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To receive quick, automatic notification when new publications and other items of interest are posted to our provider education websites, 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 eNews" link on the navigational menu and follow the prompts.



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 websites: <http://www.connecticutmedicare.com> and <http://www.floridamedicare.com>.

Routing Suggestions:

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

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Medicare B Update!

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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:

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A PHYSICIAN'S Focus

FCSO Office of the Medical Director Announces the Appointment of New Medical Directors

As a contractor for the Centers for Medicare & Medicaid Services (CMS), First Coast Service Options, Inc. (FCSO) administers traditional Medicare Part B for Florida and Connecticut and Part A for a majority of Florida providers. Medicare contractor medical directors provide medical leadership for the capabilities and decision making of the carrier and intermediary. Medical policy development, medical review, quality improvement, and physician and allied professional relationships are major areas of focus.



Florida

Last December, Dr. John Montgomery took the challenge of a new, exciting position with our parent company, Blue Cross and Blue Shield of Florida. With this background, I am pleased to announce the appointment of *Eugene J. Winter, M.D.*, as FCSO Florida Medical Director effective June 18, 2005.

Dr. Winter received his M.D. from Wolfgang Goethe University, Frankfurt am Main, Germany. His post-graduate training included internships in Medicine and Surgery at Hanau Municipal Hospital-Frankfurt University and a fellowship in Cardiology at Frankfurt University Medical Center. He completed a residency in Internal Medicine at Vanderbilt University in Nashville, TN and later took a full time faculty position as an assistant professor of Medicine at Vanderbilt University School of Medicine where he taught and supervised medical students and resident physicians. He has extensive experience in both health care administration and patient care. He enjoyed private practice for over two decades with a special interest in practice management computer systems. Most recently, Dr. Winter served as the contractor medical director for CIGNA HealthCare Medicare Administration (Part B Tennessee). He is board certified in Internal Medicine since 1978.

Dr. Winter's contact information at our Jacksonville office is phone: 904-791-8182 and e-mail: Eugene.Winter@fcsso.com. He will share Part B and A responsibility with me in Florida.

Connecticut

Recently, Dr. Frank Delli Carpini has taken the challenge of a new job as the Medical Director of the QIC (Qualified Independent Contractor). The QIC, a new line of work for FCSO, performs Medicare Part A reconsiderations (second-level appeal decisions) for the Part A west jurisdiction.

With this background, I am pleased to announce the appointment of *Neil Sandler, M.D.*, as FCSO Connecticut Part B Medical Director effective July 11. Dr. Sandler received his MD from New York Medical College. His post-graduate training included internship and residency in Internal Medicine at St. Vincent Hospital in Worcester, MA and a fellowship year in Cardiology at Hartford Hospital in Connecticut. Dr. Sandler practiced emergency medicine for well over a decade at several Connecticut hospitals and was a clinical instructor in Internal Medicine at University of Connecticut Medical School. He has extensive health care management experience and recently worked as a Medical Director for Health Net, a full service health plan with PPO, HMO, and managed Medicare and Medicaid programs. He is board certified in Internal Medicine since 1985.

Dr. Sandler's contact information at the Meriden, CT office is phone: 203-634-5410 and e-mail: Neil.Sandler@fcsso.com.

I am excited about the opportunity to work closely with Dr. Winter and Dr. Sandler in the Medicare program.

James J. Corcoran, M.D., M.P.H.
FCSO Chief Medical Officer
James.Corcoran@fcsso.com

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 2005 are:

Publication Name	Publication Date	Effective Date of Changes
First Quarter 2005	Mid-November 2004	January 1, 2005
Second Quarter 2005	Mid-February 2005	April 1, 2005
Third Quarter 2005	Mid-May 2005	July 1, 2005
Fourth Quarter 2005	Mid-August 2005	October 1, 2005

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 (please see the hardcopy/CD-ROM registration form on page 117 of the First Quarter 2005 *Update!*).

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!* 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** (waiver 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

CLAIMS

Billing for Air Ambulance Mileage

Payment for air ambulance mileage is made for each “loaded” mile. “Loaded” meaning the number of miles for which the Medicare beneficiary is transported in the ambulance vehicle.

For air ambulance, the point of origin includes the beneficiary loading point and runway taxiing until the beneficiary is offloaded from the air ambulance which means the actual mileage the air ambulance travels once the patient is on board would be billed.

Source: CMS Internet Online Manual, Pub. 100-4, Chapter 15, Section 20.5

2005 Ambulatory Surgical Center HCPCS Additions, Deletions, and Master Listing

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

Provider Types Affected

Ambulatory Surgical Centers (ASCs) providing services to Medicare beneficiaries and billing Medicare carriers or fiscal intermediaries (FIs) for those services.

Provider Action Needed

Be aware of the ASC HCPCS codes that are being added to and deleted from the ASC list, effective July 1, 2005.

Background

The Centers for Medicare & Medicaid Services (CMS) is updating the ASC HCPCS codes list to reflect the Medicare-approved ASC procedures added to and deleted from the ASC list, as outlined in an interim final rule in the May 4, 2005 Federal Register (70 CFR 23690). (The interim rule is available at http://www.cms.hhs.gov/suppliers/asc/1478_42805.pdf on the CMS website.)

The following codes are being added to the ASC list, effective for services performed on or after July 1, 2005:

HCPCS Code	Short Descriptor	ASC Payment Group	ASC Payment Rate
15001	Skin graft add-on	1	\$333.00
15836	Excise excessive skin tissue	3	\$510.00
15839	Excise excessive skin tissue	3	\$510.00
19296	Place po breast cath for rad	9	\$1339.00
19298	Place breast rad tube/caths	1	\$333.00
21120	Reconstruction of chin	7	\$995.00
21125	Augmentation, lower jaw bone	7	\$995.00
28108	Removal of toe lesions	2	\$446.00
29873	Knee arthroscopy/surgery	3	\$510.00
30220	Insert nasal septal button	3	\$510.00
31545	Remove vc lesion w/scope	4	\$630.00
31546	Remove vc lesion scope/graft	4	\$630.00
31603	Incision of windpipe	1	\$333.00
31636	Bronchoscopy, bronch stents	2	\$446.00
31637	Bronchoscopy, stent add-on	1	\$333.00
31638	Bronchoscopy, revise stent	2	\$446.00
33212	Insertion of pulse generator	3	\$510.00
33213	Insertion of pulse generator	3	\$510.00
33233	Removal of pacemaker system	2	\$446.00
36475	Endovenous rf, 1 st vein	3	\$510.00
36476	Endovenous rf, vein add-on	3	\$510.00
36478	Endovenous laser, 1 st vein	3	\$510.00
36479	Endovenous laser vein add-on	3	\$510.00
36834	Repair AV aneurysm	3	\$510.00
37500	Endoscopy ligate perf veins	3	\$510.00
42665	Ligation of salivary duct	7	\$995.00
43237	Endoscopic us exam, esoph	2	\$446.00
43238	Upper gi endoscopy w/us fn bx	2	\$446.00
44397	Colonoscopy w/stent	1	\$333.00
45327	Proctosigmoidoscopy w/stent	1	\$333.00
45341	Sigmoidoscopy w/ultrasound	1	\$333.00

HCPSC Code	Short Descriptor	ASC Payment Group	ASC Payment Rate
45342	Sigmoidoscopy w/us guide bx	1	\$333.00
45345	Sigmoidoscopy w/stent	1	\$333.00
45387	Colonoscopy w/stent	1	\$333.00
45391	Colonoscopy w/endoscope us	2	\$446.00
45392	Colonoscopy w/endoscopic fnb	2	\$446.00
46230	Removal of anal tags	1	\$333.00
46706	Repr of ana fistula w/glue	1	\$333.00
46947	Hemorrhoidopexy by stapling	3	\$510.00
49419	Insrt abdom cath for chemotx	1	\$333.00
51992	Laparo sling operation	5	\$717.00
52301	Cystoscopy and treatment	3	\$510.00
52402	Cystourethro cut ejacul duct	3	\$510.00
55873	Cryoablate prostate	9	\$1339.00
57155	Insert uteri tandems/ovoids	2	\$446.00
57288	Repair bladder defect	5	\$717.00
58346	Insert heyman uteri capsule	2	\$446.00
58565	Hysteroscopy, sterilization	4	\$630.00
58970	Retrieval of oocyte	1	\$333.00
58974	Transfer of embryo	1	\$333.00
58976	Transfer of embryo	1	\$333.00
62264	Epidural lysis on single day	1	\$333.00
64517	N block inj, hypogastric plexus	2	\$446.00
64561	Implant neuroelectrodes	3	\$510.00
64581	Implant neuroelectrodes	3	\$510.00
64681	Injection treatment of nerve	2	\$446.00
65780	Ocular reconst, transplant	5	\$717.00
65781	Ocular reconst, transplant	5	\$717.00
65782	Ocular reconst, transplant	5	\$717.00
65820	Relieve inner eye pressure	1	\$333.00
66711	Ciliary endoscopic ablation	2	\$446.00
67343	Release eye tissue	7	\$995.00
67445	Explr/decompress eye socket	5	\$717.00
67570	Decompress optic nerve	4	\$630.00
67912	Correction eyelid w/implant	3	\$510.00
68371	Harvest eye tissue, allograft	2	\$446.00

The following HCPCS codes are being deleted from the ASC list, effective July 1, 2005:

HCPSC Code	Short Descriptor
21440	Treat dental ridge fracture
23600	Treat humerus fracture
23620	Treat humerus fracture
53850	Prostatic microwave thermotx
69725	Release facial nerve

The complete list of Medicare-approved ASC HCPCS codes, including the codes being added to and deleted from the ASC list effective July 1, 2005, is available as an addendum to the interim rule (starting at page 104) at http://www.cms.hhs.gov/suppliers/asc/1478_42805.pdf on the CMS website.

Additional Information

For complete details, please see the official instruction issued to your carrier/FI 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 3905 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/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) #: 3905	Medlearn Matters Number: MM3905
Related CR Release Date: June 17, 2005	Related CR Transmittal #: 584
Effective Date: July 1, 2005	Implementation Date: July 5, 2005

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

2005 HCPCS Codes for Ambulatory Surgical Centers—Information to Accompany Medlearn Matters Number MM3905

In a recent Medlearn Matters article, the Centers for Medicare & Medicaid Services (CMS) provided information concerning revisions to the list of codes payable to an ambulatory surgical center (ASC), effective for dates of service on and after July 1, 2005. This article contains a table that provides newly covered (in an ASC) HCPCS codes and short descriptors, the appropriate ASC payment group, and a column entitled ASC Payment Rate. ASCs should be aware that these rates are the national factors *before* application of local wage index percentages.

The local rates for ASCs in Connecticut and Florida were published in the February 2004 Special Issue *Medicare B Update!* entitled “Changes in Payment for Services Furnished in Ambulatory Surgical Centers for Fiscal Year 2004.” These rates remain unchanged for 2005, and will be used to pay both existing and newly covered HCPCS codes, instead of the rates published in Medlearn Matters article MM3905.

We apologize for any misunderstanding this may have caused.

Source: CMS Pub. 100-4, Transmittal 584, CR 3905

Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification

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

Provider Types Affected

Physicians, suppliers, hospitals and other providers billing Medicare contractors (carriers, durable medical equipment regional carriers [DMERCs], and fiscal intermediaries [FIs])

Provider Action Needed

STOP—Impact to You

Medicare will soon issue the annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) to Medicare contractors.

This update will apply for claims with service dates on or after October 1, 2005 and discharges and through dates on or after October 1, 2005 for institutional providers.

CAUTION—What You Need to Know

An ICD-9-CM code is required for all professional claims, e.g., physicians, nonphysician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs), and for all institutional claims, but **not** for ambulance supplier claims. Remember that as of October 1, 2004, Medicare no longer provides a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes.

GO—What You Need to Do

Be ready to use the updated codes on October 1, 2005. Please refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

Background

This instruction is a reminder that Medicare carriers, DMERCs, and FIs will use the annual *ICD-9-CM* coding update effective for:

- Dates of service on or after October 1, 2005, and
- Discharges and through dates on or after October 1, 2005 for institutional providers

The use of ICD-9-CM codes at the Centers for Medicare & Medicaid Services (CMS) has evolved as follows:

- Beginning in 1979, ICD-9-CM codes became mandatory for reporting provider services on Form CMS-1450.
- On April 1, 1989, the use of ICD-9-CM diagnosis codes became mandatory for all physician services submitted on Form CMS-1500.
- Effective October 1, 2003, an ICD-9-CM diagnosis code was required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59) (see CR2725, dated June 6, 2003, at http://www.cms.hhs.gov/manuals/pm_trans/B03045.pdf)

Important Note: Effective for dates of service on and after October 1, 2004, CMS no longer provided a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The health insurance portability and accountability act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR3094, dated February 6, 2004 at:

http://www.cms.hhs.gov/manuals/pm_trans/R95CPdf.pdf.)

Additional Information

Publication of ICD-9-CM Codes

- Updated ICD-9-CM codes are published in the federal register in April/May of each year as part of the proposed changes to the hospital inpatient prospective payment system, and are effective each October first. Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2005.
- After the ICD-9-CM codes are published in the federal register, CMS places the new, revised, and discontinued codes on the following website: <http://www.cms.hhs.gov/medlearn/icd9code.asp>. The update should be available at this site in June.
- The updated ICD-9-CM diagnosis codes can also be viewed at the National Center for Health Statistics (NCHS) website at: <http://www.cdc.gov/nchs/icd9.htm>. This posting should be available at this site in June.
- Providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

Implementation

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

Related Instructions

The Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service) has been revised. The updated manual instructions are included in the official instruction issued to your carrier, and it can be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that website, look for CR3888 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 or intermediary 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) #: 3888
Related CR Release Date: June 24, 2005
Effective Date: October 1, 2005

Medlearn Matters Number: MM3888
Related CR Transmittal #: 591
Implementation Date: October 3, 2005

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

Billing Partial Month ESRD Related Visits

Background

Change request 3414 instructed physicians and practitioners to submit CPT code 90999 for partial month ESRD-related visits furnished in the following scenarios:

- Transient patients – Patients traveling away from home (less than full month);
- Partial month without a complete assessment of the patient. For example, the patient was hospitalized before a complete assessment was furnished, dialysis stopped due to death, or the patient had a transplant.
- Patients who have a change in their MCP physician during the month.

Change request 3595 revised the descriptors for HCPCS G0324 – G0327 which removed the word “home”:

HCPCS Descriptor

G0324	End-stage renal disease (ESRD) related services less than full month, per day; for patients under two years of age
G0325	End-stage renal disease (ESRD) related services less than full month, per day; for patients between two and eleven years of age
G0326	End-stage renal disease (ESRD) related services less than full month, per day; for patients between twelve and nineteen years of age
G0327	End-stage renal disease (ESRD) related services less than full month, per day; for patients twenty years of age and over

Action Required by Providers

Effective for claims submitted September 1, 2005, with dates of service on or after January 1, 2005, partial month ESRD-related visits are to be submitted using the applicable HCPCS procedure G0324-G0327 (dependent on the patient's age).

NOTE: Services submitted prior to September 1, 2005 with procedure code 90999 should not be resubmitted using the “G” code. Doing so would result in a duplicate service denial.

When billing for a consecutive range of dates, indicate the beginning and ending date with the total days indicated in the number billed field. **EXAMPLE:** A nephrologist visits a 70 year old patient each day from July 13, 2005 to July 18, 2005. The nephrologist will bill procedure code G0327 (End stage renal disease [ESRD] related services less than full month, per day; for patients twenty years of age and over) indicating six in the number billed field.

Source: Pub 100-4, Transmittal 414, Change Request 3595

Quarterly Update to Correct Coding Initiative Edits, Version 11.2, Effective July 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 Correct Coding Initiative (CCI) edits will be effective on July 1, 2005. Physicians may view the current CCI edits and the current mutually exclusive code (MEC) edits on the Centers for Medicare & Medicaid (CMS) website at:

<http://www.cms.hhs.gov/physicians/cciedits>.

The website will be updated with the version 11.2 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 11.2, is effective on July 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 and MEC Edits.

Additional Information

The CCI and MEC files will be maintained 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.

Related Change Request (CR) #: 3823

Medlearn Matters Number: MM3823

Related CR Release Date: May 20, 2005

Related CR Transmittal #: 563

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

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

Procedures Denied as Secondary Procedures with Primary Procedure not Present

Claims submitted for CPT codes 88155, 88311, 88312, 88313 and 88314 processed on or after January 1, 2005, were incorrectly denied as a secondary procedure absent the primary procedure.

This error was corrected on May 6, 2005. Claims processed on or after May 7, 2005 were adjudicated correctly.

No Action Required by Providers

Providers, whose claims were incorrectly denied due to this error, do not need to take any actions. FCSO will perform adjustments to correct the error on all the affected claims.

We apologize for any inconvenience this may have caused.

Italicized and/or quoted material is excerpted from the American Medical Association Current Procedural Terminology. CPT codes, descriptions and other data only are copyrighted 2003 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.

Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines

This information was previously published in the Third Quarter 2005 Medicare B Update! pages 17-21.

Providers should emphasize to their beneficiaries the importance of immunizations. The following article contains information for providers and suppliers regarding the billing and processing of claims for pneumococcal, hepatitis B, and influenza virus vaccines. Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Part B deductible and coinsurance do not apply for PPV and influenza virus vaccine. Part B of Medicare also covers the hepatitis B vaccine and its administration. Part B deductible and coinsurance **do** apply for hepatitis B vaccine.

Pneumococcal Pneumonia Vaccinations. The Medicare Part B program covers pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable state law by any provider of services or any entity or individual with a supplier number. This includes revaccination of patients at highest risk of pneumococcal infection. Typically, these vaccines are administered once in a lifetime except for persons at highest risk. Effective July 1, 2000, Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Frequency of PPV Vaccinations. Typically, PPV is administered once in a lifetime. Claims are paid for beneficiaries who are at high risk of pneumococcal disease and have not received PPV within the last five years or are revaccinated because they are unsure of their vaccination status.

An initial PPV may be administered only to persons at high risk (see below) of pneumococcal disease. Revaccination may be administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least five years have passed since receipt of a previous dose of pneumococcal vaccine.

High Risk of Pneumococcal Disease. Persons at high risk for whom an initial vaccine may be administered include:

- All people age 65 and older;
- Immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and
- Individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkin's disease, lymphoma, multiple myeloma, chronic renal failure, Human Immunodeficiency Virus (HIV) infection, nephritic syndrome, sickle cell disease, or organ transplantation).

Persons at highest risk and those most likely to have rapid declines in antibody levels are those for whom revaccination may be appropriate. This group includes persons with functional or anatomic asplenia (e.g., sickle cell disease, splenectomy), HIV infection, leukemia, lymphoma, Hodgkin's disease, multiple myeloma, generalized malignancy chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy. Routine revaccinations of people age 65 or older that are not at highest risk are not appropriate.

Those administering the vaccine should not require the patient to present an immunization record prior to administering the pneumococcal vaccine, nor should they feel compelled to review the patient's complete medical record if it is not available.

Instead, if the patient is competent, it is acceptable for them to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about their vaccination history in the past five years, the vaccine should be given. However, if the patient is certain he/she was vaccinated in the last five years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than five years have passed since receipt of the previous dose, revaccination is not appropriate unless the patient is at highest risk.

Hepatitis B Vaccine. Effective for services furnished on or after September 1, 1984, P.L. 98-369 provides coverage under Part B for hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B. This coverage is effective for services furnished on or after September 1, 1984.

High-risk groups currently identified include (see exception below):

- ESRD patients;
- Hemophiliacs who receive Factor VIII or IX concentrates;
- Clients of institutions for the mentally retarded;
- Persons who live in the same household as an Hepatitis B Virus (HBV) carrier;
- Homosexual men; and
- Illicit injectable drug abusers.

Intermediate risk groups currently identified include:

- Staff in institutions for the mentally retarded; and
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

EXCEPTION: Persons in both of the above-listed groups in paragraph B, would not be considered at high or intermediate risk of contracting hepatitis B, however, if there were laboratory evidence positive for antibodies to hepatitis B. (ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy.)

For Medicare program purposes, the vaccine may be administered upon the order of a doctor of medicine or osteopathy, by a doctor of medicine or osteopathy, or by home health agencies, skilled nursing facilities, ESRD facilities, hospital outpatient departments, and persons recognized under the incident to physicians' services provision of law.

A charge separate from the ESRD composite rate will be recognized and paid for administration of the vaccine to ESRD patients.

Influenza Virus Vaccine. Effective for services furnished on or after May 1, 1993, the influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law.

Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the vaccine. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Typically, one influenza vaccination is allowable per flu season.

Frequency of Vaccinations

Typically, PPV is administered once in a lifetime. Medicare may pay claims for beneficiaries who are at high risk of pneumococcal disease and have not received PPV within the last five years or are revaccinated because they are unsure of their vaccination status.

Typically, one influenza vaccination is allowable per flu season. Claims for beneficiaries who have received more than one influenza virus vaccine in a 12-month period will be reviewed to determine whether the service was reasonable and necessary (e.g., a patient receives an influenza injection in January for the current flu season and is vaccinated again in November of the same year for the next flu season.)

Billing for Additional Services

When a physician/supplier administers PPV, influenza virus, or hepatitis B vaccines without providing any other additional services during the visit, the provider may only bill for the vaccine and its administration.

These services are always separately payable, whether or not other services are also provided during the same encounter. The physician/supplier may bill for additional reasonable and necessary services in addition to the administration of PPV, influenza virus, and/or hepatitis B vaccines.

Nonparticipating Physicians and Suppliers

Nonparticipating physicians and suppliers (including local health facilities) that do not accept assignment may collect payment from the beneficiary but must submit an unassigned claim on the beneficiary's behalf. Entities, such as local health facilities, that have never submitted Medicare claims must obtain a provider identification number for Part B billing purposes.

Separate Claims for Vaccines and Their Administration

In situations in which the vaccine and the administration are furnished by two different entities, the entities should submit separate claims. For example, a supplier (e.g., a pharmacist) may bill separately for the vaccine, using the Healthcare Common Procedural Coding System (HCPCS) code for the vaccine, and the physician or supplier (e.g., a drugstore) who actually administers the vaccine may bill separately for the administration, using the HCPCS code for the administration. This procedure results in carriers receiving two claims, one for the vaccine and one for its administration.

For example, when billing for influenza vaccine administration only, billers should list only HCPCS code G0008 in block 24D of the Form CMS-1500. When billing for the influenza vaccine only, billers should list only HCPCS code 90658 in block 24D of the Form CMS-1500. The same applies for PPV and hepatitis B billing using PPV and hepatitis B HCPCS codes.

CPT/HCPCS Codes

The following CPT codes are used for billing influenza virus, pneumococcal pneumonia, and hepatitis B vaccines:

90655	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use;
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use;
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use; (discontinued December 31, 2003)
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use;
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use;
90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use;
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use;
90746	Hepatitis B vaccine, adult dosage, for intramuscular use; and
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use.

These codes are for the vaccines only and do not include their administration. The following HCPCS "G" codes are used to bill for administration of vaccines:

G0008	Administration of influenza virus vaccine;
G0009	Administration of pneumococcal vaccine; and
G0010	Administration of hepatitis B vaccine.

These three codes should be reimbursed at the same rate as CPT code 90782 on the Medicare physician fee schedule (MPFS) for the year that corresponds to the date of service of the claim.

Billing Requirements

Physicians and suppliers submit claims on Form CMS -1500. The Unique Physician Identification Number (UPIN) (or National Provider Identifier (NPI), when effective) must be entered in Item 17A of Form CMS-1500 for PPV (prior to July 1, 2000) and hepatitis B vaccines. Medicare does not require that the influenza vaccine be administered under a physician's order or supervision. Effective for claims with dates of service on or after July 1, 2000, PPV claims also no longer require that the vaccine be administered under a physician's order or supervision.

Diagnosis Codes

One of the following diagnosis codes must be reported as appropriate. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim the applicable following diagnosis code may be used.

V03.82	PPV
V04.8*	Influenza
V05.3	Hepatitis B.

*Effective for influenza virus claims with dates of service October 1, 2003, and later, the correct diagnosis code to be used is V04.81.

If a diagnosis code for PPV, hepatitis B, or influenza virus vaccination is not reported on a claim and the carrier can determine that the claim is a PPV, hepatitis B, or influenza claim, the carrier may enter the proper diagnosis code and continue processing the claim.

These claims should not be returned, rejected, or denied for lack of a diagnosis code by the carrier. Effective for dates of service on or after October 1, 2003, carriers may no longer enter the diagnosis on the claim. Carriers must follow current resolution processes for claims with missing diagnosis codes.

If the diagnosis code and the narrative description are correct, but the HCPCS code is incorrect, the carrier or intermediary may correct the HCPCS code and pay the claim.

For example, if the reported diagnosis code is V04.8 (V04.81 if claim is October 1, 2003, and later) and the narrative description (if annotated on the claim) says “flu shot” but the HCPCS code is incorrect, contractors may change the HCPCS code and pay for the flu vaccine.

In addition, if a doctor of medicine or osteopathy does not order the influenza virus vaccine, the intermediary claims require UPIN code SLF000 to be reported.

Reimbursement Guidelines

Payment for PPV, influenza virus, and hepatitis B vaccines follows the same standard rules that are applicable to any injectable drug or biological.

The administration of PPV, influenza virus, and hepatitis B vaccines, (HCPCS codes G0009, G0008, and G0010), though not reimbursed directly through the MPFS, is reimbursed at the same rate as HCPCS code 90782 on the MPFS for the year that corresponds to the date of service of the claim.

Beginning March 1, 2003, HCPCS codes G0008, G0009, and G0010 should be reimbursed at the same rate as HCPCS code 90741. Assignment for the administration is not mandatory, but is applicable should the provider be enrolled as a provider type “Mass Immunizer,” submits roster bills, or participates in the centralized billing program.

Limiting charge does not apply to PPV, influenza virus vaccine, or hepatitis B vaccine and their administration. The administration of the influenza virus vaccine is covered in the flu shot benefit, rather than under the physicians’ services benefit; therefore, it is not eligible for the ten percent Health Professional Shortage Area (HPSA) incentive payment.

Nongovernmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. Thus, for example, Medicare may not pay for flu vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees.

Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients.

Nongovernmental entities that do not charge patients who are unable to pay or reduce their charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided, may bill Medicare and expect payment.

Governmental entities (such as public health clinics (PHCs)) may bill Medicare for PPV, hepatitis B, and influenza virus vaccine administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

Simplified Roster Bills

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs offered by Public Health Clinics (PHCs) and other individuals and entities that give the vaccine to a group of beneficiaries, e.g. at public health clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. Roster billing is not available for hepatitis B vaccinations.

Properly licensed individuals and entities conducting mass immunization programs may submit claims using a simplified claims filing procedure known as roster billing to bill for the influenza virus vaccine benefit for multiple beneficiaries if they agree to accept assignment for these claims. They may not collect any payment from the beneficiary.

Effective November 1, 1996, roster billing is also available to individuals and entities billing for PPV.

Effective July 1, 1998, immunization of at least five beneficiaries on the same date is no longer required for any individual or entity to qualify for roster billing to carriers.

However, the rosters should not be used for single patient claims and the date of service for each vaccination administered must be entered.

Entities that submit claims on roster claims must accept assignment and may not collect any “donation” or other cost sharing of any kind from Medicare beneficiaries for PPV or influenza vaccinations. However, the entity may bill Medicare for the amount, which is not subsidized from its own budget. For example, an entity that incurs a cost of \$7.50 per vaccination and pays \$2.50 of the cost from its budget may bill Medicare the \$5.00 cost which is not paid out of its budget.

Provider Enrollment Criteria. Those entities and individuals that desire to provide mass immunization services, but may not otherwise be able to qualify as a Medicare provider, may be eligible to enroll as a provider type “Mass Immunizer.”

These individuals and entities must enroll with the carrier by completing the Provider/Supplier Enrollment Application, Form CMS-855. Specialized instructions for these individuals and entities are available in order to simplify the enrollment process.

Individuals and entities that use the specialized instructions to complete the form may not bill Medicare for any services other than PPV, influenza virus vaccines and their administration.

Modified CMS-1500. If the PHC or other individual or entity qualifies to use the simplified billing process, it may use a preprinted CMS-1500 that contains standardized information about the entity and the benefit.

CLAIMS

Entities submitting roster claims to carriers must complete the following blocks on a single modified Form CMS-1500, which serves as the cover document for the roster for each facility where services are furnished. In order for carriers to reimburse by correct payment locality, a separate Form CMS-1500 must be used for each different facility where services are furnished.

Item 1	An X in the Medicare block
Item 2	(Patient's Name): "SEE ATTACHED ROSTER"
Item 11	(Insured's Policy Group or FECA Number): "NONE"
Item 17A	(I.D. Number or Referring Physician): This number is required for PPV claims with dates of service prior to July 1, 2000. This number is also required for Hepatitis B vaccines.
Item 20	(Outside Lab?): An "X" in the NO block
Item 21	(Diagnosis or Nature of Illness): Line 1: PPV = "V03.82", Influenza Virus: = "V04.8" <i>Effective for claims with dates of service on or after October 1, 2003, use V04.81.</i>
Item 24B	(Place of Service [POS]): Line 1: "60" Line 2: "60" NOTE: POS Code '60' must be used for roster billing
Item 24D	(Procedures, Services or Supplies): Line 1: PPV: "90732" Influenza Virus: "90658" Line 2: PPV: "G0009" Influenza Virus: "G0008"
Item 24E	(Diagnosis Code): Lines 1 and 2: "1"
Item 24F	(\$ Charges): The entity must enter the charge for each listed service. If the entity is not charging for the vaccine or its administration, it should enter 0.00 or "NC" (no charge) on the appropriate line for that item. If your system is unable to accept a line item charge of 0.00 for an immunization service, do not key the line item. Likewise, electronic media claim (EMC) billers should submit line items for free immunization services on EMC PPV or influenza virus vaccine claims only if your system is able to accept them.
Item 27	(Accept Assignment): An "X" in the YES block.
Item 29	(Amount Paid): "\$0.00"
Item 31	(Signature of Physician or Supplier): The entity's representative must sign the modified Form CMS-1500.
Item 32	N/A
Item 33	(Physician's, Supplier's Billing Name): If the provider number is not shown on the roster billing form, the entity must complete this item to include the Provider Identification Number (not the Unique Physician Identification Number) or Group Number, as appropriate.

Sample rosters and samples of modified CMS Form-1500s are available to view, print, or download from our provider websites at <http://www.connecticutmedicare.com> and <http://www.floridamedicare.com>, in the "Forms" area.

Sources: Internet Online Manual (IOM) Pub 100-4, Chapter 18, Section 10
Pub 100-2, Chapter 15, Section 50.4.4.2

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.

Revision to Health Professional Shortage Area and Physician Scarcity Area Payment Rules

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

Provider Types Affected

Physicians billing carriers for services provided in a designated health professional shortage area (HPSA) or in a physician scarcity area (PSA).

Provider Action Needed

STOP – Impact to You

This article includes information from change request (CR) 3822, which instructs Medicare carriers to allow payment of the bonus on just the professional component of services that have a professional component (PC)/technical component (TC) indicator of 1 (even when a global service code is submitted).

CAUTION – What You Need to Know

Effective for claims received on or after October 1, 2005, carriers will accept claims for a service with a PC/TC of 1 and consider those claims for the bonus payment, when the service is provided in a HPSA or PSA. For claims received prior to October 1, 2005, please refer to CR 3827 and the Medlearn Matters article MM3827, which is located at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3827.pdf>.

GO – What You Need to Do

See the Background section of this article to find out further details regarding this change.

Background

Currently, physicians may not receive the HPSA or physician scarcity area PSA bonus payments on globally billed services.

CR 3822 revises this policy and allows the payment of the bonus on just the professional component of services that have a PC/TC indicator of 1 even when a global service code is submitted. Effective for claims received on or after October 1, 2005, when carriers receive a claim for a service with a PC/TC of 1 and the service is provided in a HPSA or PSA bonus payment area, they shall accept the claim *and pay the bonus on the professional component of the service*.

CR3822 instructs your carrier(s) to:

- Make any necessary revision to their systems to be able to calculate the bonus payment just for the professional component of the service. This action must be taken for bonuses paid automatically as well as bonuses paid based on the submission of the following modifiers:
- QB (physician providing a service in a rural HPSA),
- QU (physician providing a service in an urban HPSA), and
- AR (physician providing services in a PSA) modifiers;
- Continue to pay the service, but still withhold bonuses for physicians who have indicated that they do not want to receive the bonus payments; and
- Continue to reject as unprocessable those services that have a PC/TC of 4 (global test only - only the professional component of the service qualifies for the bonus payment). The physician/provider needs to re-bill the service as separate professional and technical component procedure codes.

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 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 3822 in the CR NUM column on the right, and click on the file for that CR.

On that same Web page, you may also want to look for CR3827 and review the related material in that CR on claims received prior to October 1, 2005. (CR 3822 relates to claims received on or after October 1, 2005.) You may also want to review the Medlearn Matters article MM3827, which is at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3827.pdf> on the CMS website.

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) #: 3822

Medlearn Matters Number: MM3822

Related CR Release Date: May 6, 2005

Related CR Transmittal #: 556

Effective Date: Claims received on or after October 1, 2005

Implementation Date: October 3, 2005

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Override of Automated Health Professional Shortage Area and/or Physician Scarcity Bonus Payments for Globally Billed Services

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

Provider Types Affected

Physicians billing services to Medicare carriers.

Provider Action Needed

STOP – Impact to You

This article is based on information from change request (CR) 3827, which relates to physicians who do not want to receive the health professional shortage area (HPSA) and/or physician scarcity area (PSA) bonus payment. Currently, those physicians cannot get their claims paid without having to resubmit the services as separate components.

CAUTION – What You Need to Know

CR3827 directs Medicare carriers to bypass certain edits when notified by a physician that they do not want to receive the physician bonus payment.

GO – What You Need to Do

Please see the Background section of this article for further details regarding these changes.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Sections 413(a) and (b)) required the Centers for Medicare & Medicaid Services (CMS) to revise some of the policy for the current HPSA bonus payment and to develop a new PSA bonus. Medicare automatically pays HPSA/PSA bonuses on a quarterly basis without the need for a modifier on claims for services provided in zip code areas that fully fall within a county designated as a HPSA or PSA. CMS policy did not address providers who wish not to receive the HPSA/PSA bonus payment.

As of 2005, CMS has a new HPSA/PSA automated payment file that lists zip codes that will receive the bonus payment. Currently, carriers are returning the services as unprocessable if:

- A procedure is globally billed (i.e. the professional component/technical component (PC/TC) indicator is 1 or 4) and
- The zip code where the service was performed is on the list to receive the automated payment.

Carriers are then notifying the physician that the professional and technical components must be rebilled separately if performed in a qualifying bonus area. Subsequently, some providers wish to forgo the HPSA/PSA incentive rather than have to bill the components separately.

As of June 13, 2005, effective for claims with dates of services on or after January 1, 2005, Medicare carriers will accept claims from physicians who are eligible to receive automated HPSA/PSA bonus payments but have billed services globally. If approved, the services will be paid, but no bonus payment will be made. These procedures will change for claims received on or after October 1, 2005. See the reference under "Additional Information"

In addition, Medicare carriers will re-open and re-process claims brought to their attention should physicians indicate they wish to have the global services paid without the bonus payment. Physicians choosing not to receive the HPSA and/or PSA bonus payment **must** notify their carrier.

Implementation

The implementation date for this instruction is June 13, 2005.

Additional Information

The Medicare Information for Health Professional Shortage Areas (HPSAs) and PSAs can be found at the following CMS website: <http://www.cms.hhs.gov/providers/hpsa/>.

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.

Once at that page, scroll down the CR NUM column on the right looking for CR3827 and click on the link for that file.

For information on claims received by Medicare on or after October 1, 2005, use this same link and view CR3822. You may also want to view the Medlearn Matters article for CR3822, which can be found at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3822.pdf>.

If you have any questions regarding this issue, please contact your Medicare carrier at their toll free number, which is available 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) #: 3827

Medlearn Matters Number: MM3827

Related CR Release Date: May 13, 2005

Related CR Transmittal #: 559

Effective Date: January 1, 2005

Implementation Date: June 13, 2005

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Temporary Instructions to Forego HPSA/PSA Incentive Payment for Globally Billed Services

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. Currently, carriers are returning the services as unprocessable if:

- A procedure is globally billed (i.e. the professional component/technical component [PC/TC] indicator is 1 or 4) and
- The ZIP code where the service was performed is on the list to receive the automated payment.

Carriers are then notifying the physician that the professional and technical components must be rebilled separately if performed in a qualifying bonus area. Subsequently, some providers wish to forego the HPSA/PSA incentive rather than have to bill the components separately.

Effective June 13, 2005, for claims with dates of services **on or after January 1, 2005**, Medicare carriers will accept claims from physicians who are eligible to receive automated HPSA/PSA bonus payments and choose to forego the HPSA/PSA incentive payment when billing services globally. If approved, the services will be paid, but no bonus payment will be made.

Action Required by Providers

Providers choosing not to receive the HPSA/PSA bonus payment on globally billed 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 236

Jacksonville, FL 32231-0018

Connecticut Providers

Attention: Correspondence

Medicare Part B

P.O. Box 45010

Jacksonville, FL 32232-5010

FCSO will notify providers once their records have been updated to allow global billing of services that are subjected to the HPSA/PSA bonus payment. Once notified, providers should refile their denied claims.

This process is temporary through September 30, 2005. Effective October 1, 2005, new procedures will be in place. The new procedures will be communicated at a later date.

Source: CMS Pub. 100-4, Transmittal 559, CR 3827, PCM #0513602

CMS Pub. 100-4, Transmittal 556, CR 3822, PCM #0512913

New Health Professional Shortage Area (HPSA) Modifier

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

Provider Types Affected

Physicians and critical access hospitals (which must be located in a HPSA) that provide services in health professional shortage areas and bill Medicare carriers and intermediaries for those services.

Provider Action Needed

STOP – Impact to You

For dates of service on or after January 1, 2006, a new modifier **AQ** replaces the two existing modifiers, **QB** and **QU**, for physician services provided in HPSAs.

CAUTION – What You Need to Know

Make certain that all HPSA services claims filed for dates of service on or after January 1, 2006 and where a HPSA modifier is required, use the correct AQ modifier. There will no longer be a distinction between physicians providing HPSA services in a rural area (QB) and physicians providing services in an urban HPSA (QU).

GO – What You Need to Do

See the Background and Additional information Sections of this article for further details regarding this Medicare Modernization Act (MMA) update.

Background

The two modifiers, QB and QU, currently used on claims qualifying for the HPSA bonus payments, will be deleted on January 1, 2006 and one new modifier, AQ, created, for HPSA. Claims with dates of service prior to January 1, 2006 must continue to use the current modifiers QB and QU.

Thus, for services rendered in ZIPcode areas: 1) that do not fall within a designated full county HPSA; 2) are not considered to fall within the county based on a determination of dominance made by the United States Postal Service; or 3) are partially within a non-full county HPSA, the physician or CAH must still submit a QB or QU modifier to receive payment for claims with dates of service prior to January 1, 2006.

Effective for similar claims with dates of service on or after January 1, 2006, the modifier AQ, “Physician providing a service in a health professional shortage area (HPSA),” must be submitted.

Implementation

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

Additional Information

Within the official instructions issued by CMS are detailed instructions regarding services eligible for HPSA and physician scarcity bonus payments, HPSA incentive payments for services rendered in a critical access hospital (CAH), as well as HPSA designations and information regarding zip codes. The official instruction issued to your carrier and intermediary regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that Web page, look for CR3935 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/intermediary. To find their toll free phone numbers go to:

<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).

Additional information on the HPSA bonus and the physician scarcity area bonus is on the CMS website.

The Guide for Using the HPSA/PSA Web Page can be viewed by going to: <http://www.cms.hhs.gov/providers/bonuspayment/guide.pdf>.

Related Change Request (CR) #: 3935
Medlearn Matters Number: MM3935
Related CR Release Date: July 22, 2005
Related CR Transmittal #: 608
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

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Payment Issue with HPSA Bonus Payments

Bonus payments issued for claims processed on or after July 7, 2005 were calculated using the April quarter data. For this reason, claims processed during this period may potentially have resulted in an overpayment of services. The problem was corrected on July 12, 2005 utilizing data from the quarter ending June 30, 2005. Claims processed on or after July 13, 2005 will be correct.

Action Required by Providers

If you received payments in error for services processed from July 7, 2005 through July 11, 2005, you will receive a demand letter requesting refund of payment.

Health Professional Shortage Area Listing

The following are counties/area names/parts designated as geographic HPSAs (and therefore eligible for the bonus payment), as of April 12, 2005.

FLORIDA—Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Clay/Keystone Heights division		Urban
Collier/Imokalee/Everglades		Rural
Dixie		Rural
Escambia	0038.00, 0039.00, 0040.00	Rural
Gadsden		Urban
Glades		Rural
Hamilton		Rural
Hardee		Rural
Hendry/Labelle	9604.00, 9603.00	Rural
Holmes		Rural
Lafayette		Rural
Liberty		Rural
Madison		Rural
Martin/Indiantown/Indiantown division		Urban
Sumter		Rural
Suwannee		Rural
Wakulla		Rural
Walton (terminated January 1, 2005)		Rural
Washington		Rural

FLORIDA—Mental Health

County	Type
Bradford	Rural
Columbia	Rural
Dixie	Rural
Gilchrist	Rural
Hamilton	Rural
Holmes	Rural
Jackson	Rural
Lafayette	Rural
Monroe	Rural
Putnam	Rural
St Johns	Urban
Suwannee	Rural
Union	Rural
Walton	Rural
Washington	Rural

CONNECTICUT—Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Fairfield/Southwest Bridgeport	0702.00, 0703.00, 0704.00, 0705.00, 0706.00, 0707.00, 0708.00, 0709.00, 0710.00, 0711.00, 0712.00	Urban
Fairfield/Central/East Bridgeport	0713.00, 0714.00, 0715.00, 0716.00, 0717.00, 0735.00, 0736.00, 0738.00, 0739.00, 0740.00, 0741.00, 0742.00, 0743.00, 0744.00	Urban
Fairfield/Central Norwalk	0440.00, 0441.00, 0444.00, 0445.00	Urban
Hartford/North Central Hartford/ Rice Heights	5005.00, 5008.00, 5009.00, 5010.00, 5011.00, 5012.00, 5013.00, 5014.00, 5015.00, 5016.00, 5017.00, 5018.00, 5020.00, 5021.00, 5022.00, 5031.00, 5032.00, 5033.00, 5034.00, 5035.00, 5036.00, 5037.00, 5038.00, 5039.00, 0040.00, 5041.00, 5042.00, 5044.00	Urban
Hartford/Charter Oak Terrace/	5001.00, 5002.00, 5003.00, 5004.00, 5019.00, 5027.00, 5028.00, 5029.00, 5030.00, 5043.00, 5045.00, 5046.00, 5049.00	Urban
New Haven/ Fair Haven	1421.00, 1422.00, 1423.00, 1424.00, 1425.00, 1426.01, 1426.02	Urban
New London/ Central Groton (terminated April 12, 2005)	7022.00, 7023.00, 7025.00, 7027.00, 7028.00	Urban

Source: CMS Atlanta Regional Office Memorandum (Florida), May 23, 2005
MS Boston Regional Office Memorandum (Connecticut), dated June 1, 2005

Update to the Place of Service Code Set to Add a Code for Pharmacy

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

The *Medicare Claims Processing Manual* and claims processing systems are being revised to include a new Place of Service (POS) code for pharmacy of 01.

CAUTION – What You Need to Know

Claims for covered services rendered using the new POS code for a pharmacy setting will be paid at the nonfacility rate. Your carrier’s medical directors will develop policies, as needed, to adjudicate claims containing this new code.

GO – What You Need to Do

Stay current on POS coding in order to remain compliant with HIPAA.

Additional Information

The new POS code for pharmacy is 01. In the POS code set, pharmacy is defined as a facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. The POS code set with the pharmacy place of service code can be found in the *Medicare Claims Processing Manual, Chapter 26, Section 10.5*, which is attached to CR3819, the official instruction issued to your carrier/DMERC 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 CR3819 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/DMERC. To find that toll free phone number, go to <http://www.cms.hhs.gov/medlearn/tollnums.asp> on the CMS website.

Related Change Request (CR) #: 3819

Medlearn Matters Number: MM3819

Related CR Release Date: April 29, 2005

Related CR Transmittal #: 549

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

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Removal of Special Edition Article SE0516

Medlearn Matters Special Edition article SE0516 titled “Modified Edits for Matching Claims Data to Beneficiary Records” and published in the Third Quarter 2005 *Medicare B Update!* page 100 has been removed from the Center for Medicare & Medicaid Services (CMS) website. This article is no longer valid.

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COVERAGE/REIMBURSEMENT**AMBULANCE****Medical Review of Rural Air Ambulance Service**

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

Provider Types Affected

Providers billing Medicare carriers or fiscal intermediaries (FIs) for rural air ambulance services.

Note: CMS revised this article on February 2, 2005 to reflect that CR 3571 was re-issued on February 1, 2005. The CR release date and transmittal number have changed. The article and the related CR3571 were revised to show that the issue applies to rural air ambulance services billing Medicare carriers, as well as those billing Medicare fiscal intermediaries. All other information remains the same.

Provider Action Needed**STOP – Impact to You**

Providers of rural air ambulance services should note that Section 415 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 includes new instructions regarding rural air ambulance services.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has revised Chapter 6 “Intermediary MR Guidelines for Specific Services” of the Medicare Program Integrity Manual to include Section 6.4 – Medical Review of Rural Ambulance Services.

GO – What You Need to Do

Be sure to understand these new rules surrounding billing for and medical review of rural air ambulance services as a result of changes in the MMA.

Background

This article provides information on Medicare’s implementation of Section 415 of the MMA, which amends the Social Security Act (SSA) (Section 1834(l)) to provide appropriate coverage of rural air ambulance services. A summary of these changes include:

Reasonable Requests

When performing a medical review of rural air ambulance claims, your fiscal intermediary/carrier must determine if a physician or other qualified medical personnel who reasonably determined or certified that the individual’s condition required air transport due to time or geographical factors requested the transport. Medicare considers the following to be qualified personnel to order air ambulance services:

- Physician
- Registered nurse practitioner (from the transferring hospital)
- Physician’s assistant (from the transferring hospital)
- Paramedic or emergency medical technician (EMT) (at the scene)
- Trained first responder (at the scene)

Emergency Medical Services (EMS) Protocols

Please note that the reasonable and necessary requirement for rural air transport can be “deemed” to be met when service is provided pursuant to an established state or regional protocol that has been recognized or approved by the Secretary of the Department of Health and Human Services, which administers Medicare through its Centers for Medicare & Medicaid Services.

Air ambulance providers anticipating transports will be made pursuant to such a state or regional protocol must submit the written protocol to their FI/carrier in advance for review and approval. Your Medicare intermediary/carrier will post instructions for submission of the protocol on its website.

Your Medicare intermediary/carrier must review the protocol to ensure the contents are consistent with the statutory requirements of 1862(1)(A) directing that all services paid for by Medicare must be reasonable and necessary for the diagnosis or treatment of an illness or injury. The intermediary/carrier will notify you of its protocol review determinations within 30 days of receipt of the protocol.

Remember: You must adhere to all requirements in the Act at 1861 (s) (7) and regulatory requirements at 42CFR 424.10 which directs that all services paid by Medicare must be reasonable and necessary including the requirement that payment can be made only to the closest facility capable of providing the care needed by the beneficiary.

Prohibited Air Ambulance Relationships

Your intermediary/carrier will not apply the “deemed” reasonable and necessary determination in the following cases:

- If there is a financial or employment relationship between the person requesting the air ambulance service and the entity furnishing the service;
- If an entity is under common ownership with the entity furnishing the service; or
- If there is a financial relationship between an immediate family member of the person requesting the service and the entity furnishing the service.

The only exception to this provision occurs when the referring hospital and the entity furnishing the air ambulance service are under common ownership. Then the above limitation does not apply to remuneration by the hospital for provider based physician services furnished in a hospital reimbursed under Part A and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.

Reasonable and Necessary Services

Medicare intermediaries and carriers may perform medical review of rural air ambulance claims with “deemed” medical necessity status when there are questions as to whether:

- the decision to transport was reasonably made;
- the transport was made pursuant to an approved protocol; or
- the transport was inconsistent with an approved protocol.

In addition, the intermediary/carrier may conduct a medical review in those instances where there is a financial or employment relationship between the person requesting the air ambulance transport and the person providing the transport.

Additional Information

For purposes of these revised sections of the Medicare Program Integrity Manual, the term “rural air ambulance service” means fixed wing and rotary wing air ambulance services in which the point of pick up of the individual occurs in a rural area (as defined in Section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification published in the *Federal Register* on February 27, 1992 (57 Fed. Reg. 6725)).

The official instruction issued to your intermediary/carrier regarding this change, including the revised portion of Chapter 6 of the Medicare Program Integrity Manual may be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that Web page, look for CR 3571 in the CR NUM column on the right and click on the file for that CR.

If you have any questions, please contact your intermediary/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) Number: 3571 *Revised*

Related CR Release Date: February 1, 2005

Related CR Transmittal Number: 102

Effective Date: January 1, 2005

Implementation Date: February 14, 2005

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Medicare Billing Rules for Ambulance Services Rendered to Medicare Patients During an Inpatient Hospital Stay

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

Provider Types Affected

Suppliers of ambulance services billing Medicare carriers for services provided to Medicare patients during an inpatient hospital stay.

Provider Action Needed**STOP – Impact to You**

The purpose of this special edition is to remind ambulance service suppliers of the rules regarding payment for certain services provided to Medicare patients in an inpatient hospital stay.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) will add an edit in the Medicare’s claims processing systems to prevent payment by carriers for services that are bundled in the hospital’s payment under the applicable inpatient prospective payment system (PPS).

GO – What You Need to Do

Please see the Background and Additional Information Sections of this article for further details.

Background

The Social Security Act (Section 1886(d) and (g)) established several prospective payment systems (PPS) for inpatient services furnished to Medicare beneficiaries, and under the IPPSs, Medicare fiscal intermediaries (FIs) reimburse hospitals a predetermined amount for services furnished to Medicare beneficiaries based on the beneficiary's condition and severity of treatment modalities. All services received by hospital inpatients must be supplied by the hospital either directly or under arrangements. With the exception of the days of admission and discharge, costs for transportation of a hospital inpatient by ambulance (to and from another hospital, freestanding facility, or physician's office) to receive specialized services, and costs for radiology services (including computed tomography scans) furnished to inpatients by a physician's office, another hospital or a radiology clinic are not payable by Medicare.

CMS will add an edit in its claims processing systems to prevent payment by carriers for services that are bundled to the hospital. As an initial implementation of this policy, Medicare will cease making payments to independent suppliers of ambulance services for beneficiaries in an inpatient hospital stay.

Additional Information

As a reminder, all Medicare claims processing information is in the Medicare Claims Processing Manual.

This manual may be viewed at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the CMS website.

If you have any questions, please contact your carrier or intermediary 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) #: N/A

Medlearn Matters Number: SE0536

Related CR Release Date: N/A

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AMBULATORY SURGICAL CENTERS

Payments to Ambulatory Surgery Centers for New CPT Code 66711

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

Provider Types Affected

Physicians and providers billing carriers for services involving ciliary body destruction.

Provider Action Needed**STOP – Impact to You**

The Centers for Medicare & Medicaid Services (CMS) inadvertently failed to include the new CPT code 66711 (ciliary body destruction, cyclophotocoagulation, endoscopic) in the ambulatory surgery center (ASC) list on January 1, 2005. CPT 66711 should have been added to the list effective January 1, 2005.

CAUTION – What You Need to Know

This article and related CR 3817 provide information on the appropriate CPT code for endoscopic treatment involving ciliary body destruction.

GO – What You Need to Do

Awareness of and implementation of these revised coding guidelines will help Medicare make prompt and correct payments for this procedure.

Background

On an annual basis the American Medical Association Current Procedural Terminology (CPT) Editorial Panel revises and updates the CPT codes. The Centers for Medicare & Medicaid Services (CMS) found that CPT code 66711, ciliary body destruction, cyclophotocoagulation, endoscopic, inadvertently was not added to the ASC list. CMS will add CPT code 66711 to the ASC list of covered procedures in the July 2005 update, with an effective date of January 1, 2005.

Prior to January 1, 2005, the procedure was included in the 2004 CPT code 66710, Ciliary body destruction, cyclophotocoagulation that was included in the ASC list. The existing code 66710 was revised to read Ciliary body destruction; cyclophotocoagulation, transscleral and 66711 was created, effective January 1, 2005.

Note: You may bill procedures performed between January 1, 2005 and July 1, 2005 retroactively using the new code 66711, and payment may be made at the group 2 level.

To see the official instruction regarding this update to the 2005 ASC list, go to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that web page, look for CR 3817 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>.

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) #: 3817

Medlearn Matters Number: MM3817

Related CR Release Date: May 9, 2005

Related CR Transmittal #: 155

Effective Date: January 1, 2005

Implementation Date: July 5, 2005

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CONSOLIDATED BILLING

Change to the Common Working File Skilled Nursing Facility Consolidated Billing Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site

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

Important Note: This article (MM3427) was based on Change Request (CR) 3427, which has been fully replaced by CR3676 (Transmittal 459), dated February 4, 2005, Subject: *Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Transports to or from a Diagnostic or Therapeutic Site. Full Replacement of Change Request (CR) 3427, Transmittal 342, Issued on October 29, 2004.*

To see CR3676 (Transmittal 459), go to the following CMS website:

http://www.cms.hhs.gov/manuals/pm_trans/R459CP.pdf.

Also, to see the Medlearn Matters article related to CR3676 (Transmittal 459), go to the following CMS website:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3676.pdf>.

Related Change Request (CR) #: 3427

Medlearn Matters Number: MM3427

Related CR Release Date: October 29, 2004 *Revised*

Related CR Transmittal #: 342

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

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

July Quarterly Update to 2005 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement

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

Provider Types Affected

Physicians, providers, and suppliers billing services to carriers and intermediaries

Provider Action Needed

STOP – Impact to You

This article is based on information from Change Request (CR) 3873, which corrects the effective date of excluded healthcare common procedure coding system (HCPCS) L5781 for skilled nursing facility (SNF) consolidated billing (CB).

CAUTION – What You Need to Know

The correct effective date of excluded HCPCS L5781 for SNF CB should be January 1, 2003.

GO – What You Need to Do

See the Background section of this article to find out further details regarding this change.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of CPCS codes that are subject to the CB provision of the SNF PPS. Claims for services appearing on this list (which are submitted to Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs)) will not be paid by Medicare to providers, other than a SNF, when **included** in SNF CB.

- For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay;
- For physical and occupational therapies and speech-language pathology services, SNF CB applies whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay; and
- Services **excluded** from SNF PPS and CB may be paid to providers (other than SNFs) for beneficiaries, even when in a SNF stay.

Separate instructions are published for FIs and carriers/DMERCs for the annual notice on SNF CB each January. The 2005 Annual Update can be found on the following CMS websites for:

- FIs at http://www.cms.hhs.gov/manuals/pm_trans/R360CP.pdf (Transmittal R360CP, CR3542, dated November 5, 2004); and
- Carriers at <http://www.cms.hhs.gov/medlearn/snfcode.asp>.

Quarterly updates now apply to both FIs and carriers/DMERCs. An April 2005 Quarterly Update for FIs and carriers has been published subsequent to the 2005 annual update, and it is available at the CMS website for 2005 transmittals at http://www.cms.hhs.gov/manuals/pm_trans/R449CP.pdf (transmittal R449CP, CR3683 dated January 21, 2005).

CR3873 provides one HCPCS correction under Major Category III. D. Customized Prosthetic Devices.

HCPCS L5781 was previously excluded under the 2005 Annual Update to SNF CB with an incorrect effective date of January 1, 2005. The effective date for excluded HCPCS L5781 should be January 1, 2003.

Suppliers may bill L5781 retroactively to January 1, 2003. However, there may be situations in which a SNF has already reimbursed a supplier for L5781. Providers and suppliers cannot collect money from a SNF and Medicare Part B twice for the same service, equipment, or device for the same date of service.

Suppliers that now receive payment from Medicare Part B are expected in all cases to refund any money they received from the SNF for the same item.

Effective for claims with dates of service on or after January 1, 2003 to December 31, 2004, your Medicare carrier and FI will reopen and reprocess claims with the code L5781 and override timely filing when necessary. The carrier/FI will only do this, however, when you bring such claims to their attention.

Implementation

The implementation date for this instruction is July 5, 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.

From that Web page, look for CR3873 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>.

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) #: 3873

Medlearn Matters Number: MM3873

Related CR Release Date: May 27, 2005

Related CR Transmittal #: 568

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

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DIABETIC SERVICES**Infusion Pumps: C-Peptide Levels as a Criterion for Use**

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

Provider Types Affected

Physicians, suppliers, and providers providing continuous subcutaneous insulin infusion and related drugs/supplies in the treatment of diabetic patients in the home setting and billing Medicare carriers or fiscal intermediaries (FIs).

Provider Action Needed***STOP – Impact to You***

This article and related CR 3705 adds beta cell auto antibody testing as an alternative diagnostic per the updated C-peptide testing requirement for the use of insulin infusion pumps, effective for services performed on or after December 17, 2004.

CAUTION – What You Need to Know

Providers/suppliers treating Medicare diabetic patients with infusion pumps should be aware of this new Medicare coverage policy.

GO – What You Need to Do

Ensure that your staff is aware of this new coverage and that they bill according to the information in this article.

Background

On August 26, 1999, the Centers for Medicare & Medicaid Services (CMS) issued the first decision memorandum (DM) for continuous subcutaneous insulin infusion pumps (CSII) that utilized a C-peptide testing requirement for Medicare coverage of CSII pump therapy. On May 11, 2001, CMS issued a second DM for insulin pump: "C-Peptide Levels as a Criterion for Use," and on January 1, 2002, CMS revised the laboratory value for the C-peptide testing requirement for Medicare coverage of CSII pump therapy.

Effective for services performed on or after December 17, 2004, in addition to meeting criterion A or B, the beneficiary with diabetes must be insulinopenic per the fasting C-peptide testing requirement or, as an alternative must be beta cell autoantibody positive.

Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. For patients with renal insufficiency and a creatinine clearance (actual or calculated from age, gender, weight, and serum creatinine) < 50 ml/minute, insulinopenia is defined as a fasting C-peptide level that is less than or equal to 200% of the lower limit of normal of the laboratory's measurement method.

CMS establishes that fasting C-peptide levels will only be considered valid when a concurrently obtained fasting glucose is < 225 mg/dL.

Levels need only be documented once in the patient's medical records.

Coverage of all other uses of CSII that adheres with the Category B IDE clinical trials regulation (42 CFR 405.201) or routine cost under the clinical trials policy (Medicare NCD Manual Chapter 1, Part 4, Section 310.1) will continue.

Those billing for these services should note that Medicare carriers/intermediaries will accept, effective for services on or after December 17, 2004, CPT code 84681 (C-peptide) or CPT code 86337 (insulin antibodies) when diagnosis codes 250.00-250.93 are also reported on a claim.

Additional Information

The official instruction issued to your Medicare carrier/intermediary regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that web page, look for CR 3705 in the CR NUM column on the right, and 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>.

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) #: 3705

Medlearn Matters Number: MM3705

Related CR Release Date: March 30, 2005

Related CR Transmittal #: 27 and 513

Effective Date: December 17, 2004

Implementation Date: February 18, 2005

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DRUGS AND BIOLOGICALS

Abarelix for the Treatment of Prostate Cancer

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

Note: This article was revised on July 26, 2005, to reflect changes made to CR 3775, which was revised and reissued by the Centers for Medicare & Medicaid Services on July 22, 2005. The changes made as a result of the revised CR 3775 are to clarify that GnRH therapy is GnRH *agonist* therapy. Also, providers billing Medicare intermediaries for the use of abarelix should note that revenue code 0250 should be used on inpatient claims.

Provider Types Affected

Providers who care for Medicare beneficiaries with prostate cancer.

Provider Action Needed

STOP – Impact to You

Effective March 15, 2005, you may bill for the use of abarelix (Plenaxis™) for certain patients with advanced, symptomatic prostate cancer.

CAUTION – What You Need to Know

Effective March 15, 2005, CMS is extending national coverage for the use of abarelix as a palliative treatment, for the indications described below, in patients with advanced, symptomatic prostate cancer.

GO – What You Need to Do

Make sure that your billing staff is aware of this new coverage.

Background

Treatment Options for Prostate Cancer

Treatment options for prostate cancer vary depending on patient age, cancer stage, and individual medical conditions. Surgery (e.g., radical prostatectomy) or radiation is typically used for early-stage disease, whereas hormonal therapy, chemotherapy, and radiation (or combinations of these treatments) are used for more advanced disease.

Hormonal therapy for prostate cancer has evolved from orchiectomy and estrogens to the use, in recent years, of synthetic drugs known as gonadotropin-releasing hormone (GnRH) agonists, such as leuprolide (Lupron™) and goserelin (Zoladex™).

Abarelix

More recently, newer GnRH receptor antagonist compounds, such as abarelix, are, in contrast, thought to be devoid of agonist activity and to lack an initial androgen-stimulating effect. Abarelix has been proposed as a substitute for GnRH agonists (with and without antiandrogens) in the treatment of patients with advanced prostate cancer, for whom a surge in androgen blood levels may pose a risk of “clinical flare.” For this indication, abarelix is the first GnRH receptor antagonist that the Food and Drug Administration (FDA) has approved.

CMS determines that the evidence is adequate to conclude that abarelix is reasonable and necessary as a palliative treatment in patients with advanced symptomatic prostate cancer who: (1) decline surgical castration; (2) when GnRH agonist therapy is not appropriate, and (3) who present with one of the following indications:

- Risk of neurological compromise due to metastases,
- Ureteral or bladder outlet obstruction due to local encroachment or metastatic disease, or
- Severe bone pain from skeletal metastases persisting on narcotic analgesia.

Please note that the following additional conditions for coverage must be met, in accordance with the Food and Drug Administration (FDA) labeling requirements, to ensure that abarelix is used only in patients for whom the drug is indicated:

In evaluating this prostate cancer patient, the physician must attest to, and accept the following qualifications and responsibilities, and must have enrolled in the post-market-risk management program that the drug manufacturer has established.

The physician must attest willingness and ability to:

- Diagnose and manage advanced symptomatic prostate cancer;
- Diagnose and treat allergic reactions, including anaphylaxis;
- Have access to medication and equipment necessary to treat allergic reactions, including anaphylaxis;
- Have patients observed for development of allergic reactions for 30 minutes following each administration of abarelix;
- Understand the risks and benefits of palliative treatment with abarelix;
- Educate patients on the risks and benefits of palliative treatment with abarelix; and
- Report serious adverse events as soon as possible to the manufacturer and/or the FDA.

Finally, be aware that CMS has also determined that the evidence is not adequate to conclude that abarelix is reasonable and necessary for indications other than those specified above. Therefore, all other uses of abarelix are not covered. Further, in light of the concern regarding safety risks of abarelix, off-label uses that may appear in listed statutory drug compendia on which Medicare and its contractors rely to make coverage determinations will remain non-covered until CMS completes a reconsideration of this national coverage determination.

Additional Information

The following claims processing points should be noted:

- Use HCPCS code J0128 for claims when billing Medicare for abarelix used for treatment of prostate cancer patients in accordance with the requirements specified by the NCD.
- Medicare fiscal intermediaries will accept abarelix claims on types of bill 11x, 13x, 18x, 83x, and 85x.

Also, use revenue code 0636 on outpatient claims and revenue code 0250 on inpatient claims to reflect a drug requiring detailed coding.

- Medicare carriers and intermediaries will pay separately for abarelix chemotherapy injections when billed using an appropriate chemotherapy administration procedure code in addition to the visit furnished on the same day.
- For services performed on or after March 15, 2005, Medicare will deny claims for uses of abarelix that are not covered under the NCD, (NCD Manual Section 110.18). An appropriate remittance advice code will be sent to reflect the denial using MSN 6.5 (*Medicare cannot pay for this in injection because one or more requirements for coverage were not met, reason code 47 (this, these) diagnosis(es) is (are) not covered, missing, or are invalid*), and remark code M76 — *missing/incomplete invalid diagnosis or condition*.

You can find more information about abarelix for the treatment of prostate cancer by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that web page, look for CR 3775 in the CR NUM column on the right, and click on the file for that CR.

You might also want to look at Chapter 1, Part 2, Section 110.18 of the Medicare National Coverage Determinations Manual that is an attachment to CR 3775.

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>.

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) #: 3775

Medlearn Matters Number: MM3775

Related CR Release Date: July 22, 2005 *Revised*

Related CR Transmittal #: 612

Effective Date: March 15, 2005

Implementation Date: May 25, 2005

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Coverage of Aprepitant for Chemotherapy-Induced Emesis

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

Note: This article was revised on July 5, 2005, to add some clarifying language, but no substantive changes were made to the billing or coverage requirements.

Provider Types Affected

Providers and suppliers rendering services to beneficiaries with cancer chemotherapy-induced nausea and vomiting (CINV).

Provider Action Needed

STOP – Impact to You

Effective April 4, 2005, you may submit claims for the use of the oral anti-emetic drug aprepitant (Emend®), when used in combination with a 5-HT₃ antagonist and dexamethasone in beneficiaries receiving certain cancer chemotherapeutic agents as outlined below.

CAUTION – What You Need to Know

CMS has announced a National Coverage Determination (NCD) that covers the use of aprepitant, an orally administered neurokinin-1 (NK₁) antagonist, in both acute and delayed phases of chemotherapy-induced emesis. Effective April 4, 2005,

CMS will cover the use of the oral anti-emetic drug combination of aprepitant, a 5-HT₃ antagonist, and dexamethasone in beneficiaries receiving certain cancer chemotherapeutic agents (see *Background* section below).

GO – What You Need to Do

Make sure that your billing staffs are aware of this new coverage.

Background

Aprepitant, a human substance P/neurokinin-1 (NK₁) receptor antagonist, is the first Food and Drug Administration-approved anti-emetic drug of its type. It has been approved to function in combination with other oral anti-emetics for the prevention of both acute and delayed chemotherapy-induced nausea and vomiting (CINV) associated with initial and repeat courses of highly emetogenic chemotherapeutic agents.

CINV can range in severity from mild to severe, with the most severe cases resulting in dehydration, malnutrition, metabolic imbalances, and potentially requiring withdrawal from future chemotherapy treatments. CINV incidence and severity are influenced by the specific chemotherapeutic agent(s) used, their dosage, schedule and route of administration, and by

drug combinations. In addition, they can also be affected by patient-specific risk factors such as sex, age, history of motion sickness, and prior exposure to chemotherapeutic agents.

While progress has been made in reducing CINV, symptoms that occur more than a day after chemotherapy, during repeat cycles of chemotherapy, and when chemotherapy is given on more than one day or in very high doses remain hard to control. No single anti-emetic agent is completely effective in all patients.

CMS has determined that the evidence is adequate to conclude that use of the oral anti-emetic drug combination of aprepitant, a 5-HT₃ antagonist, and dexamethasone is reasonable and necessary for a specified patient population receiving one or more of the following anti-cancer chemotherapeutic agents:

- Carmustine
- Cisplatin
- Cyclophosphamide
- Dacarbazine
- Mechlorethamine
- Streptozocin
- Doxorubicin
- Epirubicin
- Lomustine

Note: The evidence is adequate to conclude that aprepitant cannot function alone as a full replacement for intravenously administered anti-emetic agents for patients who are receiving highly emetogenic chemotherapy.

Important Billing Information

You must bill your claims for aprepitant, on Form CMS-1450 (UB-92), or the electronic equivalent, with the appropriate cancer diagnosis and HCPCS code of J8501 (Aprepitant, oral, 5mg) or appropriate CPT code. Those providers submitting claims to Medicare fiscal intermediaries (FIs) should also include revenue code 0636 (Drugs requiring detailed coding).

For FIs, the following payment methodologies apply when aprepitant is provided by a hospital or skilled nursing facility (SNF) outpatient department:

- Based on ambulatory payment classification (APC) for hospitals subject to the outpatient prospective payment system (OPPS);

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Q0136—Pricing Revision

The Medicare Part B Drugs average sales price (ASP) allowance for procedure Q0136 was increased from \$10.18 to \$10.60 for claims with dates of service January 1, 2005 – March 31, 2005. FCSO implemented the change on April 1, 2005.

No Action Required by Providers

Providers who have had claims paid based on the original allowance do **not** need to take any action. Adjustments were performed on July 13, 2005 (Florida) and July 7, 2005 (Connecticut) to allow additional payment on the affected claims based on the revised ASP allowance.

Note: Some claims could not be mass adjusted due to system editing. These claims will be addressed manually.

For additional information regarding ASP pricing changes, refer to the CMS website at <http://www.cms.hhs.gov/providers/drugs/asp.asp>.

- Under current payment methodologies for hospitals not subject to OPPS; or
- On a reasonable cost basis for SNFs.

Critical access hospital (CAH) claims will be paid as follows:

- Method I – technical services are paid at 101% of reasonable cost;
- Method II – technical services are paid at 101% of reasonable cost, and professional services are paid at 115% of the Medicare physician fee schedule database.

Claims submitted to Medicare's durable medical equipment regional carriers (DMERCs) will be paid based on the average sales price (ASP) pricing file for claims with dates of service on or after April 4, 2005. Effective January 1, 2005, the payment allowance limit is based on the ASP + 6%.

Note: Inpatient claims submitted for oral anti-emetic drugs are processed under the current payment methodologies.

Your Medicare DMERC or FI will adjust claims with dates of service 04/04/05 (effective date) through 07/04/05 (implementation date), if brought to their attention.

Additional Information

You can find more information about the coverage of aprepitant for chemotherapy-induced emesis by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR 3831 in the CR NUM column on the right, and click on the file(s) for that CR. The file with transmittal number 40 will contain the national coverage determination and the file with transmittal number 590 will contain the claims processing instructions.

Finally, if you have any questions, please contact your DMERC/FI 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) #: 3831

Medlearn Matters Number: MM3831

Related CR Release Date: June 24, 2005 *Revised*

Related CR Transmittal #: 40 and 590

Effective Date: April 4, 2005

Implementation Date: July 5, 2005

Anti-Cancer Chemotherapy for Colorectal Cancer

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

Note: CMS revised this article on May 23, 2005, to reflect the revision of the original CR 3742. The CR was revised to show that revenue code 0636 is used when billing Medicare fiscal intermediaries (FIs) for anti-cancer drugs furnished during a clinical trial on outpatient claims, but revenue code 0250 should be used when billing for anti-cancer drugs furnished during a clinical trial on inpatient claims. In addition, CMS revised the article on June 21, 2005, to reflect a revision to CR 3742. The CR was revised to show that Medicare FIs has implemented the change on or before July 5, 2005, instead of April 18, 2005. The effective date of CR 3742 and all other information remains the same. The original article was published in the [Third Quarter 2005 Medicare B Update!](#) (pages 55-57).

Provider Types Affected

Providers and suppliers billing Medicare FI and carriers, including durable medical equipment regional carriers (DMERCs) for anti-cancer chemotherapy

Provider Action Needed

This article is based on information contained in Change Request (CR) 3742, which states that the Centers for Medicare & Medicaid Services (CMS) will cover the off-label use of Oxaliplatin (EloxatinTM), Irinotecan (Camptosar[®]), Cetuximab (ErbixTM), or Bevacizumab (AvastinTM) in clinical trials identified by CMS and sponsored by the National Cancer Institute (NCI).

This national coverage decision does not:

- Modify existing requirements for coverage of these and other anti-cancer chemotherapeutic agents for FDA-approved indications or for off-label indications listed in an approved compendium; or
- Change existing coverage for any off-label uses of these drugs provided outside the clinical trials identified.

Medicare FIs, carriers, and DMERCs will continue to make local coverage determinations for medically accepted uses of off-label indications based on guidance provided by the Secretary of the Department of Health & Human Services (DHHS).

Background

On January 28, 2005, CMS announced a national coverage determination (NCD) covering the off-label use of certain colorectal anti-cancer drugs in identified clinical trials of colorectal cancer and other cancer types. These clinical trials study the use of one or more off-label uses of these four drugs in colorectal and other cancer types.

Note: The clinical trials for which these drugs and other items and services are covered appear in Appendix A in the NCD on the CMS website at <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=90>.

Anti-cancer chemotherapeutic agents are eligible for coverage in a clinical trial setting when the following occurs:

- They are used in accordance with Food and Drug Administration (FDA)-approved labeling;
- Their use is supported in one of the authoritative drug compendia; or
- The Medicare contractor (FI, carriers and DMERCs) determines an off-label use is medically accepted based on guidance provided by Secretary of DHHS.

Effective for services provided on or after January 28, 2005, CMS covers the following anti-cancer chemotherapeutic agents, which have been approved by the FDA for the treatment of colorectal cancer, when used in clinical trials identified by CMS and sponsored by the National Cancer Institute:

- Oxaliplatin (EloxatinTM)
- Irinotecan (Camptosar[®])
- Cetuximab (ErbixTM)
- Bevacizumab (AvastinTM)

Under the concept of linking Medicare coverage determinations to clinical studies, the investigational items and services provided in qualified scientific studies are covered (including clinical trials, practical trials, and systematic data collection systems) when:

- They provide for the accrual of supporting evidence of medical necessity; and
- They collect data to support decisions about whether or not a technology is reasonable and necessary.

Note: The list of identified clinical trials for which the routine costs of the items and services are covered appears in the clinical trials section, on the CMS website at <http://www.cms.hhs.gov/coverage>.

Non-routine clinical costs include items and services that are provided in either the investigational or the control arms of a clinical trial specified by CMS for coverage. The following nonroutine items and services **are not covered** and include items and services:

- Provided solely to satisfy data collection, and that are not used in the direct clinical management of the patient;
- Provided solely to determine trial eligibility;
- Customarily provided by the research sponsors free-of-charge for any enrollee in the trial;
- That are statutorily excluded from Medicare coverage; or
- That do not fall into a benefit category.

This NCD, issued on January 28, 2005, does not withdraw Medicare coverage for items and services that may be covered according to the existing national coverage policy for Routine Costs in a Clinical Trial (See National Coverage Determination Manual, Section 310.1 on the CMS website at http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp).

Note: The existing requirements for coverage of oxaliplatin, irinotecan, cetuximab, bevacizumab, or other anticancer chemotherapeutic agents for FDA-approved indications or for indications listed in an approved compendium are not modified.

Medicare contractors will continue to make reasonable and necessary coverage determinations under the Social Security Act (Section 1861(t)(2)(B)(ii)(II)) based on guidance provided by CMS for medically accepted uses of off-label indications of Oxaliplatin, Irinotecan, Cetuximab, Bevacizumab, or other anticancer chemotherapeutic agents provided outside of the identified clinical trials appearing on the CMS website noted previously.

Some important points to remember when billing Medicare for these anti-cancer drugs are as follows:

- FIs will accept claims for these drugs on types of bill (TOB) 11x, 12x, 13x, 18x, 21x, 22x, 23x, and 85x. Use revenue code 0636 used for anti-cancer drugs furnished during a clinical trial for outpatient claims and use revenue code 0250 for inpatient claims.
- Claims submitted to FIs should also contain an ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position to show that the claim involves a clinical trial.
- When billing FIs, carriers and DMERCs on a claim other than an inpatient claim, include modifier **QR** to show the drug was furnished during a clinical trial.
- When using modifier **QR**, also be sure to include a HCPCS code of J9035, J9055, J9206, J9263, J8520, J8521, J9190, or J9201, as appropriate for the anti-cancer drug being billed.
- Providers are also to include modifier **QR** when billing for nonroutine costs associated with these clinical trials.
- DMERCs will accept claims with HCPCS codes of J8520 and J8521 as clinical trial codes for **oral anticancer** drugs, when accompanied by the QR modifier to show use in a clinical trial.
- When billing for covered routine costs associated with clinical trials as described in section 310 of the NCD manual, be sure to include modifier **QV** on the claim.
- Submit an appropriate cancer diagnosis code for the clinical trial on the claim.

Note: While this NCD is effective as of January 28, 2005, Medicare systems were not able to process claims containing modifier QR received before April 1, 2005. For that reason, provider were asked not to send claims for drugs or other nonroutine services covered under this NCD until April 1, 2005. Claims for nonroutine services containing modifier QV associated with this NCD were not affected.

Additional Information

For complete details, please see the official instruction issued to your FI/carrier/DMERC regarding this change. That instruction includes the NCD section 110.17 and it may be viewed by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that Web page, look for CR 3742 in the CR NUM column on the right, and click on the file for that CR.

You should see two versions of CR 3742 on this website. The version of CR 3742 with a transmittal number of R38NCD will contain the NCD information and the version with a transmittal number of R588CP will contain the Medicare claims processing instructions.

If you have any questions, please contact your FI/carrier/DMERC 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) Number: 3742

Related CR Release Date: June 17, 2005

Related CR Transmittal Number: 38 and 588

Effective Date: January 28, 2005

Implementation Date: April 18, 2005 (Medicare carriers), on or before July 5, 2005 (Medicare FIs)

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Drug and Drug Administration Redetermination Requests No Longer Acceptable Via the Telephone

First Coast Service Options, Inc. (FCSO) has identified some potential payment issues related to drug and drug administration services (HCPCS codes beginning with “G”, “J” and “Q”) through the contractor data analysis process. As a result of this finding, request for payment redetermination (formally known as appeal process) of these services may no longer be accepted via telephone request.

Action Required by Providers

Effective May 20, 2005, all requests for redetermination of drug and drug administration services must be submitted in writing by completing the “Request for Redetermination of a Medicare Part B Claim” form (Form #17503 305R SR). **Medical records documentation must be included with every redetermination request.**

Requests without medical documentation to support the medical need for the service and the service rendered will result in a nonfavorable redetermination decision.

Exception

Circumstances, which result in FCSO performing MASS adjustments, would **not** require a redetermination request.

A copy of the “Request for Redetermination of a Medicare Part B Claim” form may be found at:

<http://www.floridamedicare.com/provider/content/forms/FL-Request-for-Written-Redetermination.pdf>.

New April 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File and Revisions to January 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File

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

Provider Types Affected

All Medicare providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs).

Provider Action Needed

STOP – Impact to You

CR 3846 revises payment allowance limits in the January 2005 and the April 2005 drug pricing files. For the codes listed below, the revised payment limits supersede the payment limits cited in any previously published document.

CAUTION – What You Need to Know

Effective January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals (that are not paid on a cost or prospective payment basis) are 106 percent of the average sales price (ASP).

GO – What You Need to Do

Make sure that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA), Section 303, revises the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs and biologicals are paid based on the new ASP drug payment methodology.

The ASP file, used in the ASP methodology, is based on data that CMS receives quarterly from manufacturers. Each quarter, CMS will update your carrier and fiscal intermediary (FI) payment allowance limits with the ASP drug pricing files based on these manufacturers’ data.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. However, you should be aware that there are exceptions to this general rule as summarized below:

- For **blood and blood products** (with certain exceptions like blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. **The payment allowance limits will be updated quarterly;**
- For **infusion drugs** furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the DME is implanted. **The payment allowance limits will not be updated in 2005.** **Note:** For infusion drugs (furnished through a covered item of durable medical equipment) that were not listed in the published compendia as of October 1, 2003 (i.e., new drugs), the payment allowance limits are 95 percent of the first published AWP.
- For influenza, pneumococcal, and hepatitis B vaccines, payment allowance limits are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated quarterly.

- For drugs (other than new drugs) not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, payment allowance limits are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the WAC-based payment limit, carriers/DMERCs/FIs will follow the methodology specified in the Medicare Claims Processing Manual for calculating the AWP, but substitute WAC for AWP. Please see Pub. 100-04, Chapter 17 (Drugs and Biologicals) at the following CMS website: http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf. The payment limit is 100 percent of the lesser of the lowest brand or median generic WAC.

Your carrier or FI may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting carrier/FI or will post them in an MS Excel file on the CMS web site. If the payment limit is available from CMS, carriers/FIs will substitute the CMS-provided payment limits for pricing based on WAC or invoice pricing.

- For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File**, payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.

Table 1 below displays the revised 1st Quarter 05 payment allowance limits for the indicated codes, effective for services provided on or after January 1, 2005.

Table 1

HCPCS	Short Description	HCPCS Code/Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit
90371	Hep B ig, im	1 ML	\$115.878	\$115.878
J2790	Rho d immune globulin, inj	300 MCG	\$101.733	\$101.733
J2792	Rho (D) immune globulin	100 IU	\$13.101	\$13.101
Q0187	NovoSeven	Per 1.2 MG	\$1,211.050	\$1,211.050

Table 2 below displays the revised 2nd Quarter 2005 payment allowance limits for the indicated codes, effective for services provided on or after April 1, 2005.

Table 2

HCPCS	Short Description	HCPCS Code/Dosage	2Q05 Payment Limit	2Q05 Independent ESRD Limit	2Q05 Vaccine Limit	2Q05 Blood Limit
90747	Hep B vacc, ill pat 4 dose im	40 MCG	\$113.915	\$113.915	\$113.915	
J0135	Adalimumab injection	20 MG	\$294.632	\$294.632		
J0287	Amphotericin b lipid complex	10 MG	\$11.724	\$11.724		
J0725	Chorionic gonadotropin	1000 UNITS	\$2.976	\$2.976		
J2597	Inj desmopressin acetate	1 MCG	\$2.493	\$2.493		
J7190	Factor viii	1 IU	\$0.641	\$0.641		
J7192	Factor viii recombinant	1 IU	\$1.063	\$1.063		
J7193	Factor IX non-recombinant	1 IU	\$0.882	\$0.882		
J7194	Factor ix complex	1 IU	\$0.650	\$0.650		
J7195	Factor IX recombinant	1 IU	\$0.982	\$0.982		
J7197	Antithrombin iii injection	1 IU	\$1.543	\$1.543		
J7198	Anti-inhibitor	1 IU	\$1.241	\$1.241		
J7344	Nonmetabolic active tissue	1 SQ CM	\$52.777	\$52.777		
J9098	Cytarabine liposome	10 MG	\$359.359	\$359.359		

Table 2 (continued)

HCPCS	Short Description	HCPCS Code/Dosage	2Q05 Payment Limit	2Q05 Independent ESRD Limit	2Q05 Vaccine Limit	2Q05 Blood Limit
J9245	Inj melphalan hydrochl	50 MG	\$513.694	\$513.694		
J9266	Pegaspargase single dose vial	1 EA	\$1,499.306	\$1,499.306		
P9041	Albumin (human), 5%	50 ML	\$14.545	\$14.545		\$14.545
P9043	Plasma protein fraction, 5%	50 ML	\$14.545	\$14.545		\$14.545
P9046	Albumin (human), 25%	20 ML	\$14.545	\$14.545		\$14.545
P9048	Plasma protein fraction, 5%	250 ML	\$29.099	\$29.099		\$29.099
Q0187	NovoSeven	Per 1.2 MG	\$1,228.438	\$1,228.438		
Q2002	Elliotts b solution per ml	1ML	\$3.350	\$3.350		
Q2005	Corticotropin ovine triflutat	1 EA	\$379.06	\$379.067		
Q2012	Pegademase bovine	25 IU	\$158.048	\$158.048		
Q2018	Urofollitropin, 75 iu	75 IU	\$43.865	\$43.865		
Q9941	IVIG lyophil	1 G	\$38.735	\$38.735		
Q9942	IVIG lyophil	10 MG	\$0.387	\$0.387		
Q9943	IVIG non-lyophil	1 G	\$56.221	\$56.221		
Q9944	IVIG non-lyophil	10 MG	\$0.562	\$0.562		
Q9954	Oral MR contrast	100 ML	\$8.844	\$8.844		

Notice that J2910 is no longer included in the April 2005 pricing file.

You should note that the new April 2005 ASP drug pricing files will contain three decimal places in the currency fields. You can find more information on the April 2005 ASP data format in CR 3436, which instructs the carriers/DMERCs/FIs to accommodate 3 places after the decimal point, and to follow standard rounding procedure, round to 2 decimal places, after multiplying the number in the "units" field of the line item by the payment allowance applicable to the HCPCS code.

You should also note that the absence or presence of a HCPCS code and its associated payment limit in the payment files do not indicate Medicare coverage of the drug or biological. Nor does inclusion of a payment limit within a specific column indicate Medicare coverage of the drug in that specific category. The carrier/DMERC/FI processing your claim will make these determinations.

To comply with these requirements, your carrier, DMERC, or FI will:

- Use the new April 2005 ASP drug pricing file to pay for Medicare Part B drugs, effective April 1, 2005 for dates of service from April 1, 2005 through June 30, 2005;
- Determine (for any drug or biological not listed in the ASP or NOC drug pricing files) the payment allowance limits in accordance with the policies described in CR3232, dated December 16, 2004 (corrected). See http://www.cms.hhs.gov/manuals/pm_trans/R397CP.pdf.
- Use the new April 2005 ASP drug pricing file for (1) those claims where the provider asks the carrier/DMERC/FI to retroactively adjust claims processed with the original April 2005 file, and (2) those claims with dates of service on or after April 1, 2005 and before July 1, 2005 that are processed after July 4, 2005. **Your carrier or FI will not search and adjust claims that have already been processed unless brought to their attention.**

Additional Information

The new April 2005 and revisions to the January ASP Pricing Files are available at:

<http://www.cms.hhs.gov/providers/drugs/asp.asp>.

For complete details of CR 3846, on which this article is based, please see the official instruction issued to your FI/intermediary regarding this change. That instruction may be viewed at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that Web page, look for CR 3846 in the CR NUM column on the right, and click on the file for that CR.

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>

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) #: 3846

Medlearn Matters Number: MM3846

Related CR Release Date: May 13, 2005

Related CR Transmittal #: 561

Effective Date: April 1, 2005

Implementation Date: July 5, 2005

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New Healthcare Common Procedure Coding System Drug Codes

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), or fiscal intermediaries (FIs) for high osmolar contrast material and iloprost inhalation solution

Provider Action Needed

Effective July 1, 2005, for dates of service on or after July 1, 2005, HCPCS code Q4080, for iloprost inhalation solution, and HCPCS codes Q9958 – Q9964, for high osmolar contrast material, are being added to the HCPCS. Be aware of the new codes for iloprost inhalation solution and high osmolar contrast material when reporting these services to Medicare.

Additional Information

Effective July 1, 2005, the following codes are being added to the HCPCS for iloprost inhalation solution and high osmolar contrast material.

HCPCS	Short Descriptor	Long Descriptor
Q4080	Iloprost inhalation solution	loprost, inhalation solution, administered through DME, 20 mcg
Q9958	HOCM <=149 mg/ml iodine, 1 ml	High osmolar contrast material (HOCM), up to 149 mg/ml iodine concentration, per ml
Q9959	HOCM 150-199 mg/ml iodine, 1 ml	High osmolar contrast material, 150 - 199 mg/ml iodine concentration, per ml
Q9960	HOCM 200-249 mg/ml iodine, 1 ml	High osmolar contrast material, 200 - 249 mg/ml iodine concentration, per ml
Q9961	HOCM 250-299 mg/ml iodine, 1 ml	High osmolar contrast material, 250 - 299 mg/ml iodine concentration, per ml
Q9962	HOCM 300-349 mg/ml iodine, 1 ml	High osmolar contrast material, 300 - 349 mg/ml iodine concentration, per ml
Q9963	HOCM 350-399 mg/ml iodine, 1 ml	High osmolar contrast material, 350 - 399 mg/ml iodine concentration, per ml
Q9964	HOCM >= 400 mg/ml iodine, 1 ml	High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

Also, please note the following:

- As stated in Section 30 of Chapter 13 of the Medicare Claims Processing Manual (Publication 100-04), payment for HOCMs is included in the payment for the procedure and separate payment for the HOCMs is not allowed.
- As stated in CR3846, the payment allowance limits for new drugs and biologicals not included in the average sales price (ASP) Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file are based on 106 per cent of the wholesale acquisition cost (WAC). A Medlearn Matters article related to CR3846 is available at www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3846.pdf on the CMS website.
- Those billing Medicare carriers may note that code Q4080 will be assigned to status indicator "E", and codes Q9958-Q9964 will be assigned status indicator "B" in the Medicare physician fee schedule database.

- While Medicare carriers and DMERCs will accept Q4080 to report iloprost inhalation solution, only Medicare DMERCs will make payment for Q4080.
- Where appropriate, revenue code 0636 should be assigned when billing these HOCM HCPCS codes.
- Critical Access Hospital outpatient departments should bill for codes Q4080 and Q9958-Q9964 using type of bill (TOB) 85X. Payment for such services will be based on reasonable cost and beneficiary deductible and coinsurance does apply.
- Skilled Nursing Facilities billing under Medicare Part B should use TOB 22X (for inpatient Part B) and 23X (outpatient) for codes Q4080 and Q9958-Q9964. Payments to the SNFs will also be made on a reasonable cost basis and beneficiary deductible and coinsurance does apply.

The official instruction issued to your carrier/DMERC/FI regarding this change may be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that Web page, look for CR 3847 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/DMERC/FI on their toll free number, which is available 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) #: 3847

Related CR Release Date: June 10, 2005

Effective Date: July 1, 2005

Medlearn Matters Number: MM3847

Related CR Transmittal #: 580

Implementation Date: July 5, 2005

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Supply Codes and Payments for Immunosuppressive Drugs

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

Provider Types Affected

Pharmacies, hospitals not subject to the outpatient prospective payment system (OPPS), and dialysis facilities in the state of Washington billing Medicare for immunosuppressive drugs

Provider Action Needed

STOP – Impact to You

Effective January 1, 2005, Medicare pays a supplying fee for immunosuppressive drugs, oral anticancer chemotherapeutic drugs, and oral anti-emetic drugs used as part of an anti-cancer chemotherapeutic regimen in accordance with Section 303(e) (2) of the Medicare Modernization Act.

CAUTION – What You Need to Know

Most supplies of immunosuppressive drugs are billed to the Medicare durable medical equipment regional carriers (DMERCs). However, Medicare fiscal intermediaries (FIs) will also pay for 30-day supplies of immunosuppressive drugs when provided by a dialysis facility in the state of Washington, or by hospital outpatient departments not subject to OPPS. **When billing Medicare, both the drug and the supply fee must be billed on the same claim. If the supply fee is billed alone on the claim, it will be denied.** Furthermore, you may only submit a claim for G0369 once per beneficiary per transplant.

GO – What You Need to Do

To ensure accurate claims processing, review the information included here and stay current with instructions for Medicare dispensing/supply fees.

Background

Section 303(e) (2) of the MMA implements a supplying fee for immunosuppressive drugs. Beginning January 1, 2005, Medicare pays a separately billable supplying fee of \$24.00 to a pharmacy or other entity providing an immunosuppressive drug to a Medicare beneficiary.

These payments are generally made by the DMERC to the pharmacy. However, in the state of Washington, FIs pay the supplying fee to the dialysis facility that supplies immunosuppressive drugs to kidney transplant beneficiaries. In addition, FIs will pay this \$24.00 supplying fee to non-OPPS hospitals supplying 30-day supplies of immunosuppressive drugs. The code for this supplying fee is G0370. The code description is as follows:

G0370 – Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s)

Effective January 1, 2005, Medicare pays a supplying fee of \$50.00 to a pharmacy for the initial supplied prescription of immunosuppressive drugs to the patient during the first month following the transplant. The code for this supplying fee is G0369. This is a one-time payment per beneficiary, **per transplant**. The code description is as follows:

G0369 – Pharmacy supply fee for initial immunosuppressive drug(s) first month following transplant

Effective October 1, 2005 for claims submitted to DMERCs, edits will apply to the G0369 to ensure that only one such claim is paid per beneficiary for each transplant received by that beneficiary.

Note: You cannot bill both the G0369 and G0370 with the first prescription. G0369 must be billed within one (1) year of the date of the patient's discharge from the hospital stay during which the transplant was performed.

Implementation

The implementation date for this instruction is October 3, 2005

Additional Information

Beneficiaries are required to pay the normal co-pay and deductible on both the drug and the supplying fee.

Your FI will process any adjustment requests you submit for immunosuppressive drugs with dates of service on and after January 1, 2005 and pay the supplying fee to the dialysis facility or non-OPPS hospital.

For complete details of CR 3830, on which this article is based, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that web page, look for CR 3830 in the CR NUM column on the right, and click on the file for that CR.

Additional information may also be found in Medlearn Matters Article MM3620, and the related CR 3620, which that addresses new dispensing/supply fee codes for oral anti-cancer, oral anti-emetic, immunosuppressive, and inhalation drugs when billed to DMERCs.

MM3620 may be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3620.pdf>.

CR 3620 may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

Once at that site, look for CR 3620 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions regarding this issue, please contact your DMERC or FI at their toll free number, which you will find at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

Related Change Request (CR) #: 3830

Medlearn Matters Number: MM3830

Related CR Release Date: April 29, 2005

Related CR Transmittal #: 551

Effective Date: January 1, 2005 for editing claims submitted to Medicare fiscal intermediaries and October 1, 2005 for editing claims submitted to durable medical equipment regional carriers

Implementation Date: October 3, 2005

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DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

July Quarterly Update for 2005 DMEPOS Fee Schedule

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).

Provider Action Needed

This article is based on CR 3779 and provides specific information regarding the July quarterly update of the 2005 durable medical equipment, prosthetics, orthotics, and supplies (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 to 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 (Section 1834 (a), (h), and (i), and payment of a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

CR 3779 provides specific details regarding the July quarterly update for the 2005 DMEPOS fee schedule, which are as follows:

Batteries Used with Cochlear Implant Devices

Code **L8620** with the description of "Lithium Ion Battery for Use with the Cochlear Implant Device" was added to the HCPCS effective January 1, 2005. When the fee schedule amounts were calculated and implemented for this code on January 1, 2005, pricing information for the different

types of batteries used with cochlear implant devices was not included.

The fee schedule amounts for **L8620** are being revised as part of the quarterly update to include pricing information for the different types of lithium ion batteries used with cochlear implant devices. CMS is revising the fee schedule for the code using the standard gap-filling process. Local carriers, therefore, do not need to gap fill fees for this code.

Note: Previously paid claims for L8620 with dates of service from January 1, 2005 thru June 30, 2005 will be adjusted if resubmitted by suppliers as adjustments on or after July 1, 2005.

Code **L8620** is being made invalid for Medicare claims with the dates of service on or after July 1, 2005.

The following codes are being added to the HCPCS effective for dates of service on or after July 1, 2005:

- **K0731**-Lithium Ion Battery for Use With Cochlear Implant Device Speech Processor, Other than Ear Level, Replacement, Each; **Short Description:** Lith ion batt cid, non-ear level
- **K0732** Lithium Ion Battery for Use With Cochlear Implant Device Speech Processor, Ear Level, Replacement, Each; **Short Description:** Lith ion batt cid, ear level

These codes are to be used to bill for replacement batteries previously coded under **L8620** that are furnished on or after July 1, 2005. Also, please note that codes **L8110** and **L8120** do not meet the Medicare definition of prosthetic devices.

Controlled Dose Inhalation Drug Delivery System

The following code is also added to the HCPCS on July 1, 2005 and is effective for claims with service dates on or after April 1, 2005: **K0730**-Controlled Dose Inhalation Drug Delivery System.

Note: The allowed rental payment amount for this device is based on your Medicare contractor's individual consideration of each claim until fee schedule amounts can be established for this new code. code K0670 was added to the HCPCS effective on April 1, 2005, but the fee schedule amount for K0670 was based on incorrect information and the amount is revised with this change. Your DMERC or FI will adjust previously processed claims for code K0670 with dates of service on or after April 1, 2005, but only if you resubmit the claim for adjustment.

Parenteral and Enteral Nutrition (PEN) Equipment and Supplies

There are no changes to the PEN fee schedule file for July 2005.

Implementation

The implementation date for this instruction is July 5, 2005.

Additional Information

The quarterly updates process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 60 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule), which can be reviewed at the following CMS website:

http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf.

The official instruction issued to your carrier/DMERC/intermediary regarding this change may be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that web page, look for CR 3779 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/intermediary. To find their toll free phone numbers go to: <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) #: 3779

Related CR Release Date: April 29, 2005 *Revised*

Effective Date: January 1, 2005

Medlearn Matters Number: MM3779

Related CR Transmittal #: 536

Implementation Date: July 5, 2005

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An Algorithmic Approach to Determine if Mobility Assistive Equipment Is Reasonable and Necessary for Medicare Beneficiaries with a Personal Mobility Deficit (CR 3791 - Mobility Assistive Equipment)

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

Provider Types Affected

Providers billing Medicare durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs) for mobility assistive equipment (MAE).

Provider Action Needed**STOP – Impact to You**

This article includes information from change request (CR) 3791, in which the Centers for Medicare and Medicaid Services (CMS) addresses numerous items that it has termed MAE.

CAUTION – What You Need to Know

MAE includes (but is not limited to) canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. CMS determines that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

Determination of the presence of a mobility deficit will be made by an algorithmic process (as outlined in the Clinical Criteria for MAE Coverage included in this article) to provide the appropriate MAE to correct the mobility deficit.

GO – What You Need to Do

You should sequentially consider specific questions in CR 3791 that provide clinical guidance for the coverage of equipment (of appropriate type and complexity) to restore the beneficiary's ability to participate in mobility-related activities of daily living (MRADLs) (toileting, feeding, dressing, grooming, bathing, etc.) in customary locations in the home. These questions correspond to the numbered decision points on the Clinical Criteria for MAE Coverage flow chart in CR3791.

Background

Recently, considerable public interest has been focused on the provision of wheelchairs under the Medicare benefit. The agency has responded with a multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them. One facet of this plan is the delineation of suggested clinical conditions of wheelchair coverage. The CMS solicited public comment through a number of open door forums and other methods. Many advocacy groups suggested that the agency adopt a function-based interpretation of its historical "bed or chair confined" criterion for wheelchair coverage.

CMS believes that an algorithmic process that sequentially considers the appropriate MAE that corrects the mobility deficit is the appropriate process to follow in covering MAEs.

CMS believes that the Clinical Criteria for MAE Coverage, in Section 280.3, Chapter 1, of Medicare Publication 100-03 (Medicare National Coverage Determinations), sufficiently describes this process.

Utilizing such a process will ensure that the beneficiary (or caregiver) is able to maintain as much independence as physically and mentally possible, thereby ensuring the beneficiary's MRADLs are maintained.

CMS is extending national coverage regarding MAE for beneficiaries who have a personal mobility deficit sufficient to impair their participation in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. Determination of the presence of a mobility deficit will be made by an algorithmic process, as outlined in the Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters.

CR 3791 instructs Medicare carriers, DMERCs, and RHHIs to:

- Disregard the “bed- or chair-confined” criterion which has been historically used to determine if a wheelchair is reasonable and necessary as defined by the Social Security Act (Section 1862(A)(1)(a)).
- Use the algorithmic approach as outlined in the Medicare National Coverage Determinations Manual (Pub. 100-03, Section 280.3), Clinical Criteria for MAE Coverage (and included below) to determine coverage eligibility of MAE. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters.

As in other cases, if data analysis indicates potentially aberrant billing, Medicare DMERCs and FIs will use these standards when performing medical review of claims.

Medicare beneficiaries may require mobility assistance for a variety of reasons and for varying durations because the etiology of the disability may be due to a congenital cause, injury, or disease. Thus, some beneficiaries experiencing temporary disability may need mobility assistance on a short-term basis, while in contrast, those living with chronic conditions or enduring disabilities will require mobility assistance on a permanent basis.

In addition, Medicare beneficiaries who depend upon mobility assistance are found in varied living situations. Some may live alone and independently while others may live with a caregiver or in a care facility. The beneficiary's environment is relevant to the determination of the appropriate form of mobility assistance that should be employed.

For many patients, a device of some sort is compensation for the mobility deficit. However, some beneficiaries experience co-morbid conditions that can impact their ability to safely utilize MAE independently or to successfully regain independent function even with mobility assistance.

The functional limitation (as experienced by a beneficiary) depends on:

- The beneficiary's physical and psychological function,
- The availability of other support, and
- The beneficiary's living environment.

A few examples include muscular spasticity, cognitive deficits, the availability of a caregiver, and the physical layout, surfaces, and obstacles that exist in the beneficiary's living environment.

Nationally Covered Indications

Effective May 5, 2005, CMS finds that the evidence is adequate to determine that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their performance of MRADL such as toileting, feeding, dressing, grooming, and bathing in customary areas in the home. **Determination of the presence of a mobility deficit will be made by an algorithmic process, Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit.**

Clinical Criteria for MAE Coverage

The beneficiary, the beneficiary's family or other caregiver, or a clinician, will usually initiate the discussion and consideration of MAE use. **Sequential consideration of the questions below provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the beneficiary's ability to participate in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.** These questions correspond to the numbered decision points on the accompanying flow chart.

1. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs in the home? A mobility limitation is one that:
 - a. Prevents the beneficiary from accomplishing the MRADLs entirely, or,
 - b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs, or,
 - c. Prevents the beneficiary from completing the MRADLs within a reasonable time frame.
2. Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?
 - a. Some examples are significant impairment of cognition or judgment and/or vision.
 - b. For these beneficiaries, the provision of MAE might not enable them to participate in MRADLs if the co morbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with MAE.

3. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?
 - a. A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.
 - b. If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of MAE.
4. Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?
 - a. Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
 - b. A history of unsafe behavior in other venues may be considered.
5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?
 - a. The cane or walker should be appropriately fitted to the beneficiary for this evaluation.
 - b. Assess the beneficiary's ability to safely use a cane or walker.
6. Does the beneficiary's typical environment support the use of wheelchairs including scooters/poweroperated vehicles (POVs)?
 - a. Determine whether the beneficiary's environment will support the use of these types of MAE.
 - b. Keep in mind such factors as physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home.
7. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured (seating options, wheelbase, device weight, and other appropriate accessories) for this determination.
 - a. Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
 - b. A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
 - c. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
 - d. Assess the beneficiary's ability to safely use a manual wheelchair.

Note: If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.

8. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
 - a. A POV is a 3- or 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation.
 - b. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a POV.
 - c. Assess the beneficiary's ability to safely use a POV/scooter.
9. Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?
 - a. The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
 - b. The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
 - c. The beneficiary's home should provide adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
 - d. Assess the beneficiary's ability to safely use a power wheelchair.

Note: If the beneficiary is unable to use a power wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair is appropriate. A caregiver's inability to operate a manual wheelchair can be considered in covering a power wheelchair so that the caregiver can assist the beneficiary.

Nationally Noncovered Indications

Medicare beneficiaries not meeting the clinical criteria for prescribing MAE as outlined above, and as determined by the beneficiary's physician, would not be eligible for Medicare coverage of the MAE.

Note: All other durable medical equipment (DME) not meeting the definition of MAE as described in this instruction will continue to be covered, or noncovered, as is currently described in the NCD Manual at section 280, Medical and Surgical Supplies.

Also note that CR 3791 revises the Medicare National Coverage Determinations Manual (Pub. 100-03, Section 280.3), and this revision is a National Coverage Determination (NCD) made under the Social Security Act (section 1862(a)(1)).

NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see the Code of Federal Regulations (CRF), Title 42, Sections 405.732, 405.860). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an administrative law judge may not review an NCD. (See the Social Security Act (Section 1869(f)(1)(A)(i)).)

Implementation

The implementation date for this instruction is July 5, 2005. Your DMERC or FI will adjust claims affected by this change, but processed before July 5, 2005, if you bring such claims to the attention of the DMERC/FI.

Additional Information

For complete details, please see the official instruction issued to your DMERC or FI regarding this change.

That instruction includes the complete section 280.3 and the 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 3791 in the CR NUM column on the right, and click on the files for that CR. You will note two files for CR 3791. The file reflecting transmittal number 37 contains the revisions to the Medicare National Coverage Determinations Manual and the file with transmittal number 574 contains the Medicare claims processing business requirements/instructions.

If you have any questions, please contact your DMERC/FI at their toll-free number, which may be found at

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

Related Change Request (CR) #: 3791

Medlearn Matters Number: MM3791

Related CR Release Date: June 3, 2005

Related CR Transmittal #: 37 and 574

Effective Date: May 5, 2005

Implementation Date: July 5, 2005

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New HCPCS Codes and System Edits for Supplies and Accessories for Ventricular Assist Devices—Full Replacement of CR 3761

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

Note: The *Medlearn Matters* article MM3761, addressing guidelines for change request (CR) 3761, was originally posted the provider education website www.floridamedicare.com on May 10, 2005. Since then, CMS has rescinded CR 3761 and issued CR 3931 as a replacement.

Provider Types Affected

Providers and suppliers who bill Medicare carriers or fiscal intermediaries (FIs) for supplies and accessories for ventricular assist devices

Provider Action Needed

STOP – Impact to You

This instruction and related CR 3761 announce new Healthcare Common Procedure Coding System (HCPCS) codes and implement related Medicare system edits for replacement accessories and supplies for implanted ventricular assist devices (VADs) that are covered under the prosthetic device benefit in section 1834(h) of the Social Security Act.

CAUTION – What You Need to Know

Providers and suppliers furnishing replacement accessories and supplies for VADs should be aware of the new codes that are being added, effective October 1, 2005.

GO – What You Need to Do

Be sure your billing staff is aware of these changes that affect billing for these services on or after October 1, 2005.

Background

The fee schedules that Medicare uses to pay for durable medical equipment, prosthetics, and orthotics (DMEPOS), are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise, as necessary, any fee schedule amounts for existing codes. The Social Security Act (Sections 1834 (a), (h)(i)), requires that payment for DMEPOS be made on a fee schedule basis.

This article provides the new codes that are being added to HCPCS edits for replacement accessories and supplies for (VADs), effective October 1, 2005. Instructions regarding the implementation of the fee schedule amounts for these codes will be included in the October quarterly DMEPOS fee schedule update instructions.

Following are the codes that describe replacement accessories and supplies for VADs that are being added to the HCPCS effective 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 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

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

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 cover 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

Medicare payment for VADs is made under Medicare Part A, since they are implanted in the beneficiary in an inpatient setting. Payment for supplies and accessories, including all the accessories necessary for the VAD to function, that are provided in the inpatient setting, are included in the Part A payment made by the Medicare FI.

Medicare payment can be made under Medicare Part B by carriers or FIs, for the medically necessary supplies and replacement accessories after the patient is discharged from the hospital. Claims for replacement of supplies and accessories used with the VAD that are furnished by suppliers should be billed to the local carriers. Claims for replacement of supplies and accessories that are furnished by providers (e.g., hospitals outpatient departments) should be billed to the FIs.

Based on information provided to the Centers for Medicare & Medicaid Services (CMS) by VAD manufacturers, CMS has determined that the lifetime of the batteries is six months and the lifetime of all other accessories is one year. Thus, CMS will implement edits to deny claims for replacement supplies and accessories before the lifetime of the item has expired (six or 12 months following discharge from the hospital or previous Part B payment for replacement of the item).

There are instances where replacement supplies and accessories HCPCS should be covered before the lifetime of the item has expired (i.e. cases where the item is lost, stolen, or irreparably damaged). In these situations, the local carrier or FI is responsible for determining if this item should be covered before the lifetime of the item has expired. Suppliers and hospitals are required to add HCPCS modifier "RP" (replacement and repair) to the claim with codes Q0480 thru Q0499 and Q0501 thru Q0504, in those instances where replacement is needed before the lifetime of the item has expired.

Also, Medicare will process claims for replacement of supplies and accessories in instances where the VAD was not covered by Part A, for example, where the patient did not have Medicare Part A coverage, but does have Part B. In these cases, the provider should bill under code L9900 and your Medicare carrier or FI will determine if payment is warranted.

Note: Hospitals must bill HCPCS codes Q0480 through Q0505 with revenue code 274.

Implementation Date

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

Additional Information

The quarterly updates process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 60 (Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule), which may be reviewed at:

http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf.

The official instruction issued to your FI/carrier regarding this change may be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

Once at that site, scroll down the CR NUM column on the right and click on the file for CR 3761.

If you have any questions, please contact your FI/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) Number: 3931

Related CR Release Date: July 22, 2005

Related CR Transmittal Number: 613

Effective Date: October 1, 2005

Implementation Date: October 3, 2005

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JURISDICTIONAL PRICING

Temporary Change in Carrier Jurisdictional Pricing Rules for Purchased Diagnostic Services

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

This information was previously published in the 2005 January 2005 Medicare B Update! Special Issue pages 49-50.

Note: This article was revised on May 26, 2005 to include this reference to related change requests CR3481 (Implementation of the Medicare Physician Fee Schedule (MPFS) National Abstract File for Purchased Diagnostic Tests and Interpretations), and CR3694 (Implementation of the Abstract File for Purchased Diagnostic Tests/Interpretations [Supplemental to CR 3481]).

To see the Medlearn Matters article related to CR3481, go to the following CMS website:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3481.pdf>.

To see the Medlearn Matters article related to CR3694, go to the following CMS website:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3694.pdf>.

Provider Types Affected

Physicians, laboratories, and independent diagnostic testing facilities (IDTFs)

Provider Action Needed

This instruction implements a temporary change in carrier jurisdictional pricing rules for purchased diagnostic services to allow physicians/suppliers purchasing out-of-jurisdiction diagnostic tests/interpretations to bill their local carrier for these services.

It also instructs carriers to revoke any previously issued provider identification numbers (PINs) used to allow IDTFs physically located outside of the carrier's jurisdiction to bill and be paid for purchased diagnostic tests/interpretations payable under the Medicare Physician Fee Schedule (MPFS).

Effective January 25, 2005, and until further notice, physicians/suppliers must bill their local carrier for all purchased diagnostic tests and interpretations, regardless of the location where the service was actually furnished.

Background

Effective for claims with dates of service on or after April 1, 2004, **Medicare carriers must use the zip code of the location where the service was rendered** to determine both the carrier jurisdiction for processing the claim and the correct payment locality for any service paid under the MPFS (see the Medicare Claims Processing Manual (Pub.100-04), Chapter 1, Section 10.1.1). Diagnostic tests and their interpretations are paid under the MPFS, and are therefore subject to the same payment rules as all other services paid under the MPFS.

Laboratories, physicians, and IDTFs may bill for purchased tests and interpretations, but under the current carrier jurisdictional pricing rules, these suppliers must bill the purchased test or interpretation to the carrier that has jurisdiction over the geographic location where the test or service is performed.

Since the implementation of carrier jurisdictional pricing edits on April 1, 2004, the Centers for Medicare & Medicaid Services (CMS) has received reports that, due to current enrollment restrictions, **some physicians/suppliers purchasing diagnostic tests/interpretations are unable to receive reimbursement for these services when the services are performed outside of their local carrier's jurisdiction.**

This article and related CR3630 address these reported problems by temporarily changing the carrier jurisdictional pricing rules that apply when billing for an out-of-jurisdiction area purchased diagnostic service. Carrier jurisdictional pricing rules for all other services payable under the MPFS remain in effect.

Until further notice:

- Physicians/suppliers must bill their local carrier for all purchased diagnostic tests/interpretations, regardless of the location where the service was furnished
- The billing physician/supplier must:
- Ensure that the physician/supplier that furnished the purchased test/interpretation is enrolled with Medicare, and is in good standing (i.e., the physician/supplier is not sanctioned, barred, or otherwise excluded from participating in the Medicare program); and
- Be responsible for any existing billing arrangements between the purchasing entity and the entity providing the service.

Note: The Office of Inspector General (OIG) maintains a database of information concerning parties that are excluded from participation in the Medicare, Medicaid, or other Federal health programs. The OIG exclusions database is available to the public on the OIG website at the following address: www.oig.hhs.gov/fraud/exclusions.html. Physicians/suppliers may access this database, or use another available source, to determine whether another supplier is eligible to participate with Medicare prior to billing for a purchased diagnostic test or interpretation.

When billing for an out-of-jurisdiction purchased diagnostic service, physicians/suppliers must use their own PIN to bill for the service and must report their local facility address in the service facility location area of the claim. (For these services only, the place of service is deemed to be the billing physician's/supplier's location, rather than the location where the service was actually performed. The billing physician/supplier should use the same address reported for the portion of the service that the physician/supplier performed when reporting the address for the purchased portion of the test.)

When submitting paper claims (form CMS-1500), physicians/suppliers billing their local carrier for a purchased test/interpretation performed outside of the carrier's jurisdiction must report their name and use their own PIN to bill both the purchased portion of the test and the portion of the test that they performed.

When billing for a purchased interpretation, the billing physician/supplier should **not** report the PIN of the physician who performed the interpretation in item 19 of the claim. Instead, the billing physician/supplier must maintain a record of the name and address of the physician performing the purchased interpretation and supply it to the Medicare carrier upon request. In addition, when billing for the test/interpretation, the purchasing physician/supplier must enter the address of that portion of the service they actually performed as the address where the purchased service was performed in block 32 of the CNMS-1500 claim form.

When submitting a claim for a purchased service on the form CMS-1500, remember that the billing physician/supplier must check box 20 "Yes" or continue to bill for the technical and professional components on separate claim forms.

When using electronic claims submissions (ANSI X12 837, version 4010A) physicians/suppliers billing for the purchased test/interpretation performed outside their carrier's jurisdiction must report their name and their PIN to bill for the purchased diagnostic service. The billing physician/supplier should continue to report the 1C qualifier (Medicare Provider Number) in the reference identification segment of the 2310C (Purchased Service Provider Secondary ID) loop.

When reporting the 2400 PS1 segment (Purchased Service Information) of the 837 format, billing physicians/suppliers must report their own PIN. The reference identifier entered in the REF02 segment of the 2310C loop must also be the PIN of the billing physician/supplier, **not** the PIN of the physician/supplier who actually performed the service.

In addition, the billing physician/supplier must enter as the service facility location the **same** address as the location where they performed the non-purchased portion of the test. Enter this address in the appropriate service facility location (Service Facility Location Loop 2310D for claim level or 2420C for the line level on the claim).

Also, a physician/supplier billing a carrier for a purchased diagnostic test must continue to report on the claim the amount that the physician/supplier charged, net of any discounts. (Independent laboratories are exempt from reporting the amount charged for purchased tests.)

When billing for a diagnostic service purchased within the local carrier's geographical service area, the physician/supplier must continue to follow existing guidelines for reporting the location where the service was furnished.

Physicians/suppliers are advised that:

- They must bill their local carrier for purchased diagnostic tests/interpretations, and they may no longer use, effective 14 days after receiving notification from the carrier, PINs issued in out-of-jurisdiction carrier sites to bill for these services; and
- They will not be penalized when they change the service facility location on the claim (even if the location reported on the claim does not correspond with the location where the service was actually performed).
- They should not use any PINs previously issued to any supplier that is physically located outside of the carrier's jurisdiction in order for such supplier to bill and be paid for purchased diagnostic services payable under the MPFS. In particular, this includes independent clinical diagnostic laboratories [Specialty Type "69"].

Medicare carriers will accept and process claims billed by suppliers (including radiologists, physicians, and IDTFs) enrolled in the carrier's jurisdiction based on the zip code entered on the claim, regardless of where the service was actually furnished. Suppliers billing for purchased diagnostic tests/interpretations must meet all other enrollment criteria, and must be eligible to bill for the purchased component of the test.

If your carrier determines (during the claims review process) that the service was performed at a location other than the service facility address entered on the claim, the carrier must hold the physician/supplier harmless for this discrepancy, and may not deny the claim on this basis.

Note: For audit purposes, physicians/suppliers must maintain, and provide upon request, supporting documentation demonstrating that the test/interpretation was purchased, and documenting the location where the service was performed.

Finally, carriers will not reopen claims, but will allow physicians/suppliers to resubmit claims under this revised policy, where such claims were denied due to problems with billing out-of-jurisdiction purchased services. Such claims may be resubmitted to the local carrier for processing, but they must be filed within the time limits established for timely filing of claims.

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/pm_trans/R415CP.pdf.

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>.

Related Change Request (CR) #: 3630

Medlearn Matters Number: MM3630

Related CR Release Date: December 23, 2004 *Revised* Related CR Transmittal #: 415

Effective Date: January 25, 2005

Implementation Date: January 25, 2005

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LABORATORY/PATHOLOGY

New CLIA Waived Tests

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under the CLIA (Clinical Laboratory Improvement Amendments 1988). The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test.

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare only pay 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.

CPT Code/Modifier	Effective Date	Description
86701QW	11-5-2004	Trinity Biotech Uni-Gold Recombigen HIV Test (Fingerstick, Venipuncture Whole Blood)
87804QW	12-1-2004	BinaxNOW® Influenza A & B Test in nasopharyngeal (NP) swab and nasal wash/aspirate specimens
85018QW	12-22-2004	Biosafe Laboratories, Inc., Anemiapro Self Screener
86318QW	1-13-2005	Cardinal Health SP Brand Rapid Test H. pylori
87880QW	1-25-2005	Cardinal Health SP Brand Rapid Test Strep A Dipstick
80101QW	1-26-2005	Branan Medical Corporation Fastect II Drug Screen Dipstick Test
82962, 82465QW	2-15-2005	Polymer Technology Systems Cardiochek PA Analyzer (PTS Panels Chol + Glu Test Panel)
80101QW	2-17-2005	Accu-Stat Drugs of Abuse Home Test for Marijuana, Cocaine, Amphetamine, Methamphetamines, Opiates and Phencyclidine
85576QW	2-23-2005	Accumetrics VerifyNow Aspirin Assay

New CLIA Waived Test (continued)

Effective for dates of service on or after February 23, 2005, the new waived code, 85576QW, has been assigned for the platelet aggregation test performed using the Accumetrics VerifyNow Aspirin Assay.

The complete list of tests granted waived status under CLIA is available on the Centers for Medicare & Medicaid Services (CMS) website http://www.cms.hhs.gov/manuals/pm_trans/R538CP.pdf. The list of CLIA waived tests has been reorganized so that the column mentioning the CPT code is listed first. Approved waived tests are listed under their appropriate CPT code, the list is sorted primarily by CPT code, and the information in the "Use" column explains the purpose of the waived test. Page 1 lists those waived tests that have a unique CPT code for the waived test that does not require a QW modifier (i.e., CPT codes: 81002, 81025, 82270, G0107, 82962, 83026, 84830, 85013, and 85651).

Source: CMS Pub 100-04, Transmittal 548, Change Request 2533

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

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

Note: This article was revised on May 12, 2005, to correct the Web address for the Medicare Claims Processing Manual.

Provider Types Affected

Clinical diagnostic laboratories billing Medicare carriers or fiscal intermediaries (FIs).

Provider Action Needed

CR 3806 announces changes to the list of codes included in the July 2005 release of the Medicare laboratory national coverage determination (NCD) edit module for clinical diagnostic laboratory services. These changes are a result of coding analysis completed by the Centers for Medicare & Medicaid Services (CMS).

Background

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

In addition, the laboratory edit module for the NCD is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCD developed through the NCD 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.

CR 3806 announces the changes that will be included in the July 2005 release of the edit module for clinical diagnostic laboratory services. Those changes are as follows:

- In accordance with the coding analysis published on the coverage Internet site on November 23, 2004 (See <http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=138>), CMS is adding ICD-9-CM code 733.02, idiopathic osteoporosis, to the list of "ICD-9-CM Codes Covered by Medicare" for the thyroid testing NCD.
- In accordance with the coding analysis published on the coverage Internet site on March 14, 2005 (See <http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=146>), CMS is adding diagnosis code 156.0, malignant neoplasm of the gallbladder, and code 156.2, malignant neoplasm of the ampulla of vater, to the list of "ICD-9-CM Codes Covered by Medicare" for the tumor antigen by Immunoassay CA 19-9 NCD.
- In accordance with the coding analysis published on the coverage Internet site on March 14, 2005 (See <http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=147>), CMS is deleting diagnosis code 784.69, Other symbolic dysfunction, from the list of "ICD-9-CM Codes Covered by Medicare" for the hepatitis panel NCD.
- In accordance with the coding analysis published on the coverage internet site on March 17, 2005 (See <http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=149>), CMS is adding diagnosis code 789.39, Abdominal or pelvic swelling, mass or lump of other specified site, to the list of "ICD-9-CM Codes Covered by Medicare" for the tumor antigen by Immunoassay CA 125 NCD.
- In accordance with the coding analysis published on the coverage Internet site on March 17, 2005 (See <http://cms.hhs.gov/mcd/viewdecisionmemo.asp?id=150>), CMS is adding diagnosis codes V77.1, special screening for diabetes mellitus, V81.0, special screening for ischemic heart disease, V81.1, special screening for hypertension, and V81.2, special screening for other an unspecified cardiovascular conditions, to the list of "ICD-9-CM Codes That Do Not Support Medical Necessity" for the blood counts NCD.

Implementation Date

The implementation date for these changes is July 5, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/FI regarding these changes at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that web page, look for CR 3806 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/FI 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) #: 3806
Related CR Release Date: April 29, 2005
Effective Date: July 1, 2005

Medlearn Matters Number: MM3806
Related CR Transmittal #: 534
Implementation Date: July 5, 2005

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2005 Clinical Laboratory Fees for Florida — Correction

We published information on the 2005 Clinical Laboratory Fees for Florida in the January 2005 *Medicare B Update!* Special Issue (pages 29-34).

The fees for the codes listed below were inadvertently omitted from the list of fees provided in that article.

G0306	10.86	84450QW	7.22	82565	7.16	86701QW	12.41
G0307	9.04	85055	37.41	83009	94.11	87269	16.76
G0328	20.28	86064	19.97	83630	16.12	87660	28.02
G0328QW	20.28	86335	41.00	84156	5.12	87804QW	16.76
36415	3.00	86379	19.97	84157	5.12	87807	16.76
82045	47.43	86587	19.97	84163	16.29	89225	4.67
				84166	24.92	89235	6.74

We apologize for any inconvenience this may have caused.

Correction of 2005 Payment Fees for Clinical Laboratory Travel Codes P9603 and P9604

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

Provider Types Affected

Clinical laboratories and providers billing Medicare carriers or fiscal intermediaries for travel to perform a specimen collection.

Provider Action Needed

STOP – Impact to You

This instruction relates corrections to the 2005 payment fees provided in CR 3526 for P9603 and P9604, which relate to transportation to a nursing home or homebound patient to perform a specimen collection.

CAUTION – What You Need to Know

Article MM 3526 and related CR 3526 incorrectly stated the standard mileage rate for transportation to a nursing home or homebound patient to perform a specimen collection as \$.385 per mile. Effective for dates of service January 1, 2005 through December 31, 2005, the correct standard mileage rate for transportation is \$.405 per mile. Effective for dates of service January 1, 2005 through December 31, 2005, the personnel payment is \$.45 per mile. Accordingly, the corrected 2005 payment fees for code P9603 is \$.855 and for code P9604 is \$.855.

GO – What You Need to Do

To ensure accurate claims processing, please review the information included in this instruction and stay current with updates for clinical laboratory fee schedule and laboratory services.

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Additional Information

Please note that Medicare carriers and intermediaries will not automatically adjust any claims paid prior to the implementation of this correction. However, they will make corrections if the provider brings such claims to their attention.

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

From that web page, look for CR 3785 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>.

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) #: 3785
Medlearn Matters Number: MM3785
Related CR Release Date: May 6, 2005
Related CR Transmittal #: 154
Effective Date: January 1, 2005
Implementation Date: July 5, 2005

MEDICARE PHYSICIAN FEE SCHEDULE

July Update to the 2005 Medicare Physician Fee Schedule Database

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

Provider Types Affected

Physicians and providers billing Medicare carriers or fiscal intermediaries (FIs) for services paid under the Medicare physician fee schedule (MPFS).

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 impact their practice.

Background

CR 3870 amends payment files issued to carriers based upon the November 15, 2004, Final Rule for the 2005 MPFSDB. Key changes include two new G codes (G0375 and G0376) related to Medicare's national coverage determination for smoking cessation, which was effective

March 22, 2005, and practice expense values for Current Procedural Terminology (CPT) codes 97810, 97811, 97813 and 97814. These CPT codes, which relate to acupuncture, are non-covered under the MPFS.

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 July update to the 2005 MPFSDB are described in an attachment to CR 3870, which is the official instruction issued to your carrier/FI. 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 3870 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/FI 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) #: 3870

Medlearn Matters Number: MM3870

Related CR Release Date: May 6, 2005

Related CR Transmittal #: 558

Effective Date: January 1, 2005

Implementation Date: July 5, 2005

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3rd Update to the 2004 Medicare Physician Fee Schedule Database

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

This information was previously published in the Final Update to the 2004 Medicare Physician Fee Schedule Database Special Issue pages 1-4.

Important Note: This instruction (MM 3415) was based on Change Request (CR) 3415 which has been fully replaced by CR 3505 (Transmittal 306, dated October 1, 2004, Subject: Full Replacement of CR 3415, **3rd Update to the 2004 Medicare Physician Fee Schedule Database**. CR 3415 is rescinded). See CR 3505 (Transmittal 306) at:

http://www.cms.hhs.gov/manuals/pm_trans/R306CP.pdf.

Also, see the Medlearn Matters article related to CR 3505 (Transmittal 306) at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3505.pdf>.

Related Change Request (CR) #: 3415

Medlearn Matters Number: MM3415

Related CR Release Date: August 13, 2004 *Revised*

Related CR Transmittal #: 278

Effective Date: January 1, 2004

Implementation Date: October 4, 2004

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Full Replacement of CR 3415, 3rd Update to the 2004 Medicare Physician Fee Schedule Database. CR 3415 Is Rescinded

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

This information was previously published in the 1st Quarter 2005 Medicare B Update! Special Issue pages 18-20.

Provider Types Affected

Physicians, providers, and suppliers.

Provider Action Needed

Physicians, providers, and suppliers should note the changes to the Medicare physician fee schedule database and identify those changes that affect their practice.

Background

Payment files were issued to carriers based upon the November 7, 2003 and January 7, 2004 Final Rules. This instruction amends those payment files and replaces CR 3415.

CR 3415 included changes to the professional component/technical component (PC/TC) indicator for Current

Procedural Terminology (CPT) codes 96400, 96408, 96425, 96520, and 96530 from a 5 to 0. **Changes to the PC/TC indicator for these codes should not have been included.**

Implementation

The implementation date for this instruction is October 4, 2004.

Additional Information

The actual changes to the fee schedule involve numerous CPT/HCPCS codes and the actual effective dates vary. These changes to the revised 3rd Update to the 2004 Medicare physician fee schedule database are described in the following.

Changes to Revised 3rd Update to the 2004 Medicare Physician Fee Schedule Database

CODE ACTION

G0336 Description: PET imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. fronto-temporal dementia
Short Descriptor: PET imaging brain Alzheimer's
Procedure Status = C
PC/TC = 1
Site of Service = 1
Global Surgery = XXX
Multiple Procedure Indicator = 0
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 9
Co-Surgery Indicator = 0
Team Surgery Indicator = 0
Type of Service = 4
Diagnostic Supervision = 9

Note: Effective for services performed on or after September 15, 2004.

G0336 TC Description: PET imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. fronto-temporal dementia
Short Descriptor: PET imaging brain Alzheimer's
Procedure Status = C
PC/TC = 1
Site of Service = 1
Global Surgery = XXX
Multiple Procedure Indicator = 0
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 9
Co-Surgery Indicator = 0
Team Surgery Indicator = 0
Type of Service = 4
Diagnostic Supervision = 9

Note: Effective for services performed on or after September 15, 2004

G0336 26 Description: PET imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. fronto-temporal dementia
Short Descriptor: PET imaging brain Alzheimer's
Procedure Status = A
WRVU = 1.50
Non-Facility PE RVU = .51

CODE ACTION

G0336 26 (continued)
Facility PE RVU = .51
Malpractice RVU = .05
PC/TC = 1
Site of Service = 1
Global Surgery = XXX
Multiple Procedure Indicator = 0
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 9
Co-Surgery Indicator = 0
Team Surgery Indicator = 0
Type of Service = 4
Diagnostic Supervision = 9

Note: Effective for services performed on or after September 15, 2004

G0341 Description: Percutaneous islet cell transplant, includes portal vein catheterization and infusion (To report imaging bill 75887 or 75885)
Short Descriptor: Percutaneous islet cell trans
Procedure Status = A
WRVU = 6.98
Non-Facility PE RVU = 2.73
Facility PE RVU = 2.73
Malpractice RVU = 0.48
PC/TC = 0
Site of Service = 1
Global Surgery = 000
Multiple Procedure Indicator = 2
Bilateral Procedure Indicator = 0
Assistant at Surgery Indicator = 9
Co-Surgery Indicator = 1
Team Surgery Indicator = 0
Type of Service = 2
Diagnostic Supervision = 9

Note: Effective for services performed on or after October 1, 2004

G0342 Description: Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion
Short Descriptor: Laparoscopy Islet cell Trans
Procedure Status = A
WRVU = 11.92

CODE ACTION**G0342** (continued)

Non-Facility PE RVU = 5.32

Facility PE RVU = 5.32

Malpractice RVU = 1.46

PC/TC = 0

Site of Service = 1

Global Surgery = 090

Pre Op = 0.09

Intra Op = 0.81

Post Op = 0.10

Multiple Procedure Indicator = 2

Bilateral Procedure Indicator = 0

Assistant at Surgery Indicator = 2

Co-Surgery Indicator = 1

Team Surgery Indicator = 0

Type of Service = 2

Diagnostic Supervision = 9

Note: Effective for services performed on or after October 1, 2004**G0343** Description: Laparotomy for islet cell transplant, includes portal vein catheterization and infusion

Short Descriptor: Laparotomy Islet cell transp

Procedure Status = A

WRVU = 19.85

Non-Facility PE RVU = 8.82

Facility PE RVU = 8.82

Malpractice RVU = 2.05

PC/TC = 0

Site of Service = 1

Global Surgery = 090

Pre Op = 0.09

Intra Op = 0.81

Post Op = .10

Multiple Procedure Indicator = 2

Bilateral Procedure Indicator = 0

Assistant at Surgery Indicator = 2

Co-Surgery Indicator = 1

Team Surgery Indicator = 0

Type of Service = 2

Diagnostic Supervision = 9

Note: Effective for services performed on or after October 1, 2004**23410** Bilateral Status Indicator = 1**33979** Bilateral Status Indicator = 0**33980** Bilateral Status Indicator = 0**52320** Endobase Code = 52000**52325** Endobase Code = 52000**52327** Endobase Code = 52000**52327** Bilateral Status Indicator = 1**52330** Endobase Code = 52000**52332** Endobase Code = 52000**52334** Endobase Code = 52000**52341** Endobase Code = 52000**52342** Endobase Code = 52000**52343** Endobase Code = 52000**52344** Endobase Code = 52000**CODE ACTION****69440** Bilateral Surgery Indicator = 1**69450** Bilateral Surgery Indicator = 1**69501** Bilateral Surgery Indicator = 1**69502** Bilateral Surgery Indicator = 1**69505** Bilateral Surgery Indicator = 1**69511** Bilateral Surgery Indicator = 1**69530** Bilateral Surgery Indicator = 1**69535** Bilateral Surgery Indicator = 1**69540** Bilateral Surgery Indicator = 1**69550** Bilateral Surgery Indicator = 1**69552** Bilateral Surgery Indicator = 1**69554** Bilateral Surgery Indicator = 1**69601** Bilateral Surgery Indicator = 1**69602** Bilateral Surgery Indicator = 1**69603** Bilateral Surgery Indicator = 1**69604** Bilateral Surgery Indicator = 1**69605** Bilateral Surgery Indicator = 1**69610** Bilateral Surgery Indicator = 1**69620** Bilateral Surgery Indicator = 1**69631** Bilateral Surgery Indicator = 1**69632** Bilateral Surgery Indicator = 1**69633** Bilateral Surgery Indicator = 1**69635** Bilateral Surgery Indicator = 1**69636** Bilateral Surgery Indicator = 1**69637** Bilateral Surgery Indicator = 1**69641** Bilateral Surgery Indicator = 1**69642** Bilateral Surgery Indicator = 1**69643** Bilateral Surgery Indicator = 1**69644** Bilateral Surgery Indicator = 1**69645** Bilateral Surgery Indicator = 1**69646** Bilateral Surgery Indicator = 1**69650** Bilateral Surgery Indicator = 1**69660** Bilateral Surgery Indicator = 1**69661** Bilateral Surgery Indicator = 1**69662** Bilateral Surgery Indicator = 1**69666** Bilateral Surgery Indicator = 1**69667** Bilateral Surgery Indicator = 1**69670** Bilateral Surgery Indicator = 1**69700** Bilateral Surgery Indicator = 1**69711** Bilateral Surgery Indicator = 1**69714** Bilateral Surgery Indicator = 1**69715** Bilateral Surgery Indicator = 1**69717** Bilateral Surgery Indicator = 1**69718** Bilateral Surgery Indicator = 1

CODE	ACTION
69720	Bilateral Surgery Indicator = 1
69725	Bilateral Surgery Indicator = 1
69740	Bilateral Surgery Indicator = 1
69745	Bilateral Surgery Indicator = 1
69799	Bilateral Surgery Indicator = 1
69801	Bilateral Surgery Indicator = 1
69802	Bilateral Surgery Indicator = 1
69805	Bilateral Surgery Indicator = 1
69806	Bilateral Surgery Indicator = 1
69820	Bilateral Surgery Indicator = 1
69840	Bilateral Surgery Indicator = 1
69905	Bilateral Surgery Indicator = 1
69910	Bilateral Surgery Indicator = 1
69915	Bilateral Surgery Indicator = 1
69930	Bilateral Surgery Indicator = 1
69949	Bilateral Surgery Indicator = 1
69950	Bilateral Surgery Indicator = 1
69955	Bilateral Surgery Indicator = 1

CODE	ACTION
69960	Bilateral Surgery Indicator = 1
69970	Bilateral Surgery Indicator = 1
69979	Bilateral Surgery Indicator = 1
0001T	Co-Surgery Indicator = 2

For complete details, please see the official instruction issued to your carrier and intermediary 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 CR3505 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 or intermediary 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) #: 3505

Medlearn Matters Number: MM3505

Related CR Release Date: October 1, 2004

Related CR Transmittal #: 306

Effective Date: January 1, 2004

Implementation Date: October 4, 2004

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MULCULOSKELETAL

Ultrasonic Stimulators for Nonunion Fracture Healing

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers and intermediaries, including regional home health intermediaries (RHHIs) and durable medical equipment regional carriers (DMERCs), for ultrasonic osteogenic stimulators.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 3836, which informs physicians, providers, and suppliers that the Centers for Medicare & Medicaid Services (CMS) announced a reconsideration of the national coverage determination (NCD) covering the use of ultrasonic osteogenic stimulators, effective April 27, 2005.

CAUTION – What You Need to Know

Upon reconsideration of the existing policy, CMS determined that ultrasound stimulation for nonunion fracture healing will remain covered with an additional expansion of coverage to patients without prior surgeries to the non-healing fracture.

GO – What You Need to Do

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

Background

CMS announced a reconsideration of the NCD covering the use of ultrasonic osteogenic stimulators, effective April 27, 2005.

An ultrasonic osteogenic stimulator is a non-invasive device that emits low intensity, pulsed ultrasound signal to stimulate fracture healing. The device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via a conductive coupling gel to stimulate fracture healing. An ultrasonic osteogenic stimulator:

- Is not to be used concurrently with other noninvasive osteogenic devices; and
- Is intended for use with cast immobilization.

Nationally Covered Indications

Ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of non-

union fractures when the following is demonstrated:

- A minimum of two sets of radiographs is obtained prior to starting treatment with the osteogenic stimulator, each separated by a minimum of 90 days. Each radiograph must include multiple views of the fracture site accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

The national noncoverage policy relating to ultrasonic osteogenic stimulators for fresh fractures and delayed unions remains in place. In addition, nonunion fractures of the skull, vertebrae and tumor-related fractures are excluded from coverage.

Effective for services performed on or after April 27, 2005 Medicare will cover an osteogenic stimulator for beneficiaries who meet the criteria described above carriers & RHHIs will allow payment for an osteogenic stimulator with the following CPT code:

- 20979 Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)
- DMERCs will allow payment for osteogenic stimulators with the following HCPCS codes :
- E0760 for low intensity ultrasound, or
- E1399 for other ultrasound stimulation.
- RHHIs pay for the ultrasonic osteogenic stimulator only when the services are submitted on types of bills (TOBs) 32x, 33x, or 34x.
- **HHAs need to know** that this ultrasonic osteogenic stimulator must be in the patient's home health plan of care if billed on TOBs 32x or 33x. HHAs billing on TOBs 32x, 33x and 34x for the osteogenic stimulator will be paid based on the durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

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- **Hospitals need to know** that they cannot bill for the ultrasonic osteogenic stimulator. Hospitals may only instruct patients on how to use the ultrasonic osteogenic stimulator and **not** provide the ultrasonic osteogenic stimulator.

Implementation

The implementation date for this change is August 1, 2005.

Additional Information

See the Medicare National Determinations Manual (Pub. 100-03), Section 160.11 (Osteogenic Stimulators) at the following CMS website: http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103c1_Part2.pdf.

For more information about the medical coverage of clinical trials, see the following CMS website: <http://www.cms.hhs.gov/coverage/8d.asp>.

For complete details on this change, please see the official instruction issued to your carrier/DMERC/intermediary 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 CR3836 in the CR NUM column on the right, and click on the files for that CR. You will note two files for CR3836. The file with transmittal number 41 is the NCD itself and the file with transmittal number 597 contains the billing requirements.

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>.

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) #: 3836
Medlearn Matters Number: MM3836
Related CR Release Date: June 24, 2005
Related CR Transmittal #: 41 and 597
Effective Date: April 27 2005
Implementation Date: August 1, 2005

PREVENTIVE SERVICES

Diagnosis Requirements for Screening Mammography

Procedure codes 76083, 76092, and G0202 are only payable when billed with diagnosis code V76.12 for dates of service prior to July 1, 2005. Effective for dates of service on or after July 1 2005, procedure codes 76083, 76092, and G0202 are payable when billed with diagnoses V76.11 and V76.12. For additional coverage requirements, refer to the 2nd Quarter 2005 Medicare B Update! (page 43).

First Coast Service Options was not editing procedure codes 76083, 76092, and G0202 for diagnosis on claims processed from January 1, 2005 through June 30, 2005. For this reason, claims processed during this period may potentially have resulted in an overpayment of services.

Action Required by Providers

If you received payments in error for dates of service January 1, 2005 through June 30, 2005, please return the overpaid amount to:

Financial Services Department
P O Box 44141
Jacksonville FL 32231

If you fail to refund any payments made in error, a letter demanding payment will be sent to you.

Reminder

Radiologists who interpret screening mammography's are allowed, per the Balanced Budget Act (BBA) of 1997, to order and interpret additional films based on the results of the screening mammogram while a beneficiary is still at the facility for the screening exam. Where a radiologist's interpretation results in the need for additional films, the mammography is no longer considered a screening exam for payment purposes. When this occurs, the claim will be paid as a diagnostic mammogram instead of a screening mammogram. In this instance, the claim must be prepared utilizing CPT code 76082, 76090, 76091, G0204, or G0206 with modifier GH. The treating physician's UPIN is to be used to represent the ordering physician. It is expected that the radiologist will refer back to the treating physician for his/her UPIN and also report to the treating physician the condition of the patient.

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SURGERY**Addition of CLIA Edits to Mohs Surgery Procedure Codes**

The procedure codes for Mohs micrographic surgery (17304, 17305, 17306, 17307, and 17310) require a physician to act as both a surgeon and a pathologist. These codes include the physician's microscopic examination and interpretation of tissue specimens.

Since these procedures include a laboratory component in the performance of the procedure, effective for claims with dates of service July 1, 2005, the previously mentioned procedure codes will require a CLIA number. Providers must hold a CLIA Certificate Type 1 – Certificate of Compliance (Regular certificate), Type 3 – Certificate of Accreditation, or Type 9 – Certificate of Registration. All other CLIA certificate types will be denied.

Medicare carriers will deny payment if a CLIA number is not submitted on claims for procedure codes of 17304, 17305, 17306, 17307, and 17310.

Additional information is available via Medlearn Matters article MM3458 at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3458.pdf>.

Source: Pub 100-04, Transmittal 434, Change Request 3458, January 14, 2005

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Cochlear Implantation

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

Provider Types Affected

Physicians and providers billing Medicare carriers and fiscal intermediaries (FIs) for cochlear implantation services to Medicare patients.

Provider Action Needed**STOP – Impact to You**

The coverage for cochlear implantation has expanded and is effective for services performed on or after April 4, 2005.

CAUTION – What You Need to Know

CMS will cover treatment of bilateral pre- or post-linguistic, sensorineural, moderate to profound hearing loss for individuals with hearing test scores equal to or less than 40% correct in the best aided listening condition on tape-recorded tests of open-set sentence recognition. More detailed coverage requirements are further listed in this article.

Additionally, CMS will cover cochlear implants of individuals with open-set sentence recognition test scores of greater than 40% to less than or equal to 60% correct, where the device was implanted in an acceptable clinical trial/study. See further details listed below.

GO – What You Need to Do

This revision is a binding national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act. The remainder of this article provides more detailed billing instructions for these services.

Background

A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture, analyze, and code sound. The purpose

of implanting the device is to provide awareness and identification of sounds and to facilitate communication for persons who are moderately to profoundly hearing impaired. Cochlear implant devices are available in single-channel and multi-channel models.

Additional Information

The information in this section outlines the policy guidelines for cochlear implantation coverage, the coverage criteria for an acceptable clinical trial/study, billing requirements for cochlear implantation, and a listing of healthcare common procedural coding system (HCPCS) associated with cochlear implantation.

Nationally Covered Indications

Medicare coverage is provided only for those patients who meet all of the following selection guidelines.

- Diagnosis of bilateral moderate-to-profound sensorineural hearing impairment with limited benefit (test scores of less than or equal to 40% correct in the best-aided listening condition on tape recorded tests of open-set sentence cognition) from appropriate hearing (or vibrotactile) aids;
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation;
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system;
- No contraindications to surgery; and
- The device must be used in accordance with Food and Drug Administration (FDA)-approved labeling.

Criteria for Acceptable Clinical Trials and Studies

The coverage criteria that allows for services for individuals meeting the above guidelines and with hearing test scores greater than 40% and less than or equal to 60% requires the provider to participate in and the patient to enroll in an acceptable clinical trial/study, which includes the following:

- FDA-approved category B investigational device exemption clinical trial as defined in 42 CFR 405.201;
- Trial under the CMS clinical trial policy as defined in Section 310.1 of the Medicare National Coverage Determinations Manual; or a
- Prospective, controlled comparative trial approved by CMS as consistent with the evidentiary requirements for national coverage analyses and meeting specific quality standards.

Billing requirements for cochlear implantation when billing FIs and carriers

These services should be billed on an approved electronic claim form or a paper CMS form 1500. For services performed on and after April 4, 2005:

Medicare contractors (FIs and Carriers) pay for:

1. Cochlear implant devices and services for moderate-to-profound hearing loss in patients with hearing test scores equal to or less than 40%.
2. Cochlear implant devices for patients with hearing test scores of greater than 40 % to less than or equal to 60% hearing provided in a clinical trial setting that is billed with the QR modifier.
3. Other services related to cochlear implantation, but not the device itself, for patients with hearing test scores of greater than 60% hearing who are in a clinical trial. (These services must be identified with a QV modifier.)
4. Services for patients with hearing test scores of greater than 40% to less than or equal to 60% hearing who are in a prospective, controlled comparative trial approved by CMS. (These services must be billed with the QR modifier.)
5. Any covered diagnostic audiology or therapy services related to the cochlear implant. (The QR or QV does not need to be applied to HCPCS 92601-92604 and 92506 and 92507)

Also, when billing FIs for cochlear implantations, follow these additional instructions:

1. Submit claims on the following bill types (TOB):
 - a. 11x
 - b. 12x
 - c. 13x
 - d. 83x (for non-OPPS providers)
 - e. 85x
2. Report diagnosis code V70.7 (Examination of participant in clinical trial) as the second or subsequent diagnosis code, along with the appropriate principal diagnosis code, for patients in a clinical trial.

HCPCS associated with cochlear implantation

Some of the HCPCS codes used when billing for cochlear implant services and devices provided by audiologists or physicians, and for the services of 92506 and 92507, by speech language pathologists include:

1. 69930 – Cochlear device implantation, with or without mastoidectomy.
2. L8614 – Cochlear Device/System
3. L8619 – Cochlear implant external speech processor, replacement.
4. L7500 – Repair of prosthetic device, hourly rate (excludes V5335 repair of oral laryngeal prosthesis or artificial larynx).
5. L7510 – Repair of prosthetic device, repair or replace minor parts.
6. 92506 – Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status.
7. 92507 – Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual.
8. 92601 – Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming.
9. 92602 – Diagnostic analysis of cochlear implant, patient under 7 years of age; subsequent programming. **(Do not report 92602 in addition to 92601).**
10. 92603 – Diagnostic analysis of cochlear implant, age 7 years or older; with programming.

Note: Codes 92601 and 92603 describe post-operative analysis and fitting of previously placed external devices, connection to the cochlear implant, and programming of the stimulator.

Codes 92602 and 92604 describe subsequent sessions for measurements and adjustment of the external transmitter and re-programming of the internal stimulator.

Medicare beneficiaries not meeting all of the coverage criteria for cochlear implantation specified above, or the specific coverage criteria for cochlear implantation in the context of a clinical trial/study, also specified above, are deemed not eligible for Medicare coverage under section 1862(a)(1)(A) of the Social Security Act.

A National Coverage Determination revision is binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see 42 CFR section 405.732, 405.860).

Because it expands coverage, the NCD is also binding on a Medicare advantage organization. In addition, an administrative law judge may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

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.

From that web page, look for CR 3796 in the CR NUM column on the right, and click on the file(s) for that CR. You will note two files for CR3796. The file with transmittal number 42 is the NCD itself and the file with transmittal number 601 contains the claims processing instructions.

For additional information relating to this issue, please refer to your local carrier or FI. To find the toll free phone number for your local carrier, go to: <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) #: 3796

Medlearn Matters Number: MM3796

Related CR Release Date: June 24, 2005

Related CR Transmittal #: 42 and 601

Effective Date: April 4, 2005

Implementation Date: July 25, 2005

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Expansion of Coverage for Percutaneous Transluminal Angioplasty

Provider Types Affected

Hospitals, physicians, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for percutaneous transluminal angioplasty (PTA) services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

MM 3811 and related CR 3811 announce the expansion of Medicare coverage for PTA of the carotid artery.

CAUTION – What You Need to Know

Effective March 17, 2005, Medicare revised its coverage of PTA of the carotid artery as detailed in this article and CR 3811.

GO – What You Need to Do

If you are a provider of PTA services, be aware of the coverage changes and make certain that your billing staff is aware of the expanded national coverage allowed to Medicare beneficiaries receiving PTA services

Background

Medicare covers PTA of the carotid artery concurrent with carotid stent placement when all the requirements stipulated by the Food and Drug Administration (FDA)-approved policies for Category B Investigational Device Exemption (IDE) clinical trials are met, effective for dates of service on or after July 1, 2001.

PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent for an FDA-approved indication is covered, when all the requirements stipulated by the FDA-approved policies for post-approval studies are met, for dates of service on or after October 12, 2004.

Expanded Coverage

Effective March 17, 2005, The Centers for Medicare & Medicaid Services (CMS) expanded the coverage of PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent with embolic protection for the following:

- Patients who are at high risk for carotid endarterectomy (CEA) and who also have symptomatic carotid artery stenosis $\geq 70\%$. Coverage is limited to procedures performed using FDA-approved carotid artery stenting systems and embolic protection devices;
- Patients who are at high risk for CEA and have symptomatic carotid artery stenosis between 50% and 70% in accordance to the Category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (Medicare National Coverage Determination [NCD] Manual, Section 310.1), or according to the NCD on carotid artery stenting (CAS) post-approval studies (Medicare NCD Manual, Section 20.7); and
- Patients who are at high risk for CEA and have asymptomatic carotid artery stenosis $\geq 80\%$ (according to the Category B IDE clinical trials regulation (42 CFR 405.201)), as a routine cost under the clinical trials policy (Medicare NCD Manual 310.1), or according to the NCD on CAS post-approval studies (Medicare NCD Manual, Section 20.7).

CMS defines high risk patients as those having significant comorbidities and/or anatomic risk factors and are considered by a surgeon to be poor candidates for CEA. The significant comorbidities, include, but are not limited to, those listed in Section 20.7 of the Medicare NCD Manual as follows:

- Congestive heart failure (CHF) class III/IV;
- Left ventricular ejection fraction (LVEF) $< 30\%$;
- Unstable angina;
- Contralateral carotid occlusion;
- Recent myocardial infarction (MI);
- Previous CEA with recurrent stenosis ;
- Prior radiation treatment to the neck; and
- Other conditions that were used to determine patients at high risk for CEA in the prior CAS trials and studies, such as ARCHER, CABERNET, SAPPHIRE, BEACH, and MAVERIC II.

Symptoms of carotid artery stenosis include carotid transient ischemic attack (distinct focal neurologic dysfunction persisting less than 24 hours), focal cerebral ischemia producing a non-disabling stroke (modified Rankin scale < 3 with symptoms for 24 hours or more), and transient molecular blindness (amaurosis fugax). Patients who have had a disabling stroke (modified Rankin > 3) would be excluded from coverage.

The appropriate documentation confirming that a patient is at high risk for CEA and records of the patient's symptoms of carotid artery stenosis should be available in the patient medical records prior to performing any procedure. The degree of carotid artery stenosis should be measured by duplex doppler ultrasound or carotid artery angiography and recorded in the patient medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. If the stenosis is determined to be less than 70% by angiography, the CAS should not proceed.

- Carotid artery stenting with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes. All facilities must at least meet the minimum standards outlined in Pub 100-03, Section 20.7 of the NCD Manual in order to receive coverage for CAS for high-risk patients. Briefly, facilities must have high quality X-ray imaging equipment, device inventory, staffing, and infrastructure to support a dedicated CAS program.
- Advanced physiologic monitoring, including real time and archived physiologic, hemodynamic, and cardiac rhythm monitoring equipment, and associated support staff capable of interpreting findings and responding appropriately.
- Readily available emergency management equipment and systems, such as resuscitation equipment, a defibrillator, vasocative and antiarrhythmic drugs, endotracheal intubation capability, and anesthesia support.
- A clearly delineated program for granting CAS privileges and for monitoring the quality of the individual interventionists and the program as a whole. The oversight committee for this program is encouraged to apply published standards from national specialty societies recognized by the American Board of Medical Specialties to determine appropriate physician qualifications. Examples of standards and clinical competence guidelines include those published in the December 2004 edition of the American Journal of Neuroradiology and those published in the August 18, 2004, Journal of the American College of Cardiology.
- A data collection system maintained by the facility or its contractor on all CAS procedures done at that facility. The data must be analyzed routinely to ensure patient safety (to be determined by the facility but should not be less frequent than 6-month intervals), will be used in re-credentialing the facility, and must be made available to CMS upon request.

For evaluation purposes, all facilities must provide written documentation to CMS indicating it meets one of the following criteria:

- Was a FDA-approved site that enrolled patients in prior CAS IDE trials, such as SAPPHIRE, and ARCHER;
- Is a FDA-approved site that is participating and enrolling patients in ongoing CAS IDE trials, such as CREST;
- Is a FDA-approved site for one or more FDA post-approval studies; or
- Has provided a written affidavit to CMS affirming that the facility meets the minimum facility standards.

The affidavit must include the facility's name and complete address, Medicare provider number, point-of-contact name and telephone number, CAS procedure data collection mechanism, and a senior facility administrative official's signature. (Note that a new affidavit is required every 2 years.) The affidavit should be sent to:

Director, Coverage and Analysis Group
7500 Security Boulevard, Mail-stop C1-09-06
Baltimore, MD 21244

Note: Performance of PTA to treat obstructive lesions of the vertebral and cerebral arteries remains noncovered. All other indications of PTA for which CMS has not specifically indicated coverage remain noncovered.

Additional Information

All providers should note that the following relate to services on or after March 17, 2005:

- FIs and carriers will only pay CAS claims from providers who are listed on the approved facility list, which is at: <http://www.cms.hhs.gov/coverage/carotid-stent-facilities.asp>.
- Carriers will pay claims containing ICD-9 CM 433.10 and any of the following procedure codes: 37215, 37216, 0075T, or 0076T, for beneficiaries meeting the high risk criteria previously specified.
- FIs will pay claims containing ICD-9 CM 433.10 and both procedure codes 00.61 and 00.63.
- FIs will reject claims that do not have both procedure codes 00.61 and 00.63
- FIs and carriers will deny CAS services for patients at high risk if the appropriate diagnosis code is not on the claim and use the appropriate Medicare Summary Notice (MSN) message and claim adjustment reason code in doing so.
- FIs and carriers will deny claims where the service was performed in an unapproved facility and use the appropriate MSN message and claim adjustment reason code in doing so.

Note: Providers must also bill V70.7 (Exam – clinical trial) as a secondary diagnosis for claims with “From” dates before October 1, 2005. Providers must bill V70.7 in order to avoid unintentional Medicare Code Editor (MCE) editing.

For claims that have “From” dates **on or after** October 1, 2005, hospitals are not required to bill V70.7 as the unintentional MCE editing will be corrected.

You may also want to review the following Medlearn Matters article 3489 and CR 3489 for additional information relating to Medicare coverage of PTA. They are available at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3489.pdf>

http://www.cms.hhs.gov/manuals/pm_trans/R314CP.pdf

The official instruction issued to your carrier/FI regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that Web page, look for CR 3811 in the CR NUM column on the right, and then click on the files for that CR. You will see two versions of CR 3811. One version identified by transmittal number 33 contains the NCD Manual revision, and transmittal number 531 contains the revisions to the Medicare Claims Processing Manual.

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>.

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) #: 3811
Related CR Release Date: April 22, 2005
Effective Date: March 17, 2005

Medlearn Matters Number: MM3811
Related CR Transmittal #: 33 and 531
Implementation Date: July 5, 2005

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Updated Requirements for Autologous Stem Cell Transplantation for Amyloidosis

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

Provider Types Affected

Physicians and providers billing Medicare carriers and intermediaries for autologous stem cell transplantation (AuSCT).

Provider Action Needed

This article is based on information contained in Change Request (CR) 3797, which informs physicians and providers that, effective for services on or after March 15, 2005, high dose mephalan (HDM) and AuSCT is reasonable and necessary for all Medicare beneficiaries with primary amyloid light chain (AL) amyloidosis who meet the following criteria:

- 1) Amyloid deposition in two or fewer organs; and
- 2) Cardiac left ventricular ejection fraction (EF) greater than 45 percent.

Primary AL amyloidosis is covered for all beneficiaries who meet the above criteria regardless of age. All forms of non-primary AL amyloidosis remain noncovered.

Background

Stem cell transplantation is a process by which stem cells are harvested from either a patient's or a donor's bone marrow (or peripheral blood) for intravenous infusion. AuSCT is a technique for restoring a patient's stem cells using the patient's own previously stored cells (ICD-9-CM procedure code 41.01, 41.04, 41.07, and 41.09 and CPT-4 code 38241).

AuSCT **must** be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high dose chemotherapy [HDCT]) and/or radiotherapy used to treat various malignancies.

Allogeneic stem cell transplant may also be used to restore function in recipients who have an inherited or acquired deficiency or defect.

Coverage Policy Changes

For Medicare beneficiaries age 64 years or older who have primary AL amyloidosis (ICD-9-CM 277.3), the Centers for Medicare & Medicaid Services (CMS) previously had a national noncoverage policy for HDM, together with AuSCT. This noncoverage policy was based on the lack of sufficient data to establish definitive conclusions regarding the efficacy of AuSCT, and for those beneficiaries age 63 years or younger, coverage of HDM/AuSCT was left to the local Medicare carrier's/intermediary's discretion.

However, CR3797 informs physicians, providers, and suppliers that (effective for services on or after March 15, 2005) when recognized clinical risk factors are employed to select patients for transplantation, HDM together with AuSCT is reasonable and necessary for Medicare beneficiaries of **any age group** with primary AL amyloidosis who meet the following criteria:

- Amyloid deposition in 2 or fewer organs; and
- Cardiac left ventricular Ejection Fraction (EF) greater than 45 percent.

Primary AL amyloidosis is covered for all beneficiaries who meet the above criteria regardless of age, and all forms of non-primary AL amyloidosis remain noncovered.

To clarify existing coverage, AuSCT must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (HDCT) and/or radiotherapy used to treat various malignancies.

Please refer to the National Coverage Determinations Manual (Pub. 100-03), Section 110.8.1 for complete coverage guidelines; and the Medicare Claims Processing Manual (Pub. 100-04), Chapter 3, Section 90.3.2 (FI), plus Chapter 32, Section 90-90.6 (Carrier) for complete claims processing guidance.

Updates to Medicare Claims Processing Manual

CR3797 updates the Medicare Claims Processing Manual (Pub.100-04), Chapter 3, Section 90.3.2 (FI claims) and Chapter 32, Section 90.3 (carrier claims) with the new coverage guidelines for primary AL amyloidosis for high-dose melphalan together with autologous stem cell transplantation (HDM/AuSCT).

The criteria for multiple myeloma (durie-salmon) within the fiscal intermediary (FI) section is also revised to coincide with the Nation Coverage Determination Manual (NCD) (Pub. 100-03), Section 110.8.1 and the non-coverage guidelines have been updated to remove the age requirement language to in Chapter 32, Section 90.3.2.

In addition, CMS removed reference to revenue code 0891 in the Medicare Claims Processing Manual (Pub. 100-04, Chapter 3, Section 90.3.3), since that revenue code no longer exists. CMS also removed the reference to physicians that does not belong in the hospital chapter. All other information within the claims processing manual remains the same.

Implementation

The implementation date for this instruction is May 16, 2005.

Additional Information

For complete details (including the manual updates listed in the previous section), 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.

From that Web page, look for CR3797 in the CR NUM column on the right, and click on the files for that CR.

Please note that there will be two files representing CR3797 on this web page. One file will contain the National Coverage Determination manual changes and the other will contain the changes to the Medicare Claims Processing Manual.

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>.

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) #: CR3797

Medlearn Matters Number: MM3797

Related CR Release Date: April 15, 2005

Related CR Transmittal #: 32

Effective Date: March 15, 2005

Implementation Date: May 16, 2005

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THERAPEUTIC SERVICES**Continuous Positive Airway Pressure Therapy for Obstructive Sleep Apnea**

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs) for OSA-related claims.

Provider Action Needed

Providers need to be aware that on April 4, 2005, the Centers for Medicare & Medicaid Services (CMS) declared that the national coverage policy for CPAP therapy for OSA will remain unchanged. Unattended home sleep testing for the diagnosis of OSA is **not** considered reasonable and necessary.

Polysomnography must be performed in a facility-based sleep study laboratory, not in the home or a mobile facility.

Background

CR3843 is updating and confirming the National Coverage Determination (NCD) policy section 240.4 of the Medicare NCD Manual (Pub. 100-03), which states that polysomnography must be performed in a facility-based sleep study laboratory, not in the home or a mobile facility.

The use of CPAP is covered under Medicare when used in adult patients with moderate or severe OSA for whom surgery is a likely alternative to CPAP. The use of CPAP

devices must be ordered and prescribed by the licensed treating physician to be used in adult patients with moderate to severe OSA if either of the following criteria using the Apnea-Hypopnea Index (AHI) is met:

- AHI greater than or equal to 15 events per hour, or
- AHI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of 2 hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected). Apnea is defined as a cessation of airflow for at least 10 seconds.

Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent oxygen desaturation.

Initial claims must be supported by medical documentation (separate documentation where electronic billing is used), such as a prescription written by the patient's attending physician that specifies:

- A diagnosis of moderate or severe obstructive sleep apnea, and
- Surgery is a likely alternative.

The claim must also certify that the documentation supporting a diagnosis of OSA (described above) is available.

Implementation

The implementation date of CR3843 is June 6, 2005.

Additional Information

The HCPCS codes that can be used for billing covered Medicare CPAP devices and various accessories are E0601, A7030-A7039, A7044-A7046, and E0561-E0562.

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary 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 CR3843 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/intermediary. To find their toll free phone numbers go to: <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) #: 3843
Related CR Release Date: May 6, 2005
Effective Date: April 4, 2005

Medlearn Matters Number: MM3843
Related CR Transmittal #: 35
Implementation Date: June 6, 2005

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Outpatient Rehabilitation Therapy Services

Revisions to the Medicare Benefit Policy Manual (Pub 100-02), Chapter 15, Sections 220 and 230

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

Note: CMS has revised this article on July 25, 2005, to reflect that portions of CR 3648 relating to the qualifications required for staff providing services billed as physical therapy and occupational therapy services incident to the services of a physician or nonphysician practitioner must be implemented immediately. The United States District Court for the Northern District of Texas has dismissed the lawsuit brought by the National Athletic Trainer's Association (NATA). That lawsuit had challenged the requirements for qualifications for staff providing services billed as physical and occupational therapy services incident to a physician or nonphysician practitioner. The Centers for Medicare & Medicaid Services (CMS) had previously delayed implementation of these requirements as a result of an agreement made with NATA and contained in a June 3, 2005 order issued by the court. The agreement to delay implementation has expired and the court has dismissed the litigation, so CMS is implementing immediately the challenged requirements. All other information in the article remains unchanged from the June 27 version of this article. This article continues to replace the special edition Medlearn Matters article SE0533 that was posted to provider education website(s) www.floridamedicare.com/www.connecticutmedicare.com on May 13, 2005 and later removed from the websites on July 7, 2005, per CMS request.

Provider Types Affected

Physicians and other providers who bill fiscal intermediaries (FIs) and carriers for therapy services lawyer

Provider Action Needed

STOP – Impact to You

This manual revision re-organizes sections 220 and 230 in Chapter 15 of the Medicare Benefit Policy Manual; it adds reference information and clarifies current policy concerning physician visits and certification. In addition, it defines the qualifications of therapists.

CAUTION – What You Need to Know

Please note that to ensure payments for therapy services you must meet the conditions and standards for therapy services described in the manuals. In addition, the qualified therapy service must be furnished by qualified professionals/personnel as defined in the Medicare Benefit Policy Manual.

GO – What You Need to Do

To ensure accurate and timely processing of therapy claims, be familiar with instructions and requirements described in the Centers for Medicare & Medicaid Services (CMS) Manual System related to such claims. Read the detailed policies in the manuals and contact your intermediary or carrier if you have any questions about these changes.

Background

In summary, this revision to the Medicare Benefit Policy Manual (Pub 100-02), Chapter 15, Sections 220 and 230, does the following:

- Clarifies policies concerning orders, visits, plans of care, delayed certification, and private practice; and
- Incorporates the information in the *Final Rule* of November 15, 2004 concerning the definition of therapy services, the qualifications of therapists, therapy services provided incident to a physician, and supervision in private practice settings.

Some key points in this modification include:

- Medicare carriers and FIs will pay for services only when the services meet the conditions and standards described in the Medicare Benefit Policy Manual. This includes requirements regarding the qualifications of the person who provides the service as detailed in that manual.
- Medicare carriers/FIs will not deny therapy claims based only on the absence of an order or referral for therapy services. However, claims will be denied if there is no certification of the plan of care for each 30 day interval of treatment. The certification indicates the patient was under the care of a physician, and needed the treatment that was approved by the physician or nonphysician practitioner who certified the plan.
- On prepay or postpay review, if the carrier/FI finds there is no documentation indicating a physician or nonphysician practitioner certification of a therapy plan of care for treatment for the first 30 days of treatment or finds there is no certified plan of care for treatment for each interval of 30 days from the last certified interval of treatment, the claim will be denied, unless there is a delayed certification. On review, the carrier/FI will count the days from the first date treated by the therapist to determine if the certification of the plan is delayed.
- Medicare carriers/FIs will accept delayed certification of services that would otherwise be covered unless the claim, the justification, or any accompanying documentation indicates the treatment was not clinically necessary, i.e., the service does not meet the patient's need.
- Medicare does not require a physician visit prior to certification, but the physician or nonphysician practitioner who certifies the plan may require a visit prior to certification.

Additional Information

This manual change does not require a change in the way therapy services are currently provided. You may continue to obtain an order, send the plan of care promptly to the physician, obtain certification as soon as you can and recommend a visit to the physician when needed. However, in the case where a physician does not promptly return a certification of the plan of care for a patient under his/her care, this change provides some flexibility in obtaining the certification. Also, a physician retains the authority to require that a patient under his/her care must return for a visit prior to certification, and the physician may limit the length of time for which the plan is certified, or may choose to certify an interval in advance if it is medically appropriate.

The revised sections of the Medicare Benefit Policy Manual are attached to the official instruction issued to your carrier/FI regarding this change. That instruction, CR 3648, may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

On the above page, scroll down the CR NUM column on the right to find the link for CR 3648. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your FI or 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) Number: 3648

Related CR Release Date: June 24, 2005

Related CR Transmittal Number: 36

Effective Date: June 6, 2005

Implementation Date: June 6, 2005

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GENERAL COVERAGE

Coverage by Medicare Advantage Organizations for National Coverage Determination Services Not Previously Included in the Medicare Advantage's Capitated Rates

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article. This information was previously published in the 1st Quarter 2005 Medicare B Update! pages 48-49.

Note: This article was revised on April 22, 2005, to reflect that the correct effective date for the NCD on ventricular assist devices is October 1, 2003.

Provider Types Affected

Physicians, providers, and suppliers billing for the services mentioned below.

Provider Action Needed

STOP – Impact to You

Medicare Advantage (MA) rates were recently adjusted to account for three national coverage determination (NCD) services. These services are implantable automatic defibrillators (effective 10/1/03), ventricular assist devices (effective 10/1/03), and lung volume reduction surgery (effective 1/1/04). MA organizations are liable for payment for these NCD services beginning January 1, 2005.

CAUTION – What You Need to Know

For services rendered prior to January 1, 2005, payment for services relating to the three NCD services mentioned above are paid by Medicare on a fee-for-service basis for MA plan enrollees. Note that, prior to January 1, 2005, beneficiaries are not responsible for Part A or Part B deductibles associated with these services, though they are responsible for coinsurance amounts appropriate under Medicare fee-for-service rules.

GO – What You Need to Do

Be aware that these services will not be paid on a fee-for-service basis on or after January 1, 2005. Instead, the MA plan will be responsible for making payment. Note also that MA enrollees receiving services for lung volume reduction surgery services must receive these services in designated hospitals.

Background

When Medicare issued these NCDs initially, new coverage was introduced and the cost of that coverage was not reflected in the rates paid to MA plans. Thus, Medicare paid for these services separately on a fee-for-service basis until such time as the cost could be considered in determining MA rates. The Centers for Medicare & Medicaid Services will factor these costs into the MA payment rates as of January 1, 2005. At that time, Medicare will no longer pay for these services on the fee-for-service basis.

Additional Information

If you have any questions regarding this issue, please contact your carrier or intermediary on 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) #: 3301

Related CR Release Date: N/A (CR is not available) *Revised*

Effective Date: January 1, 2005

Medlearn Matters Number: MM3301

Related CR Transmittal #: N/A

Implementation Date: January 3, 2005

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Smoking and Tobacco Use Cessation Counseling

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

Provider Types Affected

Physicians, other Medicare-recognized practitioners, and providers billing Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and carriers for smoking and tobacco use cessation counseling.

Provider Action Needed

STOP – Impact to You

Medicare Part B covers two new levels of counseling, intermediate and intensive, for smoking and tobacco use cessation, effective March 22, 2005. The coverage is limited to beneficiaries who use tobacco and have a disease or adverse health effect

found by the U.S. Surgeon General to be linked to tobacco use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use as based on Food and Drug Administration (FDA)-approved information. Patients must be competent and alert at the time that services are provided. Two attempts are covered each year and each attempt may include a maximum of four intermediate or intensive sessions. A maximum of 8 sessions in a one year are covered.

CAUTION – What You Need to Know

The Centers for Medicaid & Medicare Services (CMS) has established two new “G” codes for billing for the new levels of smoking and tobacco use cessation counseling, effective for dates of service on or after March 22, 2005. **Note:** For the interim period of March 22, 2005, through July 4, 2005, when billing for smoking and tobacco use cessation counseling, use the unlisted code 99199. On July 5, 2005 and thereafter, when billing for this counseling, use the appropriate new “G” codes. Include one unit per session in the unit’s field of the claim.

GO – What You Need to Do

Make sure your billing staff is aware of the new codes and the interim coding requirements when submitting claims for the smoking and tobacco use cessation counseling services you provide on or after March 22, 2005.

Background

Based on a 2004 request from the Partnership for Prevention to review the issue for a national coverage determination (NCD), CMS determined that the evidence is adequate to conclude that smoking and tobacco use cessation counseling, based on current Public Health Service (PHS) guidelines, is reasonable and necessary for certain individuals who use tobacco and have a disease or an adverse health effect caused or complicated by tobacco use. Patients must be competent and alert at the time that services are provided.

What is Covered

When certain coverage conditions, frequency and other limitations are met, smoking and tobacco cessation counseling is covered under Medicare Part B. Medicare Part B coverage includes 2 attempts each year.

Each attempt may include a maximum of 4 intermediate or intensive sessions. A total of 8 sessions are covered in a 12-month period. The qualified practitioner and the patient have flexibility to choose between intermediate or intensive cessation strategies for each session.

Billing Codes

The following two new health common procedure coding system (HCPCS) codes have been created for billing for the two new levels of smoking and tobacco-use cessation counseling Medicare now covers:

- **G0375** - Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. **Short Descriptor:** Smoke/Tobacco counseling 3-10.
- **G0376** - Smoking and tobacco-use cessation visit; intensive, greater than 10 minutes. **Short Descriptor:** Smoke/Tobacco counseling greater than 10.

Because these new “G” codes will not be in the Medicare system until July 5, 2005, for the interim period of March 22, 2005, through July 4, 2005, use the unlisted code 99199 when billing for smoking and tobacco use cessation counseling. Include one unit per session in the units field of the claim. Effective for claims received by Medicare on or after July 5, 2005, the claim should reflect HCPCS codes G0375 or G0376 (effective back to March 22, 2005, the effective date of the new coverage).

Note: Code 99199 is carrier priced. Also, providers whose claims are subject to payment under the Outpatient Prospective Payment System (OPPS) should use the G codes instead of 99199. Such claims will be held by your FI until July 5, at which time they will be processed.

This additional coverage, as described by the above HCPCS codes G0375 and G0376 does not change the existing coverage for minimal cessation counseling (defined as 3 minutes or less in duration) bundled into the normal evaluation and management (E/M) visit.

Smoking and tobacco use cessation counseling claims are to be submitted with the appropriate diagnosis code. Diagnosis codes should reflect the condition the patient has that is adversely affected by the use of tobacco or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by the use of tobacco.

Note: Providers are reminded that they should keep on file appropriate documentation in the patient’s medical records to adequately demonstrate that Medicare coverage conditions were met for any services provided and billed to Medicare for smoking and tobacco use cessation counseling.

Physicians and other Medicare-recognized practitioners who need to bill for E&M services on the same day as smoking cessation services are billed should use the appropriate HCPCS code in the 99201-99215 range AND modifier 25 to show that the E&M service is a separately identifiable service from a smoking and tobacco-use cessation counseling service.

Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge; meaning charges to the beneficiary may be no more than 115% of the allowed amount.

Smoking and tobacco use cessation counseling services may be billed to FIs and RHHIs on types of bills (TOB) 12x, 13x, 14x, 22x, 23x, 34x, 71x, 73x, 74x, 75x, 83x, and 85x. On TOBs 71x and 73x (rural health clinics (RHCs) and federally qualified health centers (FQHCs)), FIs will pay for claims with revenue code 052x. For TOB 13x (Indian health service (HIS)), FIs shall accept revenue code 0510. For other TOBs, on claims received on or after July 5, 2005, FIs and RHHIs will pay for G0375 and G0376 codes when accompanied by revenue code 0942 (other therapeutic services; education/training).

Payment by FIs/RHHIs is as follows:

Type of Facility	Method of Payment
RHCs/FQHCs	All-inclusive rate (AIR) for the encounter
IHS/tribally owned or operated hospitals and hospital based facilities	AIR
IHS/tribally owned or operated non-hospital based facilities	Medicare physician fee schedule (MPFS)
IHS/tribally owned or operated critical access hospitals (CAHs)	Facility specific visit rate
Hospitals subject to the outpatient prospective payment system (OPPS)	Ambulatory payment classification (APC)
Hospitals not subject to OPPS Payment is made under current methodologies skilled nursing facilities (SNFs) Note: Included in Part A PPS for skilled patients.	MPFS
Comprehensive outpatient rehabilitation facilities (CORFs)	MPFS
Home health agencies (HHAs)	MPFS
CAHs	Method I: Technical services are paid at 101% of reasonable cost; Method II: Professional services are paid at 115% of the MPFS database
Maryland Hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC). That is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.

Additional Information

Note: When these services are provided by a clinical nurse specialist in the RHC/FQHC setting, the services are considered “incident to” and do not constitute a billable visit. In addition, Medicare will not cover tobacco cessation services for patients in an inpatient hospital stay if tobacco cessation is the primary reason for the inpatient stay.

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

From that Web page, look for CR 3834 in the CR NUM column on the right, and then click on the files for that CR. You will note two documents with CR 3834 in that column. The file with transmittal number 36 will contain the NCD information and the one with transmittal number 562 will contain the changes to Medicare claims processing requirements.

If you have questions regarding this issue, contact your carrier/FI/RHHI on their toll free number, which is available 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) #: 3834

Medlearn Matters Number: MM3834

Related CR Release Date: May 20, 2005

Related CR Transmittal #: 36 and 562

Effective Date: March 22, 2005

Implementation Date: July 5, 2005

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List of Medicare Telehealth Services

CMS has issued the following “Medlearn Matters... Information for Medicare Providers” article. This information was previously published in the Third Quarter 2005 Medicare B Update! pages 54-55.

Note: This article was revised on May 17, 2005, to correct the code in the example on page 3 to read G0318 GT, instead of G3018GT.

Providers Affected

Physicians and providers billing Medicare carriers for telehealth services.

Provider Action Needed

STOP – Impact to You

Effective for services provided on or after January 1, 2005, the Centers for Medicare & Medicare Services (CMS) added Healthcare Common Procedure Coding System (HCPCS) codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 (for ESRD-related services) to the list of Medicare telehealth services, effective January 1, 2005. Medicare carriers will pay for these ESRD-related services when billed with the telehealth modifiers.

CAUTION – What You Need to Know

Providers treating ESRD beneficiaries should also be aware that the above telehealth modifiers “GT” or “GQ” are valid when billed with one of the above-mentioned HCPCS codes.

GO – What You Need to Do

Be sure staff is aware of the addition of these ESRD-related services to the list of Medicare telehealth services and the appropriate billing procedures.

Background

In the final rule published November 7, 2003, (68 FR 63216) CMS established new G codes for managing patients on dialysis with payments varying based on the number of visits provided within each month.

Under this methodology, separate codes are billed for providing one visit per month, two to three visits per month, and four or more visits per month.

The lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would have to provide at least four ESRD-related visits per month. The G codes are reported once per month for services performed in an outpatient setting that are related to the patient’s ESRD.

Since changing the payments for managing patients on dialysis, CMS has received a number of comments from the nephrology community expressing concerns that the change in payments results in hardships for rural and isolated areas, especially in frontier areas where physicians would be required to make multiple long-distance trips during a month to see their patient or vice versa.

To address this issue, CMS added ESRD related services under the monthly capitation payment (MCP) to the list of Medicare telehealth services in the physician fee schedule final rule published November 15, 2004 (69FR 66276). ESRD-related services included in the MCP with 2 or 3 visits per month, and ESRD-related services with 4 or more visits per month, may be paid as Medicare telehealth service.

To bill for ESRD-related service under the MCP as a telehealth service, at least one visit must be furnished face to face “hands on” to examine the patient’s vascular access site. Examination of the vascular access site must be done by a physician, clinical nurse, specialist, nurse practitioner, or physician assistant. Only the facilities, authorized under Section 1834 (m) of the Social Security Act, may serve as a Medicare telehealth-originating site.

Prior to the issuance of CR 3747, the list of Medicare telehealth services only included consultations (CPT codes 99241-99275); office and other outpatient visits (CPT codes 99201-99215); individual psychotherapy (CPT codes 90804 – 90809); pharmacologic management (CPT code 90862); and psychiatric diagnostic interview examination (CPT code 90801), effective for services on or after March 1, 2003.

This article and related CR 3747 informs that the ESRD-related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) are added to the list of Medicare telehealth services, effective for services furnished on or after January 1, 2005. The telehealth modifier “GT” (providing visits through the use of interactive audio and video telecommunications system) and modifier “GQ” (providing visits through the use of asynchronous telecommunications system) are valid when billed with these ESRD-related service HCPCS codes. The use of the telehealth modifiers indicates that a clinical examination of the vascular access site was furnished face-to-face “hands on” by a physician clinical nurse specialist, nurse practitioner, or physician assistant.

Addition of the above ESRD-related services to the list of Medicare telehealth service does not change the eligibility criteria, conditions of payment, payment or billing procedure regarding Medicare telehealth services as established in publication 100-2, Chapter 15, Section 270 and publication 100-4 Chapter 12, Section 190 of the Medicare Benefit Policy Manual. Thus, originating sites only include a physician’s or practitioner’s office, hospital, critical access hospital, rural health clinic, or Federally qualified health center.

Originating sites must be in a non-Metropolitan Statistical Area (MSA) county or a rural health professional shortage area. Also, the use of modifier “GQ” is only permitted in Federally funded telemedicine demonstration programs conducted in Alaska or Hawaii.

Clarification for originating sites billing for the telehealth originating site facility fee

With regard to ESRD-related services included in the MCP, the originating site facility fee payment may be made for each visit furnished through an interactive telecommunications system. When the physician or practitioner at the distant site furnishes an ESRD-related patient visit included in the MCP through an interactive telecommunications system, the originating site may bill for a telehealth facility fee.

Example: A 70-year-old ESRD beneficiary receives two ESRD-related visits through an interactive telecommunications system and the required face-to-face visit (to examine the vascular access site) during the month of November. In this scenario, the originating site should bill for two originating site facility fees as described by HCPCS code Q3014, and the MCP physician at the distant site should bill for ESRD-related services with 2 to 3 visits as a telehealth service, e.g. G0318 GT.

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.

From that Web page, look for CR 3747 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 on their toll free number, which is available at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

Related Change Request (CR) #: 3747

Medlearn Matters Number: MM3747

Related CR Release Date: April 1, 2005 *Revised*

Related CR Transmittal #: 31 and 517

Effective Date: January 1, 2005

Implementation Date: May 2, 2005

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HIPAA - THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims—Important Information for Paper Claims Submitters

This information was previously published in the Third Quarter 2005 Medicare B Update! pages 89-90.

The provision of the Administrative Simplification Compliance Act (ASCA) requiring electronic submission of all initial claims with limited exceptions, for reimbursement under Medicare has been in effect since October 16, 2003. Change Request 3440 implemented the enforcement of this provision for which its amendment to Section 1862(a) of the Act, prescribes that 'no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services' for which a claim is submitted in a non-electronic form.

Providers who have not converted to electronic submission need to:

- Perform a self-assessment to determine if you meet one of the exceptions outlined in the related Medlearn Matters article which can be found at: <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3440.pdf>.
- If you determine you meet an exception that qualifies for submission of paper claims, no further action is necessary at this time. Please do not submit documentation supporting your determination in the absence of a request from this office.
- If you determine you do not qualify for continued submission of paper claims, free HIPAA-compliant billing software for submission of Medicare claims is available from our office. There are also commercial billing software, billing agent, and clearinghouse services available that often include services other than Medicare billing and may better meet your needs.
- When you receive a 'Review of Paper Claims Submission Practices' letter, your response **must** be received within 30 calendar days from the date of the letter with documentation demonstrating your eligibility to continue to submit paper claims to Medicare.
- If a response to this letter is **not** received within 30 days of the date of the letter or, if you do respond and your response **does not establish** your eligibility to submit paper claims, the contractor will notify you by mail that Medicare will deny any paper claims that you submit more than 90 calendar days after the date of the initial request letter. **This Medicare decision is not subject to appeal.**
- If the response to the letter **does** establish your eligibility to submit paper claims, the contractor will notify you by mail that you meet one or more of the exception criteria to submit paper claims. If your situation changes to the point that you no longer meet the exception criteria, you will be required to start submitting your claims electronically within 90 calendar days from that change in your status.

CONNECTICUT

Information regarding the free HIPAA-compliant billing software, PC-ACE Pro32® and the necessary forms to obtain the software can be found in the EDI section of our website at: <http://www.connecticutmedicare.com>.

If you are interested in commercial billing software, billing agent, or clearinghouse services, a list of HIPAA vendors may also be found in the EDI section of this website. If you have questions about electronic claim submission, you may contact Medicare EDI at (203) 639-3160, option 4.

FLORIDA

Information regarding the free HIPAA-compliant 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>. If you are interested in commercial billing software, billing agent, or clearinghouse services, a list of HIPAA vendors can be found in the EDI section of our website at: <http://www.floridamedicare.com>. If you have questions about electronic claim submission, you may contact Medicare EDI at (904) 791-8767, option 1.

Source: Pub. 100-04 Transmittal: 450 Change Request 3440

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Correction to the Use of Group Codes for the Enforcement of Mandatory Electronic Submission of Medicare Claims

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

Provider Types Affected

All physicians, providers and suppliers who bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Providers and suppliers need to be aware of the Administrative Simplification Compliance Act (ASCA) that requires all expenses for items and services billed to the Medicare Program be submitted electronically. Unless there is an exception in place for a given provider, paper claims will be denied.

Background

Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires you—with limited exceptions—to submit all your initial claims for reimbursement under Medicare electronically, on or after October 16, 2003. Further, ASCA amendment to Section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

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.

From that Web page, look for CR 3815 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 local FI, carrier, RHHI or DMERC.

Their toll free phone numbers 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) #: 3815

Medlearn Matters Number: MM3815

Related CR Release Date: April 29, 2005

Related CR Transmittal #: 541

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

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Access Process for Beneficiary Eligibility Inquiries/Replies (HIPAA 270/271 Transactions) (Extranet Only)

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

Provider Types Affected

All physicians, providers, and suppliers billing Medicare.

Provider Action Needed

STOP – Impact to You

This article is based on information from change request (CR) 3883, which states that the Centers for Medicare & Medicaid Services (CMS) is making changes to its information technology (IT) infrastructure. The goal is to address standards for Medicare beneficiary eligibility inquiries to 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 on a real-time transaction.

CAUTION – What You Need to Know

In June 2005, only clearinghouses, certain providers and trading partners will be permitted to send 270 transactions via the extranet, a secure, closed, and private network used to transmit data between Medicare carriers and intermediaries and CMS. CMS expects to provide limited access via the Internet for 270/271 transactions later this year.

GO – What You Need to Do

See the Background and Additional Information sections of this article for further details regarding these changes and manual revisions that explain how this access will work.

Background

Change request (CR) 3883 states that CMS is making changes to its IT infrastructure to address standards for Medicare beneficiary eligibility inquiries. This IT change will create the necessary database and infrastructure to provide a centralized HIPAA-compliant 270/271 beneficiary health care eligibility inquiry and response in real-time.

Not only will these changes satisfy the current demand for a fully functioning HIPAA-compliant 270/271 eligibility transaction for FFS providers/submitters, they will also support (over time) a national provider telephone interactive voice response (IVR) as well as Internet eligibility queries.

The new infrastructure will support the 270/271 for Medicare and will use a central national Medicare eligibility database in processing these queries bypassing the current:

- carriers,
- durable medical equipment regional carriers (DMERCs), and
- fiscal intermediaries (FIs).

However, Medicare plans to continue to use the provider newsletters and websites of the carriers, DMERCs, and FIs to share information on availability, enrollment, Internet use, and other pertinent information about the 270/271 as developments warrant.

The 270/271 implementation guide adopted for national use under HIPAA can be obtained at the Washington Publishing Co. website at: <http://www.wpc-edi.com/HIPAA>.

A provider that prefers to obtain eligibility data in an electronic data interchange (EDI) format, but does not want to use the 270/271 version 4010, may contract with a clearinghouse to translate the information on its behalf; however, that provider would be liable for those clearinghouse costs.

Access Process for Clearinghouses/Provider

To obtain access to the MDCN via the extranet, clearinghouses and providers must complete the 270/271 Access Form that can be found at <http://www.cms.hhs.gov/it> on the CMS website. The 270/271 Access Form should be completed in full and submitted electronically. The electronic submitted form will be directed to both CMS staff and the CMS' Medicare eligibility integration contractor (MEIC).

The CMS staff will ensure that all of the necessary information is provided on the form, as well as ensure the complete connectivity to the 270/271 application. The MEIC will be responsible for contacting the clearinghouses, providers, and trading partners to authenticate the accessing entity's identity.

Once authentication has been completed, the MEIC will provide the clearinghouses, providers, and trading partners with a submitter ID that is required to be used on all 270/271 transactions. Testing will be coordinated by the MEIC. After successful testing, 270 production inquiries may be sent real-time.

Note: To access the MDCN, an entity must on its own obtain the necessary telecommunication software from the AT&T reseller. The current AT&T resellers are:

- IVANS: <http://www.ivans.com>
- McKesson: <http://www.mckesson.com>

Future Requirement

CMS is developing an attestation that all clearinghouses and providers will be required to agree to provisions concerning adherence of the HIPAA Privacy and Security Rule. This attestation will be available for review through the Paperwork Reduction Act Process and will be available for public comment in the near future.

Implementation

The implementation date for this instruction is August 22, 2005.

Additional Information

For complete details, including a list of data elements that will be provided in response to the 270 transaction, please see the official instruction issued to your Medicare carrier, including DMERCs, or FI 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 3883 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>.

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) #: 3883
 Medlearn Matters Number: MM3883
 Related CR Release Date: June 15, 2005
 Related CR Transmittal #: 583
 Effective Date: May 20, 2005
 Implementation Date: August 22, 2005

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Update to the National Council for Prescription Drug Program Batch Standard 1.1 Billing Request Companion Document

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

Provider Types Affected

Durable medical equipment providers, billing agents, or clearinghouses that submit retail pharmacy drug claims electronically to Medicare durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Providers need to be aware that Medicare will only accept a value of "1" in field number 337-4C (Coordination of Benefits/Other Payments Count) of the NCPDP Companion Document.

Previously the Coordination of Benefits/Other Payments Count field accepted a value of 1-3. Medicare will only accept one primary payer and will reject claims with any value in field 337-4C other than "1." In addition, please note the following changes:

- For Data Element 412-DC (Dispensing fee Submitted), CMS has added codes G0369, G0370, G0371, and G0374 to the NCPDP companion document along with associated pricing information. See the Medlearn Matters article MM3620 for an explanation of these codes. That article is available at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3620.pdf> on the CMS website.
- CMS had added Data Element 438-E3 (Incentive Amount Submitted) to the NCPDP companion document, in which suppliers should include the \$50.00 fee allowed by Medicare for G0369.
- For Data Element 451-EG (Compound Dispensing Unit Form Indicator), CMS has added the following values to the NCPDP companion document:
 - 1 = each
 - 2 = gram
 - 3 = milliliters

Implementation

Medicare will implement these changes on September 12, 2005.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) published a companion document to supplement the *NCPDP VERSION 5.1 BATCH TRANSACTION STANDARD 1.1 BILLING REQUEST For Exchanges With Medicare DMERCs*. These are revised instructions and the companion document is available at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that web page look for CR 3882 in the CR NUM column on the right and then click on that file. Within that file are the official instructions issued to your DMERC regarding this CR.

If you have questions please contact your DMERC at their toll free number, which can be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp>.

Related Change Request (CR) #: 3882

Medlearn Matters Number: MM3882

Related CR Release Date: June 10, 2005

Related CR Transmittal #: 579

Effective Date: July 11, 2005

Implementation Date: September 12, 2005

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Sign up to our eNews electronic mailing list

Join our *eNews* mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Connecticut and Florida Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website(s) <http://www.floridamedicare.com> (Florida) or <http://www.connecticutmedicare.com> (Connecticut). It's very easy to do. Simply go to the website, click on the "eNews link" on the navigational bar and follow the prompts.

FRAUD

CMS Efforts to Identify Medicare and Medicaid Improper Payments

On July 13, 2005, Tim Hill, director of the Centers for Medicare & Medicaid Services Financial Management, presented a testimony before the Senate Homeland Security and Governmental Affairs Subcommittee, Federal Financial Management, Government Information and International Security Hearing on CMS efforts to identify incorrect or erroneous payments in the Medicare and Medicaid programs. A full-text of Tim Hill testimony may be found on the CMS website at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1504>.

Source: CMS Office of Financial Management Testimony

Office of Inspector General Reports Progress Against Waste, Abuse and Fraud

The Department of Health & Human Services (HHS) Office of Inspector General (OIG) has completed the Semiannual Report to Congress for the first half of fiscal year (FY) 2005. The report, sent to HHS and Congress, describes OIG investigations and evaluation and audit reports finalized during the reporting period. This publication is an important indicator of the progress OIG has made and the challenges the Department faces in achieving greater economy and efficiency.

For the first half of FY 2005, OIG reported savings and expected recoveries of nearly \$17 billion: \$15.6 billion in implemented recommendations and other actions to put funds to better use, \$266 million in audit receivables, and \$1.1 billion in investigative receivables.

Also for this reporting period, OIG reported exclusions of 1,695 individuals and entities for fraud or abuse of federal health care programs and/or their beneficiaries; 258 criminal actions against individuals or entities that engaged in crimes against departmental programs; and 105 civil actions, which include False Claims Act and unjust enrichment suits filed in district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters.

OIG continues to be an aggressive force within HHS to improve the efficiency of the Department and to punish those who defraud its programs. This office is dedicated to maintaining public credibility of our vital programs. Details of some of the activities are contained in the U.S. Department of Health & Human Services Office of Inspector General Semiannual Report to the Congress available at <http://oig.hhs.gov/publications/docs/semiannual/2005/SemiannualSpring05.pdf>.

Source: Office of Inspector General News, June 13, 2005

MEDICARE PHYSICIAN FEE SCHEDULE

Distribution of the Annual Fee Schedule and 2006 Participation Packages

First Coast Service Options, Inc. (FCSO) will be sending the 2006 Medicare Physician Fee Schedule (MPFS) on a CD-ROM in early November 2005. Distribution of the Annual Fee Schedule and 2006 Participation Packages 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 its release.

A CD-ROM version of the Annual Fee Schedule and Participation Packages will be distributed to all providers, regardless of the current method of receiving the quarterly *Medicare Part B Update!* The CD-ROM contains a request card that can be used to list any technical or other barrier(s) a provider has that limits access. Qualifying providers will be eligible to receive one hardcopy *if* a **valid** reason can be shown why the CD-ROM format cannot be used. For example, "I just prefer hardcopy" is an invalid reason, while a valid reason might be lack of a CD-ROM drive.

There are many benefits to using CD-ROMs. FCSO will be able to offer information in a more timely fashion while allowing for broader sharing of information within each office.

The CD-ROM will contain the Participation Announcement, Fact Sheet, Participating (PAR) Agreement, and fee schedules for Florida and Connecticut, in a state-specific arrangement to allow the information to be easily identified by state/locality. Because Florida has four pricing localities, Florida providers will have the opportunity to access fees for the entire state or by locality. All providers will be able to search the CD-ROM for pricing on a single procedure code or a range of procedure codes.

In addition, the CD-ROM will contain supplemental information and links to various websites. The CD-ROM takes up less office space, and the material can be printed and distributed. You can view and print only those articles important to your practice. These enhancements make the CD-ROM an attractive alternative to the hardcopy version, which contains only the Annual Fee Schedule and 2006 Participation Package materials.

Questions/Answers

Listed below are some of the common questions and issues we received from the 2005 CD-ROM distribution of the Fee Schedule and Participation Packages:

- Q. Do I need Internet access to view the information contained on the CD-ROM?
- A. No. You only need Internet access if you wish to visit the websites linked to in the CD-ROM. For example, the Provider Reference page contained links to the CMS website, UPIN directory, and WPC-EDI website. You need Internet access to view the information contained in those websites. However, your computer does need to have an Internet browser, installed such as Internet Explorer or Netscape Navigator.
- Q. I do not have Internet access. Do I need additional software to view the files contained on the CD-ROM?
- A. Yes. You need the Adobe Acrobat reader to view the files contained on the CD-ROM. Since this software is required to view the files, the reader is included; a link to the software is on the main page of the CD-ROM. You can also access the software through My Computer or Windows Explorer – look for a file with an “.exe” extension.
- Q. Does the CD-ROM auto-run on my computer? If not, what should I do?
- A. Yes, the CD-ROM should automatically run after it is placed in your CD-ROM drive. The main page of the CD-ROM should appear. If it does not, then open the CD-ROM drive and re-insert the CD-ROM. If it still does not auto-run, access either My Computer or Windows Explorer and double-click on the index.htm file on the CD-ROM.
- Q. Can I obtain additional copies of the CD-ROM?
- A. Yes. Eligible providers will receive one complimentary version. Additional copies can be ordered by using the Order Form published in the Third Quarter 2005 *Medicare B Update!* You may also purchase a hardcopy version by using the same form.

Source: Pub. 100-20 Transmittal 157 CR 3891

PROVIDER ENROLLMENT

CMS Announces the National Provider Identifier Enumerator Contractor and Information on Obtaining NPIs

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

Provider Types Affected

All health care providers - Medicare and non-Medicare.

Provider Action Needed

Learn about the national provider identifier (NPI) and how and when to apply for one.

Background

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a new health care identifier for use in the HIPAA standard transactions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the NPI as this identifier.

The NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). The NPI will identify health care providers in the electronic transactions for which the Secretary has adopted standards (the standard transactions) after the compliance dates. These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace health care provider identifiers that are in use today in standard transactions.

Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting HIPAA standard transactions with multiple health plans.

All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.

Important Note: While you are urged to apply for an NPI beginning May 23, 2005, the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006.

NPI Enumerator Contract Awarded

Recently, the CMS announced the selection of Fox Systems, Inc. as the contractor, to be called the Enumerator, to perform the support operations for the NPI project.

Fox Systems, Inc. will process NPI applications from health care providers and operate a help desk to assist health care providers in obtaining their NPIs.

Who may apply for the NPI?

All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices are eligible to apply for and receive an NPI. **Note:** All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required by the NPI Final Rule to obtain NPIs. This is true even if they use business associates such as billing agencies to prepare the transactions.

The NPI Application Process

Health care providers may begin applying for an NPI on May 23, 2005. Once the process begins, **it will be important to apply for your NPI** before the compliance date of May 2007 because health plans could require you to use your NPI before that date.

You will be able to apply for your NPI in one of three ways:

1. You may apply through an easy-to-use Web-based application process, beginning May 23, 2005. The web address will be <https://nppes.cms.hhs.gov>, but **please note — the website is not available until May 23, 2005.**
2. Beginning July 1, 2005, you may complete a paper application and send it to the enumerator. A copy of the application, including the enumerator's mailing address (where you will send it) will be available on <https://nppes.cms.hhs.gov> or you can call the Enumerator to receive a copy. The phone number is 1-800-465-3203 or TTY 1-800-692-2326. **But remember, paper applications may not be submitted until July 1, 2005.**
3. With your permission, an organization may submit your application in an electronic file. This could mean that a professional association, or perhaps a health care provider who is your employer, could submit an electronic file containing your information and the information of other health care providers. **This process will be available in the fall of 2005.**

You may apply for an NPI using only one of these methods. When gathering information for your application, be sure that all of your information, such as your social security number and the federal employer identification number, are correct. Once you receive your NPI, safeguard its use.

If all information is complete and accurate, the web-based process could result in you being issued a number within minutes. If there are problems with the information received, it could take longer. The paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

The transition from existing health care provider identifiers to NPIs will occur over the next couple of years.

Each health plan with which you conduct business, including Medicare, will notify you when it will be ready to accept NPIs in standard transactions like claims. You can expect to hear about the importance of applying for an NPI from a variety of sources. Be clear that you only have to apply for, and acquire, one NPI. Your unique NPI will be used for all standard transactions, Medicare and non-Medicare.

Please be particularly aware that applying for an NPI does not replace any enrollment or credentialing processes with any health plans, including Medicare.

Additional Information

For additional information on NPIs:

- Visit <http://www.cms.hhs.gov/hipaa/hipaa2> on the Web.
- Beginning May 23, 2005, visit <https://nppes.cms.hhs.gov> or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- For HIPAA information, you may call the HIPAA hotline: 1-866-282-0659, or write to AskHIPAA@cms.hhs.gov on the Web.

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0528

Related CR Release Date: N/A

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National Provider Identifier Reminder

Reminder—Health care providers are required by law to apply for a national provider identifier (NPI). To apply online, visit: <https://nppes.cms.hhs.gov>, or call 1-800-465-3203 to request a paper application.

Visit <http://www.cms.hhs.gov/hipaa/hipaa2> for the latest information regarding the NPI, including a transcript from CMS' recent NPI Roundtable conference call.

Source: CMS Joint Signature Memorandum 05402, June 29, 2005

Medicare Fee-for-Service Transition to the National Provider Identifier

The Centers for Medicare & Medicaid Services (CMS) has the following announcements on plans for transitioning to the national provider identifier (NPI) in the Medicare fee-for-service program:

- Between **May 23, 2005 and January 2, 2006**, CMS claim processing systems will accept an existing legacy Medicare number and reject as unprocessable any claim that includes only an NPI.
- Beginning **January 3, 2006, and through October 1, 2006**, CMS systems will accept an existing legacy Medicare number **or** an NPI as long as it is accompanied by an existing legacy Medicare number.
- Beginning **October 2, 2006, and through May 22, 2007**, CMS systems will accept an existing legacy Medicare number **and/or** an NPI. This will allow for six to seven months of provider testing before only an NPI will be accepted by the Medicare program on May 23, 2007.
- Beginning **May 23, 2007**, our systems will **only** accept an NPI.

To apply for an NPI, visit: <https://nppes.cms.hhs.gov> on the CMS website.

To request a paper application, call 1-800-465-3203.

Source: CMS Joint Signature Memorandum 05381, June 16, 2005

Do Not Forward Initiative - Reminder

As part of the Do Not Forward (DNF) Initiative, Centers for Medicare & Medicaid Services (CMS) has instructed Medicare carriers and DMERCs to use “return service requested” envelopes for all provider remittance advice mailings.

This requirement applies to the provider Medicare checks and remittance advices. When a provider check or remittance advice is returned to the carrier because of “return service requested”, the following will occur:

- The carrier will flag the provider number as DNF.
- Provider Enrollment will be notified of provider’s new status.
- The carrier will stop sending paper checks and remittance advices to the provider.
- Electronic fund transfers will be stopped.

Only upon verification and update of all the provider’s addresses will the flag be removed. Not only will the “pay to” address be verified, but also all “provider location” addresses will be verified. It is important that providers notify Medicare **immediately** of any change of address by complete.

Once the DNF flag has been removed, the carrier will:

- Pay any funds held due to DNF
- Reissue any remittance notices held due to DNF

Source: CMS IOM Publication 100-04, Chapter 22, Section 50.1.

GENERAL INFORMATION

New Remittance Advice Message for Referred Clinical Diagnostic/ Purchased Diagnostic Service Duplicate Claims

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

This information was previously published in the 3rd Quarter 2005 Medicare B Update! pages 67-68.

Note: This article was revised on June 13, 2005, to reflect a change to CR3679, which was reissued on June 10, 2005. The article was revised to reflect the new transmittal number of the CR, but no other changes were made.

Provider Types Affected

Physicians/suppliers who bill Medicare carriers (excluding DMERCs) for referred clinical diagnostic laboratory and purchased diagnostic services.

Provider Action Needed

STOP – Impact to You

Effective April 1, 2005, a claim for a referred clinical diagnostic/purchased diagnostic service that is identified as duplicate will be denied. For full details of this edit, please see Medlearn Matters article MM3551 at:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3551.pdf>.

CAUTION – What You Need to Know

Effective with claims processed on or after July 1, 2005, CMS will implement a new remittance advice (RA) message for such duplicate claims. Carriers will use the following remark code *on RA notices* generated for a referred clinical diagnostic/purchased diagnostic service claim line item denied as a duplicate of a previously paid service: “Your claim for a referred or purchased service cannot be paid because payment has already been made for this service to another provider by a payment contractor representing the payer.” The new remark code is N347.

GO – What You Need to Do

Be ready to accept this new remark code (N347) indicating a duplicate claim submission.

Background

Effective April 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will implement a new Common Working File (CWF) edit to check for duplicate claims for referred clinical diagnostic laboratory services and purchased diagnostic services submitted by physicians/suppliers to more than one carrier. (Per transmittal 124, CR3551, published on October 29, 2004 and described in Medlearn Matters article MM3551)

As a reminder, claims submitted for referred clinical diagnostic/purchased diagnostic services will be considered duplicate when:

- The claims contain different carrier numbers;
- and**
- All of the data matches on the following claim fields:
- Beneficiary name
- Beneficiary health insurance claim number (HICN)
- Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Code
- Date of Service
- CPT/HCPCS code modifier

The CWF duplicate claim edit will apply only to:

- Claims containing a CPT code that is included on the clinical laboratory fee schedule (available online at: <http://www.cms.hhs.gov/suppliers/clinlab/default.asp>, Clinical Laboratory Information Resource for Medicare);
- or**
- A HCPCS code that is included on the abstract file for purchased diagnostic tests/interpretations implemented in April 2005.

Effective for claims processed on or after July 1, 2005, CMS will implement a new RA message for claim items denied due to the CWF duplicate claim edit for referred clinical diagnostic/purchased diagnostic service claims:

- Carriers will use the following remark code (N347) on remittance advice notices generated for a referred clinical diagnostic/purchased diagnostic service claim line item denied as a duplicate of a previously paid service: “Your claim for a referred or purchased service cannot be paid because payment has already been made for this service to another provider by a payment contractor representing this payer.”

Additional Information

The official instruction issued to the carrier regarding this change can be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR3679. Click on the link to open and view the file for the CR. CR3551 may be accessed at:

http://www.cms.hhs.gov/manuals/pm_trans/R124OTN.pdf.

If you have questions regarding this issue, you may also 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) #: 3679

Medlearn Matters Number: MM3679

Related CR Release Date: June 10, 2005 *Revised*

Related CR Transmittal #: 582

Effective Date: July 1, 2005

Implementation Date: July 5, 2005

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New Educational Guide on Remittance Advice Notices

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

Provider Types Affected

All Medicare physicians, providers, suppliers, and their billing staff who submit claims to Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs).

Provider Action Needed

This special edition article describes the release of a national educational guide for Medicare-fee-for-service (FFS) providers, physicians, suppliers and their billing staff who may wish to use the guide to help increase their understanding of the remittance advice (RA). The guide is available at http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf on the CMS website.

Background

The Medicare FFS program serves many of the more than 40 million Medicare beneficiaries enrolled in the Medicare program. Under this program, more than 1 billion claims are submitted annually for reimbursement of health care services. Medicare contractors, FIs, RHHIs, carriers, and DMERCs process the claims. These Medicare contractors use the standard RA as their means to communicate to providers claim processing decisions regarding payments, adjustments, and denials, as well as data that was missing or incorrect on the incoming claims which need to be submitted or corrected before a payment decision can be made on a claim.

Every day Medicare FFS contractors send thousands of RAs to providers. Each of these RAs conveys information that may impact the provider’s Medicare business. CMS wants to be certain that providers understand how to read and interpret the RA; therefore, CMS has developed and is pleased to announce the release of *Understanding the Remittance Advice: A Guide for Medicare Providers, Physician, Suppliers and Billers*. This educational guide has useful information that may be used as a self-help tool.

The guide offers the user the following benefits:

- Easy access to general information about RAs without direct personal assistance from Medicare contractor customer service staff, thus saving valuable time
- Increased ability to understand and interpret the reasons for claim denials and claim adjustments
- Reduction in the resubmission of claims due to errors
- Rapid follow-up action, resulting in quicker payment
- A useful tool for training new staff or a refresher for experienced staff

The guide is comprised of four chapters each highlighting a specific aspect of the RA, an acronym list, a glossary, important web sites and phone numbers, and three comprehensive indices: 1) for key terms and concepts; 2) for institutional ERA and SPR field descriptions; 3) professional SPR field descriptions.

Each chapter and/or section of the guide can be printed according to the provider’s specific needs.

Print What Fits Your Needs

- **Chapters 1 and 2** describe a RA and its components
- **Chapter 3** specifically targets institutional providers i.e., those who submit claims to FIs and RHHIs. and includes a sample ERA and SPR with field descriptions.
- **Chapter 4** targets providers that submit claims to carriers and DMERCs and includes a crosswalk between ERA and SPR fields and a sample SPR with field descriptions, specifically for professional providers. At the end of Chapters 3 and 4, providers can find information on remittance balancing.
- **Reference A: Acronyms**, a handy tool that contains acronyms used throughout the guide
- **Reference B: Glossary**, a list that contains terms used throughout this guide
- **Reference C: Websites and Phone Numbers**, a list of Web page references and address and phone number references that assist with submitting Medicare claims and troubleshooting denials and claim rejections
- **Reference D: Resources**, a list of the resources that were used to compile the guide and where to find them on the CMS website.

Additional Information

Print copies of the guide will be available late summer of 2005. Until print copies are available *Understanding the Remittance Advice: A Guide for Medicare Providers, Physician, Suppliers and Billers* can be accessed electronically at http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf on the CMS website.

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0540

Related CR Release Date: N/A

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Understanding the Remittance Advice Guide now Available

A reference document titled Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers is now available on the Medicare Learning Network's (Medlearn) Web page located at: http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf on the CMS website. Chapter 1 and 2 describe a remittance advice (RA) and the components of an RA. For institutional providers, Chapter 3 includes a sample electronic remittance advice (ERA) and standard paper remittance (SPR) advice with field descriptions. Chapter 4 includes a crosswalk between ERA and SPR fields and a sample SPR with field descriptions, specifically for professional providers. At the end of Chapter 3 and 4, providers can find information on remittance balancing.

Print the chapter that fits your needs!

The guide also includes informative resources such as an acronym list, a glossary, and important websites and phone numbers.

Finally, the guide has three comprehensive indexes for:

- 1) key terms and concepts
- 2) institutional ERA and SPR field descriptions
- 3) professional SPR field descriptions.

Check this website today.

Source: CMS Joint Signature Memorandum 05378, June 10, 2005

Standard Paper Remittance Advice

If you are currently receiving the standard paper remittance (SPR) advice, consider utilizing the technology available to increase productivity by switching to the electronic remittance advice (ERA).

Take advantage of faster communication, payment information, and reduction of paperwork by receiving the ERA. If you are receiving both an SPR and ERA, consider canceling the SPR. Please contact our EDI department at 203-639-3160, option 4 and ask to receive the ERA and/or cancel the SPR today.

Source: CMS Joint Signature Memorandum 05378, June 10, 2005,

Administrative Law Judge Hearing Requests

Section 931 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Secretary of Health and 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.

Effective June 24, 2005, all ALJ hearing requests must be sent to:

Connecticut

HHS' Office of Medicare Hearings and Appeals
BPTower & Garage
200 Public Square, Suite 1300
Cleveland, OH 44114-2316

Florida

HHS' Office of Medicare Hearings and Appeals
100 SE 2nd Street, Suite 1700
Miami, FL 33131-2100

ALJ hearing requests sent to the carrier prior to June 24, 2005 will be prepared and forwarded to the appropriate address.

Source: CMS JSM-05306, April 18, 2005

Sign up to our eNews electronic mailing list

Join our *eNews* mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education websites <http://www.floridamedicare.com> or <http://www.floridamedicare.com>. It's very easy to do. Simply go to the website, click on the "eNews" link on the navigational menu and follow the prompts.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries, regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs)) for services

Provider Action Needed

STOP – Impact to You

The complete list, including changes made from November 1, 2004 through February 28, 2005, of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 Health Care Claim Adjustment Reason Codes can be found at: <http://www.wpc-edi.com/codes>.

CAUTION – What You Need to Know

Please refer to the Additional Information section of this article for remark and reason code changes approved February 28, 2005.

GO – What You Need to Do

Be sure your staff is aware of these changes.

Background

Two code sets, reason and remark code sets, must be used to report payment adjustments, appeal rights, and related information for transactions 835 (Health Care Claim Payment/Advice), 837 Coordination of Benefits (COB), and on standard paper remittance advice. Medicare contractors must use currently valid codes. An updated code list is published 3 times per year. Medicare contractors are informed of these changes through recurring code updates (such as this article and corresponding CR3923), and/or through a specific CR that describes the change in policy that resulted in the code change.

The remittance advice remark code list is maintained by CMS. However additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities.

- Medicare contractors must use **modified codes** for codes currently used by Medicare even if the modification was initiated by an entity other than Medicare.
- Medicare contractors do not have to use **new codes** initiated by an entity other than Medicare, unless otherwise instructed by Medicare.
- Medicare contractors must stop using a code that has been deactivated either by the effective date of deactivation, or the effective date established by the code update CR.

The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets three times a year when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes. This updated list is posted thrice per year.

- Reason code changes requested by Medicare may be included in a Medicare instruction in addition to the regular code update notification.
- Reason codes may be retired if they are no longer applicable, or if a similar code exists.
- Retirements are effective for a specified future and succeeding versions, but Medicare contractors can also discontinue use of retired codes in prior versions.
- The regular code update notification will establish the deadline for Medicare contractors to retire a reason code that could be earlier than the version specified in the Washington Publishing Company (WPC) posting.

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Additional Information

Remark and reason code changes approved by Medicare February 28, 2005 include:

Code Type	Code	New/Modified/ Deactivated/ Retired	Current Narrative	Comment
Remark	N345	New	Date range not valid with units submitted	Not Medicare Initiated
Remark	N346	New	Missing/incomplete/invalid oral cavity designation code	Not Medicare Initiated
Remark	N347	New	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.	Medicare Initiated
Remark	MA100	Modified	Missing/incomplete/invalid date of current illness or symptom	Modified effective as of March 30, 2005.
Remark	MA128	Modified	Missing/incomplete/invalid FDA approval number	Modified effective on March 30, 2005
Reason	166	New	These services were submitted after this payer's responsibility for processing claims under this plan ended.	New as of February, 2005

Note: Typographic errors were also identified and corrected in reason codes 52, 57, 70, 76 and 146. No codes were retired.

Additional Information

For additional information about Remittance Advice, please refer to: Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf.

The official instruction issued to your FI/carrier/DMERC/RHHI regarding this change may be found by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR3923 in the CR NUM column on the right, and click on the file for that CR.

Please refer to your local Medicare contractor 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) #: 3923
Related CR Release Date: July 22, 2005
Effective Date: October 1, 2005

Medlearn Matters Number: MM3923
Related CR Transmittal #: 609
Implementation Date: October 3, 2005

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Order Form—2005 Part B Materials

To obtain materials available for purchase, refer to page 134 of the [3rd Quarter 2005 Medicare B Update!](#) for a list of items and ordering instructions.

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How Long Do I Have To File For A Redetermination?

A redetermination request must be filed within 120 days from the date the services initially processed. This date can be found on your Medicare Remittance Notice (MRN). We can consider appeal requests filed late only for reasons of a “good cause” nature.

Good cause may be found when the record clearly shows, or the provider, physician or other supplier alleges and the record does not negate, that the delay in filing was due to one of the following:

- Incorrect or incomplete information about the subject claim and/or appeal was furnished by the Medicare B Carrier, Social Security Administration or the Center for Medicare & Medicaid Services (CMS) to the provider, physician, or other supplier;
- or,
- Unavoidable circumstances that prevented the provider, physician, or other supplier from timely filing a request for redetermination or hearing officer (HO) hearing. Unavoidable circumstances encompasses situations that are beyond the provider, physician or supplier’s control. Following are a couple examples of cases where good cause for late filing may be found. This list **is not** all-inclusive:
- fire destroys the physician’s records, or
- natural catastrophe (e.g. flood, tornado, etc) closes a supplier’s office for an extended period of time

Note: Failure of a billing company or other consultant (that the provider, physician, or other supplier has retained) to timely submit appeals or other information is not grounds for finding good cause for late filing. The contractor does not find good cause where the provider, physician, or other supplier claims that lack of business office management skills or expertise caused the late filing.

Source: IOM, Medicare Claims Processing Manual, Chapter 29, section 60.7.5.

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 46-49.

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) Section 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 Section 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 Section SecSection483.40(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, Section 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, Section 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, Section 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. In this case, the NP or CNS is not an employee, but has an indirect employment relationship and, thus, are not permitted to sign the certifications and re-certifications. (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 Section 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/providerupdate/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 = Non-Physician 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

Medlearn Matters Number: SE0418

Related CR Release Date: N/A *Revised*

Effective Date: N/A- This is informational only.

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Clarification for Carriers and Durable Medical Equipment Regional Carriers About Correction and Recoupment of Payments for Previously Processed Claims

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

Provider Types Affected

Providers and suppliers who bill Medicare carriers, including durable medical equipment regional carriers (DMERCs)

Provider Action Needed

STOP – Impact to You

This is a one-time notice that provides clarification about correction and recoupment of payments for previously processed Medicare claims.

CAUTION – What You Need to Know

Be aware of actions that could impact your payments.

GO – What You Need to Do

When a previously processed claim needs to be adjusted, a full claim adjustment must be done. This will happen regardless of whether Medicare is primary or secondary.

Background

Previously, Medicare's CR 1523 required that carriers and DMERCs make a full claim adjustment whenever an adjustment was processed for a claim that was previously adjudicated. CR 3772 reiterates CR 1523 by requiring a full claim adjustment when money is recouped from providers whether the claim is a Medicare Secondary Payer (MSP)

claim or non-MSP.

If money needs to be recouped, the previous payment is negated, and a new payment is recognized if payment is being reduced, and Medicare creates an account receivable in the amount that was overpaid. If there is no payment due, the previous payment is reversed, and an account receivable is created in the same amount as that previously paid.

Should you receive a demand letter from Medicare as a result of such an adjustment and overpayment, the letter will identify:

- The claim,
- The overpayment amount,
- When the overpayment must be repaid, and
- A Financial Control Number for tracking purposes.

If payment is made timely, Medicare will adjust its system to reflect the overpayment was made. However, if payment is not received timely, Medicare will adjust payments on future claims to obtain repayment.

Implementation

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

Related Instructions

Complete details of CR 1523, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification - Implementation of Version 4010 of the Accredited Standards Committee X12 835 (Payment/Remittance Advice) Transaction Standard Format, may be viewed at: http://www.cms.hhs.gov/manuals/pm_trans/B0135.pdf.

Additional Information

The official instruction issued to your carrier/DMERC regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that Web page, look for CR 3772 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 contact your carrier/DMERC via their toll free number. That number 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) #: 3772
Related CR Release Date: July 22, 2005
Effective Date: January 1, 2006

Medlearn Matters Number: MM3772
Related CR Transmittal #: 618
Implementation Date: January 3, 2006

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Number of Durable Medical Equipment Pricing Files That Must Be Maintained Online for Medicare – DMERC, FI, and RHHI Only

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

Provider Types Affected

Providers and suppliers who bill durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for durable medical equipment, supplies, prosthetics and orthotics (DMEPOS).

Provider Action Needed

This article is informational only. Providers/suppliers need take no action, but Medicare encourages you to submit claims to Medicare as soon as possible after services are supplied.

Background

Medicare created a new minimum standard for the number of online price determination files that a Medicare DMERC or RHHI will maintain. The new minimum standard is eight fee screens/pricing files (the current period and seven prior files) for payment on a fee-for-service DMEPOS that you bill. This will allow Medicare to be more precise in paying the rate in effect at the time services are provided.

While this allows for more accurate pricing, this change does not alter Medicare’s timely filing requirements and providers/suppliers should bill Medicare as promptly as possible.

Additional Information

The official instruction issued to your DMERC/FI/RHHI regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that Web page, look for CR 3792 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 contact your DMERC/FI/RHHI via their toll free number. That number may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp>.

Related Change Request (CR) #: 3792
Related CR Release Date: April 29, 2005
Effective Date: October 1, 2005

Medlearn Matters Number: MM3792
Related CR Transmittal #: 546
Implementation Date: October 3, 2005

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Medicare Chronic Care Improvement—Medicare Health Support Program

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

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.

GENERAL INFORMATION

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
AETNA, Inc.	<ul style="list-style-type: none"> •Advance Practice Nursing program for home health and nursing homes •Customized care plans •Caregiver education •Blood pressure monitors and weight scales provided based on participant need •Physician communication •Physician web access to clinical information •24-hour nurse line 	Chicago Illinois counties
American Healthways	<ul style="list-style-type: none"> •Personalized care plans •Direct-mail and telephonic messaging •Supplemental telephonic coaching •Gaps in care generate physician prompts •Intensive case management services as necessary •Remote monitoring devices (weight, blood pressure, and pulse) based on participant need •Physician web access to clinical information •Physician communication •24-hour nurse line 	Maryland and the District of Columbia
CIGNA	<ul style="list-style-type: none"> •Personalized plan of care •Telephonic nurse interventions •Oral and written communication in addition to telephonic coaching •Home monitoring equipment (weight, blood pressure and glucometers) based on participant need •Intensive case management for frail elderly and institutionalized participants, as required •Data exchange with physicians, •24-hour nurse line 	Northwest Georgia
Health Dialog	<ul style="list-style-type: none"> •Personal health coaches develop individual care management plans •Health education materials (web-based, faxed or mailed) •In-home biometric monitoring •Behavioral health case management and intensive case management as needed •Data exchange with physicians, •Active involvement of other community agencies •24-hour nurse line 	Western Pennsylvania
Humana	<ul style="list-style-type: none"> •Trademarked Personal Nurse program model •Group education and support sessions •Biometric monitoring equipment, including glucometers and weight scales as necessary •Core telephonic support supplemented with RNs, social workers and pharmacists in the field interacting with providers and beneficiaries with complex needs •Data exchange with physicians, •On-site meetings with physicians and CME (continuing medical education) programs •Physician Web access to clinical information •Electronic medical record keeping systems will be piloted in five small physician-group practices •Active involvement of other community agencies •24-hour nurse line 	Central and South FL

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CCIO	Program Features	Geographic Area
Lifemasters	<ul style="list-style-type: none"> •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	<ul style="list-style-type: none"> •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	<ul style="list-style-type: none"> •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/Queens, NY
XL Health	<ul style="list-style-type: none"> •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 	Tennessee (selected counties)

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GENERAL INFORMATION

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) Number: 3953

Related CR Release Date: July 22, 2005

Related CR Transmittal Number: 26

Effective Date: October 20, 2005

Implementation Date: October 20, 2005

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Funding of Emergency Health Services Furnished to Undocumented Aliens

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

Provider Types Affected

Hospitals, physicians and ambulance providers.

Provider Action Needed

STOP – Impact to You

This special edition article summarizes the Centers for Medicare & Medicaid Services (CMS) policy regarding section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) regarding the federal funding of emergency health services furnished to undocumented aliens.

CAUTION – What You Need to Know

On May 9, 2005, CMS announced its policy regarding section 1011, Federal Funding of Emergency Health Services Furnished to Undocumented Aliens, of the MMA. This new program will provide \$1 billion over four years to help hospitals, certain physicians, and ambulance providers recoup the costs of providing needed emergency medical care to undocumented aliens and certain other aliens. Since this provision of the MMA is not part of the Medicare program, CMS will designate a single contractor for the purposes of enrolling providers, receiving claims, calculating provider payment amounts, and effectuating payments. As soon as CMS awards a contract to perform this workload, you will be notified. CMS’ policy notice and related documents can be found be viewed at: <http://www.cms.hhs.gov/providers/section1011> on the CMS website.

GO – What You Need to Do

See the *Background* and *Additional Information* sections of this special edition article to find out further details regarding the CMS policy for Section 1011 of the MMA.

Background

Section 1011 provides \$250 million per year for the fiscal years (FY) 2005 – 2008 for payments to eligible providers for emergency health services provided to undocumented and other specified aliens. Two-thirds of the funds will be divided among all 50 states and the District of Columbia based on

their relative percentages of undocumented aliens. One-third will be divided among the six states with the largest number of undocumented alien apprehensions.

From the respective state allotments, payments will be made directly to hospitals, certain physicians, and ambulance providers for some or all of the costs of providing emergency health care required under section 1867 and related hospital inpatient, outpatient, and ambulance services to eligible individuals. Eligible providers may include an Indian Health Service facility, whether operated by the Indian Health Service or by an Indian tribe or tribal organization. A Medicare critical access hospital (CAH) is also a hospital under the statutory definition. Payments under section 1011 may only be made to the extent that care was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

Payments may be made only for services furnished to certain individuals described in the statute as:

- 1) Undocumented aliens;
- 2) Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services; and
- 3) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine-readable border crossing identification card (also referred to as a “laser visa”) issued in accordance with the requirements of regulations prescribed under a specific section of the Immigration and Nationality Act.

Additional Information

Additional information can be found be viewed at <http://www.cms.hhs.gov/providers/section1011> on the CMS website.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0535
Related CR Release Date: N/A

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PRESCRIPTION DRUG COVERAGE

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

New Educational Products Available

The Fourth in the Medlearn Matters Series of Articles on the Medicare Prescription Drug Coverage

Provider Types Affected

Physicians, providers, suppliers, and their staff providing service to people with Medicare.

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to 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.
- 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.

This article announces new educational resources available to assist Medicare beneficiaries in their understanding of the new Medicare prescription drug coverage.

Release of Notices to Medicare Beneficiaries Who Automatically Qualify for Extra Help

Starting at the end of May through June, the Centers for Medicare & Medicaid Services (CMS) is mailing notices to people who are automatically eligible for extra help paying for a Medicare prescription drug plan, including people with Medicare and Medicaid, Supplemental Security Income, and Medicare Savings Program coverage.

The notices will let these people know that Medicare prescription drug coverage is coming and that they will get extra help without needing to apply for it. The notices can be viewed at <http://www.cms.hhs.gov/medicarereform/ltr.asp> on the CMS website.

This summer, the Social Security Administration (SSA) will mail a different letter to other people who do not automatically qualify for the extra help but may be potentially eligible for it. The letter will include an application that people can fill out and return to find out if they qualify for extra help paying for a Medicare prescription drug plan. This letter can be viewed at <http://www.ssa.gov/organizations/medicareoutreach2/> on the Social Security Administration website. Select "Application for Help with Medicare Prescription Drug Plan Costs."

Posters - Now Available for Display

Posters titled "Have Limited Income? Social Security Can Help with Prescription Costs" can be ordered free of charge on the CMS web site. The posters are suitable for display in a physician's, providers, 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 and resources to a toll free number where they can find out if they are eligible for help with prescription drug costs.

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

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.

Information Tool Available on Web

The new prescription drug coverage informational tool, "Learn About Your Medicare Prescription Coverage Options" was recently released on <http://www.medicare.gov>. This awareness tool for people with Medicare provides information about what is coming and what actions they will need to take with regard to the new prescription drug coverage. By answering 2-3 questions, the individual will be provided with information such as: eligibility for extra help for people with limited income and resources, customized information based on the individual's current coverage, as well as educational resources and links to publications about the new drug coverage.

Summary

CMS understands the pressure on your clinical time with patients, which is why we ask that you inform your Medicare patients that this new prescription drug coverage could be valuable to them and worth exploring. In addition to the products discussed in this article, CMS plans to provide you with access to information you could make available to your patients in your offices.

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 beneficiary advocates 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 MMA can be found at the following CMS website: <http://www.cms.hhs.gov/medicarereform/>.

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0537

Related CR Release Date: N/A

More Web-based Educational Products Available on Medicare Prescription Drug Coverage – The Fifth in the Medlearn Matters Series

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

Provider Types Affected

Physicians, providers, suppliers, and their staff providing 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. Because of this, 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 additional information and assistance.

New Fact Sheets Available on <http://www.medicare.gov>.

There are fact sheets now available that explain Medicare’s new prescription drug coverage that can help your patients understand this new coverage:

- *Quick Facts about Medicare’s New Coverage for Prescription Drugs* - Publication Number 11102. This fact sheet provides basic information about Medicare’s new prescription drug coverage. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11102.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs for People with Limited Income and Resources* – Publication Number 11105. This fact sheet provides basic information about Medicare’s new prescription drug coverage for a person with limited income and resources. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11105.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs If You Applied for Extra Help* – Publication Number 11130. This fact sheet explains what you need to know after applying for extra help paying Medicare prescription drug coverage costs. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11130.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs for People Who Get Supplemental Security Income* – Publication Number 11116. This fact sheet provides basic information about Medicare’s new prescription drug coverage for a person who gets Supplemental Security Income benefits or help from their state Medicaid program paying their Medicare premiums. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11116.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs for People with Medicare and Medicaid* – Publication Number 11106. This fact sheet provides basic information about Medicare’s new prescription drug coverage for a person with full Medicaid benefits. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11106.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs for People Who are Nursing Home Residents* – Publication Number 11121. This fact sheet explains how the new Medicare prescription drug coverage works for nursing home residents. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11121.pdf>.
- *Quick Facts about Medicare’s New Coverage for Prescription Drugs for People Who Get Help From Their State Pharmacy Program* – Publication Number 11108. This fact sheet explains what people who get help from their state pharmacy program to pay for their prescriptions need to know about the new Medicare prescription drug coverage. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11108.pdf>.
- *Do You Have a Medigap Policy with Prescription Drug Coverage?* – Publication Number 11113. This fact sheet explains how the new Medicare prescription drug coverage works for people who have a Medigap policy with prescription drug coverage. (4 pages). <http://www.medicare.gov/Publications/Pubs/pdf/11113.pdf>.
- *Medicare Covers America* - Publication Number 11141. This brochure provides basic information for people with Medicare about Medicare prescription drug coverage. This information includes how Medicare prescription drug coverage works, how to get coverage, and how to join a Medicare prescription drug plan. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11141.pdf>.
- *Introducing Medicare Prescription Drug Coverage* - Publication Number 11142. This brochure provides basic information to people with Medicare about Medicare prescription drug coverage. This information includes who can join, when people can join, and when more information will be available. (2 pages) <http://www.medicare.gov/Publications/Pubs/pdf/11142.pdf>.

GENERAL INFORMATION

New Fact Sheets and Tip Sheets Available on the CMS website at <http://www.cms.hhs.gov/medicarereform/factsheets.asp>.

- *The Facts about Medicare Prescription Drug Plans* – Publication Number 11065. This fact sheet provides basic introductory information about Medicare's new prescription drug coverage. (2 pages)
<http://www.medicare.gov/Publications/pubs/pdf/11065.pdf>.
- *Quick Facts about Medicare's New Coverage for Prescription Drugs (en Espanol)* – Publication Number 11102-S. This fact sheet provides basic information about Medicare's new prescription drug coverage, in Spanish.
<http://www.cms.hhs.gov/medicarereform/elnewcovpresdrug.pdf>.
- *Medicaid Spend Down – Tip Sheet* (3 pages) This tip sheet provides an example of the spend down requirement for patients who have Medicaid because of high medical expenses. This sheet shows the qualifications for patients to receive extra help. <http://www.cms.hhs.gov/medicarereform/medicaid%20spend%20down.pdf>.
- *Food Stamps – Tip Sheet* (3 pages) This tip sheet provides information on income limits, resource limits and qualifications for extra help for people who have Medicare and are also on food stamps.
<http://www.cms.hhs.gov/medicarereform/foodstamps.pdf>.
- *Medicare Prescription Drug Coverage and other Federal Means -Tested Programs – Tip Sheet* (2 pages) This tip sheet is intended to help explain how Medicare prescription drug coverage will work with other federal means-tested programs such as food stamps, HUD housing assistance, Medicaid, low income home energy assistance, and supplemental security income. <http://www.cms.hhs.gov/medicarereform/lowincome.pdf>.

Other Publications/Products

- *Introducing Medicare's New Coverage for Prescription Drugs (bi-fold)* – This pamphlet provides general information about the New Medicare Prescription Drug Coverage, such as who can join, when, and the cost to join, as well as providing sources for additional information. This pamphlet is available at <http://www.medicare.gov/Publications/Pubs/pdf/11103.pdf>.
- *Vignettes/Bios/Case Studies*– These vignettes can be used to help explain how Medicare prescription drug coverage works with and affects other types of health care coverage. They can be used to supplement other outreach materials. (10 pages). These vignettes are available at <http://www.cms.hhs.gov/partnerships/news/mma/vignettesfinal.pdf>.
- *Introducing Medicare's New Coverage for Prescription Drugs (Russian, Korean, Vietnamese, and Chinese)*– To access this product, go to <http://www.medicare.gov/medicarereform/default.asp>. At the middle of the web page, select the language desired from the drop-down menu. This will reveal a link to the document in the desired language.

Outreach Toolkit

A new Outreach Toolkit is also available. This toolkit is designed to equip community-level organizations with the materials needed to provide clear, accurate information and assistance about Medicare prescription drug coverage for their clients.

The toolkit contains basic, straightforward information that can be easily conveyed to people with Medicare.

You can view and download this kit online from the CMS website, as well as order a copy to be shipped to your office, by visiting: <http://www.cms.hhs.gov/partnerships/tools/materials/medicaretraining/MPDCoutreachkit.asp> on the CMS website.

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 MMA can be found at <http://www.cms.hhs.gov/medicarereform/> on the CMS website.

Related Change Request (CR) #: N/A

Medlearn Matters Number: SE0541

Related CR Release Date: N/A

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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

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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.

ADDITIONS/REVISIONS TO LMRPs/LCDs

11055: Routine Foot Care – Policy Revised

This local coverage determination (LCD) was last revised on January 1, 2005. For the allowed indication of peripheral neuropathies involving the feet associated with traumatic injury, the following diagnosis codes were added under “ICD-9-CM Codes that Support Medical Necessity” and under “The following diagnoses related to peripheral neuropathy do not require a Q modifier”:

952.2 – Spinal cord injury without evidence of spinal bone injury, lumbar

952.3 – Spinal cord injury without evidence of spinal bone injury, sacral

952.4 – Spinal cord injury without evidence of spinal bone injury, cauda equina

952.8 – Spinal cord injury without evidence of spinal bone injury, multiple sites of spinal cord

953.2 – Injury to lumbar nerve root

953.3 – Injury to sacral nerve root

953.5 – Injury to lumbosacral plexus

953.8 – Injury to multiple sites of nerve roots and spinal plexus

956.0-956.9 – Injury to peripheral nerve(s) of pelvic girdle and lower limb

This revision is effective for claims processed on or after May 12, 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.

11730: Surgical Treatment of Nails – Policy Revised

This local coverage determination (LCD) was last revised on February 1, 2005. The following additional diagnosis codes were added under the ICD-9-CM Codes that Support Medical Necessity section of the policy:

959.5 Injury, finger (fingernail, thumb nail)

959.7 Injury, knee, leg, ankle, and foot (toenail)

This revision is effective for claims processed on or after June 20, 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.

31525: Diagnostic Laryngoscopy – Policy Revised

This local medical review policy (LMRP) was last updated on October 1, 2004. Since that time this policy has been revised. The policy was converted to local coverage determination (LCD) format. The ICD-9-CM list was updated to identify V48.3 as a secondary diagnosis and that it should not be billed as a primary diagnosis. A separate coding guideline attachment was created.

The revision is effective for claims processed on or after July 5, 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.

70544: Magnetic Resonance Angiography – Policy Revised

The local medical review policy (LMRP) for magnetic resonance angiography (MRA) was last revised effective January 5, 2004. Since that time, it was determined the following ICD-9-CM code ranges should be added to the policy for magnetic resonance angiography (MRA) of the abdomen (procedure code 74185):

401.0—401.9 Essential hypertension

402.00—402.91 Hypertensive heart disease

The Indication and Limitations of Coverage and/or Medical Necessity, ICD-9-CM Codes that Support Medical Necessity and Source of Information sections have been revised accordingly. This policy has been updated to local coverage determination (LCD) format. Italicized lettering has been used to identify national coverage information. This revision is effective for services rendered on or after June 20, 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.

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72192: Computed Tomography of the Pelvis – Policy Revised

The local coverage determination (LCD) for computed tomography of the pelvis – 72192 was previously revised on January 1, 2005. At that time, ICD-9-CM code 592.0 was inadvertently left out of the ICD-9-CM additions.

Therefore, ICD-9-CM 592.0 has been added to the policy. This change 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.connecticutmedicare.com> on or after this effective date.

76070: Bone Mineral Density Studies – Policy Revised

This local medical review policy was last updated on January 1, 2005. Since that time the policy has been revised.

Revisions were completed to convert the policy to local coverage determination (LCD) format and make changes based upon the Medicare Claims Processing Manual and the Medicare National Coverage Database.

All national guideline language throughout the LCD was italicized. Under the ICD-9-CM code list, E932.0 was identified as a secondary diagnosis and that it should not be billed as a primary diagnosis code.

The revision is effective for claims processed on or after June 7, 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.

82232: Beta₂- Microglobulin – Policy Revised

This local medical review policy (LMRP) was implemented on March 24, 2003. Since that time the policy has been revised.

This policy was converted to local coverage determination (LCD) format. Revisions made with this conversion include correcting the definition for ICD-9-CM code 042 to reflect the definition found in the ICD-9-CM book. A notation was added at the end of the ICD-9-CM list that identifies V42.0 as a secondary diagnosis and that it should not be billed as a primary diagnosis. In addition, diagnosis code 996.81 was added to the ICD-9 codes That Support Medical Necessity section of the policy.

The revision is effective for claims processed on or after July 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.

88104: Cytopathology – Policy Addition

Cytopathology is the study of alterations within individual cells reflective of changes within their environment.

Examination of such alterations at the cellular, as well as molecular level allows the diagnosis of a wide range of disorders and is of inestimable value in the accurate diagnosis of cytologic specimens. In addition, proper specimen procurement is absolutely essential for reliable interpretation.

Cytopathology tests for body sites such as lung (sputum), bladder (urine), effusions, and cerebrospinal fluids have established the utility of the cytopathology laboratory in the interpretation of nongynecologic specimens. Advances in endoscopic procedures have allowed more extensive evaluations of the respiratory, gastrointestinal, and urinary tracts by cytologic methods. The advent of fine needle aspiration (FNA) techniques utilized for both superficial or palpable masses and deep lesions requiring radiologic guidance has brought the cytopathology laboratory into the forefront of diagnostic pathology. FNA is rapid, safe, and cost-effective, and, in experienced hands, has a diagnostic accuracy approaching that of surgical biopsy.

A local coverage determination (LCD) has been developed to define the indications and limitations of coverage and/or medical necessity for cytopathology services as described by CPT codes 88104, 88106, 88107 and 88108.

This LCD is effective for services rendered on or after September 30, 2005. The full-text of this LCD will be available on our provider education website at <http://www.connecticutmedicare.com> on or after this effective date.

Italicized and/or quoted material is excerpted from the American Medical Association Current Procedural Terminology. CPT codes, descriptions and other data only are copyrighted 2003 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.

88311: Decalcification Procedure and Special Stains – Policy Addition

Decalcification procedure and special stain codes are add-on codes that can be used in addition to codes other than those that describe surgical pathology examinations (e.g., 88300-88309). While the pathologist will generally perform some type of examination or interpretation on the cells or tissue, there may be additional tests, such as special stains, that the pathologist may need to perform, even though they have not been specifically requested by the treating physician/practitioner. The pathologist may perform such additional tests under the following circumstances:

- These services are medically necessary so that a complete and accurate diagnosis can be reported to the treating physician/practitioner;
- The results of the tests are communicated to and are used by the treating physician/practitioner in the treatment of the beneficiary; and
- The pathologist documents in his/her report why additional testing was done.

The Medicare Part B extraction summary system (BESS) statistical medical data for CPT 88311, 88312, and 88313 obtained for dates of service from January through June 2004 showed Connecticut had a carrier to nation ratio of 1.56*, 1.63*, and 6.52* respectively for this time period.

Based on the above data, this local coverage determination (LCD) is being developed to include indications and limitations of coverage that support medical necessity for the following CPT codes:

88311 *Decalcification procedure (List separately in addition to code for surgical pathology examination)*

88312 *Special stains (List separately in addition to code for primary service); Group I for microorganisms (eg, Gridley, acid fast, methanamine silver), each*

88313 *Group II, all other; (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stains, each*

88314 *histochemical staining with frozen section(s)*

This LCD was presented to the carriers advisory committee February 8, 2005. It will be effective for services rendered on or after September 30, 2005. The full-text of this LCD may be viewed on our provider education website at <http://www.connecticutmedicare.com> on or after this effective date.

Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2003 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.

93000: Electrocardiography – Policy Revision

This local medical review policy (LMRP) was last updated on March 8, 2004. Since that time this policy has been revised.

The policy was converted to local coverage determination (LCD) format. The ICD-9-CM list was updated to identify V45.01-V45.09, V45.81-V45.82, V58.69, E933.1, E936.0-E936.3 and E939.0-E939.9 as secondary diagnoses and that they should not be billed as primary diagnoses. A separate coding guideline attachment was created.

The revision is effective for claims processed on or after July 19, 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.

J2820: Sargramostim (GM-CSF, Leukine®) – Policy Revision

This local medical review policy (LMRP) was last updated on January 5, 2004. This policy was converted into LCD format. References were updated with addition of new and deletion of old references.

The following additional diagnosis codes were added:

995.2 Unspecified adverse effect of drug, medicinal and biological substance

V58.44 Aftercare following organ transplant

In addition, a notation was added at the end of the ICD-9-CM list that identifies diagnosis V58.69 (Long-term (current) use of other medications) and V42.9 (Unspecified organ or tissue replaced by transplant) as secondary diagnosis codes, and that they should not be billed as primary diagnoses. The effective date of this LCD revision is for services rendered on or after May 9, 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 Revised

This local coverage determination (LCD) was last updated on January 24, 2005.

A revision to this LCD was made to add diagnosis code 230.1 (Carcinoma in situ of esophagus) under the “ICD-9-CM Codes that Support Medical Necessity” section for Porfimer (J9600). This policy revision is effective for services rendered on or after June 20, 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.

Multiple Policies Being Revised – Policy Revision

The ‘Documentation Requirements’ section of the local medical review policies (LMRP’s) and local coverage determinations (LCD’s) listed below have been revised due to change request 3457 regarding psychotherapy notes, and updated CMS national coverage policy. This change request states contractors may not request psychotherapy notes from providers as they may contain protected health information.

However, it also states the provider is responsible for extracting the required information to support the services as reasonable and necessary. Psychotherapy notes **may** be submitted with the patients’ authorization.

Policy Number	Policy Name
90853	Group Psychotherapy
90810	Interactive Individual Psychotherapy
90804	Individual Psychotherapy
94LMRP005 V1.0—90845	Medical Psychoanalysis

This change is effective for services rendered on or after February 22, 2005.

For additional information see the CMS Medlearn Matters article:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3457.pdf>

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 Non Covered Services was last revised effective January 1, 2005. After policy reconsideration it has been determined that procedure code 87522 (Infectious agent detection by nucleic acid [DNA or RNA]; hepatitis C quantification) should be removed from the policy. This revision is effective for services rendered on or after May 10, 2005. In addition, based on CMS coverage for pet scans and change request 3726, procedure code 78608 (Brain imaging, positron emission tomography; metabolic evaluation) and 78609 (Brain imaging, positron emission tomography; perfusion evaluation) will also be removed from the policy, and procedure code G0235 will be added. This revision is effective for services rendered on or after January 28, 2005.

The Indications and Limitations of Coverage/Medical Necessity section has been revised accordingly. The full-text of this LCD is available on our provider education website at <http://www.connecticutmedicare.com> on or after this effective date.

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NESP: Darbepoetin Alfa (Aranesp®) – Policy Revised

This local coverage determination was last updated on June 8, 2004. Since that time this coverage determination has been revised.

The indications and limitations section was revised to include indications for the use of Aranesp® to treat Myelodysplastic Syndrome (MDS). In addition, dosage recommendations for the treatment of MDS with Aranesp® are given. The separate coding guideline attachment was updated to identify that ICD-9-CM code 238.7 should be billed when using Aranesp® to treat MDS.

The revision is effective for claims processed on or after June 14, 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.

RETIREMENT OF EXISTING LMRPs

33216: Implantation of Automatic Defibrillators – Policy Retired

This local coverage determination (LCD) has been retired effective for services rendered on or after January 27, 2005. The decision to retire this LCD was based on data analysis and Change Request 3604. CMS has revised the National Coverage Determination section 20.4 for Implantation of Automatic Defibrillators and has defined ICD-9-CM codes for the indications.

The national coverage determination is located in the National Coverage Determinations Manual, Pub 100-3, section 20.4, and may be viewed http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp.

Additional information is also available on the Medlearn Matters article MM3604 at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3604.pdf>.

The retirement of this policy is effective for services provided on or after January 27, 2005.

64561: Sacral Neuromodulation – Policy Retired

The local medical review policy (LMRP) for sacral neuromodulation – 64561 was previously updated on January 1, 2005. Based on data analysis, and a review of the policy, 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 June 28, 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.

G0030: PET Scans – Retired

The local medical review policy (LMRP) for positron emission tomography (PET) scans is being retired, effective for services rendered on or after January 28, 2005. This decision is based on current data analysis, local standards of medical practice and national coverage determinations.

Updated information can be found in the CMS online manual Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Part 4, Section 220.6. The full-text of this LCD is available on our provider education website at <http://www.connecticutmedicare.com> on or after this effective date.

Multiple Policies Being Retired – Policy Retired

The following LMRPs have been retired effective for services rendered on or after June 20, 2005. Based on instructions received from CMS, all local medical review policies (LMRPs) are to be converted into the local coverage determination (LCD) format. LCDs are to be based on the determination as to whether a service is reasonable and necessary. The following policies are being retired as it has been determined that these policies either do not conform to the LCD format **or** based on data analysis and local standard of medical practice.

Policy Number	Policy Name
G0248	Home Prothrombin Time International Normalized Ratio (INR) Monitoring
92020	Gonioscopy
88141	PAP Smears Laboratory Testing
93025	Microvolt T-wave Alternans
92552	Audiometric Testing
78460	Myocardial Perfusion Imaging
J1745	Infliximab (Remicade™)
63650	Spinal Cord Stimulation
64420	Intercostal Nerve Blocks/Neurolysis
64622	Paravertebral Facet Joint, Nerve Destruction by a Neurolytic Agent
64470	Paravertebral Facet Joint Blocks
76700	Abdominal Ultrasound
66761	Iridotomy by Laser Surgery
11600	Excisions of Malignant Skin Lesions
93990	Duplex Scan of Hemodialysis Access
71010	Radiologic Examination of the Chest
64555	Implanted Peripheral/Sacral Electrical Nerve Stimulation
44388	Diagnostic Colonoscopy
64550	Transcutaneous Electrical Nerve Stimulator (TENS)
73218	Magnetic Resonance Imaging of Upper Extremity
G0245	Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes
93965	Non-Invasive Evaluation of Extremity Veins

The full-text of this LCD will be available on our provider education website at <http://www.connecticutmedicare.com> on or after this effective date.

ADDITIONAL INFORMATION ON LMRPs/LCDs

Billing Guidelines for Corneal Pachymetry

Corneal pachymetry aids in the diagnosis and subsequent management of patients at risk for glaucoma. It has come to our attention that some providers may be billing this service incorrectly resulting in billing errors. The correct CPT for this service is 76514 (corneal pachymetry, unilateral or bilateral, determination of corneal thickness).

According to the Medicare Physician Fee Schedule Data Base (MPFSDB), CPT 76514 has a bilateral surgery indicator of 2. RVUs are based on the procedure being performed as a bilateral procedure. CPT 76514 is a unilateral or bilateral code and should only be billed once without modifiers –50, LT, or RT.

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.

- Use this PO Box when submitting claims
Medicare Part B CLAIMS
P.O. Box 44234
Jacksonville, FL 32231-4234
- Use this PO Box when submitting appeal/hearing requests. *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. This P.O. Box is only for appeals and hearings. If you believe the payment or determination is incorrect and want a claim to be reconsidered, then send it to the attention of the appeals department. Requests for review must be made within 120 days of the date of the Medicare Summary Notice. These requests should not include review requests on Medicare Secondary Pay calculations. Claims that are denied for return/reject need to be resubmitted and should not be sent as a review. These resubmitted claims should be sent in as new claims.
- If you believe that your review determination 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.
Medicare Part B APPEALS/Hearings
P.O. Box 45041
Jacksonville, FL 32232-5041
- If you believe that your hearing determination was incorrect and want it reviewed by a Administrative Law Judge (ALJ), send your request to the following address. A request for a hearing must be made within sixty days from the Hearing Officer decision and at least \$100 or more remains in controversy.
Administrative Law Judge Hearing
HHS' Office of Medicare Hearings and Appeals
BPTower & Garage
200 Public Square, Suite 1300
Cleveland, OH 44114-2316
- Use this PO Box when submitting the following scenarios:
Correspondence 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.

Financial Services (formerly Accounting) use this P.O. Box to return duplicate payments or overpayment refunds.

Fraud and Abuse – use this PO. Box 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.
Freedom of Information –use this P.O.

Box when requesting information available under the Freedom of Information Act.

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.

Provider Enrollment -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 participation requests, and UPIN requests.
Medical Review -Questions regarding Local Medical Review Policies 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.

Hearings -If you believe that your review determination 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.

Medicare Part B
CORRESPONDENCE
P.O. Box 45010
Jacksonville, FL 32232-5010

- Use this physical address when submitting inquiries to the Carrier Medical Director; this includes requests for Individual Considerations.
Neil Sanders M.D.
Carrier Medical Director
FCSO – Medicare Part B
321 Research Parkway
Meriden, CT 06450
- Use this P.O. Box when submitting information to the Electronic Data Interchange (EDI) department. EDI handles questions and provides information on electronic claims submission (EMC).
Attention: CT Medicare EDI – 14T
First Coast Service Options, Inc.
P.O. Box 44071
Jacksonville, FL 32231-4071

CONNECTICUT MEDICARE PHONE NUMBERS

Provider Services

First Coast Service Options, Inc.
Medicare Part B
1-(866)-419-9455 (toll-free)
1-(877)-236-7851 (TTY)

Beneficiary Services

First Coast Service Options, Inc.
Medicare Part B

1-(800)-MEDICARE
1-(877)-486-2048 (TTY)

Inquiries to:

Medicare Second Payer
Provider Enrollment
Telephone Redeterminations
1-866-535-6790

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)-MEDICARE

Durable Medical Equipment

HealthNow NY
DMERC Medicare Part B

1-(800)-MEDICARE

Railroad Retirees

Palmetto GBA
Medicare Part B
1-877-288-7600

Quality of Care

Qualidigm
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 (CHOICES)

1-(800)-994-9422

Area Agency on Aging

1-(800)-994-9422

Department of Social Services/ ConnMap

1-(800)-443-9946

ConnPace/

Assistance with Prescription Drugs

1-(800)-423-5026

Coordination of Benefits

1-(800)-999-1118

1-(800)-318-8782 TTY/TDD

WEB SITES

PROVIDER

Connecticut

www.connecticutmedicare.com

Centers for Medicare & Medicaid Services

www.cms.gov or www.cms.hhs.gov

BENEFICIARY

Centers for Medicare & Medicaid Services

www.medicare.gov

Connecticut

www.connecticutmedicare.com

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
1-904-791-8465

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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.

REVISIONS LMRPs/LCDs

11055: Routine Foot Care – Policy Revision

This local coverage determination (LCD) was last revised on January 1, 2005. For the allowed indication of peripheral neuropathies involving the feet associated with traumatic injury, the following diagnosis codes were added under “ICD-9 Codes that Support Medical Necessity” and under “The following diagnoses related to peripheral neuropathy and do not require a Q modifier”:

952.2	Spinal cord injury without evidence of spinal bone injury, lumbar
952.3	Spinal cord injury without evidence of spinal bone injury, sacral
952.4	Spinal cord injury without evidence of spinal bone injury, cauda equina
952.8	Spinal cord injury without evidence of spinal bone injury, multiple sites of spinal cord
953.2	Injury to lumbar nerve root
953.3	Injury to sacral nerve root
953.5	Injury to lumbosacral plexus
953.8	Injury to multiple sites of nerve roots and spinal plexus
956.0-956.9	Injury to peripheral nerve(s) of pelvic girdle and lower limb

This revision is effective for claims processed on or after May 12, 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.

11730: Surgical Treatment of Nails – Policy Revision

This local coverage determination (LCD) was last revised on February 1, 2005. The following additional diagnosis codes were added under the “ICD-9 Codes that Support Medical Necessity” section of the policy:

959.5	Injury, finger (fingernail, thumb nail)
959.7	Injury, knee, leg, ankle, and foot (toenail)

This LCD revision is effective for claims processed on or after June 20, 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.

19318: Reduction Mammoplasty – Policy Revision

This local medical review policy (LMRP) was last updated on April 6, 2004. Since that time this policy has been revised. The policy was converted to local coverage determination (LCD) format. The ICD-9-CM list was updated to identify V51 as a secondary diagnosis and that it should not be billed as a primary diagnosis. All national language found in the policy was italicized. A separate coding guideline attachment was created.

The revision is effective for claims processed on or after July 5, 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.

31525: Diagnostic Laryngoscopy – Policy Revision

This local medical review policy (LMRP) was last updated on October 1, 2004. Since that time this policy has been revised. The policy was converted to local coverage determination (LCD) format. The ICD-9-CM list was updated to identify V48.3 as a secondary diagnosis and that it should not be billed as a primary diagnosis. A separate coding guideline attachment was created.

The revision is effective for claims processed on or after July 5, 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.

33140: Transmyocardial Revascularization – Policy Revision

This local medical review policy (LMRP) was last updated on January 1, 2001. Since that time this policy has been revised. The policy was converted to local coverage determination (LCD) format. The indications and limitations section of the LCD was updated to reflect language found in the CMS Manual System, PUB 100-3, Medicare National Coverage Determination, Chapter 1, Section 20.6. A separate coding guideline attachment was created for the use of procedure codes 33140 and 33141.

The revision is effective for claims processed on or after July 5, 2005.

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64561: Sacral Neuromodulation – Policy Revision

The local medical review policy (LMRP) for sacral neuromodulation – 64561 was previously updated on January 1, 2005. Since that time, CPT codes 64585, 64590, 64595, 95970, 95971, 95972, 95973, and HCPCS codes A4290, E0745, E0752, E0754, E0756, and E1399 were removed from this policy. This revision is effective for services rendered on or after July 11, 2005. In addition, ICD-9-CM code 788.63 (urgency of urination) was added to this policy and a coding guideline has been developed. This revision is effective for claims processed on or after July 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.

70544: Magnetic Resonance Angiography – Policy Revision

The local medical review policy (LMRP) for magnetic resonance angiography (MRA) was last revised effective January 5, 2004. Since that time, it was determined the following ICD-9-CM code ranges should be added to the policy for MRA of the abdomen (procedure code 74185):

401.0–401.9 Essential hypertension
402.00–402.91 Hypertensive heart disease

The Indication and Limitations of Coverage and/or Medical Necessity, ICD-9-CM Codes that Support Medical Necessity and Source of Information sections have been revised accordingly. This policy has been updated to local coverage determination (LCD) format. Italicized lettering has been used to identify national coverage information. This revision is effective for services rendered on or after June 20, 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 Pelvis – Policy Revision

The local coverage determination (LCD) for computed tomography of the pelvis – 72192 was previously revised on January 1, 2005. At that time, ICD-9-CM code 592.0 was inadvertently left out of the ICD-9-CM additions. Therefore, ICD-9-CM 592.0 has been added to the policy. This change 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.

76070: Bone Mineral Density Studies – Policy Revision

This local medical review policy was last updated on January 1, 2005. Since that time the policy has been revised. Revisions were completed to convert the policy to local coverage determination (LCD) format and make changes based upon the Medicare Claims Processing Manual and the Medicare National Coverage Database.

All national guideline language throughout the LCD was italicized. Under the ICD-9-CM code list, E932.0 was identified as a secondary diagnosis and that it should not be billed as a primary diagnosis code.

The revision is effective for claims processed on or after June 7, 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.

82310: Total Calcium – Policy Revision

This local coverage determination (LCD) was last updated on October 1, 2004. This policy was converted into LCD format. References were updated with addition of new and deletion of old references. In addition, under the “ICD-9 Codes that Support Medical Necessity” section the following additional diagnosis codes were added:

293.83 Mood disorder in conditions classified elsewhere (depressive type)
300.00-300.09 Anxiety states
592.0 Calculus of kidney
729.82 Other musculoskeletal symptoms referable to limbs, cramps
780.09 Other alteration of consciousness (stupor)
788.43 Nocturia
789.00 Abdominal pain (unspecified site)

Added statement that “E” codes are secondary diagnosis codes and should not be billed as primary diagnosis codes.

The effective date of this LCD revision is for services rendered on or after August 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.

82330: Ionized Calcium – Policy Revision

This local coverage determination (LCD) was last updated on October 1, 2004. This policy was converted into LCD format. References were updated with addition of new and deletion of old references. In addition, under the “ICD-9 Codes that Support Medical Necessity” section the following additional diagnosis codes were added:

293.83	Mood disorder in conditions classified elsewhere (depressive type)
298.9	Unspecified psychosis
458.9	Hypotension, unspecified
780.6	Fever
782.4	Jaundice, unspecified, not of newborn
785.0	Tachycardia, unspecified
786.06	Tachypnea
789.06	Abdominal pain, epigastric

In addition, a statement was added stating the V codes are secondary diagnosis codes and should not be billed as a primary diagnosis.

The effective date of this LCD revision is for services rendered on or after August 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.

85651: Sedimentation Rate, Erythrocyte – Policy Revision

The local medical review policy (LMRP) for sedimentation rate, erythrocyte - 85651 was previously revised on January 12, 2004. Since that time, the indications and limitations of coverage and/or medical necessity, as well as, the ICD-9-CM codes have been updated to include “inflammatory disorders caused by infection or connective tissue diseases”. In addition, the “ICD-9 Codes that Support Medical Necessity” section has been updated to include diagnosis ranges 201.00-201.28 (Hodgkins’s disease) and 410.80-410.92 (Acute myocardial infarction). In addition, the LMRP has been converted to local coverage determination (LCD) format. This change is effective for services rendered on or after June 20, 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.

94760: Noninvasive Ear or Pulse Oximetry for Oxygen Saturation – Policy Revision

The local medical review policy (LMRP) for noninvasive ear or pulse oximetry for oxygen saturation – 94760 was previously revised on October 1, 2003. Since that time, it has been determined that CPT codes 94760 and 94761 have a T-status indicator on the Medicare Physician Fee Schedule, which means these codes are packaged into payment for other services payable under the physician fee schedule billed on the same date by the same provider. Therefore, a coding guideline has been developed to clarify the status indicators for these codes. In addition, the LMRP has been converted to local coverage determination (LCD) format. This change is effective for claims processed on or after May 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.

A4644: Low Osmolar Contrast Media (LOCM) – Policy Revision

The local coverage determination (LCD) for low osmolar contrast media (LOCM) was last revised on October 1, 2004. Change request (CR) 3748, Transmittal 502, dated March 11, 2005 deleted HCPCS A4644, A4645 and A4646. The following HCPCS were added to the LCD: Q9945, Q9946, Q9947, Q9948, Q9949, Q9950, and Q9951. Providers are to use these HCPCS when billing for low osmolar contrast media. Revision to the LCD also includes the changing of the LCD number from A4644 to Q9945.

This revision is effective for services rendered on or after April 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.

NESP: Darbepoetin Alfa (Aranesp®) – Policy Revision

This local coverage determination was last updated on June 8, 2004. Since that time this coverage determination has been revised.

The indications and limitations section was revised to include indications for the use of Aranesp® to treat Myelodysplastic Syndrome (MDS). In addition, dosage recommendations for the treatment of MDS with Aranesp® are given. The separate coding guideline attachment was updated to identify that ICD-9-CM code 238.7 should be billed when using Aranesp® to treat MDS.

The revision is effective for claims processed on or after June 14, 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.

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G0030: Positron Emission Tomography (PET) Scans – Policy Revision

The local medical review policy (LMRP) for positron emission tomography (PET) scans –G0030 was previously revised on January 1, 2004. Since that time, the policy has been revised per Change Requests 3726, 3741 and 3640. The policy has been revised to include myocardial indications only. All G-codes in the policy have been removed and replaced with the corresponding CPT codes of 78459, 78491 and 78492 for myocardial imaging. The policy has been converted to the local coverage determination (LCD) format. In addition the policy number and policy title have been changed to 78459 Myocardial Imaging, Positron Emission Tomography (PET) Scan. This information can be found in the CMS online manual Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Part 4, Section 220.6.

This change is effective for services rendered on or after January 28, 2005. The full-text of this LCD is available on the provider education website <http://www.floridamedicare.com>.

J2820: Sargramostim (GM-CSF, Leukine®) – Policy Revision

This local medical review policy (LMRP) was last updated on September 23, 2002. This policy was converted into LCD format. References were updated with addition of new and deletion of old references. The following additional diagnosis codes were added:

995.2 Unspecified adverse effect of drug, medicinal and biological substance
V58.44 Aftercare following organ transplant

In addition, a notation was added at the end of the ICD-9-CM list that identifies diagnoses V58.69 (Long-term (current) use of other medications) and V42.9 (Unspecified organ or tissue replaced by transplant) as secondary diagnosis codes, and that they should not be billed as primary diagnoses.

The effective date of this LCD revision is for services rendered on or after May 9, 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 January 1, 2005. This policy was converted into LCD format. References were updated with addition of new and deletion of old references. In addition, under the “Indications and Limitations of Coverage and/or Medical Necessity” section the definition of bone metastases sites was expanded to match the United States Pharmacopeia Drug Information (the USP DI) indications. The FDA approved indication for this now reads as follows:

- Documented bone metastases from solid tumors in conjunction with standard antineoplastic therapy, including bone metastases from multiple myeloma, breast carcinoma, prostate carcinoma, and other solid tumors.

The effective date of this revision is for services rendered on or after July 12, 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) was last updated on January 24, 2005. A revision to this LCD was made to add diagnosis code 230.1 (Carcinoma in situ of esophagus) under the “ICD-9 Codes that Support Medical Necessity” section for Porfimer (J9600).

This LCD revision is effective for services rendered on or after June 20, 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 was last revised effective January 1, 2005. After policy reconsideration it has been determined that procedure code 87522 (Infectious agent detection by nucleic acid [DNA or RNA]; hepatitis C quantification) should be removed from the policy. This revision is effective for services rendered on or after May 10, 2005. In addition, based on CMS coverage for pet scans and Change Request 3726, procedure codes 78608 (Brain imaging, positron emission tomography; metabolic evaluation) and 78609 (Brain imaging, positron emission tomography; perfusion evaluation) will also be removed from the policy, and procedure code G0235 will be added. This revision is effective for services rendered on or after January 28, 2005.

The Indications and Limitations of Coverage/Medical Necessity section has been revised accordingly. The revision effective date is based on date of service. The full-text of this LCD is available on our provider education website at <http://www.floridamedicare.com> on or after this effective date.

Multiple Policies Being Revised – Policy Revision

The 'Documentation Requirements' section of the local medical review policies (LMRP's) and local coverage determinations (LCD's) listed below have been revised due to change request 3457 regarding psychotherapy notes, and updated CMS national coverage policy. This change request states contractors may not request psychotherapy notes from providers as they may contain protected health information.

However, it also states the provider is responsible for extracting the required information to support the services as reasonable and necessary. Psychotherapy notes **may** be submitted with the patients' authorization.

Policy Number	Policy Name
90845	Psychoanalysis
90810	Interactive Individual Psychotherapy
90804	Individual Psychotherapy
90801	Psychiatric Diagnostic Interview Examination
90847	Family Psychotherapy
90857	Interactive Group Psychotherapy
PHPPROG	Psychiatric Partial Hospitalization Program

This change is effective for services rendered on or after February 22, 2005.

For additional information see the CMS Medlearn Matters article:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3457.pdf>

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

33216: Implantation of Automatic Defibrillators – Policy Retired

This local coverage determination (LCD) has been retired effective for services rendered on or after January 27, 2005. The decision to retire this LCD was based on data analysis and Change Request 3604. CMS has revised the National Coverage Determination section 20.4 for Implantation of Automatic Defibrillators and has defined ICD-9-CM codes for the indications.

The national coverage determination is located in the National Coverage Determinations Manual, Pub 100-3, section 20.4, and may be viewed http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp.

Additional information is also available on the Medlearn Matters article MM3604 at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3604.pdf>.

The retirement of this policy is effective for services provided on or after January 27, 2005.

64553: Electrical Nerve Stimulation – Policy Retired

The local medical review policy (LMRP) for electrical nerve stimulation - 64553 was previously revised on January 1, 2002. Based on data analysis, and a review of the policy, it has been determined that this policy is no longer necessary and therefore, was retired effective for services rendered on or after July 12, 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.

G0102: Prostate Cancer Screening – Policy Retired

Effective for services rendered on or after May 3, 2005, local medical review policy (LMRP) G0102 Prostate Cancer Screening will be retired. Coverage guidelines for this LMRP are provided by a national coverage determination (NCD). The NCD can be located in the National Coverage Determination Manual, Pub 100-3, Section 210.1 The NCD manual may be viewed at <http://www.cms.hhs.gov/manuals>.

The full-text of this LCD is available on our provider education website at <http://www.floridamedicare.com> on or after this effective date.

G0245: Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes – Policy Retired

Effective for services rendered on or after May 3, 2005, local medical review policy (LMRP) G0245 Peripheral Neuropathy with Loss of Protective Sensation (LOPS) in People with Diabetes will be retired. Coverage guidelines for this LMRP are provided by CMS national regulations. Guidelines for this policy can be located in the CMS manual system, pub 100-3, Medicare National Coverage Determination, section 70.2.1 on the CMS website at <http://www.cms.hhs.gov/manuals>.

The full-text of this LCD is available on our provider education website at <http://www.floridamedicare.com> on or after this effective date.

G0248: Home Prothrombin Time International Normalized Ratio Monitoring – Policy Retired

Effective for services rendered on or after May 3, 2005, local medical review policy (LMRP) G0248 Home Prothrombin Time International Normalized Ratio (INR) Monitoring will be retired. Coverage guidelines for this LMRP are provided by a national coverage determination (NCD). The NCD can be located in the National Coverage Determination Manual, Pub 100-3, Section 190.11. The NCD manual may be viewed at <http://www.cms.hhs.gov/manuals>.

Multiple Policies Being Retired

The following LMRPs were retired. The decision to retire these policies was based on data analysis and standards of local practice.

Policy Number	Policy Name	Retirement Date
76700	Abdominal Ultrasound	Services rendered on or after July 12, 2005
36515	Therapeutic Adsorption Columns	Services rendered on or after August 2, 2005

WIDESPREAD MEDICAL REVIEW PROBES

Widespread Probe — 99211 and 85610 Billed on Same Date of Service by Same Provider

Procedure code 99211 was identified as aberrant for Florida during FY 2003 based on the January through June 2003 data. This data revealed a Florida to nation ratio of allowed dollars per 1,000 enrollees of 1.92, and a carrier variance in allowed dollars of \$7,086,576.00.

Based on the conclusions of the findings, a recommendation was made by the comprehensive data analysis team through the Program Safeguards Communication Group to perform a widespread probe for CPT code 99211 billed with 85610 on the same date of service by the same provider, and possibly develop a local coverage determination (LCD) for 99211. The purpose of the review was to determine if the services billed to Medicare were medically necessary, appropriately coded, and documented as having been performed.

99211 Office or other outpatient visits for the evaluation and management 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

A widespread probe review was performed on a sample of one hundred twenty-three (123) claims, with one hundred ninety-six (196) services, encompassing ninety-eight (98) beneficiaries. Below is a breakdown of the review findings:

Code 99211

- 91% of the services were allowed as billed based on the submitted documentation
- 9% of the services were denied because they did not meet the requirements of an E&M service

Code 85610

- 100% of the services were allowed as billed based on the submitted documentation.

Based on the results of the widespread probe, a LCD is not being developed at this time for CPT code 99211.

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Widespread Probe — 92225 – Ophthalmoscopy

A widespread probe review was performed for procedure code 92225 Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma), with interpretation and report; initial and the results are as follows:

Procedure code 92225 was chosen for Focused Medical Review for FY2004 based on the January through June 2003 Florida Medicare Part B data. Based on the conclusions of the findings, a widespread probe for beneficiaries receiving greater than one service from greater than one provider (episode of care) was recommended by the Comprehensive Data Analysis Team through the Program Safeguards Communication Group (PSCG) to determine why so many beneficiaries were receiving services from multiple providers and to determine if these services were medically necessary. A review was performed on a sample of one hundred five (105) claims which encompassed one hundred twenty-three (123) services. These claims were requested from sixty-eight (68) providers for the time period June 1, 2004 through November 30, 2004 and included beneficiaries who received more than one service from more than one provider. The purpose of the review was to determine if the services billed to Medicare were medically reasonable and necessary, appropriately coded, and documented as having been performed.

The summary of the findings:

One hundred five (105) claims were reviewed for sixty-eight (68) providers. These claims encompassed one hundred twenty-three (123) services for CPT code 92225 (Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial) and included beneficiaries who received more

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than one service from more than one provider. A breakdown of the review findings is given below:

- One hundred twenty-one (121) services were allowed as billed as documentation submitted supported that these services were medically reasonable and necessary, appropriately coded, and documented as having been performed. In addition, it has been determined that the beneficiaries who received more than one service from more than one provider were a result of valid referrals from either optometrists or ophthalmologists to ophthalmology specialists (eg, glaucoma specialists, vitreoretinal specialists, neuro-ophthalmologists) regarding specific ocular pathologies, which necessitated repeating this procedure.
- Two (2) services were denied for the following reasons: 1) Documentation submitted did not support procedure billed (eye not dilated). 2) Documentation submitted did not support procedure billed, as an assessment of the ocular fundus/posterior segment of the eye (vitreous, retina, optic nerve, choroid, etc.) was not documented in office notes or retinal drawing.

The current LMRP 92225 Ophthalmoscopy will be updated and revised in the following sections: Indications and Limitations of Coverage and/or Medical Necessity, Coding Guidelines and Documentation Requirements. This LMRP will also be converted into the local coverage determination (LCD) format. An article will be published in the Medicare B Update upon completion of revisions.

ADDITIONAL INFORMATION ON LMRPs/LCDs

Billing Compounded Drugs

This article addresses and provides clarification for the billing and reimbursement of compounded drugs. There has been inconsistent billing and handling of these type claims causing an increase in appeals and hearings.

Compounded medications created by a pharmacist in accordance with the Federal Food, Drug, and Cosmetic Act may be covered under Medicare when their use meets all other criteria for services incident to a physician's service. Since the compounded medications do not have an NDC number or an average wholesale price (AWP) the specific HCPCS Level II "J" codes may not be used. Instead, providers should use J3490 (unclassified drug) as appropriate for reimbursement of the drug (s).

The use of compounded medications has been especially prevalent in the filling of implantable infusion pumps CPT code 96530. Whether a single agent or a combination of agents is used, the compounded medication must be billed under HCPCS code J3490 even though the compound was similar to a

specific HCPCS code (e.g., J2275 for preservative free morphine). Of course, providers who document and use the true "off-the-shelf" product from their office supply may continue to use the specific HCPCS code. The powdered form of these medications should also be mixed /compounded by the pharmacist for the physician

To ensure that providers are paid correctly for Compounded Drugs when billed, the following guidelines should be followed when submitting your claims:

EMC claims

Name and strength of drug administered via the implantable pump should be reported in the electronic equivalent field for Block 19- of the CMS 1500 claim form or the comment screen.

- The name and phone number of the pharmacy, if applicable.
- The number (1) should always be entered in the Quantity Billed (QB) field.

- The supplier invoice must be available upon request and the total number of “cc” instilled in the pump and what drugs were provided.

If any of the above information is omitted from an electronic claim, the claim will be developed for the requesting the supplier’s invoice and the total number of “cc” instilled in the pump and what drugs were provided.

Paper claims

The term “Compounded prescription, invoice attached” must be indicated in Block 19 of the CMS-1500 claim form and a copy of the invoice from the pharmacy or supplier.

The invoice should include the following information:

- The name, NDC#, quantity, and strength of each drug in the mixture
- The suppliers invoice
- Documentation of the total number of “cc” instilled in the pump and what drugs were provided

The claim will develop for the invoice if one is not received with the claim.

In either case, the invoice cost may include a reasonable compounding fee and state tax if applicable. **Medicare will reimburse the lower of the invoice cost or 95 per cent of AWP of all components in the mixture.**

- Claims for infusion drugs furnished through implanted DME, with dates of service on or after January 1, 2004, shall be identified using the “KD” modifier.

Billing Guidelines for Corneal Pachymetry

Corneal pachymetry aids in the diagnosis and subsequent management of patients at risk for glaucoma. It has come to our attention that some providers may be billing this service incorrectly resulting in billing errors. The correct CPT for this service is 76514 (corneal pachymetry, unilateral or bilateral, determination of corneal thickness).

According to the Medicare Physician Fee Schedule Data Base (MPFSDB), CPT 76514 has a bilateral surgery indicator of 2. RVUs are based on the procedure being performed as a bilateral procedure. CPT 76514 is a unilateral or bilateral code and should only be billed once without modifiers –50, LT, or RT.

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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

Review Requests

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

Fair Hearing Requests

HHS' Office of Medicare Hearings and Appeals
100 SE 2nd Street, Suite 1700
Miami, FL 33131-2100

Administrative Law Judge Hearing

Administrative Law Judge Hearing
P. O. Box 45001
Jacksonville, FL 32232-5001

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

WEB SITES

PROVIDER

Florida

<http://www.floridamedicare.com>

Centers for Medicare & Medicaid Services

<http://www.cms.hhs.gov>

Centers for Medicare & Medicaid Services

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EDUCATIONAL RESOURCES

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CMS Quarterly Provider Update

The July 2005 *Quarterly Provider Update* is now available on the Centers for Medicare & Medicaid Services (CMS) website.

The *Quarterly Provider Update* is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all nonregulatory changes to Medicare including program memoranda, manual changes and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the *Quarterly Provider Update* is to:

- Inform providers about new developments in the Medicare program.
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions.
- Ensure that providers have time to react and prepare for new requirements.

- Announce new or changing Medicare requirements on a predictable schedule.
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