEGF isoform most directly linked to the pathogenesis of neovascular (wet) age-related macular degeneration (AMD). Pegaptanib sodium inhibits VEGF165 binding to its cognate receptors.

The intended dose and regimen for Macugen® is 0.3 mg administered once every six weeks by aseptic intravitreal injection into the eye to be treated.

Macugen® is billed using HCPCS code J3490 (unclassified drugs) Macugen (pegaptanib sodium injection) and CPT Code 67028 Intravitreal injection of a pharmacologic agent (separate procedure). This LCD has been developed to provide indications and limitations of coverage and/or medical necessity and documentation requirements for this therapy. An LCD attachment provides coding guidelines as well.

While this LCD is effective for services rendered on or after January 1, 2006, Medicare will consider Macugen® (pegaptanib sodium injection) medically reasonable and necessary for the treatment of neovascular (wet) AMD for services rendered on or after the FDA-approval date of December 17, 2004.

The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

REVISIONS TO LMRPS/LCDS

11055: Routine Foot Care – Policy Revision

This local coverage determination (LCD) was last revised on May 12, 2005. For the allowed indication of peripheral neuropathies involving the feet associated with traumatic injury, the following range of diagnosis codes was added under "ICD-9 Codes that Support Medical Necessity" and under "The following diagnoses related to peripheral neuropathy do not require a Q modifier" to include the addition of 952.00 – 952.19 and 952.9. The diagnosis range is now listed in the LCD as follows:

952.00 – 952.9 (Spinal cord injury without evidence of spinal bone injury)

Also, for clarification, ICD-9-CM code 286.9 (Other and unspecified coagulation defects (Use for Long-term (current) use of anticoagulants) is listed under "The following diagnosis related to anticoagulation therapy does not require a Q modifier". This would not include aspirin therapy. The indication for anticoagulation therapy would be for patients currently on long-term use of Warfarin/Coumadin.

This revision is effective for services rendered on or after September 6, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

20974: Osteogenic Stimulation – Policy Revision

The local medical review policy (LMRP) for osteogenic stimulation was last revised January 5, 2004. Change request 3836, dated June 24, 2005 expanded coverage of ultrasonic osteogenic stimulation for nonunion fracture healing to prior to surgery. Additional revisions to this policy unrelated to CR 3836 include the identification of V45.4 as a secondary diagnosis code. Furthermore, the LMRP has been converted to a local coverage determination (LCD).

This revision is effective for services rendered on or after April 27, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

72192: Computed Tomography of the Pelvis – Policy Revision

The local coverage determination (LCD) for Computed Tomography (CT) of the Pelvis (*72192*) was last revised on January 1, 2005. Since that time, it was determined ICD-9-CM codes 593.9 (unspecified disorder of kidney and ureter) and 752.41 (embryonic cyst of cervix, vagina, and external female genitalia) should be added to the policy.

The LCD changes are effective for services rendered on or after October 1, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

72192: Computed Tomography of the Pelvis – Policy Revision

The local coverage determination (LCD) for Computed Tomography (CT) of the Pelvis (*72192*) was last revised on October 1, 2005. This is a Florida and Connecticut combined policy. Since that time, it was determined Florida and Connecticut require individual policies. Therefore the Florida content has been removed from this combined policy.

The policy changes are effective for services rendered on or after January 1, 2006. The full text of the LCD may be viewed on the provider education website *http://connecticutmedicare.com* when it becomes available.

76514: Ocular Corneal Pachymetry – Policy Revision

The local medical review policy (LMRP) for ocular corneal pachymetry was last revised on January 1, 2005. Since that time, it has come to our attention that clarification is necessary regarding the utilization of this procedure.

Therefore, the purpose of the LMRP revision is to clarifying frequency guidelines for ocular corneal pachymetry when used to measure the corneal thickness following the diagnosis of increased intraocular pressure. Under the "Indications and Limitations of Coverage" and the "Utilization Guidelines" sections of the policy, verbiage has been added to emphasize that ocular corneal pachymetry, when measuring corneal thickness following the diagnosis of increased intraocular pressure, is a once in a lifetime benefit. In addition, the LMRP has also been converted to the local coverage determination (LCD) format.

This LCD revision is effective for claims processed on or after October 24, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

77301: Intensity Modulated Radiation Therapy – Policy Revision

The local medical review policy (LMRP) for intensity modulated radiation therapy (IMRT) was previously revised on January 1, 2005. Since that time, the policy was revised to include CPT Category III code *0073T* (Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session). In addition, the indications for coverage have been updated and all ICD-9-CM codes were removed from the policy. The policy has been updated to the new local coverage determination (LCD) format.

This revision is effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

97001: Physical Medicine and Rehabilitation Services – Policy Revision

The local coverage determination (LCD) for Physical Medicine and Rehabilitation – 97001 was last updated on February 11, 2004. Since that time, the following changes have been made. The guidelines for evaluation, treatment plans, and certification requirements have been updated, per Change Request 3648. National language has been identified with italics. Procedure code *97010* (hot or cold packs) has been moved to the coding guideline attachment with coverage guidelines. Procedure codes *97545-97546* (work hardening/conditioning) have been removed from the LCD, as these codes are non-covered. Procedure codes *97750* (physical performance test or measurement) and *97755* (assistive technology assessment) have been added to the coding guideline attachment as "codes that always represent therapy codes," (per change request 3647). In addition, coding guidelines have been added to the coding guideline attachment for manual muscle testing and range of motion services (codes *95831-95834*).

This revision is effective for services rendered on or after June 6, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

97802: Medical Nutrition Therapy – Policy Revision

The local coverage determination for Medical Nutrition Therapy (MNT) *97802* was last revised on March 8, 2005. Change request 3955, transmittal 650, dated August 12, 2005 changed the definition for diabetes mellitus based on the 2003 Medicare Physician Fee Schedule Regulation. Therefore, the LCD has been revised to reflect a change to the definition of diabetes mellitus.

The revision of this LCD is effective for services rendered on or after January 1, 2004. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

J2430: Pamidronate (Aredia®) – Policy Revision

This local coverage determination (LCD) was last updated on July 6, 2004. Since then, the LCD has been revised in the following sections:

- CMS National Coverage Policy – References updated
- Sources of Information and Basis for Decision – References updated
- Documentation Requirements – Verbiage added to include "nonphysician practitioner"
- Coverage Topic – Chemotherapy Inpatient & Outpatient was changed to Prescription Drugs

The effective date of this revision is for claims processed on or after October 11, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

J9000: Antineoplastic Drugs – Policy Revision

This local coverage determination (LCD) for Antineoplastic Drugs was last updated on June 20, 2005. A revision to this LCD was made that included updating references under "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections. The following revisions were made to the drugs listed below:

Gemcitabine (J9201) - Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, added "Intrahepatic bile duct(s) carcinoma" to the off-label indications. Under the "ICD-9 Codes that Support Medical Necessity" section, added code 155.1 (Intrahepatic bile ducts).

Irinotecan (J9206) - Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, added "Carcinoma of small intestine" to the off-label indications. Under the "ICD-9 Codes that Support Medical Necessity" section, added code range 152.0-152.9 (Malignant neoplasm of small intestine, including duodenum).

Oxaliplatin (J9263) - Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, removed off-labeled indication statement "oxaliplatin may be used alone or in combination with other chemotherapeutic drugs." Added "or small intestine" to off-labeled indication of first line treatment for colon cancer for this drug. In addition, under the "ICD-9 Codes that Support Medical Necessity" section, added code range 152.0-152.9 (Malignant neoplasm of small intestine, including duodenum).

Trastuzumab (J9355) - Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, added the following off-label indications for non-metastatic breast cancer:

For non-metastatic breast cancer, trastuzumab may be considered medically reasonable and necessary when incorporated into the adjuvant therapy in any of the following situations:

- In patients with breast cancer who over-express HER-2 (IHC 3+ or FISH amplified at the level of 2.1 or greater) and positive axillary lymph node(s).
- In patients with lymph node negative tumors greater than or equal to 1 cm and smaller than or equal to 2 cm who over-express HER-2 and are estrogen receptor negative.
- In patients with lymph node negative tumors greater than or equal to 2 cm who over-express HER-2 and are estrogen receptor positive.

The timing of therapy, combination with other agents or regimen, dosage, and duration of therapy should be based on NCCN guidelines and the package insert.

Under the "ICD-9 Codes that Support Medical Necessity" section, removed "Note" at the bottom of this section concerning dual diagnoses because dual diagnoses are no longer required for trastuzumab.

In addition to the above revisions, under the "Other Comments" of the Coding Guidelines, the following statement concerning discarded drugs and biologicals from the CMS Manuals, Pub. 100-4, Chapter 17, Section 40 was added:

> *CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded alone with the amount administered.*

Note: *The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drug.*

Revisions for procedure codes J9201, J9206, and J9236 are effective for services rendered on or after October 10, 2005. The revision for procedure code J9355 is effective for services rendered on or after October 11, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

NCSVCS: The List of Medicare Noncovered Services – Policy Revision

The local coverage determination (LCD) for the list of Medicare noncovered services - NCSVCS was previously revised on January 28, 2005. Since that time, all procedure codes were removed that have national coverage guidelines or are bundled into another service. This revision is effective for services rendered on or after October 6, 2005.

In addition, an LCD has been developed for Computerized Dynamic Posturography (*92548*). Therefore, procedure code *92548* is being removed from the local noncovered services section of the noncovered services LCD. This revision is effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

Q9941: Intravenous Immune Globulin – Policy Revision

This local coverage determination (LCD) was last updated April 1, 2005. A revision to this LCD was made to the indications and limitation section for Immunodeficiency Disorders—*Primary Humoral Immunodeficiency Syndromes.* A request was received to add an exception to the functional antibody testing requirements, found in this section, for patients whose diagnosis was established prior to this technology being in place. After review, this exception was added to the LCD.

This revision will be effective for claims processed on or after August 30, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

SKINSUB: Skin Substitutes – Policy Revision

The coding guideline for skin substitutes - SKINSUB was previously revised on January 1, 2005. Since that time, clarification regarding the use of modifier-58 when used for the application of a skin substitute per FDA approved indications. In addition, clarified information on the use of codes *15000* and *15001* with codes *15342* and *15343*. Initial preparation of the wound for skin grafting (codes *15100-15400*), may be billed on the initial day of service. Documentation must support both procedures were performed.

This revision is effective for services rendered on or after August 30, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

2006 ICD-9-CM Coding Changes

The 2006 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2005. Updated diagnosis codes must be used for all services billed on or after October 1, 2005. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued. Connecticut Medicare has reviewed all local medical review policies (LMRP)/local coverage determinations (LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2006 ICD-9-CM update. The table on the following pages lists the LCDs affected, the publication in which diagnosis criteria appeared, and the specific conditions revised as a result of the 2006 ICD-9-CM update:

LMRP/LCD Title	2006 Changes
11055 Routine Foot Care	Add 585.1-585.9 (Chronic kidney disease) for procedure codes *11055*, *11056*, *11057*, *11719*, *11720*, *11721*, and G0127.
20974 Osteogenic Stimulation	Add 996.44 (Peri-prosthetic fracture around prosthetic joint) for procedure codes *20974* and *20975*.
31525 Diagnostic Laryngoscopy	Change descriptor for 780.51 (Insomnia with sleep apnea, unspecified) and 780.53 (Hypersomnia with sleep apnea, unspecified) for procedure codes *31525* and *31575*.
51798 Post-Voiding Residual Ultrasound	Add 599.60-599.69 (Urinary obstruction) for procedure code *51798*.
70544 Magnetic Resonance Angiography (MRA)	Change descriptor for 403.00-403.91 (Hypertensive kidney disease) and 404.00-404.93 (Hypertensive heart and kidney disease) for procedure code *74185*. Add 443.82 (Erythromelalgia) for procedure code *73725*.
72192 Computed Tomography of the Pelvis	Add 567.21 (Peritonitis (acute) generalized), 567.22 (Peritoneal abscess), 567.23 (Spontaneous bacterial peritonitis), 567.29 (Other suppurative peritonitis), 567.31 (Psoas muscle abscess), 567.38 (Other retroperitoneal abscess), 567.39 (Other retroperitoneal infections), 599.60 (Urinary obstruction, unspecified), and 599.69 (Urinary obstruction, not elsewhere classified) for procedure codes *72192*, *72193*, and *72194*.
81000 Urinalysis	Add 585.1-585.9 (Chronic kidney disease), V13.02 (Urinary (tract) infection), and V13.03 (Nephrotic syndrome) for procedure codes *81000*, *81001*, *81002*, *81003*, *81005*, *81007*, and *81015*.
82232 Beta 2 Microglobulin	Add 585.1-585.9 (Chronic kidney disease) for procedure code *82232*.
82330 Ionized Calcium	Add 585.1-585.9 (Chronic kidney disease) and 276.50-276.52 (Volume depletion) for procedure code *82330*.
83735 Serum Magnesium	Add 276.50-276.52 (Volume depletion), 585.1-585.9 (Chronic kidney disease), and V58.11 (Encounter for antineoplastic chemotherapy) for procedure code *83735*.

2006 ICD-9-CM Coding Changes, continued

LMRP/LCD Title	2006 Changes
83880 B-Type Natriuretic Peptide (BNP)	Change descriptor for 404.01 (Hypertensive heart and kidney disease, malignant, with heart failure), 404.03 (Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease), 404.11 (Hypertensive heart and kidney disease, benign, with heart failure), 404.13 (Hypertensive heart and kidney disease, benign, with heart failure and chronic kidney disease), 404.91 (Hypertensive heart and kidney disease, unspecified, with heart failure), and 404.93 (Hypertensive heart and kidney disease, unspecified, with heart failure and chronic kidney disease) for procedure code *83880*.
84155 Serum Protein	Add 276.50-276.52 (Volume depletion), 287.30-287.39 (Primary thrombocytopenia), and 585.1-585.9 (Chronic kidney disease) for procedure code *84155*.
88182 Flow Cytometry and Morphometric Analysis	Add 287.30-287.39 (Primary thrombocytopenia) for procedure codes *88184*, *88185*, *88187*, *88188*, and *88189*.
90901 Biofeedback	Change descriptor for 728.87 (Muscle weakness [generalized]) for procedure code *90901*.
92135 Scanning Computerized Ophthalmic Diagnostic Imaging	Add 362.03 (Nonproliferative diabetic retinopathy NOS), 362.04 (Mild nonproliferative diabetic retinopathy), 362.05 (Moderate nonproliferative diabetic retinopathy), 362.06 (Severe nonproliferative diabetic retinopathy), and 362.07 (Diabetic macular edema) for procedure code *92135*. Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, or 362.06) for procedure code *92135*.
92225 Ophthalmoscopy	Add 362.07 (Diabetic macular edema) for procedure codes *92225* and *92226*. Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01 or 362.02) for procedure codes *92225* and *92226*.
92235 Fluorescein Angiography	Add 362.03 (Nonproliferative diabetic retinopathy NOS), 362.04 (Mild nonproliferative diabetic retinopathy), 362.05 (Moderate nonproliferative diabetic retinopathy), 362.06 (Severe nonproliferative diabetic retinopathy), and 362.07 (Diabetic macular edema) for procedure code *92235*. Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, or 362.06) for procedure code *92235*.
92250 Fundus Photography	Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, or 362.06) for procedure code *92250*.
93000 Electrocardiography	Add 799.01-799.02 (Asphyxia and hypoxemia) for procedure codes *93000*, *93005*, and *93010*.
93224 Electrocardiographic Monitoring for 24 hours (Holter Monitoring)	Add 426.82 (Long QT syndrome) for procedure codes *93230*, *93231*, *93232*, and *93233*.

2006 ICD-9-CM Coding Changes, continued

LMRP/LCD Title	2006 Changes
93701 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance	Change descriptor for 403.00-403.01 (Malignant hypertensive kidney disease), 403.11 (Benign hypertensive kidney disease with chronic kidney disease), 403.91 (Unspecified hypertensive kidney disease with chronic kidney disease), 404.00-404.03 (Malignant hypertensive heart and kidney disease), 404.11 (Benign hypertensive heart and kidney disease with heart failure), 404.12 (Benign hypertensive heart and kidney disease, with chronic kidney disease), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.91 (Unspecified hypertensive heart and kidney disease with heart failure), 404.92 (Unspecified hypertensive heart and kidney disease, with chronic kidney disease), and 404.93 (Unspecified hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for procedure code *93701*.
94010 Spirometry	Change descriptor for 780.51 (Insomnia with sleep apnea, unspecified), 780.53 (Hypersomnia with sleep apnea, unspecified), and 780.57 (Unspecified sleep apnea) for procedure codes *94010*, *94060*, *94070*, *94240*, and *94720*.
97802 Medical Nutrition Therapy (MNT)	Add 585.1-585.9 (Chronic kidney disease) for procedure codes *97802*, *97803*, *97804*, G0270, and G0271.
EPO Epoetin alfa	Change descriptor for 403.01 (Malignant hypertensive kidney disease with chronic kidney disease), 403.11 (Benign hypertensive kidney disease with chronic kidney disease), 403.91 (Unspecified hypertensive kidney disease with chronic kidney disease), 404.02 (Malignant hypertensive heart and kidney disease with chronic kidney disease), 404.03 (Malignant hypertensive heart and kidney disease with heart failure and chronic kidney disease), 404.12 (Benign hypertensive heart and kidney disease, with chronic kidney disease), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.92 (Unspecified hypertensive heart and kidney disease, with chronic kidney disease), and 404.93 (Unspecified hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for procedure codes Q0136 and Q4055. Add 585.1 (Chronic kidney disease, Stage I), 585.2 (Chronic kidney disease, Stage II [mild]), 585.3 (Chronic kidney disease, Stage III [moderate]), 585.4 (Chronic kidney disease, Stage IV[severe]) and 585.9 (Chronic kidney disease, unspecified), and V58.11 (Encounter for antineoplastic chemotherapy) for procedure code Q0136. Add 585.4 (Chronic kidney disease, Stage IV [severe]), 585.5 (Chronic kidney disease, Stage V), and 585.6 (End stage renal disease) for procedure code Q4055.
J1440 G-CSF (Filgrastim, Neupogen®)	Add V58.11 (Encounter for antineoplastic chemotherapy) for procedure codes J1440 and J1441.
J2505 Pegfilgrastim (Neulasta™)	Add V58.11 (Encounter for antineoplastic chemotherapy) for procedure code J2505.
J2792 Rho (D) Immune Globulin Intravenous	Add 287.30-287.39 (Primary thrombocytopenia) for procedure codes J2788, J2790, and J2792.
J2820 Sargramostim (GM-CSF, Leukine®)	Add V58.11 (Encounter for antineoplastic chemotherapy) for procedure code J2820.
J9000 Antineoplastic Drugs	Add 287.31 (Immune thombocytopenic purpura) and 287.32 (Evans' syndrome) for procedure code J9310.
NESP Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])	Add 585.1 (Chronic kidney disease, Stage I), 585.2 (Chronic kidney disease, Stage II [mild]), 585.3 (Chronic kidney disease, Stage III [moderate]), 585.9 (Chronic kidney disease, unspecified), and V58.11 (Encounter for antineoplastic chemotherapy) for procedure codes J0880 and Q0137. Add 585.4 (Chronic kidney disease, Stage IV [severe]), 585.5 (Chronic kidney disease, Stage V), and 585.6 (End stage renal disease) for procedure code Q4054.
Q9941 Intravenous Immune Globulin	Add 287.31 (Immune thombocytopenic purpura) and 287.32 (Evans' syndrome) for procedure codes Q9941, Q9942, Q9943, and Q9944.

RETIREMENT OF EXISTING LMRPS

70551: Magnetic Resonance Imaging (MRI) of the Brain – Policy Retired

Change request 3748, dated March 11, 2005 provided new Q codes for contrast agents. HCPCS A4643 was replaced with Q9952-Q9954. Changes to the local medical review policy were made to be in compliance with these changes **effective for services rendered on or after April 1, 2005.**

Additionally, based on data analysis and local standards of medical practice, it was determined that the need for a local medical review policy (LMRP) for this service no longer exists. Therefore, this LMRP has been retired. Providers should refer to CMS Manual Pub 100-3, Chapter 1, Section 220.2 for guidelines when rendering this service.

The effective date of retirement for this LMRP is for services rendered on or after August 9, 2005. The full-text of this LMRP is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

76090: Mammography – Policy Retired

The local medical review policy (LMRP) for mammography - *76090* was previously revised on January 1, 2004. Since that time, diagnosis code V76.11 (screening mammogram for high-risk patient) has been added to the LMRP, per Change Request 3562, effective July 1, 2005. In addition, the LMRP has been retired based on National Coverage Determination (Section 220.4) for screening mammography and based on data analysis, as well as, local practice patterns for diagnostic mammography.

This retirement is effective for services rendered on or after August 9, 2005. The full-text of this LMRP is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

90810: Interactive Individual Psychotherapy – Policy Retired

The local medical review policy (LMRP) for Interactive Individual Psychotherapy (*90810)* was last revised on February 22, 2005. Since that time, based on data analysis and local standards of medical practice, it was determined to retire the current policy. Coverage guidelines for this policy are outlined in the CMS national regulations listed below:

CMS Transmittal 98, Change Request 3457 at *http://www.cms.hhs.gov/manuals/pm_trans/R98PI.pdf*
Medicare Eligibility Manual, 100-1, Chapter 3, Sections 30-30.3 at
http://www.cms.hhs.gov/manuals/101_general/ge101c03.pdf
Medicare Claims Processing Manual, 100-4, Chapter 12, Section 210 at
http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf

The retirement of this policy is effective for services rendered on or after October 11, 2005. The full-text of this LMRP is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

90845: Medical Psychoanalysis – Policy Retired

The local medical review policy (LMRP) for Medical Psychoanalysis (*90845*) was last revised on February 22, 2005. Since that time, based on data analysis and local standards of medical practice, it was determined to retire the current policy. Coverage guidelines for this policy are outlined in the CMS national regulations listed below:

CMS Transmittal 98, Change Request 3457 at *http://www.cms.hhs.gov/manuals/pm_trans/R98PI.pdf*
Medicare Eligibility Manual, 100-1, Chapter 3, Sections 30-30.3 at
http://www.cms.hhs.gov/manuals/101_general/ge101c03.pdf
Medicare Claims Processing Manual, 100-4, Chapter 12, Section 210 at
http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf

The retirement of this policy is effective for services rendered on or after August 16, 2005. The full-text version of this LMRP may be found on the provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

92136:Optical Coherence Biometry – Policy Retired

The local medical review policy (LMRP) for Optical Coherence Biometry was last revised on January 1, 2004. Since that time, based on data analysis and standards of local medical practice, it was determined to retire the current policy.

This retirement of this policy is effective for services rendered on or after August 16, 2005. The full-text of this LMRP is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

ADDITIONAL INFORMATION ON LMRPS/LCDS

Guidelines for Independent Diagnostic Testing Facilities – Specialty Manual Revision

The Medicare Guidelines for Independent Diagnostic Testing Facilities (IDTF) Manual was last revised in April 2005. This article serves as notice that First Coast Service Options, Inc. will no longer recognize The National Certification of Ultrasound Diagnostic Technologists (NCUDT) as an approved credentialing body.

The IDTF manual will be revised accordingly and may be viewed on the provider education website *http://www.connecticutmedicare.com*.

A Review of ICD-9-CM Coding for HIV Testing

A recent claims review of CPT *87536* (HIV Quantification) denials demonstrated that many of the denials were diagnosis/medical necessity related. It was observed that many of the ICD –9 codes listed for CPT 87536 (HIV Prognosis and Monitoring) actually supported medical necessity for *HIV Testing*.

HIV Prognosis and Monitoring Codes (Quantification)

Quantification assays of HIV plasma RNA are used prognostically to assess relative risk for disease progression and predict time to death, as well as to assess efficacy of antiretroviral therapies over time. Studies indicate that HIV RNA levels can predict disease progression, assist in making decisions when to stop using an ineffective treatment and when to add or switch to a new treatment and allow patients/physicians to make treatment decision much earlier, prior to a significant loss of CD4 cells and before clinical decline occurs. CD4 cell loss is thought to be a relatively late result of increased HIV replication.

HIV quantification is achieved through the use of assays that measure the amount of circulating RNA. The tests employ nucleic acid amplification techniques to enhance sensitivity and the results are expressed as the HIV copy number.

Codes for HIV Quantification Tests

Code	Descriptor
87536	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification*
87539	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification*

HIV Diagnostic Codes

Diagnosis of Human Immunodeficiency Virus (HIV) infection is primarily made through the use of serologic assays. These assays take one of two forms: antibody detection assays and specific HIV antigen procedures. Currently, there are a total of 10 HIV diagnostic codes covered by the Medicare program for these tests. Please refer to Laboratory Nation Coverage Decision, Human Immunodeficiency Virus Diagnosis Testing (Section 190.14).

Codes for HIV Diagnostic Tests

Code	Descriptor
86689	*Qualitative or semiquantitative immunoassays performed by multiple step methods; HTLV or HIV antibody, confirmatory test (for example, Western Blot)*
86701	*Qualitative or semiquantitative immunoassays performed by multiple step methods; HIV-1*
86702	*Qualitative or semiquantitative immunoassays performed by multiple step methods; HIV-2*
86703	*Qualitative or semiquantitative immunoassays performed by multiple step methods; HIV-1 and HIV-2, single assay*
87390	*Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-1*
87391	*Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-2*
87534	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique*
87535	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique*
87537	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique*
87538	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique*

The CMS Medicare National Coverage Database website has both Laboratory National Coverage Decisions in their entirety with test specific information and a complete list of covered ICD-9 codes (updated quarterly). For Human Immunodeficiency Virus Testing (Diagnosis) see section 190.14 and for Human Immunodeficiency Virus Testing (Prognosis Including Monitoring) see section 190.13. Please refer to these documents for more detailed information.

Local Medical Review Policy to Local Coverage Determination Conversion

Section 522 of the Benefits Improvement and Protection Act (BIPA), created the term "local coverage determination (LCD)." The Centers for Medicare and Medicaid Services (CMS) published the final rule establishing LCDs on November 11, 2003. Beginning December 7, 2003, local policies were referred to as LCDs, and contractors issued draft and new policies as LCDs. All existing local medical review policies (LMRPs) shall be converted to LCDs no later than December 2005.

Policies Revised to Identify Diagnoses That Are Considered Secondary Diagnosis Codes

The use of "E" diagnosis codes is supplemental to the application of ICD-9-CM diagnosis codes. "E" diagnosis codes are never to be recorded as principal diagnoses. "E" diagnosis codes provide classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. Where an "E" code from the "Supplementary Classification of External Causes of Injury and Poisoning" section of the International Classification of Diseases is applicable, it is intended that it shall be used in addition to a code from one of the main chapters of ICD-9-CM, indicating the nature of the condition. Certain other conditions, which may be stated as being due to external causes, should be used as an additional code for more detailed analysis.

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The "Supplementary Classification of Factors Influencing Health Status and contact with Health Services" section of the International Classification of Diseases is provided to deal with occasions when circumstances other than a disease or injury are recorded as a diagnosis or problem. Certain "V" diagnosis codes may only be used as secondary codes and are identified as such in the International Classification of Diseases.

Applicable policies have been revised to identify those diagnosis codes that can only be used as secondary diagnosis codes.

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

Connecticut Medicare Part B welcomes any questions that you may have regarding the Medicare Part B program. Always be sure to clearly explain your question or concern. This will help our staff to know exactly what issues to address when developing a response to your inquiry.

Please submit your questions to the appropriate department. This will ensure that your concerns are handled in a proper and timely manner. This can be achieved by including an Attention Line below the address on the envelope. Listed below is a directory of departments that includes the issues that you would address to their attention.

With the exception of Redeterminations and Medicare EDI, please submit all correspondence with the appropriate attention line to:

Attention: (insert dept name)
Medicare Part B CT
P.O. Box 45010
Jacksonville, FL 32232-5010

Attention: Correspondence

The Correspondence attention line is used for inquiries pertaining to general issues regarding Medicare Part B. Some examples of these issues are deductibles, assignment, and beneficiary address changes. Do not use words such as *REVIEW* or *RECHECK* when sending general correspondence.

Attention: Financial Services

Use this attention line to return duplicate payments or overpayment refunds.

Attention: Fraud and Abuse

If you encounter what you believe is suspected, potential, or possible fraud or abuse of the Medicare program, we encourage you to contact this department.

Attention: Freedom of Information (FOIA)

This department handles requests for information available under the Freedom of Information Act.

Attention: Medical Review

Questions regarding LMRPs/LCDs and correct documentation for evaluation and management services are handled by this department. Documentation for off-label chemotherapy use should also be submitted to the Medical Review Department.

Attention: MSP

Write to the Medicare Secondary Payer (MSP) department when submitting an Explanation of Benefits from a primary insurance, Exhaust letters from Auto Liability claims, and MSP calculation review requests.

Attention: Pricing/ Provider Maintenance

Address your envelope to this department to apply for a new provider number, change a business or billing address of a provider, or to make any changes in the status of a provider. This department also handles fee schedule requests and inquiries, participation requests, and UPIN requests.

Attention: Resolutions

Use the Resolutions attention line when inquiring or submitting information regarding dates of death, incorrect Medicare (HIC) numbers, incorrect beneficiary information, etc.

MAILING ADDRESS EXCEPTIONS

We have established special P.O. boxes to use when mailing your redeterminations and hearings requests, paper claims, or to contact Medicare EDI:

Redeterminations/Appeals

Please mail only your requests for redeterminations to this P.O. Box. *DO NOT* send new claims, general correspondence, or other documents to this location; doing so will cause a delay in the processing of that item.

If you believe the payment or determination is incorrect and want a claim to be reconsidered, then send it to the attention of the review department. Requests for redeterminations must be made within 120 days of the date of the Medicare Summary Notice. These requests should not include redetermination requests on Medicare Secondary Pay calculations. Claims that are denied for return/reject need to be resubmitted and should **not** be sent as a redetermination. These resubmitted claims should be sent in as new claims.

Hearings

If you believe that your redetermination was incorrect and want it reviewed by a Hearing Officer, send your inquiry to the attention of the Hearing Department. A request for a hearing must be made within six months of the date of the Review Department determination and at least $100.00 must remain in controversy from this decision.

Post Office Box for Appeals/Hearings:

Medicare Part B CT Appeals/Hearings
First Coast Service Options, Inc.
P.O. Box 45041
Jacksonville, FL 32232-5041

Electronic Media Claims/EDI

The Electronic Data Interchange department handles questions and provides information on electronic claims submission (EMC).

Post Office Box for EDI:

Medicare Part B CT Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Claims

The Heath Insurance Portability and Accountability Act (HIPAA) requires electronic submission of mpst types of Medicare claims. We realize, however, that on occasion it is necessary to submit a paper claim. When this happens, submit your claims on the approved red-and-white Form CMS-1500 to:

Medicare Part B CT CLaims
P.O. Box 44234
Jacksonville, FL 32231-4234

CONNECTICUT MEDICARE PHONE NUMBERS

Provider Services
First Coast Service Options, Inc.
Medicare Part B
1-866-419-9455 ***(toll-free)***

Beneficiary Services
1-800-MEDICARE ***(toll-free)***
1-866-359-3614 *(hearing impaired)*

Electronic Data Interchange (EDI)
Enrollment
1-203-639-3160, option 1

PC-ACE® PRO-32
1-203-639-3160, option 2

Marketing and Reject Report Issues
1-203-639-3160, option 4

Format, Testing, and Remittance Issues
1-203-639-3160, option 5

Electronic Funds Transfer Information
1-203-639-3219

Hospital Services
Empire Medicare Services
Medicare Part A
1-800-442-8430

Durable Medical Equipment
HealthNow NY
DMERC Medicare Part B
1-800-842-2052

Railroad Retirees
Palmetto GBA
Medicare Part B
1-800-833-4455

Quality of Care
Peer Review Organization
1-800-553-7590

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

American Association of Retired Persons (AARP)
1-800-523-5800

To Report Lost or Stolen Medicare Cards
1-800-772-1213

Health Insurance Counseling Program
1-800-994-9422

Area Agency on Aging
1-800-994-9422

Department of Social Services/ConnMap
1-800-842-1508

ConnPace/ Assistance with Prescription Drugs
1-800-423-5026

MEDICARE WEBSITES

PROVIDER
Connecticut
http://www.connecticutmedicare.com
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

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

FLORIDA MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised medical policies/coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local medical review policies (LMRPs)/local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LMRPs/LCDs are provided instead. Providers may obtain full-text LMRPs/LCDs on our provider education website, *http://www.floridamedicare.com*. Final LMRPs/LCDs, draft LMRPs/LCDs available for comment, LMRP/LCD statuses, and LMRP/LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LMRPs/LCDs; the date the LMRP/LCD is posted to the website is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new LMRPs/LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *http://www.floridamedicare.com* , click on the "eNews" link on the navigational menu and follow the prompts.

More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LMRP/LCD, contact Medical Policy at:

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

Medical Review Table of Contents

Advance Notice Statement

Advance beneficiary notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

NEW LCDs

0067T: Computed Tomographic Colonography – New Policy

Computed tomographic colonography (CT colonography) also known as virtual colonoscopy utilizes helical computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2-D or 3-D reconstruction. The test requires colonic preparation similar to that required for standard colonoscopy (instrument colonoscopy), and air insufflation to achieve colonic distention. CT colonography has desirable features for a screening test. It does not require sedation. It is minimally invasive, rarely has complications and less expensive than conventional colonoscopy. Diagnosis and staging of colon cancer can be accomplished in one examination and detection of extracolonic abnormalities can be observed. However, gas insufflation of the intestine, which may be uncomfortable to the patient, is required and interpretation of the images is described as difficult and time consuming. When polyps are detected with CT colonography, patients could presumably undergo subsequent endoscopic colonography, which may require another bowel preparation. CT colonography is not endorsed for screening by the American Cancer Society, the U.S. Preventive Services Task Force, or any professional body and is non-covered by the Centers for Medicare and Medicaid Services (CMS).

Medicare will consider CT colonography medically reasonable and necessary for failure of conventional colonoscopy due to the inability to pass the colonoscope proximally. CT colonography will not be covered when used for routine screening.

This Local Coverage Determination (LCD) is being developed to identify indications and limitations of medical necessity for coverage and documentation requirements.

The effective date of this LCD is for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

92548: Computerized Dynamic Posturography – New Policy

Computerized dynamic posturography (CDP) is a means of assessing a patient's ability to use vestibular system information. The equipment for dynamic posturography consists of a moveable platform surrounded by a moveable screen that is computer-controlled. Both can move separately or simultaneously. CDP includes three protocols: 1). The Sensory Organization Test (SOT) assesses the patient's ability to balance using visual, vestibular, and proprioceptive information and to appropriately suppress disruptive visual and/or proprioceptive information under sensory conflict conditions. 2). The Motor Control Test (MCT) measures the ability to reflexively recover from unexpected external provocations. 3). Adaptation Test (ADT) measures the ability to modify automatic reactions when the support surface is irregular or unstable.

Posturographic methods that do not satisfy the American Academy of Otolaryngology-Head and Neck Surgery (AA)-HNS and the American Academy of Neurology (ANN) criteria cannot be considered equivalent to those that do comply with the AAO-HNS and AAN guidelines.

Computerized Dynamic Posturography (*92548*) is currently locally noncovered and is in the List of Noncovered Services LCD. A reconsideration request was received for evaluation of coverage. It was determined to develop a combined FL/CT LCD to define the indications and limitations of coverage and to remove from the Noncovered Services LCD.

This LCD was developed to define the indications and limitations of coverage and define ICD-9-CM codes that Support Medical Necessity and Documentation Requirements. . The ICD-9-CM codes include: 334.0-334.9, 386.00-386.9, 438.84, 438.85, 719.7, 780.4, 781.2, 781.3, 850.11, 850.12, 850.2, 850.3, 850.4, 850.5, 850.9, and 951.5.

This LCD is effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J0128: Abarelix for the Treatment of Prostate Cancer – New Policy

Abarelix also called Plenaxis™ is a drug used to reduce the amount of testosterone made in patients with advanced symptomatic prostate cancer for which no other treatment options are available. It belongs to the family of drugs called gonadotropin-releasing hormone (GnRH) antagonists. Abarelix has received FDA approval for palliative treatment of men with advanced symptomatic prostate cancer, in whom GnRH agonist therapy is not appropriate and who refuse surgical castration, and have one or more of the following: (1) risk of neurological compromise due to metastases, (2) ureteral or bladder outlet obstruction due to local encroachment or metastatic disease, or (3) severe bone pain from skeletal metastases persisting on narcotic analgesia.

Effective March 15, 2005, the Centers for Medicare & Medicaid Services (CMS) has extended national coverage for the use of abarelix/(Plenaxis™) as a palliative treatment in patients with advanced symptomatic prostrate cancer.

This local coverage determination (LCD) is being developed to identify the ICD-9-CM code to be used by providers when billing abarelix. Providers should use ICD-9-CM code 185-Malignant neoplasm of the prostate when billing abarelix. The entire text of coverage guidelines is located in the Medicare National Coverage Determinations Manual, Chapter 1, Part 2, Section 110.19.

This LCD is effective for service rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J0205: Ceredase/Cerezyme – New Policy

Ceredase (J0205) and Cerezyme (J1785) are analogues of the human enzyme B-glucocerebroside, produced by recombinant DNA technology. Ceredase and Cerezyme each catalyze the hydrolysis of glucocerebroside to glucose and ceramide.

Both drugs are as long-term enzyme replacement therapy for patients with a confirmed diagnosis of Type I Gaucher's disease. Data does not identify aberrancies for Ceredase. However, the most recent data obtained by the Medicare Part B Extraction Summary System (BESS) for the time period January 1, 2005 through March 31, 2005, revealed a Florida Carrier to Nation ratio of 3.86 for Cerezyme.

This local coverage determination (LCD) is being developed to define indications and limitations for Ceredase and Cerezyme.

The effective date of the LCD is for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J0800: Corticotropin – New Policy

Corticotropin stimulates the adrenal cortex to produce and secrete adrenocortical hormones. Its use is indicated for diagnostic testing of adrenocortical function and for the treatment of nonsuppurative thyroiditis hypercalcemia associated with cancer, acute exacerbations of multiple sclerosis, tuberculous meningitis when accompanied by antituberculous chemotherapy, trichinosis with neurologic or myocardial involvement, and treatment of glucocorticoid responsive rheumatic, collagenous, dermatologic, allergic, ophthalmic, respiratory, hematologic and neoplastic and GI diseases.

Most recent data obtained for HCPC J0800 revealed a Florida to nation ratio of allowed dollars per 1,000 enrollees with an aberrancy rate 12.79.

A local coverage determination (LCD) was developed to define indications and limitations for the billing of corticotropin and to provide guidance regarding the type of documentation that should be maintained to support medical necessity.

The effective date of the LCD is for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J2324: Draft LCD for Nesiritide (Natrecor®) Infusion for Chronic Congestive Heart Failure Not Finalized – New Policy Draft

Local coverage determination (LCD) draft for J2324, Nesiritide (Natrecor®) Infusion for Chronic Congestive Heart Failure, was developed for Medicare and presented to the Florida Carrier Advisory Committee on June 18, 2005. This LCD outlined entrance criteria for intravenous infusion of Nesiritide for the treatment of patients diagnosed with acutely decompensated congestive heart failure in the outpatient setting.

Due to controversy about the safety of giving Nesiritide (Natrecor®) Infusion for Chronic Congestive Heart Failure in this setting, and the fact that a request for a National Coverage Determination has been submitted to the Centers for Medicare & Medicaid Services (CMS) and is under consideration, First Coast Service Options, Inc. (FCSO) has elected not to finalize this policy. In addition, information was published from a panel of cardiology experts with recommendations to the manufacturer of this drug that its' use should be strictly limited to patients presenting to the hospital with acutely decompensated congestive heart failure.

J9041: Bortezomib (Velcade®) – New Policy

Bortezomib (Velcade®) is an antineoplastic agent which inhibits the activity of the 26S proteasome. It exhibits cytotoxicity to various malignant cells, including myeloma and lymphoma cells. Bortezomib is given by intravenous injection.

Based on documentation submitted to the Antineoplastic Drugs Workgroup meeting, a decision was made to develop a local coverage determination (LCD) to include indications and limitations of coverage, and ICD-9-CM codes that support medical necessity.

The following FDA approved indication is covered:

- Treatment of multiple myeloma patients who have received at least one prior therapy.

The following off-labeled indications are covered:

- Treatment of relapsed or refactory B-Cell Non-Hodgkin's lymphoma specifically; mantle-cell lymphoma (MCL) and follicular lymphoma (FL).

The following ICD-9-CM codes are covered:

202.00 – 202.08	Nodular lymphoma
202.80 – 202.88	Other lymphomas
203.00	Multiple myeloma without mention of remission

This LCD was presented to the Carriers Advisory Committee June 18, 2005. It will be effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

Macugen® (pegaptanib sodium injection) – New Policy

Age-related macular degeneration (AMD) is the leading cause of irreversible severe vision loss in Americans over 55 years of age. While the non-neovascular or dry form of the disease is more prevalent, neovascular or wet AMD is responsible for the majority of cases of vision loss. Neovascular (wet) AMD is characterized by choroidal neovascularization (CNV) beneath the retina. The neovascular tissue often leaks blood and fluid, and, when untreated, eventually progresses to scarring with destruction of the macula and loss of vision.

Macugen® (pegaptanib sodium injection) is an FDA-approved, treatment for neovascular (wet) age-related macular degeneration. Macugen ® is a sterile, aqueous solution, containing pegaptanib sodium, which is an aptamer consisting of a covalent conjugate of twenty-eight modified oligonucleotides. Pegylation has been added to increase the half-life of pegaptanib sodium in the vitreous.

Pegaptanib sodium binds selectively and with high affinity to extracellular VEGF165, the pathogenic VEGF isoform most directly linked to the pathogenesis of neovascular (wet) age-related macular degeneration (AMD). Pegaptanib sodium inhibits VEGF165 binding to its cognate receptors.

The intended dose and regimen for Macugen® is 0.3 mg administered once every six weeks by aseptic intravitreal injection into the eye to be treated.

Macugen® is billed using HCPCS code J3490 (unclassified drugs) Macugen (pegaptanib sodium injection) and CPT Code *67028* Intravitreal injection of a pharmacologic agent (separate procedure). This LCD has been developed to provide indications and limitations of coverage and/or medical necessity and documentation requirements for this therapy. An LCD attachment provides coding guidelines as well.

While this LCD is effective for services rendered on or after January 1, 2006, Medicare will consider Macugen® (pegaptanib sodium injection) medically reasonable and necessary for the treatment of neovascular (wet) AMD for services rendered on or after the FDA-approval date of December 17, 2004.

The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

REVISIONS TO LMRPS/LCDS

11055: Routine Foot Care – Policy Revision

This local coverage determination (LCD) was last revised on May 12, 2005. For the allowed indication of peripheral neuropathies involving the feet associated with traumatic injury, the following range of diagnosis codes was added under "ICD-9 Codes that Support Medical Necessity" and under "The following diagnoses related to peripheral neuropathy do not require a Q modifier" to include the addition of 952.00 – 952.19 and 952.9.

The diagnosis range is now listed in the LCD as follows:

- 952.00 – 952.9 (Spinal cord injury without evidence of spinal bone injury)

Also, for clarification, ICD-9-CM code 286.9 (Other and unspecified coagulation defects (use for long-term [current] use of anticoagulants) is listed under "The following diagnosis related to anticoagulation therapy does not require a Q modifier". This would not include aspirin therapy. The indication for anticoagulation therapy would be for patients currently on long-term use of warfarin/coumadin.

This revision is effective for services rendered on or after September 6, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

17304: Mohs Micrographic Surgery – Policy Revision

The local medical review policy (LMRP) for Mohs micrographic surgery (MMS) was previously revised on January 1, 2003. Since that time, the policy was revised to remove indications and ICD-9-CM codes (161.0, 161.1, 161.2, 161.3, 161.8, and 161.9) for laryngeal carcinoma, as this would not be an appropriate indication for the MMS procedure, and add ICD-9-CM diagnosis codes 140.0-140.9 and 173.4.
In addition, the LMRP has been converted to a local coverage determination (LCD) format.

This revision is effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

20974: Osteogenic Stimulation –Policy Revision

The local medical review policy (LMRP) for osteogenic stimulation was last revised January 11, 2004. Change Request 3836, dated June 24, 2005 expanded coverage of ultrasounic osteogenic stimulation for nonunion fracture healing to prior to surgery. Additional revisions to this policy unrelated to CR 3836 include the identification of V45.4 as a secondary diagnosis code. Furthermore, the LMRP has been converted to a local coverage determination (LCD).

This revision is effective for services rendered on or after April 27, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

2006 ICD-9-CM Coding Changes

The 2006 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2005. Updated diagnosis codes must be used for all services billed on or after October 1, 2005. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued. Florida Medicare has reviewed all local medical review policies (LMRPs)/local coverage determinations (LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2006 ICD-9-CM update. The table on the following pages lists the LCDs affected and the specific conditions revised as a result of the 2006 ICD-9-CM update:

LMRP/LCD Title	2006 Changes
11055 Routine Foot Care	Add 585.1-585.9 (Chronic kidney disease) for procedure codes *11055*, *11056*, *11057*, *11719*, *11720*, *11721*, and G0127.
20974 Osteogenic Stimulation	Add 996.44 (Peri-prosthetic fracture around prosthetic joint) for procedure codes *20974* and *20975*.
31231 Diagnostic Nasal Endoscopy	Change descriptor for 780.51 (Insomnia with sleep apnea, unspecified), 780.52 (Insomnia, unspecified), 780.53 (Hypersomnia with sleep apnea, unspecified), 780.54 (Hypersomnia, unspecified), 780.55 (Disruptions of 24 hour sleep wake cycle, unspecified), and 780.57 (Unspecified sleep apnea) for procedure codes *31231*, *31233*, and *31235*.
31525 Diagnostic Laryngoscopy	Change descriptor for 780.51 (Insomnia with sleep apnea, unspecified) and 780.53 (Hypersomnia with sleep apnea, unspecified) for procedure codes *31525* and *31575*.
51798 Post-Voiding Residual Ultrasound	Add 599.60-599.69 (Urinary obstruction) for procedure code *51798*.
70544 Magnetic Resonance Angiography (MRA)	Change descriptor for 403.00-403.91 (Hypertensive kidney disease) and 404.00-404.93 (Hypertensive heart and kidney disease) for procedure code *74185*. Add 443.82 (Erythromelalgia) for procedure code *73725*.
72192 Computed Tomography of the Pelvis	Add 567.21 (Peritonitis (acute) generalized), 567.22 (Peritoneal abscess), 567.23 (Spontaneous bacterial peritonitis), 567.29 (Other suppurative peritonitis), 567.31 (Psoas muscle abscess), 567.38 (Other retroperitoneal abscess), 567.39 (Other retroperitoneal infections), 599.60 (Urinary obstruction, unspecified), and 599.69 (Urinary obstruction, not elsewhere classified) for procedure codes *72192*, *72193*, and *72194*.
73218 Magnetic Resonance Imaging of Upper Extremity	Add 996.40 (Unspecified mechanical complication of internal orthopedic device, implant, and graft), 996.41 (Mechanical loosening of prosthetic joint), 996.42 (Dislocation of prosthetic joint), 996.43 (Prosthetic joint implant failure), 996.44 (Peri-prosthetic fracture around prosthetic joint), 996.45 (Peri-prosthetic osteolysis), 996.46 (Articular bearing surface wear of prosthetic joint), 996.47 (Other mechanical complication of prosthetic joint implant), and 996.49 (Other mechanical complication of other internal orthopedic device, implant, and graft) for procedure codes *73218*, *73219*, *73220*, *73221*, *73222*, and *73223*.
74150 Computed Tomography of the Abdomen	Change descriptor for 567.0-567.9 (Peritonitis and retroperitoneal infections) for procedure codes *74150*, *74160*, and *74170*. Add 599.60 (Urinary obstruction, unspecified) and 599.69 (Urinary obstruction, not elsewhere classified) for procedure codes *74150*, *74160*, and *74170*.

2006 ICD-9-CM Coding Changes, continued

LMRP/LCD Title	2006 Changes
80076 Hepatic (Liver) Function Panel	Add V58.11 (Encounter for antineoplastic chemotherapy) for procedure code *80076*.
82108 Aluminum	Add 585.1-585.9 (Chronic kidney disease) for procedure code *82108*.
82310 Total Calcium	Change descriptor for 728.87 (Muscle weakness [generalized]) for procedure code *82310*. Add 585.1-585.9 (Chronic kidney disease) for procedure code *82310*.
82330 Ionized Calcium	Add 585.1-585.9 (Chronic kidney disease) for procedure code *82330*.
83735 Magnesium	Change descriptor for 728.87 (Muscle weakness [generalized]) for procedure code *83735*. Add 276.50-276.52 (Volume depletion), 585.1-585.9 (Chronic kidney disease), and V58.11 (Encounter for antineoplastic chemotherapy) for procedure code *83735*.
83880 B-Type Natriuretic Peptide (BNP)	Change descriptor for 404.01 (Hypertensive heart and kidney disease, malignant, with heart failure), 404.03 (Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease), 404.11 (Hypertensive heart and kidney disease, benign, with heart failure), 404.13 (Hypertensive heart and kidney disease, benign, with heart failure and chronic kidney disease), 404.91 (Hypertensive heart and kidney disease, unspecified, with heart failure), and 404.93 (Hypertensive heart and kidney disease, unspecified, with heart failure and chronic kidney disease) for procedure code *83880*.
83970 Parathormone (Parathyroid Hormone)	Add 585.1-585.9 (Chronic kidney disease) for procedure code *83970*.
84100 Serum Phosphorus	Change descriptor for 403.01 (Malignant hypertensive kidney disease with chronic kidney disease), 403.11 (Benign hypertensive kidney disease with chronic kidney disease), 404.02 (Malignant hypertensive heart and kidney disease, with chronic kidney disease), 404.03 (Malignant hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.12 (Benign hypertensive heart and kidney disease, with chronic kidney disease), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease), and 728.87 (Muscle weakness [generalized]) for procedure code *84100*. Add 585.1-585.9 (Chronic kidney disease) for procedure code *84100*.
86706 Hepatitis B Surface Antibody and Surface Antigen	Change descriptor for 403.01 (Malignant hypertensive kidney disease with chronic kidney disease), 403.11 (Benign hypertensive kidney disease with chronic kidney disease), 404.02 (Malignant hypertensive heart and kidney disease, with chronic kidney disease), 404.03 (Malignant hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.12 (Benign hypertensive heart and kidney disease, with chronic kidney disease), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for procedure codes *86706* and *87340*. Add 585.4 (Chronic kidney disease, Stage IV [severe]), 585.5 (Chronic kidney disease, Stage V), and 585.6 (End stage renal disease) for procedure codes *86706* and *87340*.

2006 ICD-9-CM Coding Changes, continued

LMRP/LCD Title	2006 Changes
90801 Psychiatric Diagnostic Interview Examination	Change descriptor for 780.52 (Insomnia, unspecified) and 780.57 (Unspecified sleep apnea) for procedure code *90801*. Add 780.95 (Other excessive crying) for procedure code *90801*.
90901 Biofeedback	Change descriptor for 728.87 (Muscle weakness [generalized]) for procedure code *90901*.
92081 Visual Field Examination	Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, or 362.06) for procedure codes *92081*, *92082*, and *92083*.
92135 Scanning Computerized Ophthalmic Diagnostic Imaging	Add 362.03 (Nonproliferative diabetic retinopathy NOS), 362.04 (Mild nonproliferative diabetic retinopathy), 362.05 (Moderate nonproliferative diabetic retinopathy), 362.06 (Severe nonproliferative diabetic retinopathy), and 362.07 (Diabetic macular edema) for procedure code *92135*. Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, or 362.06) for procedure code *92135*.
92225 Ophthalmoscopy	Add 362.07 (Diabetic macular edema) for procedure codes *92225* and *92226*. Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01 or 362.02) for procedure codes *92225* and *92226*.
92235 Fluorescein Angiography	Add 362.03 (Nonproliferative diabetic retinopathy NOS), 362.04 (Mild nonproliferative diabetic retinopathy), 362.05 (Moderate nonproliferative diabetic retinopathy), 362.06 (Severe nonproliferative diabetic retinopathy), and 362.07 (Diabetic macular edema) for procedure code *92235*. Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, or 362.06) for procedure code *92235*.
92250 Fundus Photography	Diagnosis 362.07 (Diabetic macular edema) requires a dual diagnosis. It must be billed with a diagnosis code for diabetic retinopathy (362.01, 362.02, 362.03, 362.04, 362.05, or 362.06) for procedure code *92250*.
93000 Electrocardiography	Add 799.01-799.02 (Asphyxia and hypoxemia) for procedure codes *93000*, *93005*, and *93010*.
93224 Electrocardiographic Monitoring for 24 hours (Holter Monitoring)	Add 426.82 (Long QT syndrome) for procedure codes *93224*, *93225*, *93226*, *93227*, *93230*, *93231*, *93232*, *93233*, *93235*, *93236*, and *93237*.
93303 Transthoracic Echocardiography (TTE)	Change descriptor for 404.00-404.93 (Hypertensive heart and kidney disease), 780.51 (Insomnia with sleep apnea, unspecified), and 780.53 (Hypersomnia with sleep apnea, unspecified) for procedure codes *93307* and *93308*. Add 276.50 (Volume depletion, unspecified), 276.51 (Dehydration), 276.52 (Hypovolemia), and 426.82 (Long QT syndrome) for procedure codes *93307* and *93308*.

2006 ICD-9-CM Coding Changes, continued

LMRP/LCD Title	2006 Changes
93312 Transesophageal Echocardiogram	Change descriptor for 278.00- 278.01 (Overweight and obesity) for procedure codes *93312*, *93313*, *93314*, *93315*, *93316*, *93317*, and *93318*. Add 278.02 (Overweight) for procedure codes *93312*, *93313*, *93314*, *93315*, *93316*, *93317*, and *93318*.
93701 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance	Change descriptor for 403.00-403.01 (Malignant hypertensive kidney disease), 403.11 (Benign hypertensive kidney disease with chronic kidney disease), 403.91 (Unspecified hypertensive kidney disease with chronic kidney disease), 404.00-404.03 (Malignant hypertensive heart and kidney disease), 404.11 (Benign hypertensive heart and kidney disease with heart failure), 404.12 (Benign hypertensive heart and kidney disease, with chronic kidney disease), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.91 (Unspecified hypertensive heart and kidney disease with heart failure), 404.92 (Unspecified hypertensive heart and kidney disease, with chronic kidney disease), and 404.93 (Unspecified hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for procedure code *93701*.
94760 Noninvasive Ear or Pulse Oximetry For Oxygen Saturation	Change descriptor for 404.01 (Malignant hypertensive heart and kidney disease, with heart failure), 404.03 (Malignant hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.11 (Benign hypertensive heart and kidney disease with heart failure), 404.13 (Benign hyperten-sive heart and kidney disease, with heart failure and chronic kidney disease), 404.91 (Unspecified hypertensive heart and kidney disease with heart failure), and 404.93 (Unspecified hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for procedure codes *94760*, *94761*, and *94762*. Change descriptor for 780.51 (Insomnia with sleep apnea, unspecified), 780.53 (Hypersomnia with sleep apnea, unspecified), and 780.57 (Unspecified sleep apnea) for procedure code *94762*.
97802 Medical Nutrition Therapy (MNT)	Add 585.1-585.9 (Chronic kidney disease) for procedure codes *97802*, *97803*, *97804*, G0270, and G0271.
EPO Epoetin alfa	Change descriptor for 403.01 (Malignant hypertensive kidney disease with chronic kidney disease), 403.11 (Benign hypertensive kidney disease with chronic kidney disease), 403.91 (Unspecified hypertensive kidney disease with chronic kidney disease), 404.02 (Malignant hypertensive heart and kidney disease with chronic kidney disease), 404.03 (Malignant hypertensive heart and kidney disease with heart failure and chronic kidney disease), 404.12 (Benign hypertensive heart and kidney disease, with chronic kidney disease), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.92 (Unspecified hypertensive heart and kidney disease, with chronic kidney disease), and 404.93 (Unspecified hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for procedure codes Q0136 and Q4055. Add 585.1 (Chronic kidney disease, Stage I), 585.2 (Chronic kidney disease, Stage II [mild]), 585.3 (Chronic kidney disease, Stage III [moderate]), 585.4 (Chronic kidney disease, Stage IV[severe])and 585.9 (Chronic kidney disease, unspecified), and V58.11 (Encounter for antineoplastic chemotherapy) for procedure code Q0136. Add 585.4 (Chronic kidney disease, Stage IV [severe]), 585.5 (Chronic kidney disease, Stage V), and 585.6 (End stage renal disease) for procedure code Q4055.

2006 ICD-9-CM Coding Changes, continued

LMRP/LCD Title	2006 Changes
J1440 G-CSF (Filgrastim, Neupogen®)	Add V58.11 (Encounter for antineoplastic chemotherapy) for procedure codes J1440 and J1441.
J2505 Pegfilgrastim (Neulasta™)	Add V58.11 (Encounter for antineoplastic chemotherapy) for procedure code J2505.
J2792 Rho (D) Immune Globulin Intravenous	Add 287.30-287.39 (Primary thrombocytopenia) for procedure codes J2788, J2790, and J2792.
J2820 Sargramostim (GM-CSF, Leukine®)	Add V58.11 (Encounter for antineoplastic chemotherapy) for procedure code J2820.
J9000 Antineoplastic Drugs	Add 287.31 (Immune thombocytopenic purpura) and 287.32 (Evans' syndrome) for procedure code J9310.
NESP Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])	Add 585.1 (Chronic kidney disease, Stage I), 585.2 (Chronic kidney disease, Stage II [mild]), 585.3 (Chronic kidney disease, Stage III [moderate]), 585.9 (Chronic kidney disease, unspecified), and V58.11 (Encounter for antineoplastic chemotherapy) for procedure codes J0880 and Q0137. Add 585.4 (Chronic kidney disease, Stage IV [severe]), 585.5 (Chronic kidney disease, Stage V), and 585.6 (End stage renal disease) for procedure code Q4054.
OOS Outpatient Observation Services	Change descriptor for 404.01 (Malignant hypertensive heart and kidney disease, with heart failure), 404.03 (Malignant hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.11 (Benign hypertensive heart and kidney disease with heart failure), 404.13 (Benign hypertensive heart and kidney disease, with heart failure and chronic kidney disease), 404.91 (Unspecified hypertensive heart and kidney disease with heart failure), and 404.93 (Unspecified hypertensive heart and kidney disease, with heart failure and chronic kidney disease) for procedure code G0244.
PULMDIAGSVCS Pulmonary Diagnostic Services	Change descriptor for 780.51 (Insomnia with sleep apnea, unspecified), 780.53 (Hypersomnia with sleep apnea, unspecified), and 780.57 (Unspecified sleep apnea) for procedure codes *93720*, *93721*, *93722*, *94010*, *94060*, *94070*, *94200*, *94240*, *94250*, *94260*, *94350*, *94360*, *94370*, *94375*, *94620*, *94621*, *94720*, *94725*, and *94750*.
Q9941 Intravenous Immune Globulin	Add 287.31 (Immune thombocytopenic purpura) and 287.32 (Evans' syndrome) for procedure codes Q9941, Q9942, Q9943, and Q9944.

64400: Peripheral Nerve Blocks – Policy Revision

This local coverage determination (LCD) was last revised effective April 11, 2005. Since that time, this LCD has been revised. This LCD was revised to add ICD-9-CM codes 354.0 (Carpal tunnel syndrome) and 729.2 (Neuralgia, neuritis, and radiculitus, unspecified) to the "ICD-9-CM Codes that Support Medical Necessity" section of the LCD.

This revision is effective for services rendered on or after September 15, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

70551: Magnetic Resonance Imaging of the Brain – Policy Revision

This local medical review policy (LMRP) was last updated on October 1, 2004. The policy was converted into LCD format with revisions made in the following sections:

- Indications and Limitations of Coverage and/or Medical Necessity - A statement and indications of investigational reasons were added from the old format with correction of "and" instead of "or" for procedures involving spatial resolution of bone **and** calcifications.
- CMS National Coverage Policy – References were updated
- Documentation Requirements – Verbiage was changed to include "nonphysician practitioner."
- Sources of Information and Basis for Decision – References were updated

Under the ICD-9 Codes that Support Medical Necessity section, an asterisk was added to code V45.2 and statement that this code is a secondary diagnosis code and should not be billed as the primary diagnosis.

The effective date of this revision is for claims processed on or after October 18, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

72192: Computed Tomography of the Abdomen and Pelvis – Policy Revision

The local medical review policy (LMRP) for Computed Tomography (CT) of the Pelvis (*72192)* was last revised on January 1, 2005. Since that time, it was determined ICD-9-CM codes 593.9 (unspecified disorder of kidney and ureter) and 752.41 (embryonic cyst of cervix, vagina, and external female genitalia) should be added to the policy.

The LCD changes are effective for services rendered on or after October 1, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

72192: Computed Tomography of the Abdomen and Pelvis – Policy Revision

The local medical review policy (LMRP) for Computed Tomography (CT) of the Abdomen *74150* and Computed Tomography (CT) of the Pelvis *72192* was last revised on October 1, 2005. Since that time, it was determined the CT of the Pelvis and CT of the Abdomen policy should be combined. As a result of a major revision done to *combine these policies and change the policy name to Computed Tomography of the Abdomen and Pelvis (72192*). National coverage information has been italicized.

The combined Computed Tomography of the Abdomen and Pelvis policy was presented at the June 18, 2005 Carrier Advisory Committee Meeting (CAC) and the following changes were made: the ICD-9-CM codes have been removed from the policy; the Indications of Coverage/Medical Necessity and Documentation Requirements sections have been revised accordingly.

For information purposes, the CT of the Pelvis (*72192*) was a Florida and Connecticut combined policy. It was determined that individual policies were needed; therefore, the Connecticut content has been removed from this policy.

The LCD revisions are effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

76514: Ocular Corneal Pachymetry – Policy Revision

The local medical review policy (LMRP) for ocular corneal pachymetry was last revised on January 1, 2005. Since that time, it has come to our attention that clarification is necessary regarding the utilization of this procedure.

Therefore, the purpose of the LMRP revision is to clarifying frequency guidelines for ocular corneal pachymetry when used to measure the corneal thickness following the diagnosis of increased intraocular pressure. Under the "Indications and Limitations of Coverage" and "Utilization Guidelines" sections of the policy, verbiage has been added to emphasize that ocular corneal pachymetry, when measuring corneal thickness following the diagnosis of increased intraocular pressure, is a once in a lifetime benefit. In addition, the LMRP has been converted to the local coverage determination (LCD) format.

This LCD revision is effective for claims processed on or after October 24, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

77301: Intensity Modulated Radiation Therapy – Policy Revision

The local medical review policy (LMRP) for intensity modulated radiation therapy (IMRT) was previously revised on January 1, 2005. Since that time, the policy was revised to include CPT Category III code *0073T* (Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session). In addition, the indications for coverage have been updated and all ICD-9-CM codes were removed from the policy.

The policy has been updated to the new local coverage determination (LCD) format. This revision is effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

83970: Parathormone (Parathyroid Hormone) – Policy Revision

The local medical review policy (LMRP) for Parathormone (Parathyroid Hormone) was last updated on October 1, 2004. The policy was converted into LCD format and references under "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections were updated. Under the "ICD-9 Codes that Support Medical Necessity" section, the following additional ICD-9-CM codes with descriptors were added:

293.0	Delirium due to conditions classified elsewhere
293.83	Mood disorder in conditions classified elsewhere (depressive type)
728.85	Spasm of muscle
788.42	Polyuria

The effective date of this LCD revision is for services rendered on or after October 1, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

84066: Prostatic Acid Phosphatase – Policy Revision

This local medical review policy (LMRP) was last updated on January 01, 2002. The policy was converted into LCD format with revisions made to the following sections:

- CMS National Coverage Policy
- Documentation requirements
- Sources of Information and Basis for Decision

In addition, the LCD Title was changed from "Phosphatase, Acid; Prostatic" to "Prostatic Acid Phosphatase," and the Coding Guidelines and Other Comments were removed.

The effective date of this revision is for claims processed on or after October 17, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

84100: Serum Phosphorus – Policy Revision

This local medical review policy (LMRP) was last updated on October 1, 2004. Policy was converted into LCD format that included updating references under "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections. In addition, the following two ICD-9-CM codes were added under the "ICD-9 Codes that Support Medical Necessity" section of the policy:

283.9 Acquired hemolytic anemia, unspecified
646.90 Unspecified complication of pregnancy

The effective date of this LCD revision is for services rendered on or after October 1, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

92506, 97001, 97003, and 97110: Speech-Language Pathology Services, Physical Medicine and Rehabilitation, Occupational Therapy Policy for Rehabilitation Services, and Complex Decongestive Physiotherapy – Policy Revision

The above medical policies have been combines into one therapy policy titled Therapy and Rehabilitation Services (THERSVCS). This revision is for services rendered on or after June 6, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

93268: Patient Demand Single or Multiple Event Recorder – Policy Revision

This local medical review policy (LMRP) was last updated on January 01, 2003. The policy was converted into the LCD format with references updated under the "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections. Under the "ICD-9-CM Codes that support Medical Necessity" section, an asterisk was added to codes E942.0 and E942.1 and statement that these codes are secondary diagnosis codes and should not be billed as the primary diagnosis. The "Coding Guidelines" section was revised to include reasons for denial with the information on technical and professional components deleted. Under the Documentation Requirements, "nonphysician practitioner" was added with "physician."

This revision is effective for claims processed on or after October 11, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

97802: Medical Nutrition Therapy – Policy Revision

The local coverage determination for Medical Nutrition Therapy (MNT) - *97802* was last revised on March 8, 2005. Change request 3955, transmittal 650, dated August 12, 2005 changed the definition for diabetes mellitus based on the 2003 Medicare Physician Fee Schedule Regulation. Therefore, the LCD has been revised to reflect a change to the definition of diabetes mellitus.

The revision of this LCD is effective for services rendered on or after January 1, 2004. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J0640: Leucovorin (Wellcovorin®) – Policy Revision

This local coverage determination (LCD) was last updated on September 29, 2003. Additional ICD-9-CM code range 156.0 – 156.9 (Malignant neoplasm of gallbladder and extrahepatic bile ducts) was added to match the off-labeled indication of "Gallbladder and extrahepatic bile duct carcinoma when used in combination with Fluorouracil" under the "Indications and Limitations of Coverage and/or Medical Necessity" section. References under "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections were updated.

This revision is effective for claims processed on or after August 8, 2005 for services rendered on or after June 30, 2003. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J2430: Pamidronate (Aredia®) – Policy Revision

This local coverage determination (LCD) was last updated on January 1, 2005.

Since then, the LCD has been revised in the following sections:

- CMS National Coverage Policy – References updated
- Sources of Information and Basis for Decision – References updated
- Documentation Requirements – Verbiage added to include "nonphysician practitioner"
- Coverage Topic – Chemotherapy Inpatient & Outpatient was changed to Prescription Drugs

The effective date of this revision is for claims processed on or after October 11, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J3487: Zoledronic Acid (Zometa®) – Policy Revision

This local coverage determination (LCD) was last updated on July 12, 2005. Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following off-label indication was added:

- Drug-induced osteopenia, secondary to androgen-deprivation therapy in prostate cancer patients (prophylaxis).

Under the "ICD-9 Codes that Support Medical Necessity" section, added the following ICD-9-CM code with descriptor:

- 733.90 – Disorder of bone and cartilage, unspecified

In addition, revisions were also made to the "Documentation Requirements" to include physician/nonphysician practitioner and the "Sources of Information and Basis for Decision" section was updated.

The effective date of this revision is for services rendered on or after October 24, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J9000: Antineoplastic Drugs – Policy Revision

This local coverage determination (LCD) for Antineoplastic Drugs was last updated on June 20, 2005. A revision to this LCD was made that included updating references under "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections. The following revisions were made to the drugs listed below:

Gemcitabine (J9201) - Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, added "Intrahepatic bile duct(s) carcinoma" to the off-label indications. Under the "ICD-9 Codes that Support Medical Necessity" section, added code 155.1 (Intrahepatic bile ducts).

Irinotecan (J9206) - Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, added "Carcinoma of small intestine" to the off-label indications. Under the "ICD-9 Codes that Support Medical Necessity" section, added code range 152.0-152.9 (Malignant neoplasm of small intestine, including duodenum).

Oxaliplatin (J9263) - Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, removed off-labeled indication statement "oxaliplatin may be used alone or in combination with other chemotherapeutic drugs." Added "or small intestine" to off-labeled indication of first line treatment for colon cancer for this drug. In addition, under the "ICD-9 Codes that Support Medical Necessity" section, added code range 152.0-152.9 (Malignant neoplasm of small intestine, including duodenum).

Trastuzumab (J9355) - Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, added the following off-label indications for non-metastatic breast cancer:
For non-metastatic breast cancer, trastuzumab may be considered medically reasonable and necessary when incorporated into the adjuvant therapy in any of the following situations:

- In patients with breast cancer who over-express HER-2 (IHC 3+ or FISH amplified at the level of 2.1 or greater) and positive axillary lymph node(s).
- In patients with lymph node negative tumors greater than or equal to 1 cm and smaller than or equal to 2 cm who over-express HER-2 and are estrogen receptor negative.
- In patients with lymph node negative tumors greater than or equal to 2 cm who over-express HER-2 and are estrogen receptor positive.

The timing of therapy, combination with other agents or regimen, dosage, and duration of therapy should be based on NCCN guidelines and the package insert.

Under the "ICD-9 Codes that Support Medical Necessity" section, removed "Note" at the bottom of this section concerning dual diagnoses because dual diagnoses are no longer required for trastuzumab.

In addition to the above revisions, under the "Other Comments" of the Coding Guidelines, the following statement concerning discarded drugs and biologicals from the CMS Manuals, Pub. 100-4, Chapter 17, Section 40 was added:

> *CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded alone with the amount administered.*

Note: The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drug.

Revisions for procedure codes J9201, J9206, and J9236 are effective for services rendered on or after October 10, 2005. The revision for procedure code J9355 is effective for services rendered on or after October 11, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

NCSVCS: The List of Medicare Noncovered Services – Policy Revision

The local coverage determination (LCD) for the list of Medicare noncovered services - NCSVCS was previously revised on January 28, 2005. Since that time, procedure code *99199* for Gamma knife for lesions outside of the head has been removed from the Local Noncoverage Decisions section of the LCD. Procedure code *99199* would not be used to bill "Gamma knife for lesions outside of the head." Please use the appropriate G-code (i.e., G0173) and these services will be reviewed on an individual basis.

This revision is effective for services rendered on or after August 2, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

NCSVCS: List of Medicare Noncovered Services – Policy Revision

The local coverage determination (LCD) for the List of Medicare noncovered services was last revised August 2, 2005. Since that time, it was determined that CPT code *11980* (Subcutaneous hormone pellet implantation implantation of estradiol and/or testosterone pellets beneath the skin) should be removed as a noncovered procedure.

The effective date of this policy revision is for claims processed on or after September 6, 2005 for services rendered on or after January 1, 2002. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

NCSVCS: The List of Medicare Noncovered Services – Policy Revision

The local coverage determination (LCD) for the list of Medicare noncovered services - NCSVCS has been revised to remove all procedure codes that are either non-covered per national coverage guidelines or the services are bundled into another service. This revision is effective for services rendered on or after October 6, 2005. In addition, an LCD has been developed for Computerized Dynamic Posturography (*92548*). Therefore, procedure code *92548* is being removed from the local noncovered services section of the noncovered services LCD. This revision is effective for services rendered on or after January 1, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

OOS: Outpatient Observation Services – Policy Revision

The local medical review policy for Outpatient Observation Services - OOS was last revised January 5, 2004. Since that time, CR 3756, Transmittal 508, dated March 18, 2005 deleted diagnostic testing requirements when billing HCPC G0244 (Observation care provided by a facility to a patient with CHF, chest pain or asthma, minimum 8 hours).

Therefore, this policy has been revised to delete diagnostic testing requirements when billing HCPC G0244. Furthermore, the LMRP was converted to the local coverage determination (LCD) format, CMS manual references were updated, and the addition of coding guidelines is included in this revision.

This revision is effective for services rendered on or after January 1, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

Q9941: Intravenous Immune Globulin – Policy Revision

This local coverage determination (LCD) was last updated April 1, 2005. A revision to this LCD was made to the indications and limitation section for Immunodeficiency Disorders—*Primary Humoral Immunodeficiency Syndromes*. A request was received to add an exception to the functional antibody testing requirements, found in this section, for patients whose diagnosis was established prior to this technology being in place. After review, this exception was added to the LCD.

This revision will be effective for claims processed on or after August 30, 2005**.** The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

SKINSUB: Skin Substitutes – Policy Revision

The coding guideline for skin substitutes - SKINSUB was previously revised on January 1, 2005. Since that time, clarification regarding the use of modifier-58 when used for the application of a skin substitute per FDA approved indications. In addition, clarified information on the use of codes *15000* and *15001* with codes *15342* and *15343*. Initial preparation of the wound for skin grafting (codes *15100-15400*), may be billed on the initial day of service. Documentation must support both procedures were performed.

This revision is effective for services rendered on or after August 30, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

THERSVCS: Therapy and Rehabilitation Services – Policy Revision

The local coverage determination (LCD) for therapy and rehabilitation services – THERSVCS formerly known as *92506*-speech-language pathology services, *97001*- physical medicine and rehabilitation, *97003*-occupational therapy policy for rehabilitation services, and *97110* - complex decongestive physiotherapy have been incorporated into one LCD and renamed, as above. The guidelines for evaluation, treatment plans, and certification requirements have been updated, per Change Request 3648. National language has been identified with italics. Procedure code *97010* (hot or cold packs) has been moved to the coding guideline attachment with coverage guidelines. Procedure codes *97545-97546* (work hardening/conditioning) have been removed from the LCD, as these codes are non-covered. Procedure codes *97750* (physical performance test or measurement) and *97755* (assistive technology assessment) have been added to the coding guideline attachment as "codes that always represent therapy codes," (per Change Request 3647). In addition, coding guidelines have been added to the coding guideline attachment for manual muscle testing and range of motion services (codes *95831-95834*).

This revision is effective for services rendered on or after June 6, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

RETIREMENT OF EXISTING LMRPS

Multiple Policies Being Retired- Policy Retired

The following polices are being retired based on data analysis and standards of local medical practice **or** as it has been determined that the policy did not conform to the LCD format.

The following policy is retired effective for services rendered on or **after January 1, 2005:**

Policy Number	Policy Name
Q9945	Low Osmolar Contrast Media (LOCM)

The following polices are retired effective for services rendered on or after **August 2, 2005:**

Policy Number	Policy Name
76770	Retroperitoneal Ultrasound
92585	Brain Auditory Evoked Responses
G0117	Screening Glaucoma Services

The following policies are retired effective for services rendered on or after **August 16, 2005:**

Policy Number	Policy Name
55700	Biopsy of Prostate Using Image Guidance
93015	Cardiovascular Stress Test
94640	Diagnostic Aerosol or Vapor Inhalation

The following policy is retired effective for services rendered on or after **September 16, 2005:**

Policy Number	Policy Name
71010	Chest X-Ray

The following policies are retired effective for services rendered on or **after September 20, 2005:**

Policy Number	Policy Name
17000	Benign or Premalignant Skin Lesion Removal/Destruction
90999	ESRD Laboratory Services and Diagnostic Services

The following policy is retired effective for services rendered on or **after October 11, 2005:**

Policy Number	Policy Name
76519	A-Scan

76090: Diagnostic Mammography – Policy Retired

The local medical review policy (LMRP) for diagnostic mammography - *76090* was previously revised on January 1, 2004. Based on data analysis and local standards of medical practice, it has been determined that this policy is no longer necessary and therefore, was retired.

This retirement is effective for services rendered on or after August 9, 2005. The full-text of this LMRP is available on the provider education web site at The full-text of this LMRP is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

88141: Pap Smears – Policy Retired

The local medical review policy (LMRP) for pap smears - *88141* was previously revised on October 1, 2004. Since that time, diagnosis code V72.31 (routine gynecological examination) has been added to the LMRP, per Change request 3659, effective July 1, 2005. In addition, the LMRP has been retired based on National Coverage Determination (Section 190.2) for screening pap smears and based on data analysis, as well as, local practice patterns for diagnostic pap smears.

This retirement is effective for services rendered on or after August 9, 2005. The full-text of this LMRP is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

90845: Psychoanalysis –Policy Retired

The local medical review policy (LMRP) for Psychoanalysis – *90845* was last revised on February 22, 2005. Since that time a

decision has been made to retire this local medical review policy (LMRP) policy based on data analysis and local standards of medical practice.

The effective date of retirement of this LMRP is for services rendered on or after November 15, 2005. The full-text of this LCD is available [illegible] after this effective date.

WIDESPREAD MEDICAL REVIEW PROBES

Using the 25 Modifier with 99211 when Billed with 85610

A widespread probe review was performed in 2005 on a sample of one hundred twenty-three (123) claims, with one hundred ninety-six (196) services, encompassing ninety-eight (98) beneficiaries. The following CPT codes billed on the same date of service by the same provider were reviewed:

99211 *Office or other outpatient visit for the evaluation and management (E&M) of an established patient that may not require the presence of a physician. Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.*

85610 *Prothrombin time*

Some of the *99211* codes reviewed were billed with a 25 modifier. Even though *99211* is allowed when billed with *85610*, as long as the requirements of *99211* are met, a 25 modifier is not indicated for *99211* as long as the evaluation and management (E&M) service is related to the management of the patient's prothrombin time.

However, when *99211* is billed with a significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service, the 25 modifier should be added to the E&M service.

ADDITIONAL INFORMATION ON LMRPS/LCDS

80500: Clinical Pathology Consultations and Clinical Laboratory Interpretation Services

The local medical review policy (LMRP) for *80500* Clinical Pathology Consultations and Clinical Laboratory Interpretations Services was retired effective January 1, 2005. The decision to retire this LMRP was based on data analysis and standards of local medical practice. The medical necessity criteria outlined in this LMRP was based on National Coverage Guidelines. The National Coverage Guidelines can be located in the Medicare Claims Processing Manual, Chapter 12, Section 60, subsection D and E. Prior to this manual becoming effective this information was located in the Medicare Carriers Manual, Part 3, Section 8318.1.

Change request 3467, transmittal 382, released 11-26-04 also references this issue. Please see these guidelines for coverage criteria for clinical pathology consultation services and clinical laboratory interpretation services. With the retirement of the LMRP the coverage has not and does not change and all requirements found in the references listed above must be met

for the services to be considered medically necessary. It would not be appropriate to submit claims for payment if the all requirements are not met.

The CMS Internet Only Manuals can be located at *http://www.cms.hhs.gov/manuals*. The full-text of this LMRP is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

Evaluation and Management Services Provided to Patients Admitted for "Observation Status"

The following codes are used to report evaluation and management services provided to patients designated/admitted as "observation status" in a hospital.

The supervising physician uses the initial observation codes (*99218-99220*) to report the encounter(s) with the patient when designated as "observation status." This includes the initiation of observation status, supervision of the care plan for observation, and performance of periodic reassessments. When the patient is admitted to observation status less than 8 hours on the same date, then the physician should use CPT codes *99218* through *99220* and no discharge code should be reported. When patients are admitted for observation care and then discharged on a different calendar date, the physician should use CPT codes *99218* through *99220* for the initial observation and CPT observation discharge code *99217* for the discharge on the separate day.

If a patient is admitted as an observation care patient for a period of 8 or more hours, but less than 24 hours, CPT codes *99234* through *99236* (observation, including admission and discharge services) can be billed. For a physician to appropriately report CPT codes *99234* through *99236* for Medicare payment, the patient must be an observation care patient for a minimum of 8 hours on the same calendar date. The physician must satisfy the documentation requirements for both admission to and discharge from observation care, including length of time for observation care.

Reference: Federal Register, Vol. 65, No. 212, November 1, 2000, pg. 65409

Hemophilia Clotting Factors – Billing and Coding

There has been inconsistent billing and handling of these claims causing an increase in redeterminations. The applicable HCPCS codes are:

J7190	Factor VIII (antihemophilic factor, human) per I.U.
J7191	Factor VIII (anti-hemophilic factor [porcine]), per I.U.
J7192	Factor VIII (antihemophilic factor, recombinant) per I.U.
J7193	Factor IX (antihemophilic factor, purified, non-recombinant) per I.U.
J7194	Factor IX complex, per I.U.
J7195	Factor IX (antihemophilic factor, recombinant) per I.U.
J7198	Anti-inhibitor, per I.U.
Q0187	Factor VIIa (coagulation factor, recombinant) per 1.2 mg
Q2022	Von Willebrand factor complex, human, per IU

Florida LMRP J7190 regulates Medicare coverage of hemophilia clotting factors locally. Access the *http://www.floridamedicare.com* website. Select the Part B section and click on the "final" link located under Medical Coverage/Local on the navigational menu.

To ensure that providers are paid correctly for these services, the following guidelines must be followed:

- The claims for **HCPCS codes J7190 - J7195, J7198, Q2022** must include the following information for EMC or paper claims:
  - EMC: Number of international units provided/supplied in the electronic equivalent field of Item 19 of CMS Form 1500 or the comment screen. In the electronic equivalent of the Days/Unit field (Item 24G), the number of units must be one (1).
  - PAPER CLAIMS: Number of international units provided/supplied in Item 19 of CMS Form 1500. In the Days/Unit field (Item 24G), the number of units must be one (1).
- The paper or EMC claims for **HCPCS code Q0187** must include the following information:
  - The number of units billed in the Days/Unit field (Item 24G) or its electronic equivalent. For example, if 4.8 mg were supplied, the number of units billed must be "4," because one unit billed corresponds to 1.2 mg.
  - No entry is required in Item 19 of CMS Form 1500 or its electronic equivalent when billing for HCPCS code Q0187.

When billing for hemophilia clotting factors, providers should not be submitting additional documentation with the claim. If necessary, First Coast Service Options, Inc. (FCSO) will request this information by means of an additional documentation request (ADR). The response to such a request must include the following information to support the medical necessity and reasonableness of the services:

- A letter/attestation of medical necessity from the treating physician. This must include the statement that he/she is the treating provider, the patient's diagnosis, and the patient's usual or anticipated dose requirement over time. If a patient requires unusually high doses of a particular clotting factor, the reason for this must be documented in this letter (such as a high antibody titer, extraordinary frequent bleeding episodes, etc.); and
- From the treating physician, the dosage prescribed for the claim in question. This information must be indicated in the above letter, in a separate statement, or in a current prescription; and
- Supplier invoice.

Guidelines for Independent Diagnostic Testing Facilities Specialty Manual Revision

The Medicare Guidelines for Independent Diagnostic Testing Facilities (IDTF) Manual was last revised in April 2005. This article serves as notice that First Coast Service Options, Inc. will no longer recognize The National Certification of Ultrasound Diagnostic Technologists (NCUDT) as an approved credentialing body.

The IDTF manual will be revised accordingly and may be viewed on the provider education website *http://www.floridamedicare.com*.

Impacted Cerumen Removal

Billing Article

The local medical review policy (LMRP) for Impacted Cerumen Removal – *69210* was retired on September 30, 2004 based on data analysis and local standards of practice. This article is being published in order to clarify the correct billing for impacted cerumen removal.

Removal of impacted cerumen usually entails one or more of three methods of removal. The first two methods of cerumen removal must be either personally performed by the physician, or performed by the physician's employees under the "incident to" provision. Simple cerumen removal which entails two methods, either through irrigation of the ear canal(s) or involves the use of chemical solvents, which are used to soften the cerumen in order to facilitate the removal of cerumen, and is considered part of the evaluation and management service, (procedure codes *99211-99275, 99289-99290-99316, 99331-99333, 99347-99357*). Therefore, simple cerumen removal is not separately reimbursable with procedure code *69210* or G0268. The third method of cerumen removal is manual disimpaction. This method is performed by the physician under binocular magnification and generally entails grasping the cerumen plug with forceps, application of suction, and/or extraction with a right-angle hook. In cases of severely impacted ears, injections of local anesthesia may be required. Florida Medicare will consider only the manual disimpaction method of cerumen removal reimbursable as a separate procedure (*69210* or G0268).

Stereotactic Radiosurgery and Stereotactic Radiotherapy

Coding Guide

Stereotactic radiosurgery is a form of external beam radiation that delivers a high-dose during a single session to shrink or destroy lesions while leaving tissue surrounding the lesion unaffected. Initially restricted to intracranial lesions, advances in technology have extended interventions to other parts of the body for lesions inaccessible or unsuitable for open surgery. The stereotactic techniques have incorporated single session high-dose, hyper fractionation (currently defined as 2-5 high-dose sessions), and conventional fractionation collectively referred to as stereotactic radiotherapy (SRT). Stereotactic radiotherapy relies on reproducible spatial correlation of the target of interest and the radiation source using computer generated three dimensional simulations. This can be accomplished with several methodologies including specially designed external frames, implanted fiducial markers or imaging techniques.

Currently FCSO does not have a local medical policy addressing stereotactic radiotherapy. Specifically, body radiation therapy (therapy outside the CNS) is considered an emerging technology as indicated by the assignment of a Category III Code in 2005. Review of current literature and discussion with Radiation Oncologists suggest that there is no consensus on the optimal technology (planning and Rx delivery) for given indications.

Currently there are satisfactory coding and billing guidelines for hospitals to submit claims to the FI for stereotactic radiotherapy treatment planning and delivery. Free standing facilities that bill the Carrier should use this article as a guide to coding and billing the Carrier when applicable given there are no active HCPCS codes with pricing in the Medicare Fee Schedule for claims administration of stereotactic radiotherapy treatment planning and delivery. Claims to the Carrier will continue to be developed for documentation and evaluated for coverage and payment on individual consideration. The documentation must show what was done. Also it must support that the intervention was medical necessary and reasonable for the condition as well as superior to conventional radiation therapy or IMRT given the risk and benefit to the beneficiary.

This coding article addresses:

- Physician *treatment management* services: Stereotactic radiation therapy & radiosurgery is an emerging technology and involves a process of care directed by radiation oncologist, in some cases neurosurgeons, and other allied health care professionals.
- Stereotactic radiation therapy & radiosurgery *treatment planning* and *delivery* given with either Co 60 gamma rays or with mega voltage photons from a linear accelerator for claims submitted to the Carrier from a free standing facility. The goal of these treatments is great accuracy and precision in the delivery of dose to the planned target.

The conduct of a course of radiation therapy includes an episode of care with steps of consultation, clinical treatment planning, establishment of treatment parameters, and treatment delivery & management. All of the coding encompassed in an episode of care is not addressed in this article. However, it is expected that professional and technical components billed to Medicare on behalf of a beneficiary are medically necessary and reasonable with no duplication of services within the episode of care unless the medical necessity of the repeated or duplicated services is clearly documented. If multiple providers are involved in the patient's episode of care, clinical treatment planning, establishment of treatment parameters, and treatment delivery & management should be appropriately coordinated.

Coding of CPT/HCPCS Codes

SRT Treatment Management:

61793 Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions.

- Reported for work attributed to neurosurgeon or surgeon
- Same physician cannot report 77427-77432

77432 Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session):

- Generally reflects the work by the radiation oncologist

0083T Stereotactic body radiation therapy, treatment management, per day

- SRT per day management of non cerebral lesions
- Do not report 0083T in conjunction with 77427-77432, 61793

Free Standing Facilities billing technical work to the Carrier

SRT Treatment Planning:

77295-TC Therapeutic radiology simulation-aided field setting; three-dimensional, per course of treatment

Or one of the following, as appropriate:

LINAC based

G0338 Linear accelerator based stereotactic radiosurgery plan, including dose volume histograms for target critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment

Cobalt 60-based

G0242 Multi-source photon stereotactic radiosurgery (cobalt-60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment

SRT Treatment Delivery:

0082T Stereotactic body radiation therapy, treatment delivery, one or more treatment areas, per day

Use G codes as outlined below, if appropriate, unless more than five sessions, then use 0082T (per day) as noted.

The work should reflect the following descriptors currently used in the hospital setting:

LINAC based

- Image-guided robotic LINAC treatment

G0339 Image guided robotic linear accelerator base stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment

G0340 Image guided robotic linear accelerator base stereotactic radiosurgery, delivery including collimator changes in custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment

- Non-robotic LINAC treatment

G0173 Stereotactic radiosurgery, complete course of therapy in one session

G0251 Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment

- Cobalt 60-based

G0243 Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions

A Review of ICD-9 CM Coding for HIV Testing

A recent claims review of CPT *87536* (HIV Quantification) denials demonstrated that many of the denials were diagnosis/medical necessity related. It was observed that many of the ICD-9-CM codes listed for CPT *87536* (HIV Prognosis and Monitoring) actually supported medical necessity for *HIV Testing*.

HIV Prognosis and Monitoring Codes (Quantification)

Quantification assays of HIV plasma RNA are used prognostically to assess relative risk for disease progression and predict time to death, as well as to assess efficacy of antiretroviral therapies over time. Studies indicate that HIV RNA levels can

A Review of ICD-9 CM Coding for HIV Testing, continued

predict disease progression, assist in making decisions when to stop using an ineffective treatment and when to add or switch to a new treatment and allow patients/physicians to make treatment decision much earlier, prior to a significant loss of CD4 cells and before clinical decline occurs. CD4 cell loss is thought to be a relatively late result of increased HIV replication.

HIV quantification is achieved through the use of assays that measure the amount of circulating RNA. The tests employ nucleic acid amplification techniques to enhance sensitivity and the results are expressed as the HIV copy number.

Codes for HIV Quantification Tests

Code	Descriptor
87536	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification*
87539	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, quantification*

HIV Diagnostic Codes

Diagnosis of Human Immunodeficiency Virus (HIV) infection is primarily made through the use of serologic assays. These assays take one of two forms: antibody detection assays and specific HIV antigen procedures. Currently, there are a total of 10 HIV diagnostic codes covered by the Medicare program for these tests. Please refer to Laboratory Nation Coverage Decision, Human Immunodeficiency Virus Diagnosis Testing (Section 190.14).

Codes for HIV Diagnostic Tests

Code	Descriptor
86689	*Qualitative or semiquantitative immunoassays performed by multiple step methods; HTLV or HIV antibody, confirmatory test (for example, Western Blot)*
86701	*Qualitative or semiquantitative immunoassays performed by multiple step methods; HIV-1*
86702	*Qualitative or semiquantitative immunoassays performed by multiple step methods; HIV-2*
86703	*Qualitative or semiquantitative immunoassays performed by multiple step methods; HIV-1 and HIV-2, single assay*
87390	*Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-1*
87391	*Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; HIV-2*
87534	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique*
87535	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique*
87537	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, direct probe technique*
87538	*Infectious agent detection by nucleic acid (DNA or RNA); HIV-2, amplified probe technique*

The CMS Medicare National Coverage Database website has both Laboratory National Coverage Decisions in their entirety with test specific information and a complete list of covered ICD-9 codes (updated quarterly). For Human Immunodeficiency Virus Testing (Diagnosis) see section 190.14 and for Human Immunodeficiency Virus Testing (Prognosis Including Monitoring) see section 190.13. Please refer to these documents for more detailed information.

Local Medical Review Policy to Local Coverage Determination Conversion

Section 522 of the Benefits Improvement and Protection Act (BIPA), created the term "local coverage determination (LCD)." The Centers for Medicare and Medicaid Services (CMS) published the final rule establishing LCDs on November 11, 2003. Beginning December 7, 2003, local policies were referred to as LCDs, and contractors issued draft and new policies as LCDs. All existing local medical review policies (LMRPs) shall be converted to LCDs no later than December 2005.

Policies Revised to Identify Diagnoses That Are Considered Secondary Diagnosis Codes

The use of "E" diagnosis codes is supplemental to the application of ICD-9-CM diagnosis codes. "E" diagnosis codes are never to be recorded as principal diagnoses. "E" diagnosis codes provide classification of environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. Where an "E" code from the "Supplementary Classification of External Causes of Injury and Poisoning" section of the International Classification of Diseases is applicable, it is intended that it shall be used in addition to a code from one of the main chapters of ICD-9-CM, indicating the nature of the condition. Certain other conditions, which may be stated as being due to external causes, should be used as an additional code for more detailed analysis.

ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The "Supplementary Classification of Factors Influencing Health Status and contact with Health Services" section of the International Classification of Diseases is provided to deal with occasions when circumstances other than a disease or injury are recorded as a diagnosis or problem. Certain "V" diagnosis codes may only be used as secondary codes and are identified as such in the International Classification of Diseases.

Applicable policies have been revised to identify those diagnosis codes that can only be used as secondary diagnosis codes.

FLORIDA MEDICARE PART B MAIL DIRECTORY

CLAIMS SUBMISSIONS

Routine Paper Claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating Providers
Medicare Part B Participating Providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic Claims
Medicare Part B Chiropractic Unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance Claims
Medicare Part B Ambulance Dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare Secondary Payer
Medicare Part B Secondary Payer Dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD Claims
Medicare Part B ESRD Claims
P. O. Box 45236
Jacksonville, FL 32232-5236

COMMUNICATIONS

Redetermination Requests
Medicare Part B Claims Review
P. O. Box 2360
Jacksonville, FL 32231-0018

Fair Hearing Requests
Medicare Part B Fair Hearings
P. O. Box 45156
Jacksonville, FL 32232-5156

Administrative Law Judge Hearing
Administrative Law Judge Hearing
P. O. Box 45001
Jacksonville, FL 32231-5001

Status/General Inquiries
Medicare Part B Correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B Financial Services
P. O. Box 44141
Jacksonville, FL 32231-4141

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims
Palmetto GBA Medicare
DMERC Operations
P. O. Box 100141
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

MISCELLANEOUS

Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Medicare Communication and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For Seminar Registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare Claims for Railroad Retirees:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and Abuse
First Coast Service Options, Inc.
P. O. Box 45087
Jacksonville, FL 32232-5087

FLORIDA MEDICARE PHONE NUMBERS

BENEFICIARY

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

PROVIDERS

Toll-Free
Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992

For Seminar Registration Only (*not* toll-free)**:**
1-904-791-8103

EMC

Format Issues & Testing:
1-904-354-5977 option 4
Start-Up & Front-End Edits/Rejects:
1-904-791-8767 option 1
Electronic Funds Transfer
1-904-791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
PC-ACE Support:
1-904-355-0313
Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
Help Desk:
(Confirmation/Transmission):
1-904-905-8880 option 1

OCR

Printer Specifications/Test Claims:
1-904-791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
1-803-735-1034

MEDICARE PART A

Toll-Free:
1-877-602-8816

Medicare Websites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com

Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

MEDICARE PRESCRIPTION DRUG COVERAGE

Coming in 2006! – Medicare Prescription Drug Coverage

Beginning January 1, 2006, Medicare prescription drug coverage will be available to people with Medicare. Health care professionals can find information about this new coverage at *http://www.cms.hhs.gov/medlearn/drugcoverage.asp*, on the CMS website.

Source: Joint Signature Memorandum 05541, 09-22-05

New Educational Products Available on Medicare Prescription Drug Coverage

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, health care professionals, providers, suppliers, and staff who provide service to people with Medicare.

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to all people with Medicare.
- It will cover brand name and generic drugs.
- Drugs that are currently covered by Medicare Part B will continue to be covered by Part B.
- This new drug coverage is not automatic - all people with Medicare will need to make a decision this fall. Since you're a trusted source, your patients may turn to you for information about this new coverage. Therefore, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients learn more about this new coverage.
- You should encourage all your Medicare patients to learn more about the new prescription drug coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.
- If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to *http://www.medicare.gov* for additional information and assistance.

Medicare prescription drug coverage under Part D will be administered through Medicare Advantage Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs). For Medicare beneficiaries who join a MA-PD or a PDP, their provider must have a contractual relationship with that MA-PD or PDP to bill and receive payment from the plans for that individual's covered prescription drugs. FFS providers cannot bill Medicare fiscal intermediaries (FIs) or carriers for Part D covered drugs.

Our next article in this series will provide further information on Part B versus Part D billing.

New Products Available on http://www.cms.hhs.gov/medlearn/drugcoverage.asp

New products are available to download at the *Medicare Prescription Drug Coverage Information for Providers* Web page. This page is dedicated to providing the latest drug coverage information for Fee-For-Service (FFS) Medicare providers. The new products include the following:

Medicare Rx Training Course: Important Information for Health Care Professionals – Earn CME Credit

This training course covers important information about Medicare prescription drug coverage, including the fundamental components of the program, types of drug plans available, resources for people with Medicare and health care professionals, and important dates in 2005 and 2006.

The University of Kansas Medical Center (KUMC) is offering Continuing Education Credit for this course in coordination with the Centers for Medicare & Medicaid Services (CMS):

- **Doctors:** 1.5 CME Category 1 Credit
- **Nurses:** 1.8 CNE Contact Hours
- **Other Health Care Professionals:** 1.5 Credit Hours

Once you complete the course and receive a passing score on the post-assessment, you will be provided with a link to KUMC. KUMC will charge a nominal fee for credit courses.

Physician Brochure

This publication explains the new Medicare prescription drug coverage for physicians and their staff.

Physician Tear-off Sheet

This resource is appropriate for distribution in physicians' offices and other clinical settings. It contains basic information on the new coverage, as well as contact numbers for each state's State Health Insurance Assistance Program (SHIP). The SHIPs will direct people with Medicare to resources for individual counseling.

"Have Limited Income? SSA Can Help" - Posters for Your Office or Clinic

These posters direct people with Medicare who have limited income and resources to sources for help with prescription drug costs. The posters are suitable for display in healthcare settings where people with Medicare and their caregivers will see the information. To view and order the posters, go to *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website.

New Beneficiary Publications Available

New publications for people with Medicare that explain various aspects of the new coverage are available at *http://www.cms.hhs.gov/medlearn/drugcoveragepubs.asp* on the CMS website.

Additional Information

To find Medicare Prescription Drug Plans available in each state, visit the Landscape of Local Plans on the Medicare website for a complete listing.

You can use the new Medicare Prescription Drug Plan Finder to help people with Medicare learn about the new Medicare prescription drug coverage, find and compare prescription drug plans that meet personal needs, and enroll in the prescription drug plan that is right for him/her.

The new Formulary Finder on the Medicare website will help people with Medicare find plans in each state that match their required drug lists.

Bookmark the Medicare Prescription Drug Coverage Information for Providers page, *http://www.cms.hhs.gov/medlearn/drugcoverage.asp*, for the latest information and educational resources.

Medlearn Matters Number: SE0559 Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A Related CR Transmittal #: N/A Implementation Date: N/A

Clarification on Part D and Fee-For-Service Providers, New Web-based Educational Products, and the Latest Information on Medicare Prescription Drug Coverage

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, suppliers, and their staff who provide service to people with Medicare

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.
- It will cover brand name and generic drugs.
- This new drug coverage requires all people with Medicare to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Therefore, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients.
- You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.
- If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to *http://www.medicare.gov* for information and assistance.

Clarifying Information for Fee-For-Service (FFS) Medicare Providers

Billing for Drugs Covered Under Part D

There has been some confusion among FFS providers regarding their ability to bill drugs covered under Part D, commonly referred to as "Medicare Prescription Drug Coverage." In short, being an enrolled provider in the FFS program does not impart Part D-related billing privileges. Medicare Part B covers a limited number of prescription drugs and biologicals. Currently, covered Medicare drugs generally fall into three categories:

- Drugs furnished incident to a physician's service;
- Drugs furnished through a Medicare Part B covered item of durable medical equipment (DME); and
- Drugs specifically covered by statute (for example, oral immunosuppressive drugs).

These drugs continue to be covered and paid for under the FFS Medicare program (i.e., Part B) and FFS providers (e.g., physicians, hospitals, and pharmacies) will continue to bill their carriers, fiscal intermediaries, and durable medical equipment regional carriers (DMERCs) for these drugs.

This coverage under Part B continues after the January 1, 2006 effective date for Part D. (For a more detailed discussion of Medicare Part B covered drugs, see http://www.cms.hhs.gov/providers/drugs/ on the CMS website.)

How Medicare Prescription Drug Coverage Will be Administered

Medicare prescription drug coverage under Part D will be administered through Medicare Advantage Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs). For a person with Medicare who joins an MA or a PDP, their provider must have a contractual relationship with that MA-PD or PDP to bill and receive payment from the MA-PDP or PDP for that individual's covered prescription drugs. This is true regardless of whether or not the provider is enrolled in the FFS Medicare program and billing FFS Medicare for Medicare Part B covered drugs.

Example: Suppose a pharmacy is currently receiving payment under Medicare Part B for an individual's Medicare Part B covered drug, albuterol, delivered through a *nebulizer,* which is considered to be DME. The pharmacy would, as they do today, bill the local DMERC for this drug. The same individual has joined a PDP and has coverage of albuterol *delivered through a metered dose inhaler (*which is not considered DME under Part B). The pharmacy can only bill the MA-PD or PDP for covered albuterol delivered through a metered dose inhaler if the pharmacy has a contractual relationship with that MA-PD or PDP.

New Information on the Medicare Prescription Drug Coverage Information for Providers Web Page

The following new information can be found on the Medicare Prescription Drug Coverage Information for Providers web page at *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website.

Toolkit for Health Professionals: Medicare Prescription Drug Coverage

The Centers for Medicare & Medicaid Services (CMS) has released the Toolkit for Health Care Professionals: Medicare Prescription Drug Coverage, available as an Adobe PDF file (860Kb) at *http://www.cms.hhs.gov/medlearn/provtoolkit.pdf* on the CMS web site. This toolkit includes downloadable educational materials specifically for physicians and other health care professionals and their staff to learn the basics about Medicare Prescription Drug Coverage. It also includes materials that can be distributed to Medicare patients. The kit contains reproducible artwork, a letter from the CMS Administrator, a fact sheet (English and Spanish), a brochure, an article, and a list of other resources. You may add your logo and business information to these materials and copy freely.

Limited Income? SSA Can Help - Posters to Display in Health Care Settings

Flat wall posters directing people with Medicare who have limited income to a number they can call to find out if they are eligible for help with prescription drug costs are available now. Posters are suitable for display in a physician's, provider's or supplier's office, a pharmacy, or other health care setting where people with Medicare will see this information. Easel posters are no longer available. To order, visit the Medlearn Product Ordering Page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS website.

New Fact Sheets Available On the Medicare Website

The following Fact Sheets are now available at *http://www.medicare.gov*. These can help your patients better understand Medicare's new prescription drug coverage:

Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Have Coverage from an Employer or Union (Publication Number 11107)

Basic information about Medicare's new prescription drug coverage for people who have prescription coverage from an employer or union. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11107.pdf*.

Quick Facts about Medicare's New Coverage for Prescription Drugs for People with a Medicare approved Drug Discount Card (Publication Number 11104)

Basic information about Medicare's new prescription drug coverage for a person with a Medicare-approved drug discount card. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11104.pdf.*

New Medicare Prescription Drug Coverage—Who Can Help Me Apply and Enroll? (Publication Number 11125)

Explains who can help people with Medicare apply for extra help in paying for prescription drug costs and join a Medicare prescription drug plan. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11125.pdf*.

Quick Facts about Medicare's New Coverage for Prescription Drugs for People in a Medicare Health Plan with Drug Coverage (Publication Number 11135)

Basic information about Medicare's new prescription drug coverage for people with a Medicare health plan with prescription drug coverage. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11135.pdf*.

New Medicare Prescription Drug Coverage: A Message for People Who Care for Someone with Medicare (Publication Number 11126)

Explains Medicare's new prescription drug coverage to those who make health care decisions for people with Medicare. (4 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11126.pdf*.

Quick Facts about Medicare's New Coverage for Prescription Drugs for Alaskans with Limited Income and Resources (Publication Number 11105_AK)

Basic information about Medicare's new prescription drug coverage for a person with limited income and resources in Alaska. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11105_AK.pdf*.

Quick Facts about Medicare's New Coverage for Prescription Drugs for Hawaiians with Limited Income and Resources (Publication Number 11105_HI)

Basic information about Medicare's new prescription drug coverage for a person with limited income and resources in Hawaii. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11105_HI.pdf.*

Quick Facts About Medicare Prescription Drug Coverage and Protecting Your Personal Information (Publication Number 11147)

Information about how people with Medicare can protect their personal information when dealing with plans and others about Medicare prescription drug coverage. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11147.pdf*.

New Publications Available on the CMS Website

The following new publications are available by going to *http://www.cms.hhs.gov/medicarereform/factsheets.asp* on the CMS website and clicking on the appropriate links described below:

Basic Questions and Answers About Prescription Drug Coverage

We encourage you to use these basic questions and answers to respond to inquiries from people with Medicare: *http://www.cms.hhs.gov/partnerships/news/mma/qsandas.pdf*.

What Medicare Prescription Drug Coverage Means to You: A Guide to Getting Started

A new brochure available to explain the basics of prescription drug coverage: *http://www.cms.hhs.gov/medicarereform/91007_MedicareBrochure.pdf*.

Additional Information

More information on provider education and outreach regarding drug coverage can be found at *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website.

Detailed drug coverage information for CMS partners and advocates for people with Medicare can be found at *http://www.cms.hhs.gov/partnerships/news/mma/default.asp* on the CMS website.

You can also find additional information regarding prescription drug plans at *http://www.cms.hhs.gov/pdps* on the CMS website.

Further information on CMS implementation of the Medicare Modernization Act MMA can be found at *http://www.cms.hhs.gov/medicarereform/* on the CMS website.

Related Change Request (CR) #: N/A Medlearn Matters Number: SE0557
Related CR Release Date: N/A

What Do You Say when Asked About the New Medicare Prescription Drug Coverage

The Centers for Medicare & Medicaid Services has updated the public service announcements (PSAs) for health care professional previously communicated through the JSM (joint signature memo) 05541, and the Provider Education Resources Listserv, Message 200509-08.

The PSAs are designed to give health care professionals additional resources should their patients ask about the Medicare prescription drug coverage. The PSAs are posted on the CMS website under the heading, "Public Service Announcements (PSAs) for Health Care Professionals" at:

http://www.cms.hhs.gov/medlearn/psa_vert_92305.pdf

http://www.cms.hhs.gov/medlearn/psa_horz_92305.pdf

Please note that both versions contain the same content; one is a vertical orientation and the other is a horizontal orientation.

Source: CMS Joint Signature Memorandum 05541, September 22, 2005
Provider Education Resources Listserv, Message 200509-11

Public Service Announcements on Prescription Drug Coverage Available

The Centers for Medicare & Medicaid Services (CMS) has developed public service announcements (PSAs) for the provider community to increase awareness of the new prescription drug coverage and the resources available to assist people with Medicare. There are two versions of the PSAs. The only difference between the two is the graphics and orientation (horizontal versus vertical). The PSAs are posted on the CMS website under the heading, "Basic Information for Health Care Professionals."

The Web page address is: *http://www.cms.hhs.gov/medlearn/drugcoverage.asp*.

Source: Source: Provider Education Resources Listserv, Message 200509-08

New Products on Medicare Drug Coverage for Health Care Professionals

The Centers for Medicare & Medicaid Services (CSM) has developed two new PowerPoint® educational products for health care professionals and others who want to learn more details about the Medicare Prescription Drug Coverage program. These products are available on CMS website at *http://www.cms.hhs.gov/medlearn/drugcoverage.asp*.

These PowerPoint slides are available in two versions:

1) a comprehensive version that contains detailed information.
2) an abbreviated version that is suitable for short presentations or a quick overview.

These PowerPoint slides may be used for presentations or for individuals to review to learn more about the Medicare Drug Coverage program. The shorter version is suitable for "Lunch and Learn" sessions, short seminars/lectures, or as part of "grand rounds."

CMS is currently marketing these materials to entities who accredit educational products with the suggestion that they make this information available to health care professionals for continuing education credit. As CMS becomes aware of entities that pick up this product and offer it for CME, their Web links will be posted to CMS Medlearn drug coverage Web page.

Source: Provider Education Resources Listserv, Message 200509-2

Posters Now Available!

Posters titled "Have Limited Income? Social Security Can Help with Prescription Costs" can be ordered free of charge on the Centers for Medicare and Medicaid Services' (CMS) website. The posters are suitable for display in a physician's, provider's, or supplier's office, a pharmacy, or other health care setting where Medicare beneficiaries will see this information. The posters direct Medicare beneficiaries with limited income to a toll free number where they can find out if they are eligible for help with prescription drug costs. Flat posters are suitable for wall display. Easel posters are suitable for counter display. Order the size and style appropriate for your use. Artwork cannot be specified, as posters will be sent based on availability at the time the order is received. To view and order the posters, go to the Medlearn Prescription Drug Coverage Web page located at *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website.

We need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

Source: JSM 05355 dated May 20, 2005

PREVENTIVE SERVICES

Informational and Educational Materials for the New Preventive Services

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and Fiscal Intermediaries (FIs)

Introduction

This Special Edition article provides an overview of the many informational and educational products developed by the Centers for Medicare & Medicaid Services (CMS) to inform and educate physicians, providers, suppliers, and other health care professionals, including non-physician practitioners, about the array of Medicare-covered preventive services and screenings available. These include the following three new services that became effective January 1, 2005:

- Diabetes Screening Tests
- Cardiovascular Screening Blood Tests
- The Initial Preventive Physical Examination (IPPE)

(For the purpose of this article, non-physician practitioners are physician assistants, nurse practitioners, or clinical nurse specialists.)

Note: It is important to emphasize that the diabetes screening tests and cardiovascular screening blood tests are each stand alone billable services separate from the Initial Preventive Physical Examination (IPPE) or "Welcome to Medicare" Physical Exam. The IPPE is a unique benefit for beneficiaries new to the Medicare program. This benefit must be received in the first six months after the effective date of the beneficiary's first Part B coverage period, which must begin on or after January 1, 2005.

To ensure that your Medicare patients receive the best possible health care, it is important to be aware of the preventive benefits available for these patients.

Diabetes Screening Tests

Section 613 of the MMA provides for coverage, under Medicare Part B, of diabetes screening tests, effective for services furnished on or after January 1, 2005, for beneficiaries at risk for diabetes (see eligibility below) or those diagnosed with pre-diabetes.

Medicare provides coverage for the following diabetes screening blood tests:

- A fasting blood glucose test; and
- A post-glucose challenge test:
- an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults; or
- a two-hour post-glucose challenge test alone.

Who Is Eligible?

To be eligible for the diabetes screening tests, beneficiaries must have any of the risk factors or at least two of the characteristics discussed below.

Risk Factors

Individuals who have any of the following risk factors are eligible for diabetes screening:

- Hypertension;
- Dyslipidemia;
- Obesity (with a body mass index greater than or equal to 30 kg/m2); or
- Previous identification of elevated impaired fasting glucose or glucose tolerance.

Characteristics

Alternatively, individuals who have a risk factor consisting of at least two of the following characteristics are eligible for diabetes screening:

- Overweight (a body mass index >25, but <30kg/m2);
- A family history of diabetes;
- Age 65 years or older; or
- A history of gestational diabetes mellitus or giving birth to a baby weighing > 9 lb.

Frequency of Screening Tests

Effective for services performed on or after January 1, 2005, Medicare provides coverage for diabetes screening tests with the following frequency:

- Two screening tests per calendar year are covered for individuals diagnosed with pre-diabetes.
- One screening test per year is covered for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested.

Nationally Non-Covered Indications

- No coverage is permitted under the MMA benefit for individuals previously diagnosed with diabetes.
- Other diabetes screening blood tests for which Medicare has not specifically indicated national coverage continue to be non-covered.

CMS provides the following definitions for the purpose of this article:

Diabetes: diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on two different occasions; a 2-hour post-glucose challenge > 200 mg/dL on two different occasions; or a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

Pre-diabetes: abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to125 mg/dL, or a 2-hour post-glucose challenge of 140 to 199 mg/dL. The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance.

Post-glucose challenge test: an oral glucose tolerance test with a glucose challenge of 75 gms of glucose for non-pregnant adults, or a 2-hour post-glucose challenge test alone.

Reimbursement

Reimbursement for the diabetes screening tests is made under the Medicare Clinical Laboratory Fee Schedule. There is no deductible or co-payment for this benefit.

For detailed instructions regarding Type of Bills (TOBs) to use, including special instructions for Maryland Hospitals and Critical Access Hospitals (CAHs), see CR3637 (Transmittal 446, Re-issued on January 21, 2005, "MMA – Diabetes Screening Tests") at *http://www.cms.hhs.gov/manuals/pm_trans/R446CP.pdf* on the CMS website. There is a related Medlearn Matters article (MM3637) at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3637.pdf* on the CMS website.

Cardiovascular Screening Blood Tests

Section 612 of the MMA provides for coverage, under Medicare Part B, of cardiovascular screening blood tests (tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk for that disease) effective for services performed on or after January 1, 2005.

The MMA permits coverage of tests for cholesterol and other lipid or triglycerides levels for this purpose.

Therefore, effective January 1, 2005, coverage is provided for the following three screening blood tests:

- Total cholesterol test;
- Cholesterol test for high density lipoproteins; and
- Triglycerides test.

Other cardiovascular screening tests for which CMS has not specifically indicated national coverage continue to be non-covered.

The implementation of this new benefit permits Medicare beneficiaries who have not been previously diagnosed with cardiovascular disease to receive cardiovascular screening blood tests for risk factors associated with cardiovascular disease. This includes individuals who have no prior knowledge of heart problems but recognize that their behavior or lifestyle may put them at risk because of diet or lack of exercise.

Under Part B, Medicare provides coverage for each of these three cardiovascular screening blood tests once every five years (i.e., 59 months after the last covered screening tests). These tests must be ordered by the physician who is treating the beneficiary for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms.

Reimbursement

Reimbursement for the cardiovascular screening blood tests is made under the Medicare Clinical Laboratory Fee Schedule. There is no deductible or co-payment for this benefit.

Details regarding HCPCS/CPT codes and diagnosis codes, and how carriers and intermediaries will treat claims, are described in CR3411 (Transmittal 408, dated December 17, 2004, "MMA – Cardiovascular Screening Blood Tests," which can be found at *http://www.cms.hhs.gov/manuals/pm_trans/R408CP.pdf* on the CMS website. In addition, there is a related Medlearn Matters article (MM3411) at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3411.pdf* on the CMS website.

The Initial Preventive Physical Examination (IPPE)

Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), provides for coverage, under Medicare Part B, of an Initial Preventive Physical Examination (IPPE), including a screening electrocardiogram (EKG) for new beneficiaries, effective for services furnished on or after January 1, 2005 (subject to certain eligibility and other limitations).

Once in a Lifetime Benefit

The IPPE is a once-in-a-lifetime benefit that must be performed within six months after the effective date of the beneficiary's first Part B coverage, but only if such Part B coverage begins on or after January 1, 2005.

An IPPE furnished on January 10, 2005, for example, to a beneficiary whose Medicare Part B coverage was effective initially on December 1, 2004, would not be covered under this benefit. If a beneficiary is first covered by Part B on January 1, 2005, however, then a physical provided on January 10, 2005 ***would*** be covered by this new benefit.

This service provides for payment for an IPPE to be performed in various provider settings by physicians, or qualified non-physician practitioners (NPPs). However, coverage is provided for only one IPPE per beneficiary lifetime.

Services Included in the IPPE Visit

The complete IPPE visit consists of all of the following services furnished to a beneficiary with the goal of health promotion and disease detection:

1) Review of an individual's medical and social history, with attention to modifiable risk factors for disease detection

This review includes, at a minimum, past medical and surgical history, such as experience with illnesses, hospital stays, operations, allergies, injuries and treatments, current medication and supplements (including calcium and vitamins), family history (including diseases that may be hereditary or place the individual at risk), and social history of alcohol, tobacco, and illicit drug use, diet, and physical activities.

2) Review of an individual's potential (risk factors) for depression

This review includes current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression.

The physician or other qualified NPP may select a screening instrument from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.

3) Review of the individual's functional ability and level of safety

This review is based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations. The review must include, at a minimum, a review of hearing impairment, activities of daily living, risk of falls, and home safety.

4) An examination

This examination includes measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified NPP, based on the individual's medical and social history (refer to service element 1) and current clinical standards.

5) Performance and interpretation of an EKG

As required by statute, the IPPE benefit always includes a screening EKG. If the primary physician or qualified NPP is not able to perform the EKG during the IPPE visit, arrangements should be made for the beneficiary to be referred to another physician or entity to perform and interpret the EKG. The primary physician or qualified NPP must document the results of the screening EKG in the beneficiary's medical record to complete and bill for the IPPE benefit. Both the IPPE and the screening EKG must be performed and interpreted before the physician, qualified NPP, and/or entity can submit the claims.

6) Education, counseling, and referral

These will be conducted, as deemed appropriate, by the physician or qualified NPP, based on the results of the review and evaluation services described in the previous five elements.

7) Education, counseling, and referral for other preventive services

Education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are covered separately under Medicare Part B. These services include the following:

- Pneumococcal, influenza, and hepatitis B vaccines and their administration
- Screening mammography
- Screening pap smear and screening pelvic examinations
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetes outpatient self-management training services
- Bone mass measurements
- Screening for glaucoma
- Medical nutrition therapy for individuals with diabetes or renal disease
- Cardiovascular screening blood tests
- Diabetes screening tests.

Note: The MMA did not make any provision for the waiver of Medicare coinsurance and Part B deductible for the IPPE. Payment for this service would be subject to the required deductible, which is $110 for calendar year 2005, if the deductible has not been met, with the exception of federally qualified health centers (FQHCs). In addition, the usual coinsurance provisions would apply.

For more detailed instructions regarding HCPCS codes to use, including special instructions for rural health clinics/federally qualified health centers (RHCs)/FQHCs, Maryland hospitals, critical access hospitals (CAHs), and indian health service (IHS) hospitals, review change request (CR) 3638 (transmittal 417, dated December 22, 2004, "MMA – Initial Preventive Physical Examination") at *http://www.cms.hhs.gov/manuals/pm_trans/R417CP.pdf* on the CMS website. You can also view the related Medlearn Matters article (MM3638) at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3638.pdf* on the CMS website.

Preventive Services Informational and Educational Products

CMS has developed a variety of informational and educational products for health care professionals to:

- Increase your awareness about Medicare's coverage for disease prevention and early detection;
- Provide you with important information about Medicare coverage, coding, billing, and reimbursement;
- Help you file preventive services claims effectively; and
- Give you information that will equip you to encourage utilization of these benefits.

The *Additional Information* section of this Special Edition article will tell you where you can find informational/educational products specifically for Medicare beneficiaries.

The following informational and educational products have been developed especially for you, the Medicare fee-for-service physician, provider, supplier, and health care professional.

The Preventive Services Educational Resource Web Guide

CMS has developed a Medlearn Web page where Medicare fee-for-service providers can find links to all provider/supplier specific informational and educational related preventive services products and resources.

The Web page is located at *http://www.cms.hhs.gov/medlearn/preventiveservices.asp* on the CMS website. Access to products discussed in this Special Edition article can be found on that Web page.

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals

This comprehensive guidebook to Medicare-covered preventive services and screenings is intended to provide physicians, providers, suppliers, and other health care professionals that bill Medicare fee-for-service contractors with information on coverage, coding, billing, and reimbursement to help them file claims effectively.

It also gives providers information that will enable them to encourage utilization of these benefits as appropriate. You may order a print copy of *The Guide* or download, view, and print a copy by going to *http://www.cms.hhs.gov/medlearn/preventive/psguide.asp* on the CMS website.

Brochures

Five two-sided, tri-fold brochures provide an overview of the coverage information for each preventive service covered by Medicare. These brochures may be ordered through the Medlearn product ordering system, or they may be downloaded, viewed, and printed at *http://www.cms.hhs.gov/medlearn/preventiveservices.asp* on the CMS website.

Expanded Benefits

The *Expanded Benefits* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for the three new preventive services and screenings (the IPPE, cardiovascular screening blood tests, and diabetes screening tests), as well as other covered diabetes benefits. This brochure can be found at *http://www.cms.hhs.gov/medlearn/expanded_benefits_06-08-05.pdf* on the CMS website.

Cancer Screenings

The *Cancer Screenings* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for screening mammography, screening Pap test, pelvic examination, colorectal cancer screening, and prostate cancer screening benefits. This brochure can be found at *http://www.cms.hhs.gov/medlearn/cancer_screening_06-08-05.pdf* on the CMS website.

Adult Immunizations

The *Adult Immunizations* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for influenza, hepatitis B, and pneumococcal polysaccharide vaccines and their administration. This brochure can be found at *http://www.cms.hhs.gov/medlearn/adult_immunization_06-08-05.pdf* on the CMS website.

Glaucoma Screening

The *Glaucoma Screening* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for the glaucoma screening benefit. This brochure can be found at *http://www.cms.hhs.gov/medlearn/glaucoma_06-08-05.pdf* on the CMS website.

Bone Mass Measurements

The *Bone Mass Measurements* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for the bone mass measurements (bone density studies) benefit. The *Bone Mass Measurements* brochure is available at *http://www.cms.hhs.gov/medlearn/bone_mass_06-08-05.pdf* on the CMS website.

The above brochures can be ordered or downloaded, viewed, and printed by going to *http://www.cms.hhs.gov/medlearn/preventiveservices.asp* on the CMS website.

Quick Reference Information: Medicare Preventive Services

This two-sided laminated chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings. It identifies coding requirements, eligibility, frequency parameters, and co-payment/coinsurance and deductible information for each benefit. You may order copies of the *Quick Reference Chart* or download, view, and print a copy by going to *http://www.cms.hhs.gov/medlearn/preventiveservices.asp* on the CMS website.

Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals (CD ROM)

CMS has created a special CD ROM titled *Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals* that contains useful preventive services resources for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals who bill Medicare fee-for-service contractors (FIs and carriers).

These resources include:

- The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals;
- The Quick Reference Information: Medicare Preventive Services chart; and
- The following five brochures (described above):
- Expanded Benefits
- Cancer Screenings
- Adult Immunizations
- Glaucoma Screenings
- Bone Mass Measurements

To order the *Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals* CD ROM, go to *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS website.

Preventive Services Web-Based Training (WBT) Courses

The current WBT course, Medicare Preventive Services: Osteoporosis, Diabetes, and Prostate Cancer, is being expanded to include the new MMA benefits, and will be renamed Medicare Preventive Services Series: Part 3 Expanded Benefits. The Medicare Preventive Services Series: Part 1 Adult Immunizations WBT is being updated to include hepatitis B, and the Medicare Preventive Services Series: Part 2 Women's Health WBT is also being updated.

These updated products will be available later in 2005. To access the preventive services web-based training courses, see the Provider Education section of the Preventive Services Educations Resource Web Guide at *http://www.cms.hhs.gov/medlearn/preventiveservices.asp* on the CMS website.

Preventive Services Medlearn Matters Articles

CMS issued the following *Medlearn Matters* articles in January 2005 for each new preventive service as corresponding implementing instructions were released:

- The Initial Preventive Physical Examination (MM3638) at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3638.pdf*
- Cardiovascular Screening Blood Tests (MM3411) at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3411.pdf*; and
- Diabetes Screening Tests (MM3637) at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3637.pdf*.

Coming Soon! An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals (Video and Audio programs)

This educational video and audio program will provide an overview of Medicare's coverage for preventive services and screenings, including the new MMA services. The program will also discuss risk factors associated with various diseases and highlight the importance of disease prevention and early detection.

The video will be available in three formats, VHS, DVD, and CD to accommodate changing technological demands of the provider community, and the audio will be available in CD format. You will be able to order these in late 2005.

Summary

In addition to helping you file your claims more effectively, these new products will help you increase your awareness about Medicare's coverage for disease prevention and early detection so you are better prepared to:

- Talk to your Medicare patients about the new services; and
- Encourage their utilization of Medicare-covered preventive services and screenings for which they may be eligible.

We encourage you to order and use these products; however, provider-specific products are not meant for distribution to Medicare beneficiaries. They have been developed for you, the Medicare physician, provider, and supplier.

Additional Information

For Medicare Beneficiaries

In addition to the variety of products for Medicare providers, CMS has also developed resources that can be used by physicians, partners, and beneficiary advocates to educate beneficiaries about Medicare covered preventive screenings and services. A few of the many products available are listed below:

2005 Prevention ToolKit

CMS joined forces with the American Cancer Society (ACS), the American Diabetes Association (ADA), and the American Heart Association (AHA) to develop materials that you can use as a reference and to educate beneficiaries in your community about the new preventive benefits. These resources including brochures, fact sheets, FAQs, a poster, and booklets can be downloaded, viewed, and printed at *http://www.cms.hhs.gov/partnerships/tools/2005preventive/toolkit/default.asp* on the CMS website.

Guide to Medicare's Preventive Services Booklet

This guide is available at *http://www.medicare.gov/Publications/Pubs/pdf/10110.pdf* on the CMS website.

The "Staying Healthy" Website

This website is located at *http://www.medicare.gov/health/overview.asp*. This website provides information about preventive services that are available to people with Medicare. The site includes the following information:

Resource Web Page

Diabetes Screening, Supplies, and Self Management Training *http://www.medicare.gov/health/diabetes.asp*
Cardiovascular Screening *http://www.medicare.gov/health/cardio.asp*
One-time "Welcome to Medicare" Physical Exam *http://www.medicare.gov/health/physicalexam.asp*
Cancer Tests *http://www.medicare.gov/health/cancer.asp*

Resource Web Page

Breast Cancer Screening (Mammograms)
http://www.medicare.gov/health/mammography.asp

Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) *http://www.medicare.gov/health/cervical.asp*

Colon Cancer Screening (Colorectal)
http://www.medicare.gov/health/coloncancer.asp

Prostate Cancer Screening (PSA)
http://www.medicare.gov/health/prostate.asp

Shots *http://www.medicare.gov/health/shots.asp*

Flu *http://www.medicare.gov/health/flu.asp*

Pneumococcal *http://www.medicare.gov/health/pneumococcal.asp*

Hepatitis B *http://www.medicare.gov/health/hepatitis.asp*

Bone Mass Measurements
http://www.medicare.gov/health/osteoporosis.asp

Glaucoma Tests
http://www.medicare.gov/health/glaucoma.asp

Patient Publications may be ordered online at *http://www.medicare.gov* or by calling 1-800-MEDICARE (1-800-633-4227).

If you have any questions, please contact your carrier or FI at their toll-free number, which may be found at *http://www.cms.hhs.gov/medlearn/tollnums.asp* on the CMS website.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Medlearn Matters Special Edition: SE0556 Related CR Release Date: N/A

Medicare Preventive Services Resource CD Now Available

The Division of Provider Information Planning & Development (DPIPD) staff of CMS Provider Communication Group is pleased to announce the availability of the following new educational product for providers:

The Medicare preventive services resources for physicians, providers, suppliers, and other health care providers CD ROM contains:

a. The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Providers

b. Five brochures:

- *Expanded Benefits*
- *Glaucoma Screenings*
- *Cancer Screenings*
- *Bone Mass Measurements*
- *Adult Immunizations*

c. *Quick Reference Information: Medicare Preventive Services* chart.

These resources are useful for Medicare fee-for service (FFS) physicians, providers, suppliers, and other health care professionals that bill Medicare FFS contractors (fiscal intermediaries and carriers).

This new product may be ordered, free of charge, from the Medicare Learning Network Medlearn product ordering system on the CMS website at: *http://www.cms.hhs.gov/medlearn*.

Source: Provider Education Resources Listserv, Message 200508-3

Preventive Services Guide now Available

The Centers for Medicare & Medicaid Services (CSM) is pleased to announce that the ***"Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals"*** is now available to order. This comprehensive guide to Medicare-covered preventive services and screenings is intended to give physicians, providers, suppliers, and other health care professionals that bill Medicare fee-for-service contractors information on coverage, coding, billing, and reimbursement to help them file claims effectively, while also giving providers information that will enable them to encourage utilization of these benefits as appropriate. A downloadable PDF version of the guide is available on the CMS website at *http://www.cms.hhs.gov/medlearn/preventiveservices.asp*.

The Guide is also one of the resources included in the Medicare Preventive Services Resources CD ROM for health care professionals. Copies of both the Guide and the CD ROM may be ordered, free of charge, through the Medicare Learning Network's Medlearn home page on the Web at *http://www.cms.hhs.gov/medlearn*.

Order your copies today!

Source: Provider Education Resources Listserv, Message 200508-10

GENERAL EDUCATION

Mobility Assistive Equipment Web Page now Available

The Centers for Medicare & Medicaid Services (CSM) announces the publication of its new regulation, CMS-3017-IFC, Power Mobility Devices (PMD).

This regulation includes new conditions of payment that will affect how DME (durable medical equipment) suppliers dispense and submit claims for PMDs, how physicians and treating practitioners will evaluate beneficiaries for PMDs, and new requirements for PMD prescriptions and the submission of supporting medical record documentation.

CMS has developed several materials for your reference, including a fact sheet and frequently asked questions. To view these item—as well as a full copy of the regulations—please visit the "mobility Assistive Equipment " page on the Medicare Coverage website at *http://www.cms.hhs.gov/coverage/wheelchairs.asp*.

To view the press release, go to CMS website at *http://www.cms.hhs.gov/media/press/release.asp?Counter=1540*.

Source: Provider Education Resources Listserv, Message 200508-11

ORDER FORM — 2006 PART B MATERIALS

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to BCBSFL – FCSO with the account number listed by each item.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

QUANTITY	ITEM	ACCOUNT NUMBER	COST PER ITEM
❒	***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Hardcopy or CD-ROM distribution is limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers who meet these criteria must register to receive the *Update!* 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 can be shown why the electronic publication available free of charge on the Internet cannot be utilized. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published during calendar year 2006 (back issues will be sent upon receipt of order).	700395	$25.00 (Hardcopy) $20.00 (CD-ROM)
❒	**2006 Fee Schedule –** The revised Medicare Part B Physician and Non-Physician Practitioner Fee Schedule, effective for services rendered January 1, 2006, through December 31, 2006, is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Providers who do not have Internet access may purchase a hardcopy or CD-ROM. The Fee Schedule contains calendar year 2006 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	Hardcopy: $5.00 (CT) $10.00 (FL) CD-ROM: $6.00 (Specify CT or FL)

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