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

Highlights In This Issue…

Features

To receive quick, automatic notification when new publications and other items of interest are posted to our provider education 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 "Join our Electronic Mailing List FCSO eNews" link and follow the prompts. The *FCSO eNews* is sent at least every other week, more frequently as required.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

- ❑ Physician/Provider
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_____

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The *Medicare B Update!* is published monthly by First Coast Service Options, Inc. (FCSO) Provider Outreach and Education Division, to provide timely and useful information to Medicare Part B providers in Connecticut and Florida.

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

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

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

The *Medicare B Update!* is a comprehensive magazine published monthly by First Coast Service Options, Inc. (FCSO) for Part B providers in Connecticut and Florida.

The Provider Outreach & Education Publications team will begin distributing the *Medicare B Update!* on a monthly basis. We are making this change to better serve our customers by making valuable information available in a more timely manner. The previous quarterly publications have become too large in scope and size making it difficult to navigate through the large volume of information.

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

Who Receives the *Update?*

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

Distribution of the *Update!* in hardcopy or CD-ROM format is limited to individual providers and professional association (PA) groups who have billed at least one Part B claim to either Connecticut or Florida Medicare for processing during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us*. Registration forms must be submitted annually or when you experience a change in circumstances that impacts your eletronic access.

For additional copies, providers may purchase a separate annual subscription in hardcopy or CD-ROM format (see order form on page 66). 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 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 coverage determination (LCD) summaries are maintained in separate sections.

Publication Format

The *Update!* is arranged into distinct sections.

NOTE: Since the Update! is being published more frequently, the Carrier Medical Director and Medical Review sections will appear on an "as needed" basis.

Following the table of contents, a letter from the Carrier Medical Director (as needed), 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.

Advance Beneficiary Notices (ABNs)

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

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

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

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

New Patient Liability Notice

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

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

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

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

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

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

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

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

OR

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

AMBULANCE

Ambulance Inflation Factor for Calendar Year 2007

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

Provider Types Affected

Providers and suppliers of ambulance services billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

Provider Action Needed

This article is for your information only. It provides the ambulance inflation factor (AIF) for calendar year (CY) 2007. The AIF for CY 2007 is 4.3 percent.

Background

Section 1834(l)(3)(B) of the Social Security Act (SSA) provides the basis for updating the payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services. The national fee schedule for ambulance services has been phased in over a five-year transition period beginning April 1, 2002. The AIF updates payments annually and is equal to the percentage increase in consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year.

The AIF for calendar year (CY) 2007 will be 4.3 percent. The following table displays the AIF for CY 2007 and for the previous 4 years.

Ambulance Inflation Factor by CY

2007	4.3 percent
2006	2.5 percent
2005	3.3 percent
2004	2.1 percent
2003	1.1 percent

Additionally, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established that the ground ambulance base rate (for services furnished during the period July 1, 2004 through December 31, 2009) will have a baseline "floor" amount.

Payment will not be less than this "floor," which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule to calculate a regional conversion factor and a regional mileage payment.

Some key issues related to the AIF include:

National or Regional Fee Schedules

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division's fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate.

Payments Based on Blended Methodology

During the five-year transition period, your payments are based on a blended methodology. For CY 2007, this blend will be 20 percent regional ground base rate and 80 percent national ground base rate

Before January 1, 2007, for each ambulance provider or supplier, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional) and to the reasonable cost/charge portion. Then, these two amounts were added together to determine each provider or supplier's total payment amount. As of January 1, 2007, the total payment amount for air ambulance providers and suppliers continues to be based on 100 percent of the national ambulance fee schedule, while the total payment amount for ground ambulance providers and suppliers will be based on either 100 percent of the national ambulance fee schedule or 80 percent of the national ambulance fee schedule and 20 percent of the regional ambulance fee schedule.

Part B Coinsurance and Deductible Requirements

Part B coinsurance and deductible requirements apply.

Additional Information

You can find more information about the ambulance inflation factor by going to CR 5358, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1102CP.pdf* on the CMS website. There you will find updated *Medicare Claims Processing Manual* (100-04), Chapter 15 (Ambulance), Section 20.6.1 (Ambulance Inflation Factor [AIF]) as an attachment to that CR.

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

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).

MLN Matters Number: MM5358
Related Change Request (CR) #:5358
Related CR Release Date: November 3, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1102CP
Implementation Date: January 2, 2007

COMPETITIVE ACQUISITION PROGRAM

Competitive Acquisition Program for Part B Drugs—Appeals

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

Provider Types Affected

Physicians billing Medicare carriers for Part B drugs and biologicals under the Medicare Competitive Acquisition Program (CAP) program.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5207, which instructs local Medicare carriers and the CAP designated carrier how to execute the appeals process within the unique requirements of CAP. Please note that the CAP claims processing arrangement is **not the same** as the standard Part B claims processing routine.

CAUTION – What You Need to Know

CR 5207 provides additional information and instructions for the implementation of the CAP pertaining to the CAP appeals and dispute resolution process. This is not a stand-alone CR. It builds on previously published related CAP CRs, which include: CRs 4064, 4306, 4309, and 4404. The links to those CRs and the related *Medicare Learning Network* (*MLN*) articles are provided in the *Additional Information* section below.

GO – What You Need to Do

See the *Background* section of this article and the information in CR 5207 for further details regarding these special CAP appeals requirements and delivery of dispute resolution services.

Background

Section 303 (d) of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals ("drugs") not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians will be given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. A participating CAP physician will submit a claim for drug administration to the Medicare local carrier. An approved CAP vendor will submit a claim for the drug product to the CAP Medicare designated carrier.

Appeal Process for CAP Drug Claims

As mentioned above, the CAP claims processing arrangement departs from the standard Part B claims processing routine Specifically, the CAP uses a local carrier's determination about the physician's drug administration claim that is associated with a CAP drug's claim as an indicator of whether a CAP vendor's matching drug claim should be paid. Therefore, if a local carrier denies the physician's drug administration claim that is to be matched to a CAP vendor's drug claim and causes the vendor's CAP drug claim to deny, the appeals process for the vendor's drug claim's denial must begin with the local carrier that denied the claim. In this situation, in order to pursue an appeal of a denied CAP drug claim, the approved CAP vendor becomes a party to the appeal of a denied drug administration claim filed by a participating CAP physician with the local carrier.

If a CAP vendor's drug claim has been denied because there is no matching participating CAP physician claim on file with the local carrier, the Medicare designated carrier will deny the claim and will suppress appeal rights if there is still no matching drug administration claim after 90 days. The remittance notice will instruct the approved CAP vendor that it may request a reopening. In this case, if the approved CAP vendor accepts the designated Medicare carrier's offer and requests a reopening, the designated carrier will call the participating CAP physician to encourage the physician to file the drug administration claim. If the participating CAP physician does not file the claim, the designated Medicare carrier will engage in dispute resolution activities which may result in a recommendation to terminate the participating CAP physician's involvement in CAP.

The Medicare designated carrier will use group code CO for claims that are denied because the participating CAP physician has not filed his/her claim, will return the following messages:

- Medicare Summary Notice (MSN) – 16.34 – "You should not be billed for this service. You do not have to pay this amount."
- Remark code N211 – "You may not appeal this decision."
- These messages are provided in addition to MSN message 21.21 and remittance advice (RA) reason code 107 for these claim denials. (See CR 4064, Business Requirement (BR) 4064.9.2.1, link provided below.)

Additional Information

CR 5207 adds sections 100.9-100.94 to Publication 100-04, the Medicare Claims Processing Manual, Chapter 17, "Drugs and Biologicals for CAP." CR 5207 is the official instruction issued to your Medicare carrier regarding changes mentioned in this article. CR 5207 may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1076CP.pdf* on the CMS website.

Competitive Acquisition Program for Part B Drugs—Appeals, continued

CR 4064, dated December 9, 2005, "Competitive Acquisition Program (CAP) for Part B Drugs" is located at *http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf* on the CMS website. The related MLN article, MM4064 "Competitive Acquisition Program (CAP) for Part B Drugs" can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf* on the CMS website.

CR 4306, dated February 6, 2006, "MCS Screen Expansion for the Prescription Order Number for the Competitive Acquisition Program (CAP) for Part B Drugs to be Developed Over the July 2006 and October 2006 Release, With Final Implementation on October 2, 2006" is available at the following link *http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf* on the CMS website.

CR 4309, dated February 17, 2006, "Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs" can be found at the following link *http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf* on the CMS website.

The related MLN article, MM4309 "Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs" can be reached at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf* on the CMS website.

CR 4404, dated April 28, 2006 "Competitive Acquisition Program (CAP) for Part B Drugs Physician Election" is located at *http://www.cms.hhs.gov/transmittals/downloads/R932CP.pdf* on the CMS website. MM4404, "Competitive Acquisition Program (CAP) for Part B Drugs Physician

Election" the related MLN article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4404.pdf* on the CMS website.

If you have questions, please contact your Medicare carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/CallCenterTollNumDirectory.zip* 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).

MLN Matters Number: MM5207	Related Change Request (CR) #: 5207
Related CR Release Date: October 13, 2006	Effective Date: July 1, 2006
Related CR Transmittal #: R1076CP	Implementation Date: November 13, 2006

Competitive Acquisition Program Billing: Do Not Bill a Prescription Order Number More Than Once

URGENT REMINDER

The Centers for Medicare and Medicaid Services (CMS) is providing a clarification on billing for drugs under the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals. In order for the CAP vendor's drug claim to be processed and paid, physicians must submit a corresponding drug administration claim, and a no-pay claim line for the drug.

The vendor's drug claim and the physician's claim are then matched in the claims processing system by the prescription order number and the vendor is paid for the drug that was administered.

A physician's no-pay claim line consists of the CAP drug's HCPCS code, a billed amount (which must not equal zero), and the number of HCPCS billing units that were administered. The CAP prescription order number is a unique number generated by the approved CAP vendor that is used to match CAP claims in the payment system and is also associated with a line on an electronic claim. Therefore, the prescription order number should not be reused on additional lines of a claim or on other claims.

It has come to our attention that in some cases drugs ordered under one, unique prescription order number are being billed on multiple claim lines and the prescription order number is being reused with the modifier 76 appended. This is causing CAP claims to not process correctly.

A CAP prescription order number must only be used on ONE claim line; it must not be reused on another claim line on the same claim or any other claim. If a CAP vendor has shipped a drug using one prescription order number but the drug is administered in several doses, the total amount administered should be identified in the number of billing units, for example:

The approved CAP vendor has shipped 20 heparin units of J1642 heparin sodium (heparin lock flush) under the prescription order number QXXXJ1642YYYYY. The patient's IV lines required two 10 Unit heparin flushes during the course of the office visit. Since the HCPCS code defines J1642 as 10 Units of heparin and a total of 20 units of heparin were administered, this situation would be billed as two billing units of J1642 on a line containing a J1 no-pay CAP modifier and associated with prescription order number QXXXJ1642YYYYY.

For additional information about CAP billing refer to the billing tip sheet on CMS website at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/cap_billtips.pdf*

Source: CMS Learning Resource, Message 200611-11

DIAGNOSTIC IMAGING PROCEDURES

Multiple Procedure Reduction on the Technical Component of Certain Diagnostic Imaging Procedures and Cap on the TC of Imaging Procedures

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

Provider Types Affected

Physicians and suppliers billing Medicare carriers for imaging supplies and services

Provider Action Needed

STOP – Impact to You

This special edition article provides details regarding the Centers for Medicare & Medicaid Services (CMS) revised policies for the payment of the technical component (TC) of imaging procedures.

CAUTION – What You Need to Know

CMS has 1) modified the multiple procedure payment reduction to the TC of certain diagnostic imaging procedures and 2) implemented a procedure specific payment cap on the TC payment of imaging procedures effective January 1, 2007, as required by the Deficit Reduction Act of 2005.

GO – What You Need to Do

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

Background

CMS is implementing two provisions in 2007 affecting imaging services. First, CMS is modifying the multiple procedure payment reduction on certain diagnostic imaging procedures implemented in 2006. Second, they are implementing a new provision of the Deficit Reduction Act of 2005 (DRA) which imposes a payment cap on most imaging procedures. (More information on the DRA is available at *http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf* on the CMS website. More information on the fee schedule final rules is available at *http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage* on the CMS website).

The first CMS provision for 2007 addresses payment for certain multiple diagnostic imaging procedures, with:

- A full payment for the first procedure, but
- A 25 percent reduction in the technical component (TC) payment for additional imaging procedures (furnished on contiguous body parts during the same session). This is a smaller reduction than the 50 percent that had previously been proposed for 2007. Table 1 below in the Additional Information Section contains a list of procedures subject to the multiple procedure payment reduction.

The second CMS provision limits the TC payment for most imaging procedures paid under the Medicare Physician Fee Schedule (MPFS) to the amount paid under the outpatient prospective payment system (OPPS). Table 2 below in the Additional Information Section contains a list of procedures subject to the OPPS payment cap.

Both provisions apply to TC-only services and the TC of global services. The professional component (PC) is paid in full for all procedures.

For imaging services subject to both the multiple imaging reduction policy and the outpatient hospital cap, CMS is applying:

- First, the multiple imaging adjustment, and
- Second, the outpatient cap.

Additional Information

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

Multiple Procedure Reduction on the TC of Certain Diagnostic Imaging Procedures and Cap on the TC of Imaging Procedures, continued

Table 1
Diagnostic Imaging Services Subject to the Multiple Procedure Payment Reduction

Diagnostic Imaging Services

Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical

76604 Us exam, chest, b-scan
76700 Us exam, abdom, complete
76705 Echo exam of abdomen
76770 Us exam abdo back wall, comp
76775 Us exam abdo back wall, lim
76778 Us exam kidney transplant
76831 Echo exam, uterus
76856 Us exam, pelvic, complete
76857 Us exam, pelvic, limited

Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)

71250 Ct thorax w/o dye
71260 Ct thorax w/ dye
71270 Ct thorax w/o & w/ dye
71275 Ct angiography, chest
72191 Ct angiography, pelv w/o & w/ dye
72192 Ct pelvis w/o dye
72193 Ct pelvis w/ dye
72194 Ct pelvis w/o & w/ dye
74150 Ct abdomen w/o dye
74160 Ct abdomen w/ dye
74170 Ct abdomen w/o & w/ dye
74175 Ct angiography, abdom w/o & w/ dye
75635 Ct angio abdominal arteries
0067T Ct colonography; dx

Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)

70450 Ct head/brain w/o dye
70460 Ct head/brain w/ dye
70470 Ct head/brain w/o & w/ dye
70480 Ct orbit/ear/fossa w/o dye
70481 Ct orbit/ear/fossa w/ dye
70482 Ct orbit/ear/fossa w/o & w/ dye
70486 Ct maxillofacial w/o dye
70487 Ct maxillofacial w/ dye
70488 Ct maxillofacial w/o & w/ dye
70490 Ct soft tissue neck w/o dye
70491 Ct soft tissue neck w/ dye
70492 Ct soft tissue neck w/o & w/ dye
70496 Ct angiography, head
70498 Ct angiography, neck

Family 4 MRI and MRA (Chest/Abd/Pelvis)

71550 Mri chest w/o dye
71551 Mri chest w/ dye
71552 Mri chest w/o & w/ dye
71555 Mri angio chest w/ or w/o dye
72195 Mri pelvis w/o dye
72196 Mri pelvis w/ dye
72197 Mri pelvis w/o &w/ dye
72198 Mri angio pelvis w/ or w/o dye
74181 Mri abdomen w/o dye
74182 Mri abdomen w/ dye
74183 Mri abdomen w/o and w/ dye
74185 Mri angio, abdom w/ or w/o dye

Family 5 MRI and MRA (Head/Brain/Neck)

70540 Mri orbit/face/neck w/o dye
70542 Mri orbit/face/neck w/ dye
70543 Mri orbit/face/neck w/o & w/dye
70544 Mr angiography head w/o dye
70545 Mr angiography head w/dye
70546 Mr angiography head w/o & w/dye
70547 Mr angiography neck w/o dye
70548 Mr angiography neck w/dye
70549 Mr angiography neck w/o & w/dye
70551 Mri brain w/o dye
70552 Mri brain w/dye
70553 Mri brain w/o & w/dye

Family 6 MRI and MRA (spine)

72141 Mri neck spine w/o dye
72142 Mri neck spine w/dye
72146 Mri chest spine w/o dye
72147 Mri chest spine w/dye
72148 Mri lumbar spine w/o dye
72149 Mri lumbar spine w/dye
72156 Mri neck spine w/o & w/dye
72157 Mri chest spine w/o & w/dye
72158 Mri lumbar spine w/o & w/dye

Family 7 CT (spine)

72125 CT neck spine w/o dye
72126 Ct neck spine w/dye
72127 Ct neck spine w/o & w/dye
72128 Ct chest spine w/o dye
72129 Ct chest spine w/dye
72130 Ct chest spine w/o & w/dye
72131 Ct lumbar spine w/o dye
72132 Ct lumbar spine w/dye
72133 Ct lumbar spine w/o & w/dye

Family 8 MRI and MRA (lower extremities)

73718 Mri lower extremity w/o dye
73719 Mri lower extremity w/dye
73720 Mri lower ext w/ & w/o dye
73721 Mri joint of lwr extre w/o dye
73722 Mri joint of lwr extr w/dye
73723 Mri joint of lwr extr w/o & w/dye
73725 – MRA Mr angio lower ext w or w/o dye

Family 9 CT and CTA (lower extremities)

73700 Ct lower extremity w/o dye
73701 Ct lower extremity w/dye
73702 Ct lower extremity w/o & w/dye
73706 Ct angio lower ext w/o & w/dye

Family 10 Mr and MRI (upper extremities and joints)

73218 Mri upper extr w/o dye
73219 Mri upper extr w/dye
73220 Mri upper extremity w/o & w/dye
73221 Mri joint upper extr w/o dye
73222 Mri joint upper extr w/dye
73223 Mri joint upper extr w/o & w/dye

Family 11 CT and CTA (upper extremities)

73200 Ct upper extremity w/o dye
73201 Ct upper extremity w/dye
73202 Ct upper extremity w/o & w/dye
73206 Ct angio upper extr w/o & w/dye

Multiple Procedure Reduction on the TC of Certain Diagnostic Imaging Procedures and Cap on the TC of Imaging Procedures, continued

Table 2
Addendum F CPT/HCPCS Imaging Codes Defined by DRA 5102(b)

Code	Short Descriptor
31620	Endobronchial us add-on
37250	Iv us first vessel add-on
37251	Iv us each add vessel add-on
51798	Us urine capacity measure
70010	Contrast x-ray of brain
70015	Contrast x-ray of brain
70030	X-ray eye for foreign body
70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70170	X-ray exam of tear duct
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70332	X-ray exam of jaw joint
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70373	Contrast x-ray of larynx
70380	X-ray exam of salivary gland
70390	X-ray exam of salivary duct
70450	Ct head/brain w/o dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/dye
70488	Ct maxillofacial w/o & w/dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70557	Mri brain w/o dye
70558	Mri brain w/dye
70559	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71040	Contrast x-ray of bronchi
71060	Contrast x-ray of bronchi
71090	X-ray & pacemaker insertion
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye

Multiple Procedure Reduction on the TC of Certain Diagnostic Imaging Procedures and Cap on the TC of Imaging Procedures, continued

Code	Short Descriptor
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr angio spine w/o&w/dye
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
72240	Contrast x-ray of neck spine
72255	Contrast x-ray, thorax spine
72265	Contrast x-ray, lower spine
72270	Contrast x-ray, spine
72275	Epidurography
72285	X-ray c/t spine disk
72291	Percut vertebroplasty fluor
72293	Percut vertebroplasty, ct
72295	X-ray of lower spine disk
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73040	Contrast x-ray of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73085	Contrast x-ray of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73115	Contrast x-ray of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye

Code	Short Descriptor
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73225	Mr angio upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73525	Contrast x-ray of hip
73530	X-ray exam of hip
73540	X-ray exam of pelvis & hips
73542	X-ray exam, sacroiliac joint
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73580	Contrast x-ray of knee joint
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73615	Contrast x-ray of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74190	X-ray exam of peritoneum
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74235	Remove esophagus obstruction
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract

Multiple Procedure Reduction on the TC of Certain Diagnostic Imaging Procedures and Cap on the TC of Imaging Procedures, continued

Code	Short Descriptor
74250	X-ray exam of small bowel
74251	X-ray exam of small bowel
74260	X-ray exam of small bowel
74270	Contrast x-ray exam of colon
74280	Contrast x-ray exam of colon
74283	Contrast x-ray exam of colon
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74300	X-ray bile ducts/pancreas
74301	X-rays at surgery add-on
74305	X-ray bile ducts/pancreas
74320	Contrast x-ray of bile ducts
74327	X-ray bile stone removal
74328	X-ray bile duct endoscopy
74329	X-ray for pancreas endoscopy
74330	X-ray bile/panc endoscopy
74340	X-ray guide for GI tube
74350	X-ray guide, stomach tube
74355	X-ray guide, intestinal tube
74360	X-ray guide, GI dilation
74363	X-ray, bile duct dilation
74400	Contrst x-ray, urinary tract
74410	Contrst x-ray, urinary tract
74415	Contrst x-ray, urinary tract
74420	Contrst x-ray, urinary tract
74425	Contrst x-ray, urinary tract
74430	Contrast x-ray, bladder
74440	X-ray, male genital tract
74445	X-ray exam of penis
74450	X-ray, urethra/bladder
74455	X-ray, urethra/bladder
74470	X-ray exam of kidney lesion
74475	X-ray control, cath insert
74480	X-ray control, cath insert
74485	X-ray guide, GU dilation
74710	X-ray measurement of pelvis
74740	X-ray, female genital tract
74742	X-ray, fallopian tube
74775	X-ray exam of perineum
75552	Heart mri for morph w/o dye
75553	Heart mri for morph w/dye
75554	Cardiac MRI/function
75555	Cardiac MRI/limited study
75556	Cardiac MRI/flow mapping
75600	Contrast x-ray exam of aorta
75605	Contrast x-ray exam of aorta
75625	Contrast x-ray exam of aorta
75630	X-ray aorta, leg arteries
75635	Ct angio abdominal arteries
75650	Artery x-rays, head & neck
75658	Artery x-rays, arm
75660	Artery x-rays, head & neck
75662	Artery x-rays, head & neck
75665	Artery x-rays, head & neck
75671	Artery x-rays, head & neck
75676	Artery x-rays, neck
75680	Artery x-rays, neck
75685	Artery x-rays, spine
75705	Artery x-rays, spine
75710	Artery x-rays, arm/leg

Code	Short Descriptor
75716	Artery x-rays, arms/legs
75722	Artery x-rays, kidney
75724	Artery x-rays, kidneys
75726	Artery x-rays, abdomen
75731	Artery x-rays, adrenal gland
75733	Artery x-rays, adrenals
75736	Artery x-rays, pelvis
75741	Artery x-rays, lung
75743	Artery x-rays, lungs
75746	Artery x-rays, lung
75756	Artery x-rays, chest
75774	Artery x-ray, each vessel
75790	Visualize A-V shunt
75801	Lymph vessel x-ray, arm/leg
75803	Lymph vessel x-ray,arms/legs
75805	Lymph vessel x-ray, trunk
75807	Lymph vessel x-ray, trunk
75809	Nonvascular shunt, x-ray
75810	Vein x-ray, spleen/liver
75820	Vein x-ray, arm/leg
75822	Vein x-ray, arms/legs
75825	Vein x-ray, trunk
75827	Vein x-ray, chest
75831	Vein x-ray, kidney
75833	Vein x-ray, kidneys
75840	Vein x-ray, adrenal gland
75842	Vein x-ray, adrenal glands
75860	Vein x-ray, neck
75870	Vein x-ray, skull
75872	Vein x-ray, skull
75880	Vein x-ray, eye socket
75885	Vein x-ray, liver
75887	Vein x-ray, liver
75889	Vein x-ray, liver
75891	Vein x-ray, liver
75893	Venous sampling by catheter
75894	X-rays, transcath therapy
75896	X-rays, transcath therapy
75898	Follow-up angiography
75900	Intravascular cath exchange
75901	Remove cva device obstruct
75902	Remove cva lumen obstruct
75940	X-ray placement, vein filter
75945	Intravascular us
75946	Intravascular us add-on
75953	Abdom aneurysm endovas rpr
75956	Xray, endovasc thor ao repr
75957	Xray, endovasc thor ao repr
75958	Xray, place prox ext thor ao
75959	Xray, place dist ext thor ao
75960	Transcath iv stent rs&i
75961	Retrieval, broken catheter
75962	Repair arterial blockage
75964	Repair artery blockage, each
75966	Repair arterial blockage
75968	Repair artery blockage, each
75970	Vascular biopsy
75978	Repair venous blockage
75980	Contrast xray exam bile duct
75982	Contrast xray exam bile duct

Multiple Procedure Reduction on the TC of Certain Diagnostic Imaging Procedures and Cap on the TC of Imaging Procedures, continued

Code	Short Descriptor
75984	Xray control catheter change
75989	Abscess drainage under x-ray
75992	Atherectomy, x-ray exam
76000	Fluoroscope examination
76001	Fluoroscope exam, extensive
76010	X-ray, nose to rectum
76080	X-ray exam of fistula
76098	X-ray exam, breast specimen
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76140	X-ray consultation
76150	X-ray exam, dry process
76350	Special x-ray contrast study
76376	3d render w/o postprocess
76377	3d rendering w/postprocess
76380	CAT scan follow-up study
76390	Mr spectroscopy
76496	Fluoroscopic procedure
76497	Ct procedure
76498	Mri procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76529	Echo exam of eye
76536	Us exam of head and neck
76604	Us exam, chest, b-scan
76645	Us exam, breast(s)
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76778	Us exam kidney transplant
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76817	Transvaginal us, obstetric
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76830	Transvaginal us, non-ob
76831	Echo exam, uterus

Code	Short Descriptor
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76872	Us, transrectal
76873	Echograp trans r, pros study
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76930	Echo guide, cardiocentesis
76932	Echo guide for heart biopsy
76936	Echo guide for artery repair
76937	Us guide, vascular access
76940	Us guide, tissue ablation
76941	Echo guide for transfusion
76942	Echo guide for biopsy
76945	Echo guide, villus sampling
76946	Echo guide for amniocentesis
76948	Echo guide, ova aspiration
76950	Echo guidance radiotherapy
76965	Echo guidance radiotherapy
76970	Ultrasound exam follow-up
76975	GI endoscopic ultrasound
76977	Us bone density measure
76998	Ultrasound guide intraoper
77001	Fluoroguide for vein device
77002	Needle localization by x-ray
77003	Fluoroguide for spine inject
77011	Ct scan for localization
77012	Ct scan for needle biopsy
77013	Ct guide for tissue ablation
77014	Ct scan for therapy guide
77021	Mr guidance for needle place
77022	Mri for tissue ablation
77031	Stereotactic breast biopsy
77032	X-ray of needle wire, breast
77053	X-ray of mammary duct
77054	X-ray of mammary ducts
77058	Magnetic image, breast
77059	Magnetic image, both breasts
77071	X-ray stress view
77072	X-rays for bone age
77073	X-rays, bone evaluation
77074	X-rays, bone survey
77075	X-rays, bone survey
77076	X-rays, bone evaluation
77077	Joint survey, single view
77078	Ct bone density, axial
77079	Ct bone density, peripheral
77080	Dxa bone density, axial
77081	Dxa bone density/peripheral
77082	Dxa bone density/v-fracture
77083	Radiographic absorptiometry
77084	Magnetic image, bone marrow
77417	Radiology port film(s)
77421	Stereoscopic x-ray guidance
78006	Thyroid imaging with uptake
78007	Thyroid image, mult uptakes
78010	Thyroid imaging
78011	Thyroid imaging with flow
78015	Thyroid met imaging

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Code	Short Descriptor
78016	Thyroid met imaging/studies
78018	Thyroid met imaging, body
78020	Thyroid met uptake
78070	Parathyroid nuclear imaging
78075	Adrenal nuclear imaging
78102	Bone marrow imaging, ltd
78103	Bone marrow imaging, mult
78104	Bone marrow imaging, body
78135	Red cell survival kinetics
78140	Red cell sequestration
78185	Spleen imaging
78190	Platelet survival, kinetics
78195	Lymph system imaging
78201	Liver imaging
78202	Liver imaging with flow
78205	Liver imaging (3D)
78206	Liver image (3d) with flow
78215	Liver and spleen imaging
78216	Liver & spleen image/flow
78220	Liver function study
78223	Hepatobiliary imaging
78230	Salivary gland imaging
78231	Serial salivary imaging
78232	Salivary gland function exam
78258	Esophageal motility study
78261	Gastric mucosa imaging
78262	Gastroesophageal reflux exam
78264	Gastric emptying study
78278	Acute GI blood loss imaging
78282	GI protein loss exam
78290	Meckel's divert exam
78291	Leveen/shunt patency exam
78300	Bone imaging, limited area
78305	Bone imaging, multiple areas
78306	Bone imaging, whole body
78315	Bone imaging, 3 phase
78320	Bone imaging (3D)
78350	Bone mineral, single photon
78351	Bone mineral, dual photon
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Ven thrombosis images, bilat
78459	Heart muscle imaging (PET)
78460	Heart muscle blood, single
78461	Heart muscle blood, multiple
78464	Heart image (3d), single
78465	Heart image (3d), multiple
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart, planar, single
78473	Gated heart, multiple
78478	Heart wall motion add-on
78480	Heart function add-on
78481	Heart first pass, single
78483	Heart first pass, multiple
78491	Heart image (pet), single
78492	Heart image (pet), multiple

Code	Short Descriptor
78494	Heart image, spect
78496	Heart first pass add-on
78580	Lung perfusion imaging
78584	Lung V/Q image single breath
78585	Lung V/Q imaging
78586	Aerosol lung image, single
78587	Aerosol lung image, multiple
78588	Perfusion lung image
78591	Vent image, 1 breath, 1 proj
78593	Vent image, 1 proj, gas
78594	Vent image, mult proj, gas
78596	Lung differential function
78600	Brain imaging, ltd static
78601	Brain imaging, ltd w/flow
78605	Brain imaging, complete
78606	Brain imaging, compl w/flow
78607	Brain imaging (3D)
78608	Brain imaging (PET)
78609	Brain imaging (PET)
78610	Brain flow imaging only
78615	Cerebral vascular flow image
78630	Cerebrospinal fluid scan
78635	CSF ventriculography
78645	CSF shunt evaluation
78647	Cerebrospinal fluid scan
78650	CSF leakage imaging
78660	Nuclear exam of tear flow
78700	Kidney imaging, static
78701	Kidney imaging with flow
78704	Imaging renogram
78707	Kidney flow/function image
78708	Kidney flow/function image
78709	Kidney flow/function image
78710	Kidney imaging (3D)
78715	Renal vascular flow exam
78730	Urinary bladder retention
78740	Ureteral reflux study
78760	Testicular imaging
78761	Testicular imaging/flow
78800	Tumor imaging, limited area
78801	Tumor imaging, mult areas
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78804	Tumor imaging, whole body
78805	Abscess imaging, ltd area
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess
78811	Tumor imaging (pet), limited
78812	Tumor image (pet)/skul-thigh
78813	Tumor image (pet) full body
78814	Tumor image pet/ct, limited
78815	Tumorimage pet/ct skul-thigh
78816	Tumor image pet/ct full body
78890	Nuclear medicine data proc
78891	Nuclear med data proc
93303	Echo transthoracic
93304	Echo transthoracic
93307	Echo exam of heart
93308	Echo exam of heart
93312	Echo transesophageal

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Code	Short Descriptor
93313	Echo transesophageal
93314	Echo transesophageal
93315	Echo transesophageal
93316	Echo transesophageal
93317	Echo transesophageal
93318	Echo transesophageal intraop
93320	Doppler echo exam, heart
93321	Doppler echo exam, heart
93325	Doppler color flow add-on
93350	Echo transthoracic
93555	Imaging, cardiac cath
93556	Imaging, cardiac cath
93571	Heart flow reserve measure
93572	Heart flow reserve measure
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93893	Tcd, emboli detect w/inj
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing
0028T	Dexa body composition study
0042T	Ct perfusion w/contrast, cbf
0066T	Ct colonography;screen
0067T	Ct colonography;dx
0080T	Endovasc aort repr rad s&i
0081T	Endovasc visc extnsn s&i
0144T	CT heart wo dye; qual calc
0145T	CT heart w/wo dye funct
0146T	CCTA w/wo dye
0147T	CCTA w/wo, quan calcium
0148T	CCTA w/wo, strxr
0149T	CCTA w/wo, strxr quan calc
0150T	CCTA w/wo, disease strxr
0151T	CT heart funct add-on
0152T	Computer chest add-on
G0120	Colon ca scrn; barium enema
G0122	Colon ca scrn; barium enema
G0130	Single energy x-ray study
G0219	Pet imaging whole body; melanoma for non-covered items
G0235	PET not otherwise specified
G0275	Renal angio, cardiac cath
G0278	Iliac art angio,cardiac cath
G0288	Recon, CTA for surg plan
G0365	Vessel mapping hemo access

MLN Matters Number: SE0665 Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Disclosure of the Payment Cap for the Technical Component of Imaging Services

Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of imaging services. Effective January 1, 2007, payment for the TC of imaging services including the TC portion of the global imaging service will be capped based on the outpatient prospective payment system (OPPS).

To determine if the payment is to be capped, the MPFS amount is compared to the cap amount for the TC and global portion of imaging services. CMS performed this comparison and the list on the following pages represents the allowances for the imaging services, which will be paid, based on the OPPS.

Source: CMS Pub 100-04/1083, Change Request 5357

Connecticut Payment Cap for the Technical Component of Imaging Procedures for Disclosure

PROC	MOD	PAR	NONPAR	LMT CHG
70336		395.45	375.68	454.77
70336	TC	323.68	307.50	372.23
70480		282.47	268.35	324.84
70480	TC	220.31	209.29	253.36
70482		414.42	393.70	476.58
70482	TC	344.55	327.32	396.23
70486		275.36	261.59	316.66
70486	TC	220.11	209.10	253.13
70496		430.42	408.90	494.98
70496	TC	345.61	328.33	397.45
70498		430.42	408.90	494.98
70498	TC	345.61	328.33	397.45
70540		470.72	447.18	541.33
70540	TC	405.48	385.21	466.30
70542		515.39	489.62	592.70
70542	TC	437.12	415.26	502.69
70543		683.87	649.68	786.45
70543	TC	579.49	550.52	666.41
70544		462.42	439.30	531.78
70544	TC	404.04	383.84	464.65
70545		494.06	469.36	568.17
70545	TC	436.10	414.30	501.51
70546		667.93	634.53	768.12
70546	TC	580.83	551.79	667.95
70547		462.00	438.90	531.30
70547	TC	404.04	383.84	464.65
70548		493.74	469.05	567.80
70548	TC	435.78	413.99	501.15
70549		667.93	634.53	768.12
70549	TC	580.83	551.79	667.95
70551		475.24	451.48	546.53
70551	TC	403.51	383.33	464.04
70552		521.82	495.73	600.09
70552	TC	435.47	413.70	500.79
70553		690.40	655.88	793.96
70553	TC	576.39	547.57	662.85
71250		275.63	261.85	316.97
71250	TC	219.58	208.60	252.52
71260		350.65	333.12	403.25
71260	TC	290.35	275.83	333.90
71270		411.35	390.78	473.05
71270	TC	344.56	327.33	396.24
71275		440.16	418.15	506.18
71275	TC	346.95	329.60	398.99
71550		474.99	451.24	546.24
71550	TC	404.75	384.51	465.46
71551		520.93	494.88	599.07
71551	TC	436.91	415.06	502.45
71552		689.58	655.10	793.02
71552	TC	580.20	551.19	667.23
72125		275.63	261.85	316.97
72125	TC	219.58	208.60	252.52
72126		349.48	332.01	401.90
72126	TC	290.35	275.83	333.90
72127		406.35	386.03	467.30
72127	TC	344.56	327.33	396.24
72128		275.63	261.85	316.97
72128	TC	219.58	208.60	252.52
72129		349.48	332.01	401.90
72129	TC	290.35	275.83	333.90
72130		406.35	386.03	467.30
72130	TC	344.56	327.33	396.24
72131		275.63	261.85	316.97
72131	TC	219.58	208.60	252.52
72132		349.48	332.01	401.90
72132	TC	290.35	275.83	333.90
72133		406.03	385.73	466.93
72133	TC	344.24	327.03	395.88
72141		481.26	457.20	553.45
72141	TC	403.73	383.54	464.29
72142		529.11	502.65	608.48
72142	TC	435.47	413.70	500.79
72146		480.83	456.79	552.95
72146	TC	403.31	383.14	463.81
72147		528.90	502.45	608.23
72147	TC	435.69	413.91	501.04
72148		475.46	451.69	546.78
72148	TC	403.31	383.14	463.81
72149		522.25	496.14	600.59
72149	TC	435.47	413.70	500.79
72156		701.09	666.04	806.25
72156	TC	576.71	547.87	663.22
72157		700.56	665.53	805.64
72157	TC	576.61	547.78	663.10
72158		690.72	656.18	794.33
72158	TC	576.71	547.87	663.22
72191		434.74	413.00	499.95
72191	TC	346.85	329.51	398.88
72192		272.86	259.22	313.79
72192	TC	219.90	208.91	252.88
72193		346.40	329.08	398.36
72193	TC	290.35	275.83	333.90
72194		403.47	383.30	463.99
72194	TC	344.35	327.13	396.00
72195		475.63	451.85	546.97
72195	TC	404.96	384.71	465.70
72196		520.83	494.79	598.95
72196	TC	436.81	414.97	502.33
72197		688.04	653.64	791.25
72197	TC	578.66	549.73	665.46
72270		245.33	233.06	282.13
72270	TC	181.31	172.24	208.51
73200		272.75	259.11	313.66
73200	TC	219.79	208.80	252.76
73202		403.58	383.40	464.12
73202	TC	344.45	327.23	396.12
73206		434.54	412.81	499.72
73206	TC	346.64	329.31	398.64
73218		470.72	447.18	541.33
73218	TC	405.48	385.21	466.30
73219		516.24	490.43	593.68
73219	TC	437.54	415.66	503.17
73220		683.87	649.68	786.45
73220	TC	579.49	550.52	666.41
73221		470.62	447.09	541.21
73221	TC	405.37	385.10	466.18
73222		516.13	490.32	593.55
73222	TC	437.44	415.57	503.06
73223		684.29	650.08	786.93
73223	TC	579.07	550.12	665.93
73700		272.75	259.11	313.66
73700	TC	219.79	208.80	252.76
73702		403.58	383.40	464.12
73702	TC	344.45	327.23	396.12
73706		439.31	417.34	505.21
73706	TC	346.74	329.40	398.75
73718		470.72	447.18	541.33
73718	TC	405.48	385.21	466.30
73719		515.39	489.62	592.70
73719	TC	437.12	415.26	502.69
73720		683.45	649.28	785.97
73720	TC	579.49	550.52	666.41
73721		470.30	446.78	540.85
73721	TC	405.06	384.81	465.82
73722		515.81	490.02	593.18
73722	TC	437.12	415.26	502.69
73723		683.45	649.28	785.97
73723	TC	579.07	550.12	665.93
74150		277.49	263.62	319.11
74150	TC	219.90	208.91	252.88
74160		352.24	334.63	405.08
74160	TC	290.45	275.93	334.02
74170		412.51	391.88	474.39
74170	TC	344.55	327.32	396.23
74175		438.99	417.04	504.84
74175	TC	346.85	329.51	398.88
74181		475.10	451.35	546.37
74181	TC	404.86	384.62	465.59
74182		520.93	494.88	599.07
74182	TC	436.91	415.06	502.45
74183		688.04	653.64	791.25
74183	TC	578.66	549.73	665.46
74260		126.48	120.16	145.45
74260	TC	102.29	97.18	117.63
74283		199.83	189.84	229.80
74283	TC	101.99	96.89	117.29
74350		156.71	148.87	180.22
74350	TC	120.24	114.23	138.28
75552		482.61	458.48	555.00
75552	TC	404.24	384.03	464.88
75553		536.23	509.42	616.66
75553	TC	436.40	414.58	501.86
75554		497.40	472.53	572.01
75554	TC	404.86	384.62	465.59
75555		494.46	469.74	568.63
75555	TC	404.86	384.62	465.59
75635		464.55	441.32	534.23
75635	TC	347.46	330.09	399.58
75660		508.06	482.66	584.27
75660	TC	443.09	420.94	509.55
75705		550.71	523.17	633.32

Connecticut Payment Cap for the Technical Component of Imaging Procedures for Disclosure

PROC	MOD	PAR	NONPAR	LMT CHG
75705	TC	443.41	421.24	509.92
75733		509.85	484.36	586.33
75733	TC	443.62	421.44	510.16
75860		500.45	475.43	575.52
75860	TC	442.99	420.84	509.44
75870		499.51	474.53	574.44
75870	TC	442.99	420.84	509.44
75893		469.84	446.35	540.32
75893	TC	443.31	421.14	509.81
75962		470.06	446.56	540.57
75962	TC	443.21	421.05	509.69
75966		509.54	484.06	585.97
75966	TC	442.89	420.75	509.32
75978		469.32	445.85	539.72
75978	TC	442.78	420.64	509.20
76376		53.87	51.18	61.95
76376	TC	43.55	41.37	50.08
76377		148.28	140.87	170.52
76377	TC	108.24	102.83	124.48
76380		156.48	148.66	179.95
76380	TC	109.26	103.80	125.65
76506		103.78	98.59	119.35
76506	TC	70.87	67.33	81.50
76812		156.24	148.43	179.68
76812	TC	67.78	64.39	77.95
76857		89.58	85.10	103.02
76857	TC	70.76	67.22	81.37
76885		106.45	101.13	122.42
76885	TC	70.77	67.23	81.39
76936		248.29	235.88	285.53
76936	TC	149.45	141.98	171.87
76942		117.64	111.76	135.29
76942	TC	85.00	80.75	97.75
76965		215.44	204.67	247.76
76965	TC	148.72	141.28	171.03
77011		350.03	332.53	402.53
77011	TC	291.28	276.72	334.97
77012		345.78	328.49	397.65
77012	TC	289.73	275.24	333.19
77014		150.73	143.19	173.34
77014	TC	109.26	103.80	125.65
77021		397.74	377.85	457.40
77021	TC	323.78	307.59	372.35
77031		287.16	272.80	330.23
77031	TC	209.79	199.30	241.26
77054		142.46	135.34	163.83
77054	TC	120.56	114.53	138.64
77078		95.75	90.96	110.11
77078	TC	83.84	79.65	96.42
77080		94.27	89.56	108.41
77080	TC	83.43	79.26	95.94
77084		401.41	381.34	461.62
77084	TC	323.89	307.70	372.47
77421		97.44	92.57	112.06
77421	TC	78.25	74.34	89.99
78075		229.84	218.35	264.32
78075	TC	193.31	183.64	222.31
78190		197.87	187.98	227.55
78190	TC	142.69	135.56	164.09
78206		360.91	342.86	415.05
78206	TC	314.01	298.31	361.11
78456		222.94	211.79	256.38
78456	TC	172.02	163.42	197.82
78458		216.30	205.49	248.75
78458	TC	172.12	163.51	197.94
78465		536.83	509.99	617.35
78465	TC	462.27	439.16	531.61
78496		132.93	126.28	152.87
78496	TC	107.05	101.70	123.11
78607		391.49	371.92	450.21
78607	TC	331.15	314.59	380.82
78630		282.02	267.92	324.32
78630	TC	249.00	236.55	286.35
78647		292.75	278.11	336.66
78647	TC	248.99	236.54	286.34
78710		275.06	261.31	316.32
78710	TC	243.21	231.05	279.69
78730		53.48	50.81	61.50
78730	TC	43.35	41.18	49.85
78803		337.81	320.92	388.48
78803	TC	284.43	270.21	327.09
78804		475.70	451.91	547.05
78804	TC	423.81	402.62	487.38
78806		325.97	309.67	374.87
78806	TC	284.13	269.92	326.75
78807		338.23	321.32	388.96
78807	TC	284.75	270.51	327.46
93880		204.44	194.22	235.11
93880	TC	174.56	165.83	200.74
93886		223.08	211.93	256.54
93886	TC	174.66	165.93	200.86
93888		102.03	96.93	117.33
93888	TC	70.25	66.74	80.79
93890		162.10	153.99	186.41
93890	TC	110.55	105.02	127.13
93892		168.75	160.31	194.06
93892	TC	110.23	104.72	126.76
93893		169.07	160.62	194.43
93893	TC	110.55	105.02	127.13
93925		204.21	194.00	234.84
93925	TC	175.07	166.32	201.33
93926		131.00	124.45	150.65
93926	TC	111.16	105.60	127.83
93930		197.69	187.81	227.34
93930	TC	174.35	165.63	200.50
93931		126.49	120.17	145.46
93931	TC	110.86	105.32	127.49
93970		208.02	197.62	239.22
93970	TC	174.04	165.34	200.15
93971		132.45	125.83	152.32
93971	TC	110.23	104.72	126.76
93975		264.62	251.39	304.31
93975	TC	174.66	165.93	200.86
93976		232.80	221.16	267.72
93976	TC	174.04	165.34	200.15
93978		143.40	136.23	164.91
93978	TC	110.55	105.02	127.13
93979		132.55	125.92	152.43
93979	TC	110.33	104.81	126.88
93981		131.31	124.74	151.01
93981	TC	109.40	103.93	125.81
93990		123.71	117.52	142.27
93990	TC	111.16	105.60	127.83
G0365		187.10	177.74	215.16
G0365	TC	174.87	166.13	201.10

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

CODE/MOD		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
70336		331.68	354.67	380.86	315.10	336.94	361.82	381.43	407.87	437.99
70336	TC	266.13	286.42	309.65	252.82	272.10	294.17	306.05	329.38	356.10
70480		237.22	252.88	270.59	225.36	240.24	257.06	272.80	290.81	311.18
70480	TC	180.45	193.77	208.93	171.43	184.08	198.48	207.52	222.84	240.27
70482		346.12	369.61	396.23	328.81	351.13	376.42	398.04	425.05	455.66
70482	TC	282.41	303.38	327.28	268.29	288.21	310.92	324.77	348.89	376.37
70486		231.11	246.72	264.44	219.55	234.38	251.22	265.78	283.73	304.11
70486	TC	180.67	194.26	209.78	171.64	184.55	199.29	207.77	223.40	241.25
70496		361.08	385.53	413.31	343.03	366.25	392.64	415.24	443.36	475.31
70496	TC	283.64	304.94	329.26	269.46	289.69	312.80	326.19	350.68	378.65
70498		361.08	385.53	413.31	343.03	366.25	392.64	415.24	443.36	475.31
70498	TC	283.64	304.94	329.26	269.46	289.69	312.80	326.19	350.68	378.65
70540		389.44	414.80	443.23	369.97	394.06	421.07	447.86	477.02	509.71
70540	TC	329.89	352.85	378.65	313.40	335.21	359.72	379.37	405.78	435.45
70542		427.39	455.20	486.41	406.02	432.44	462.09	491.50	523.48	559.37
70542	TC	355.94	380.91	409.02	338.14	361.86	388.57	409.33	438.05	470.37
70543		567.70	605.07	647.09	539.32	574.82	614.74	652.86	695.83	744.15
70543	TC	472.38	505.84	543.58	448.76	480.55	516.40	543.24	581.72	625.12
70544		384.68	411.60	442.21	365.45	391.02	420.10	442.38	473.34	508.54
70544	TC	331.48	356.30	384.62	314.91	338.49	365.39	381.20	409.75	442.31
70545		410.73	439.66	472.57	390.19	417.68	448.94	472.34	505.61	543.46
70545	TC	357.87	384.72	415.36	339.98	365.48	394.59	411.55	442.43	477.66
70546		550.43	585.36	624.26	522.91	556.09	593.05	632.99	673.16	717.90
70546	TC	470.91	502.64	538.04	447.36	477.51	511.14	541.55	578.04	618.75
70547		384.34	411.25	441.83	365.12	390.69	419.74	441.99	472.94	508.10
70547	TC	331.48	356.30	384.62	314.91	338.49	365.39	381.20	409.75	442.31
70548		410.28	439.06	471.77	389.77	417.11	448.18	471.82	504.92	542.54
70548	TC	357.42	384.11	414.56	339.55	364.90	393.83	411.03	441.73	476.74
70549		550.43	585.36	624.26	522.91	556.09	593.05	632.99	673.16	717.90
70549	TC	470.91	502.64	538.04	447.36	477.51	511.14	541.55	578.04	618.75
70551		396.80	424.44	455.88	376.96	403.22	433.09	456.32	488.11	524.26
70551	TC	331.25	356.19	384.67	314.69	338.38	365.44	380.94	409.62	442.37
70552		436.58	466.86	501.34	414.75	443.52	476.27	502.07	536.89	576.54
70552	TC	357.76	384.85	415.84	339.87	365.61	395.05	411.42	442.58	478.22
70553		578.98	620.01	666.90	550.03	589.01	633.55	665.83	713.01	766.93
70553	TC	474.99	511.89	554.29	451.24	486.30	526.58	546.24	588.67	637.43
71250		231.58	247.32	265.22	220.00	234.95	251.96	266.32	284.42	305.00
71250	TC	180.45	194.15	209.83	171.43	184.44	199.34	207.52	223.27	241.30
71260		293.67	314.02	337.18	278.99	298.32	320.32	337.72	361.12	387.76
71260	TC	238.73	256.93	277.78	226.79	244.08	263.89	274.54	295.47	319.45
71270		344.13	368.10	395.40	326.92	349.69	375.63	395.75	423.32	454.71
71270	TC	283.20	304.72	329.36	269.04	289.48	312.89	325.68	350.43	378.76
71275		367.34	390.40	416.21	348.97	370.88	395.40	422.44	448.96	478.64
71275	TC	282.17	301.74	323.72	268.06	286.65	307.53	324.50	347.00	372.28
71550		393.96	419.81	448.86	374.26	398.82	426.42	453.05	482.78	516.19
71550	TC	329.89	353.23	379.55	313.40	335.57	360.57	379.37	406.21	436.48
71551		432.92	461.28	493.17	411.27	438.22	468.51	497.86	530.47	567.15
71551	TC	356.17	381.40	409.87	338.36	362.33	389.38	409.60	438.61	471.35
71552		570.63	606.62	646.75	542.10	576.29	614.41	656.22	697.61	743.76
71552	TC	470.80	502.77	538.52	447.26	477.63	511.59	541.42	578.19	619.30
72125		231.58	247.32	265.22	220.00	234.95	251.96	266.32	284.42	305.00
72125	TC	180.45	194.15	209.83	171.43	184.44	199.34	207.52	223.27	241.30
72126		292.63	312.95	336.09	278.00	297.30	319.29	336.52	359.89	386.50
72126	TC	238.73	256.93	277.78	226.79	244.08	263.89	274.54	295.47	319.45
72127		339.62	363.48	390.67	322.64	345.31	371.14	390.56	418.00	449.27
72127	TC	283.20	304.72	329.36	269.04	289.48	312.89	325.68	350.43	378.76
72128		231.58	247.32	265.22	220.00	234.95	251.96	266.32	284.42	305.00
72128	TC	180.45	194.15	209.83	171.43	184.44	199.34	207.52	223.27	241.30

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
72129		292.63	312.95	336.09	278.00	297.30	319.29	336.52	359.89	386.50
72129	TC	238.73	256.93	277.78	226.79	244.08	263.89	274.54	295.47	319.45
72130		339.62	363.48	390.67	322.64	345.31	371.14	390.56	418.00	449.27
72130	TC	283.20	304.72	329.36	269.04	289.48	312.89	325.68	350.43	378.76
72131		231.58	247.32	265.22	220.00	234.95	251.96	266.32	284.42	305.00
72131	TC	180.45	194.15	209.83	171.43	184.44	199.34	207.52	223.27	241.30
72132		292.63	312.95	336.09	278.00	297.30	319.29	336.52	359.89	386.50
72132	TC	238.73	256.93	277.78	226.79	244.08	263.89	274.54	295.47	319.45
72133		339.17	362.88	389.86	322.21	344.74	370.37	390.05	417.31	448.34
72133	TC	282.75	304.12	328.56	268.61	288.91	312.13	325.16	349.74	377.84
72141		402.57	430.62	462.57	382.44	409.09	439.44	462.96	495.21	531.96
72141	TC	331.82	357.04	385.90	315.23	339.19	366.60	381.59	410.60	443.78
72142		443.26	473.87	508.71	421.10	450.18	483.27	509.75	544.95	585.02
72142	TC	357.76	384.85	415.84	339.87	365.61	395.05	411.42	442.58	478.22
72146		402.23	430.27	462.20	382.12	408.76	439.09	462.56	494.81	531.53
72146	TC	331.48	356.68	385.52	314.91	338.85	366.24	381.20	410.18	443.35
72147		443.49	474.36	509.56	421.32	450.64	484.08	510.01	545.51	585.99
72147	TC	358.32	385.70	417.07	340.40	366.41	396.22	412.07	443.55	479.63
72148		397.37	425.29	457.11	377.50	404.03	434.25	456.98	489.08	525.68
72148	TC	331.48	356.68	385.52	314.91	338.85	366.24	381.20	410.18	443.35
72149		436.91	467.22	501.72	415.06	443.86	476.63	502.45	537.30	576.98
72149	TC	357.76	384.85	415.84	339.87	365.61	395.05	411.42	442.58	478.22
72156		588.90	630.47	677.98	559.45	598.95	644.08	677.23	725.04	779.68
72156	TC	475.44	512.50	555.10	451.67	486.88	527.35	546.76	589.38	638.37
72157		588.67	630.36	678.03	559.24	598.84	644.13	676.97	724.91	779.73
72157	TC	475.56	512.74	555.52	451.78	487.10	527.74	546.89	589.65	638.85
72158		579.44	620.61	667.70	550.47	589.58	634.32	666.36	713.70	767.86
72158	TC	475.44	512.50	555.10	451.67	486.88	527.35	546.76	589.38	638.37
72191		362.49	385.42	411.10	344.37	366.15	390.55	416.86	443.23	472.76
72191	TC	282.28	301.99	324.15	268.17	286.89	307.94	324.62	347.29	372.77
72192		229.25	245.08	263.12	217.79	232.83	249.96	263.64	281.84	302.59
72192	TC	180.90	194.76	210.63	171.85	185.02	200.10	208.04	223.97	242.22
72193		289.86	310.10	333.17	275.37	294.60	316.51	333.34	356.62	383.15
72193	TC	238.73	256.93	277.78	226.79	244.08	263.89	274.54	295.47	319.45
72194		336.53	359.89	386.44	319.70	341.90	367.12	387.01	413.87	444.41
72194	TC	282.63	303.88	328.13	268.50	288.69	311.72	325.02	349.46	377.35
72195		394.86	421.01	450.47	375.12	399.96	427.95	454.09	484.16	518.04
72195	TC	330.46	354.08	380.78	313.94	336.38	361.74	380.03	407.19	437.90
72196		433.03	461.53	493.60	411.38	438.45	468.92	497.98	530.76	567.64
72196	TC	356.28	381.65	410.30	338.47	362.57	389.78	409.72	438.90	471.84
72197		572.33	610.32	653.15	543.71	579.80	620.49	658.18	701.87	751.12
72197	TC	472.50	506.47	544.91	448.88	481.15	517.66	543.38	582.44	626.65
72270		208.21	222.37	238.55	197.80	211.25	226.62	239.44	255.73	274.33
72270	TC	149.69	161.49	175.09	142.21	153.42	166.34	172.14	185.71	201.35
73200		228.58	243.98	261.46	217.15	231.78	248.39	262.87	280.58	300.68
73200	TC	180.22	193.66	208.98	171.21	183.98	198.53	207.25	222.71	240.33
73202		336.42	359.64	386.01	319.60	341.66	366.71	386.88	413.59	443.91
73202	TC	282.52	303.63	327.71	268.39	288.45	311.32	324.90	349.17	376.87
73206		362.72	385.92	411.96	344.58	366.62	391.36	417.13	443.81	473.75
73206	TC	282.51	302.48	325.00	268.38	287.36	308.75	324.89	347.85	373.75
73218		389.44	414.80	443.23	369.97	394.06	421.07	447.86	477.02	509.71
73218	TC	329.89	352.85	378.65	313.40	335.21	359.72	379.37	405.78	435.45
73219		428.06	455.92	487.17	406.66	433.12	462.81	492.27	524.31	560.25
73219	TC	356.28	381.26	409.39	338.47	362.20	388.92	409.72	438.45	470.80
73220		567.70	605.07	647.09	539.32	574.82	614.74	652.86	695.83	744.15
73220	TC	472.38	505.84	543.58	448.76	480.55	516.40	543.24	581.72	625.12
73221		389.55	415.05	443.65	370.07	394.30	421.47	447.98	477.31	510.20
73221	TC	330.00	353.09	379.08	313.50	335.44	360.13	379.50	406.05	435.94

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

CODE/MOD		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
73222		428.18	456.16	487.59	406.77	433.35	463.21	492.41	524.58	560.73
73222	TC	356.39	381.51	409.82	338.57	362.43	389.33	409.85	438.74	471.29
73223		568.04	605.42	647.47	539.64	575.15	615.10	653.25	696.23	744.59
73223	TC	472.05	505.48	543.21	448.45	480.21	516.05	542.86	581.30	624.69
73700		228.58	243.98	261.46	217.15	231.78	248.39	262.87	280.58	300.68
73700	TC	180.22	193.66	208.98	171.21	183.98	198.53	207.25	222.71	240.33
73702		336.42	359.64	386.01	319.60	341.66	366.71	386.88	413.59	443.91
73702	TC	282.52	303.63	327.71	268.39	288.45	311.32	324.90	349.17	376.87
73706		366.75	389.94	415.92	348.41	370.44	395.12	421.76	448.43	478.31
73706	TC	282.40	302.23	324.57	268.28	287.12	308.34	324.76	347.56	373.26
73718		389.44	414.80	443.23	369.97	394.06	421.07	447.86	477.02	509.71
73718	TC	329.89	352.85	378.65	313.40	335.21	359.72	379.37	405.78	435.45
73719		427.39	455.20	486.41	406.02	432.44	462.09	491.50	523.48	559.37
73719	TC	355.94	380.91	409.02	338.14	361.86	388.57	409.33	438.05	470.37
73720		567.36	604.71	646.71	538.99	574.47	614.37	652.46	695.42	743.72
73720	TC	472.38	505.84	543.58	448.76	480.55	516.40	543.24	581.72	625.12
73721		389.10	414.45	442.85	369.64	393.73	420.71	447.46	476.62	509.28
73721	TC	329.55	352.49	378.27	313.07	334.87	359.36	378.98	405.36	435.01
73722		427.73	455.56	486.79	406.34	432.78	462.45	491.89	523.89	559.81
73722	TC	355.94	380.91	409.02	338.14	361.86	388.57	409.33	438.05	470.37
73723		567.36	604.71	646.71	538.99	574.47	614.37	652.46	695.42	743.72
73723	TC	472.05	505.48	543.21	448.45	480.21	516.05	542.86	581.30	624.69
74150		233.41	249.35	267.49	221.74	236.88	254.12	268.42	286.75	307.61
74150	TC	180.90	194.76	210.63	171.85	185.02	200.10	208.04	223.97	242.22
74160		295.04	315.44	338.66	280.29	299.67	321.73	339.30	362.76	389.46
74160	TC	238.62	256.69	277.35	226.69	243.86	263.48	274.41	295.19	318.95
74170		344.38	367.83	394.41	327.16	349.44	374.69	396.04	423.00	453.57
74170	TC	282.41	303.38	327.28	268.29	288.21	310.92	324.77	348.89	376.37
74175		366.30	389.34	415.11	347.99	369.87	394.35	421.25	447.74	477.38
74175	TC	282.28	301.99	324.15	268.17	286.89	307.94	324.62	347.29	372.77
74181		394.63	420.90	450.52	374.90	399.85	427.99	453.82	484.03	518.10
74181	TC	330.57	354.33	381.21	314.04	336.61	362.15	380.16	407.48	438.39
74182		432.92	461.28	493.17	411.27	438.22	468.51	497.86	530.47	567.15
74182	TC	356.17	381.40	409.87	338.36	362.33	389.38	409.60	438.61	471.35
74183		572.33	610.32	653.15	543.71	579.80	620.49	658.18	701.87	751.12
74183	TC	472.50	506.47	544.91	448.88	481.15	517.66	543.38	582.44	626.65
74260		104.91	111.31	118.41	99.66	105.74	112.49	120.65	128.01	136.17
74260	TC	82.86	88.40	94.58	78.72	83.98	89.85	95.29	101.66	108.77
74283		173.33	183.42	194.80	164.66	174.25	185.06	199.33	210.93	224.02
74283	TC	83.99	90.49	97.94	79.79	85.97	93.04	96.59	104.06	112.63
74350		132.40	141.43	151.74	125.78	134.36	144.15	152.26	162.64	174.50
74350	TC	99.15	106.90	115.81	94.19	101.56	110.02	114.02	122.94	133.18
75552		402.67	430.10	461.20	382.54	408.60	438.14	463.07	494.62	530.38
75552	TC	331.25	355.81	383.77	314.69	338.02	364.58	380.94	409.18	441.34
75553		447.16	476.50	509.55	424.80	452.67	484.07	514.23	547.97	585.98
75553	TC	356.74	382.63	412.00	338.90	363.50	391.40	410.25	440.02	473.80
75554		414.40	441.43	471.85	393.68	419.36	448.26	476.56	507.64	542.63
75554	TC	330.57	354.33	381.21	314.04	336.61	362.15	380.16	407.48	438.39
75555		411.58	438.59	468.99	391.00	416.66	445.54	473.32	504.38	539.34
75555	TC	330.57	354.33	381.21	314.04	336.61	362.15	380.16	407.48	438.39
75635		388.45	411.72	437.57	369.03	391.13	415.69	446.72	473.48	503.21
75635	TC	281.60	300.51	321.59	267.52	285.48	305.51	323.84	345.59	369.83
75660		425.36	456.89	493.13	404.09	434.05	468.47	489.16	525.42	567.10
75660	TC	366.19	395.29	428.88	347.88	375.53	407.44	421.12	454.58	493.21
75705		465.03	498.71	537.43	441.78	473.77	510.56	534.78	573.52	618.04
75705	TC	366.64	395.89	429.68	348.31	376.10	408.20	421.64	455.27	494.13
75733		426.60	458.07	494.21	405.27	435.17	469.50	490.59	526.78	568.34
75733	TC	366.41	395.40	428.83	348.09	375.63	407.39	421.37	454.71	493.15

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
75860		418.31	449.53	485.42	397.39	427.05	461.15	481.06	516.96	558.23
75860	TC	366.30	395.54	429.30	347.99	375.76	407.83	421.25	454.87	493.69
75870		417.75	449.06	485.09	396.86	426.61	460.84	480.41	516.42	557.85
75870	TC	366.30	395.54	429.30	347.99	375.76	407.83	421.25	454.87	493.69
75893		390.87	421.18	456.13	371.33	400.12	433.32	449.50	484.36	524.55
75893	TC	366.75	396.14	430.11	348.41	376.33	408.60	421.76	455.56	494.63
75962		391.44	422.03	457.36	371.87	400.93	434.49	450.16	485.33	525.96
75962	TC	366.87	396.39	430.53	348.53	376.57	409.00	421.90	455.85	495.11
75966		426.94	458.81	495.49	405.59	435.87	470.72	490.98	527.63	569.81
75966	TC	366.42	395.78	429.73	348.10	375.99	408.24	421.38	455.15	494.19
75978		390.65	421.07	456.18	371.12	400.02	433.37	449.25	484.23	524.61
75978	TC	366.53	396.03	430.15	348.20	376.23	408.64	421.51	455.43	494.67
76376		44.93	47.89	51.22	42.68	45.50	48.66	51.67	55.07	58.90
76376	TC	35.37	37.79	40.50	33.60	35.90	38.48	40.68	43.46	46.57
76377		128.75	139.43	152.05	122.31	132.46	144.45	148.06	160.34	174.86
76377	TC	91.53	100.10	110.27	86.95	95.09	104.76	105.26	115.11	126.81
76380		132.66	141.04	150.49	126.03	133.99	142.97	152.56	162.20	173.06
76380	TC	89.61	96.30	103.92	85.13	91.48	98.72	103.05	110.74	119.51
76506		88.57	94.61	101.53	84.14	89.88	96.45	101.86	108.80	116.76
76506	TC	58.17	62.53	67.52	55.26	59.40	64.14	66.90	71.91	77.65
76812		141.28	152.38	165.62	134.22	144.76	157.34	162.47	175.24	190.46
76812	TC	60.78	68.59	78.23	57.74	65.16	74.32	69.90	78.88	89.96
76857		74.67	79.36	84.61	70.94	75.39	80.38	85.87	91.26	97.30
76857	TC	57.49	61.44	65.87	54.62	58.37	62.58	66.11	70.66	75.75
76885		90.84	96.60	103.14	86.30	91.77	97.98	104.47	111.09	118.61
76885	TC	58.28	62.78	67.95	55.37	59.64	64.55	67.02	72.20	78.14
76936		213.83	227.56	243.24	203.14	216.18	231.08	245.90	261.69	279.73
76936	TC	123.07	132.58	143.49	116.92	125.95	136.32	141.53	152.47	165.01
76942		98.82	104.78	111.41	93.88	99.54	105.84	113.64	120.50	128.12
76942	TC	69.05	73.80	79.11	65.60	70.11	75.15	79.41	84.87	90.98
76965		184.20	196.83	211.33	174.99	186.99	200.76	211.83	226.35	243.03
76965	TC	123.07	132.96	144.39	116.92	126.31	137.17	141.53	152.90	166.05
77011		291.26	310.38	331.89	276.70	294.86	315.30	334.95	356.94	381.67
77011	TC	237.71	254.71	273.94	225.82	241.97	260.24	273.37	292.92	315.03
77012		290.54	311.58	335.73	276.01	296.00	318.94	334.12	358.32	386.09
77012	TC	239.41	258.41	280.34	227.44	245.49	266.32	275.32	297.17	322.39
77014		127.45	135.70	145.04	121.08	128.91	137.79	146.57	156.05	166.80
77014	TC	89.61	96.30	103.92	85.13	91.48	98.72	103.05	110.74	119.51
77021		333.84	357.05	383.52	317.15	339.20	364.34	383.92	410.61	441.05
77021	TC	266.01	286.17	309.23	252.71	271.86	293.77	305.91	329.10	355.61
77031		244.57	261.63	281.21	232.34	248.55	267.15	281.26	300.87	323.39
77031	TC	173.61	187.55	203.66	164.93	178.17	193.48	199.65	215.68	234.21
77054		119.56	128.27	138.27	113.58	121.86	131.36	137.49	147.51	159.01
77054	TC	99.60	107.50	116.61	94.62	102.13	110.78	114.54	123.62	134.10
77078		79.57	85.10	91.38	75.59	80.84	86.81	91.51	97.86	105.09
77078	TC	68.72	73.82	79.64	65.28	70.13	75.66	79.03	84.89	91.59
77080		78.96	85.02	92.02	75.01	80.77	87.42	90.80	97.77	105.82
77080	TC	69.17	74.81	81.34	65.71	71.07	77.27	79.55	86.03	93.54
77084		336.65	359.51	385.48	319.82	341.53	366.21	387.15	413.44	443.30
77084	TC	265.90	285.93	308.80	252.60	271.63	293.36	305.78	328.82	355.12
77421		81.20	86.38	92.18	77.14	82.06	87.57	93.38	99.34	106.01
77421	TC	63.67	68.10	73.08	60.49	64.69	69.43	73.22	78.31	84.04
78075		191.33	204.16	218.66	181.76	193.95	207.73	220.03	234.78	251.46
78075	TC	158.10	169.63	182.71	150.19	161.15	173.57	181.81	195.07	210.12
78190		167.61	178.74	191.40	159.23	169.80	181.83	192.75	205.55	220.11
78190	TC	116.89	125.53	135.37	111.05	119.25	128.60	134.42	144.36	155.68
78206		295.43	312.97	332.20	280.66	297.32	315.59	339.74	359.92	382.03
78206	TC	252.74	268.58	285.97	240.10	255.15	271.67	290.65	308.87	328.87

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

CODE/MOD		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
78456		187.60	200.25	214.64	178.22	190.24	203.91	215.74	230.29	246.84
78456	TC	141.49	152.31	164.71	134.42	144.69	156.47	162.71	175.16	189.42
78458		181.64	193.96	207.95	172.56	184.26	197.55	208.89	223.05	239.14
78458	TC	141.37	152.06	164.28	134.30	144.46	156.07	162.58	174.87	188.92
78465		447.65	479.38	515.56	425.27	455.41	489.78	514.80	551.29	592.89
78465	TC	380.33	409.49	442.91	361.31	389.02	420.76	437.38	470.91	509.35
78496		111.43	119.09	127.81	105.86	113.14	121.42	128.14	136.95	146.98
78496	TC	88.04	94.76	102.46	83.64	90.02	97.34	101.25	108.97	117.83
78607		325.65	347.48	372.12	309.37	330.11	353.51	374.50	399.60	427.94
78607	TC	270.72	290.39	312.70	257.18	275.87	297.07	311.33	333.95	359.60
78630		234.26	250.67	269.31	222.55	238.14	255.84	269.40	288.27	309.71
78630	TC	204.14	219.34	236.65	193.93	208.37	224.82	234.76	252.24	272.15
78647		243.28	259.53	277.87	231.12	246.55	263.98	279.77	298.46	319.55
78647	TC	203.35	217.99	234.57	193.18	207.09	222.84	233.85	250.69	269.76
78710		229.18	245.71	264.59	217.72	233.42	251.36	263.56	282.57	304.28
78710	TC	200.10	215.44	233.03	190.10	204.67	221.38	230.11	247.76	267.98
78730		44.75	48.03	51.79	42.51	45.63	49.20	51.46	55.23	59.56
78730	TC	35.60	38.28	41.35	33.82	36.37	39.28	40.94	44.02	47.55
78803		281.12	299.94	321.19	267.06	284.94	305.13	323.29	344.93	369.37
78803	TC	232.43	249.26	268.33	220.81	236.80	254.91	267.29	286.65	308.58
78804		390.56	415.34	442.89	371.03	394.57	420.75	449.14	477.64	509.32
78804	TC	343.36	366.33	391.93	326.19	348.01	372.33	394.86	421.28	450.72
78806		271.76	291.10	313.18	258.17	276.55	297.52	312.52	334.76	360.16
78806	TC	233.56	251.34	271.69	221.88	238.77	258.11	268.59	289.04	312.44
78807		281.46	300.30	321.57	267.39	285.29	305.49	323.68	345.34	369.81
78807	TC	232.88	249.86	269.14	221.24	237.37	255.68	267.81	287.34	309.51
93880		171.74	184.52	199.24	163.15	175.29	189.28	197.50	212.20	229.13
93880	TC	144.30	155.79	169.05	137.09	148.00	160.60	165.94	179.16	194.41
93886		188.43	201.85	217.23	179.01	191.76	206.37	216.69	232.13	249.81
93886	TC	144.18	155.54	168.62	136.97	147.76	160.19	165.81	178.87	193.91
93888		87.32	93.43	100.46	82.95	88.76	95.44	100.42	107.44	115.53
93888	TC	58.06	62.67	68.00	55.16	59.54	64.60	66.77	72.07	78.20
93890		139.21	149.20	160.76	132.25	141.74	152.72	160.09	171.58	184.87
93890	TC	92.20	100.05	109.22	87.59	95.05	103.76	106.03	115.06	125.60
93892		144.99	155.00	166.52	137.74	147.25	158.19	166.74	178.25	191.50
93892	TC	91.75	99.45	108.42	87.16	94.48	103.00	105.51	114.37	124.68
93893		145.45	155.60	167.32	138.18	147.82	158.95	167.27	178.94	192.42
93893	TC	92.20	100.05	109.22	87.59	95.05	103.76	106.03	115.06	125.60
93925		170.47	182.58	196.39	161.95	173.45	186.57	196.04	209.97	225.85
93925	TC	143.73	154.55	166.92	136.54	146.82	158.57	165.29	177.73	191.96
93926		109.95	118.06	127.37	104.45	112.16	121.00	126.44	135.77	146.48
93926	TC	91.52	98.57	106.66	86.94	93.64	101.33	105.25	113.36	122.66
93930		166.07	178.97	193.91	157.77	170.02	184.21	190.98	205.82	223.00
93930	TC	144.52	156.28	169.90	137.29	148.47	161.41	166.20	179.72	195.38
93931		106.38	114.63	124.20	101.06	108.90	117.99	122.34	131.82	142.83
93931	TC	91.86	99.31	107.94	87.27	94.34	102.54	105.64	114.21	124.13
93970		176.33	190.16	206.25	167.51	180.65	195.94	202.78	218.68	237.19
93970	TC	144.86	157.02	171.18	137.62	149.17	162.62	166.59	180.57	196.86
93971		112.16	120.82	130.88	106.55	114.78	124.34	128.98	138.94	150.51
93971	TC	91.75	99.45	108.42	87.16	94.48	103.00	105.51	114.37	124.68
93975		226.97	242.35	259.99	215.62	230.23	246.99	261.02	278.70	298.99
93975	TC	144.18	155.54	168.62	136.97	147.76	160.19	165.81	178.87	193.91
93976		198.42	212.68	229.13	188.50	202.05	217.67	228.18	244.58	263.50
93976	TC	144.86	157.02	171.18	137.62	149.17	162.62	166.59	180.57	196.86
93978		122.62	132.12	143.21	116.49	125.51	136.05	141.01	151.94	164.69
93978	TC	92.20	100.05	109.22	87.59	95.05	103.76	106.03	115.06	125.60
93979		112.04	120.57	130.45	106.44	114.54	123.93	128.85	138.66	150.02
93979	TC	91.63	99.20	107.99	87.05	94.24	102.59	105.37	114.08	124.19

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
93981		112.61	122.19	133.49	106.98	116.08	126.82	129.50	140.52	153.51
93981	TC	92.65	101.42	111.83	88.02	96.35	106.24	106.55	116.63	128.60
93990		103.27	111.05	120.01	98.11	105.50	114.01	118.76	127.71	138.01
93990	TC	91.52	98.57	106.66	86.94	93.64	101.33	105.25	113.36	122.66
G0365		155.25	166.92	180.31	147.49	158.57	171.29	178.54	191.96	207.36
G0365	TC	143.96	155.05	167.77	136.76	147.30	159.38	165.55	178.31	192.94

LABORATORY/PATHOLOGY

Changes to the Laboratory National Coverage Determination Edit Software for January 2007

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5384, which announces the changes that will be included in the January 2007 release of the edit module for clinical diagnostic laboratory national coverage determinations (NCDs).

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Subsequently, the Centers for Medicare & Medicaid Services (CMS) contracted for nationally uniform software to be developed and incorporated into its shared systems so that laboratory claims subject to one of the 23 NCDs can be processed uniformly throughout the nation effective January 1, 2003

The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 16, section 120.2, available at *http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf* on the CMS website.)

These updating changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs, and biannual updates of the ICD-9-CM codes. In addition, many of the listed changes may correct *Current Procedural Terminology* (*CPT*) codes to reflect the current CPT update.

CR 5384 informs your Medicare carrier, FI, or A/B MAC about changes to the laboratory edit module and changes in laboratory NCD code lists effective for services furnished on or after January 1, 2007.

CR 5384 specifically announces the addition of the following ICD-9-CM code(s):

- **V58.83 (Encounter for therapeutic drug monitoring)** to the list of 1) ICD-9-CM codes covered by Medicare for **the Prothrombin Time (190.17) NCD and** 2) ICD-9-CM codes covered by Medicare for **the Partial Thromboplastin Time (190.16) NCD**;
- **783.0 (Anorexia) and 793.99 (Other nonspecific abnormal findings on radiological and other examinations of body structure)** to the list of ICD-9-CM codes covered by Medicare **for the Thyroid Testing (190.22) NCD**; and
- **995.20 (Unspecified adverse effect of unspecified drug, medicinal and biological substance) to** the list of ICD-9-CM codes covered by Medicare for **the Fecal Occult Blood Test (190.34) NCD**.

CR 5384 also modifies the descriptor **for *CPT 87088* in Urine Culture, Bacterial NCD (190.12)** to read "Culture, bacterial; with isolation and presumptive identification of each isolates, urine"

Additional Information

For complete details, please see the official instruction issued to your carrier, FI, or A/B MAC regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1093CP.pdf* on the CMS website.

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

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).

MLN Matters Number: MM5384
Related Change Request (CR) #: 5384
Related CR Release Date: October 27, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1093CP
Implementation Date: January 2, 2007

MAMMOGRAPHY SERVICES

New 2007 Current Procedural Terminology Codes for Mammography Services

The American Medical Association has assigned new 2007 *Current Procedural Terminology (CPT)* codes for reporting screening and diagnostic mammography services effective for claims with dates of service **on or after January 1, 2007.** The new *CPT* codes for 2007 will replace the current *CPT* codes; however the *CPT* code descriptors for the services are unchanged.

The following new *CPT* codes have been assigned to report mammography services rendered **on or after January 1, 2007:**

New *CPT* code *77051* replaces code *76082*

New *CPT* code *77052* replaces code *76083*

New *CPT* code *77055* replaces code *76090*

New *CPT* code *77056* replaces code *76091*

New *CPT* code *77057* replaces code *76092*

Claims submitted for mammography services with dates of service on or after January 1, 2007, containing *CPT* codes *76082, 76083, 76090, 76091,* or *76092* will be returned to the provider as unprocessable.

Source: CMS Pub. 100-04, Transmittal 1070, CR 5327

SCREENING SERVICES

Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms

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

Provider Types Affected

All physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), and Medicare Administrative Contractors (MACs) for subject services.

Background

This article and related CR5235 highlight the fact that section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for abdominal aortic aneurysms (AAA) under Medicare Part B, effective for services furnished on or after January 1, 2007, subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test.

Key Points

This article and CR 5235 define the parameters for AAA to Medicare beneficiaries as follows:

- The term "ultrasound screening for abdominal aortic aneurysm" means:
  - A procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, as specified by the Secretary of Health and Human Services through the national coverage determination process) provided for the early detection of abdominal aortic aneurysms; and
  - Includes a physician's interpretation of the results of the procedure.
- Effective for dates of service on and after January 1, 2007 Medicare will pay for a one-time ultrasound screening for AAA, for beneficiaries who meet the following criteria:
  - Receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (IPPE) (See MLN Matters article MM3638 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf* for more details on the IPPE.)
  - Receives such ultrasound screening from a provider or supplier who is authorized to provide covered diagnostic services.
  - Has not been previously furnished such an ultrasound screening under the Medicare program

Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms, continued

- Is included in at least one of the following risk categories:

  1. Has a family history of abdominal aortic aneurysm;
  2. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime;
  3. Is a beneficiary, who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

Payment

- The Part B deductible for screening AAA is waived effective January 1, 2007, but coinsurance is applicable.
- If the screening is provided in a physician office, the service is billed to the carrier using the HCPCS code G0389: Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening.
- Short Descriptor: Ultrasound exam AAA screen
- Modifiers: TC, 26 (modifiers are optional)
- Payment is under the Medicare Physician Fee Schedule (MPFS).

FIs will pay for the AAA screening only when the services are performed in a hospital, including a CAH, IHS facility, an SNF, RHC, or FQHC and submitted on one of the following types of bills (TOBs): 12x, 13x, 22x, 23x, 71x, 73x, 85x.

The following table describes the payment methodology Medicare will use for AAA screening:

Facility	Type of Bill	Payment
Hospitals subject to OPPS	12x, 13x	OPPS
Method I and Method II Critical Access Hospitals (CAHs)	12x and 85x	101 percent of reasonable cost
IHS providers	13x, revenue code 051x	OMB-approved outpatient per visit all inclusive rate (AIR)
IHS providers	12x, revenue code 024x	All-inclusive inpatient ancillary per diem rate
IHS CAHs	85x, revenue code 051x	101 percent of the all-inclusive facility specific per visit rate
IHS CAHs	12x, revenue code 024x	101 percent of the all-inclusive facility specific per diem rate
SNFs **	22x, 23x	Non-facility rate on the MPFS
RHCs*	71x, revenue code 052x	All-inclusive encounter rate
FQHCs*	73x, revenue code 052x	All-inclusive encounter rate
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12x, 13x	94 percent of provider submitted charges or according to the terms of the Maryland Waiver

*If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI using TOBs 71x and 73x, respectively, and the appropriate site of service revenue code in the 052x revenue code series. If the screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier under the practitioner's ID following instructions for submitting practitioner claims to the Medicare carrier. If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI under the base provider's ID, following instructions for submitting claims to the FI from the base provider.

** The SNF consolidated billing provision allows separate part B payment for screening services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a 22x bill type. Screening services provided by other provider types must be reimbursed by the SNF.

Implementation

The implementation date for this instruction is January 2, 2007.

Information Regarding Advanced Beneficiary Notices: Medicare contractors will deny an AAA screening service billed more than one in a beneficiary's lifetime.

If a second G0389 is billed for AAA for the same beneficiary or if any of the other statutory criteria for coverage listed in section 1861(s)(2)(AA) of the Social Security Act are not met, the service would be denied as a statutory (technical) denial under Section 1861(s)(2)(AA), not a medical necessity denial.

If a provider cannot determine whether or not the beneficiary has previously had an AAA screening, but all of the other statutory requirements for coverage have been met, the provider should issue the ABN-G. Likewise, if all of the statutory requirements for coverage have been met, but a question of medical necessity still exists, the provider should issue the ABN-G.

Implementation of an Ultrasound Screening for Abdominal Aortic Aneurysms, continued

Additional Information

The official instructions for CR 5235, issued to your Medicare carrier, FI, MAC, FQHC, RHC, SNF, or CAH regarding this change may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1113CP.pdf* on the CMS website. The Medicare *Claims Processing Manual*, Publication 100-04, Chapter 18, has been updated to include the requirements to implement section 5112 of the DRA of 2005. The new sections of this chapter address the payment and allowable settings for AAA and the sections are attached to CR5235.

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

MLN Matters Number: MM5235
Related Change Request (CR) #: 5235
Related CR Release Date: November 17, 2006
Effective Date: January 2, 2007
Related CR Transmittal #: R1113CP
Implementation Date: January 1, 2007

THERAPY SERVICES

Outpatient Therapy Cap Exceptions Clarifications

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

Provider Types Affected

Providers, physicians, and non-physician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and carriers) under the Part B benefit for therapy services.

Provider Action Needed

CR 4364, released February 15, 2006, described the exception process to the caps set on outpatient therapy services (physical therapy and occupational therapy). CR 5271, upon which this article is based, clarifies questions (below) that have arisen about this exception process. Thus, the article is meant primarily for informational purposes.

Background

A brief history may be beneficial at this point. The Balanced Budget Act of 1997 placed financial limitations on Medicare covered therapy services (therapy caps) that were implemented in 1999 and again for a short time in 2003. Congress placed moratoria on these caps for 2004 and 2005, but the moratoria are no longer in place, and the caps were re-implemented on January 1, 2006. However, Congress, through the Deficit Reduction Act has provided that (only for calendar year 2006) exceptions to caps may be made when provision of additional therapy services is determined to be medically necessary.

Review of this exception process

Section 1833(g)(5) of the Social Security Act provides that, for services provided during calendar year 2006, FIs, RHHIs, and carriers can, in certain circumstances, grant an exception to the therapy cap when requested by the individual enrolled under the Part B benefit (or by a person acting on behalf of that individual).

Exception Processes fall into two categories: 1) automatic process exceptions, or 2) manual process exceptions. Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if:

- they meet specific conditions and complexities listed in the Medicare Claims Processing Manual, Publication 100-04, Chapter 5, (as revised by CR 4364) for exception from the therapy cap for 2006; or,
- meet specific criteria for exception, in addition to those listed in the above referenced Manual, when the Medicare contractor believes (based on the strongest evidence available) that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.

Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

Outpatient Therapy Cap Exceptions Clarifications, continued

The clarifications to questions generated from CR 4364

Your FI, RHHI, or carrier:

1. Will grant exceptions for any number of medically necessary services for 2006 that meet the automatic process exception criteria, if the beneficiary meets the conditions described in *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR 4364).
2. Will grant an exception to the therapy cap, by approving any number of additional therapy treatment days, when these additional treatment days are deemed medically necessary based on documentation that you have submitted in 2006.
3. Will utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance in which you do not submit all required documentation with the exception request in 2006.
4. Must reply as soon as practicable to a request for exception. They will grant an exception to the therapy cap, approving the number of treatment days that you or the beneficiary request (not to exceed 15 future treatment days), if they do not make a decision within 10 business days of receipt of any request and appropriate documentation in 2006.
5. Will allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.
6. Will follow the manual description for allowing exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process in 2006.
7. Will allow automatic process exceptions when complexities occur in combination with other conditions that may or may not be on the list in the *Medicare Claims Processing Manual* in 2006.
8. Will, when a patient is being treated under the care of two physicians for separate conditions, accept as appropriate documentation either 1) A combined plan of care certified by one of the physicians/NPPs, or 2) Two separate plans of care certified by separate physicians/NPPs.
9. Will update the list of exceptions in 2006 according to the changes provided in this transmittal. You should be aware that they may expand (but not contract) this list if their manual process exception decisions lead them to believe further exceptions should be allowed.
10. Will not require the additional documentation that is encouraged but not required in the manuals.
11. Will interpret a referral or an order or a plan of care dated after an evaluation, as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.
12. Will not deny payment for re-evaluation only because an evaluation or re-evaluation was recently done, as long as documentation supports the need for re-evaluation. A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.
13. Will, on pre or post pay medical review, require clinicians to write progress reports at least during each progress report period. Note that required elements of the progress report that are written into the treatment notes or in a plan of care, acceptably fulfill the requirement for a progress report. In these instances, a separate progress report is not required.
14. Will require, on pre or postpay medical review of documentation, that when the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each progress report period and sign the progress report.
15. Will continue to use Medicare summary notice (MSN) message 38.18 on all Medicare MSN forms, both in English and in Spanish. This message reads: "ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are $1,740 for PT and SLP combined and $1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE."
16. Will continue to enforce local coverage determinations (LCDs).

Final Note: You should keep in mind that claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable.

Outpatient Therapy Cap Exceptions Clarifications, continued

Additional Information

You can find more information about outpatient therapy cap exceptions by going to CR 5271, issued in 3 transmittals. As attachments to those transmittals, you will find updated manual sections for:

- The Medicare Claims Processing Manual, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation); (This will be at *http://www.cms.hhs.gov/Transmittals/downloads/R1106Cp.pdf*.)
- The Medicare Program Integrity Manual, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.1.1 (Exception from the Uniform Dollar Limitation ["Therapy Cap"]). (This will be at *http://www.cms.hhs.gov/Transmittals/downloads/R171PI.pdf*); and,
- The Medicare Benefit Policy Manual, Chapter 15, Section 220.3 (Documentation Requirements for Therapy Services.) This is available at *http://www.cms.hhs.gov/Transmittals/downloads/R60BP.pdf* on the CMS site.

These manual revisions include numerous additional changes clarifications.

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

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

MLN Matters Number: MM5271
Related Change Request (CR) #: 5271
Related CR Release Date: November 9, 2006
Related CR Transmittal #: R60BP, R171PI, R1106CP
Effective Date: December 9, 2006, for nonsystem changes, January 2, 2007 for system changes
Implementation Date: December 9, 2006, for nonsystem changes, January 2, 2007 for system changes

Incorrect Denials for Therapy Claims Billed with the KX Modifier

Therapy claims submitted with the KX modifier are incorrectly denying with the following message: PR-119-Benefit maximum for this time period has been reached. We are working to resolve the issue as quickly as possible. However, it may not be resolved before April 2007.

No Action Required by Providers

Providers do not need to take action at this time. We will perform adjustments on all affected claims.

Note: Therapy claims billed with the KX modifier denied correctly if the denial message is other than PR-119.

We apologize for any inconvenience this may have caused.

GENERAL COVERAGE

Common Working File Duplicate Claim Edit for the Technical Component of Radiology and Pathology Laboratory Services Provided to Hospital Patients

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

Provider Types Affected

Radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the technical component (TC) of **radiology** laboratory services provided to Medicare fee-for-service hospital inpatients. Also affected are independent laboratories billing Medicare carriers for TC of **pathology** laboratory services provided to Medicare fee-for-service hospital patients.

Provider Action Needed

Effective April 1, 2007, CMS will install systems edits to prevent improper payments to radiology suppliers, physicians and nonphysician practitioners for the TC of radiology laboratory services during an inpatient stay. The system edits will also apply to independent laboratories for the TC of pathology laboratory services provided to beneficiaries during a covered inpatient hospital stay or provided on the same date of service as an outpatient service. This change applies to claims with dates of service on or after January 1, 2007, where the claim is received on or after April 1, 2007. Please be sure billing staff are aware of these changes.

Common Working File Duplicate Claim Edit for the Technical Component of Radiology and Pathology Laboratory Services Provided to Hospital Patients, continued

Background

Current Medicare billing practices allow either the hospital or the supplier performing the TC of physician pathology laboratory services to bill the carrier for these services. This policy has contributed to the Medicare program paying twice for the TC service, first through the prospective payment system (PPS) to the hospital and again to the supplier that bills the carrier, instead of the hospital, for the TC service.

Effective for claims received on or after April 1, 2007 for services on or after January 1, 2007, CMS will install systems edits to prevent additional improper payments to radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the TC of radiology laboratory services during an inpatient stay. The edits will also apply to independent laboratories for the TC of pathology services provided to beneficiaries during an inpatient stay or for the same date of service as an outpatient service.

Key Points

- Effective for claims received on or after April 1, 2007, Medicare will reject/deny a Part B TC or globally billed radiology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay. Such services will also be rejected/denied when they match with a date of service of a hospital inpatient previously processed by Medicare.
- Effective for claims received on or after April 1, 2007, Medicare will reject/deny reject a Part B TC or globally billed pathology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay when billed by a physician/supplier. Such services will also be rejected/denied when they match with a date of service of a hospital outpatient bill (bill types 13x and 85x) previously processed by Medicare.
- If providers submit a TC of a radiology or pathology service with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay the carrier will use remittance advice reason code 109 "Claim not covered by this payer/contractor." when denying a service line item.
- Where Medicare systems detect that a Part B TC or globally billed radiology or physician pathology service has been paid and Medicare subsequently receives a hospital inpatient bill for the same date of service, the Medicare carrier will adjust a TC of a radiology or physician pathology service line item and recoup the payment made for that service from the physician/supplier. The Medicare carrier will also adjust a TC of a pathology service for an outpatient claim. The same remittance advice reason code of 109 will be used in such cases.
- Effective for claims received on or after April 1, 2007, the carrier will deny an incoming Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (noncovered level of care) from and through dates plus one day on a posted hospital inpatient bill. Again, the carrier will use remittance advice reason code 109. In addition, the Medicare carrier will recoup payment made to the physician/supplier if a subsequent hospital inpatient bill is received for those same services.
- Carriers will not search their files to either retract payment or retroactively pay claims prior to the implementation of CR 5347. However, they will adjust claims if they are brought to their attention.

Implementation

This change will be implemented on April 2, 2007.

Additional Information

For complete details regarding this CR, please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1098CP.pdf* on the CMS website.

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

MLN Matters Number: MM5347
Related Change Request (CR) #: 5347
Related CR Release Date: November 2, 2006
Effective Date: April 1, 2007
Related CR Transmittal #: R1098CP
Implementation Date: April 2, 2007

Processing All Diagnosis Codes Reported on Claims Submitted to Carriers

Provider Types Affected

All physicians and providers submitting claims to carriers.

Provider Action Needed

STOP – Impact to You

Effective, at the earliest, July 1, 2007, the carrier standard system for Medicare will automatically process all diagnosis codes that you submit on your claims.

CAUTION – What You Need to Know

CR 4276, the second phase in the implementation of the Negotiated Rulemaking agreement to automatically consider all diagnosis codes reported on claims, includes finalization of the requirements and coding development for the standard system used by Medicare carriers.

GO – What You Need to Do

Make sure that your billing staffs are aware of these changes that allow eight diagnosis codes on Medicare claims effective, at the earliest, July 1, 2007.

Background

While the American National Standards Institute (ANSI) 837P 4010A allows the reporting of up to eight diagnosis codes in the 2300 loop, the Medicare carrier standard system uses only the first four diagnosis codes when processing HIPAA format claims. Carriers have used a manual process to consider the remaining diagnosis codes in the Medicare payment determination.

In CR 4276, from which this article is taken, CMS is requiring that (effective no earlier than July 1, 2007) the Medicare carrier standard system capture and process all diagnosis codes that are reported, up to the maximum of eight, on any claim (both electronic and paper) processed.

Additional Information

You can find more information about the application of all diagnosis codes reported in processing carrier claims by viewing CR 4276 at *http://www.cms.hhs.gov/Transmittals/downloads/R1095CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

MLN Matters Number: MM4276
Related Change Request (CR) #: 4276
Related CR Release Date: October 27, 2006
Effective Date: April 1, 2007
Related CR Transmittal #: R1095CP
Implementation Date: April 2, 2007

UPIN Required for Immunosuppressive Drugs

Until October 25, 2006, First Coast Service Options, Inc. (FCSO) did not have system logic in place to deny immunosuppressive codes submitted without a valid UPIN.

The system logic was updated for services processed on/after October 26, 2006. FCSO will not pursue overpayment recovery of claims previously paid. However, immunosuppressive claims processed on/after October 26, 2006, will be denied as unprocessable, if submitted without a valid UPIN. Providers will need to resubmit a new day claim with a valid UPIN. Below is a list of the immunosuppressive codes that require a UPIN.

Impacted Procedure Codes

J0480	J0702	J0704	J0800	J1020	J1030	J1040	J1094
J1100	J1700	J1710	J1720	J2650	J2920	J2930	J3301
J3302	J3303	J7500	J7501	J7502	J7504	J7505	J7506
J7507	J7509	J7510	J7511	J7513	J7515	J7516	J7517
J7518	J7520	J7525	J7599	J7624	J7637	J7638	J7683
J7684	J8530	J8540	J8610				

Source: CMS IOM, Publication 100-04, Chapter 26, Section 10.4

HIPAA – The Health Insurance Portability and Accountability Act

Electronic Data Interchange Media Changes

Some contractors allowed providers to submit EDI claims via fax imaging, diskette, tape, or other similar storage media. It is no longer cost effective for the Medicare program to accept claims submitted in this manner.

An EDI transaction is defined by its initial manner of receipt. Depending upon the capability of a carrier, DMERC, or FI and the details as negotiated between carrier/DMERC/FI and electronic claim submitters, an electronic claim could be submitted via central processing unit (CPU) to CPU transmission, dial up frame relay, direct wire (T-1 line or similar), or personal computer modem upload or download (also see section 30.3).

When counting electronic claims for workload reporting, the contractor includes data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through another FI, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. See § 90 of this chapter for information about application of the claims payment floor when a claim is submitted electronically in a non-HIPAA compliant format.

Carriers, DMERCs, and FIs are not permitted to classify the following as electronic claims for CROWD reporting, for payment floor or Administrative Simplification Compliance Act (ASCA, see section 90) mandatory electronic claim submission purposes:

- Bills received from providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for these bills.
- Adjustment bills (FIs only).
- Misdirected bills transferred to another carrier, DMERC, or FI.
- HHA bills where no utilization is chargeable and no payment has been made, but which have been requested only to facilitate record keeping processes. (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.)
- Bills paid by an HMO and processed by the contractor
- Transactions submitted on diskettes, CDs, DVDs or similar storage media that should only be accepted as part of a disaster recovery process.

Carriers, DMERCs, DME MACs, A/B MACs, and FIs are no longer permitted to accept claims via fax imaging, tape/diskette/similar storage media. Carriers, DMERCs, DME MACs, A/B MACs, and FIs are to assist billers using such media to transition to more efficient electronic media, such as the free Medicare claim submission or commercially available software that are considered to be more cost effective.

Source: Publication 100-04, Transmittal 1081, Change Request 5225

Returning Paper Claims Received From Clearinghouses

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

Provider Types Affected

All Medicare providers who submit paper claims to clearinghouses for filing with Medicare.

Provider Impact

If a clearinghouse submits claims for you on paper (rather than electronically) your payments may be affected. The Administrative Simplification Compliance Act (ASCA) requires that claims a clearinghouse submits to Medicare on your behalf must be submitted electronically. When your carrier or fiscal intermediary (FI) identifies that a clearinghouse has submitted a claim for you on paper, they will return the claim unprocessed to the clearinghouse.

Background

Section 3 of the Administrative Simplification Compliance Act (ASCA), PL 107-105; the implementing regulation at 42 CFR 424; and the *Medicare Claims Processing Manual* Chapter 24, Section 90-90.6 and its exhibits all require (except in limited situations) that you submit claims to Medicare electronically. And, while ASCA regulations do allow you (as a provider) to submit some, or all, claims on paper in very specific and limited instances; HIPAA covered entities (other than providers) are not eligible for an exemption from these electronic Medicare claim submission requirements.

CR 5341, from which this article is taken, addresses claims that your clearinghouse submits to Medicare on your behalf. To be specific, if you contract with a clearinghouse to send claims to Medicare for you, they are required to submit these claims electronically.

But this being said, there is evidence that some clearinghouses are routinely submitting paper claims without the providers' knowledge. You should be aware that your carriers and FIs, having identified that a provider's clearinghouse has submitted your claims in paper form, will return them back to the clearinghouse without action.

Returning Paper Claims Received From Clearinghouses, continued

Additional Information

The official instruction (CR 5341) issued to your Medicare contractor (carriers, durable medical equipment regional carrier (DMERC), DME Medicare Administrative Contractor (DME MAC), fiscal intermediary (FI), or Part A/B Medicare Administrative Contractor (A/B MAC)) regarding paper claims that they receive from clearinghouses is located at *http://www.cms.hhs.gov/Transmittals/downloads/R247OTN.pdf* on the CMS website.

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

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).

MLN Matters Number: MM5341
Related Change Request (CR) #: 5341
Related CR Release Date: November 3, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R247OTN
Implementation Date: January 2, 2007

APPEALS

Reopenings and Revisions of Claim Determinations and Decisions

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

Provider Types Affected

Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs) and carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs) for payment.

Provider Action Needed

STOP – Impact to You

This article, based on change request (CR) 4147, notifies you about changes to the *Medicare Claims Processing Manual*, which ensure that claims with **clerical errors (which include minor errors and omissions)** should be processed as "**reopenings**" and not as "**appeals.**"

CAUTION – What You Need to Know

All reopenings are conducted at the discretion of your Medicare contractor and are therefore not appealable. Your Part A Medicare contractor may continue to handle some errors through the claim adjustment process. The Centers for Medicare & Medicaid Services (CMS) has added "Missing data items, such as provider number or missing date of service" to the definition of clerical errors. Note that clerical errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services. Please note that third party payor errors DO NOT constitute clerical errors.

GO – What You Need to Do

Please refer to the Additional Information section of this article and to the information in the manual attachment to CR 4147 (Pub. 100-04, The Medicare Claims Processing Manual, Chapter 34, Section 10) for detailed and updated information regarding reopenings. Please note also that this information replaces what was previously found in Chapter 29, Section 90 of The Medicare Claims Processing Manual.

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 937 of MMA requires the establishment of a process for the correction of minor errors and omissions that do not necessitate the use of the formal appeals process.

Additional Information

"A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record." (Pub. 100-04, The Medicare Claims Processing Manual, Chapter 34, Section 10)If your reopening request is denied, you may not appeal the contractor's refusal to reopen but you can appeal the original claim denial as long as the timeframe to request an appeal has not expired. Requesting a reopening does not toll the timeframe to request an appeal. If a reopening results in a revised determination, new appeal rights will be afforded on that revised determination. Not all reopenings result in a revised determination. Some important points to note about reopenings as a result of these changes are as follows:

- Medicare contractors will not use reopenings as an appeal when a formal appeal is not available.
- Medicare contractors may conduct a reopening to revise an initial determination or redetermination. Medicare Secondary Payer (MSP) beneficiary or provider/supplier recovery claims are not reopening actions except where the recovery claim is a MSP provider/supplier recovery claim. All other MSP beneficiary or provider /supplier recovery claims are initial determinations.
- If a claim is suspended for medical review, a request for additional documentation (ADR) may be required to make a determination. If no response is received within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on lack of documentation. In such cases, if appealed with the requested documentation, the Medicare contractor will perform a reopening instead of an appeal. The reopenings will be performed by the medical review department.
- For Part A Medicare, there are a limited number of clerical errors that can be corrected through the reopening process. Many FIs are handling the correction of errors through the submission of an adjustment or corrected claim. FIs who are handling errors through adjustments will continue to do so.
- Medicare contractors will accept reopening requests only if they are made in writing or over the telephone. Please note that the telephone reopenings process is not required for fiscal intermediaries.
- Medicare contractors will ask the providers or suppliers to fax in the proof to support changes and error correction, when necessary.

Reopenings and Revisions of Claim Determinations and Decisions, continued

- In cases where the issue is: (1) too complex to be handled over the phone or (2) there is a need for additional medical documents, the Medicare contractor will inform the party that their request cannot be processed over the phone. In such instances, the contractor will advise the requestor to file their request in writing.
- Medicare contractors will require the following three items from the caller, prior to conducting a telephone reopening: (1) provider/ physician/supplier name & ID # or NSC #; (2) Beneficiary last name & first initial; and (3) Medicare HICN. NOTE: Items must match exactly.

CR 4147 is the official instruction issued to your FI/RHHI, carrier, DMERC, or DME MAC regarding changes mentioned in this article. CR 4147 may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1069CP.pdf* on the CMS website.

For additional information relating to the Medicare appeals process, you may wish to refer to Chapter 29 of the Medicare Claims Processing Manual, which is available at *http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf*.

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

MLN Matters Number: MM4147
Related CR Release Date: September 29, 2006
Related CR Transmittal #: R1069CP

Related Change Request (CR) #: 4147
Effective Date: November 29, 2006
Implementation Date: November 29, 2006

Appeals of Connecticut Claims and Appeal Decisions for Medicare Part B

Effective January 1, 2006 the Medicare claim appeals process was amended. The reconsideration process has been added as the new second level of appeal. In addition, it is no longer necessary to appeal a claim if a minor error or omission was made which caused the claim to deny. In these cases, the provider can request that the claim be reopened and the error or omission corrected.

Definitions

Levels of Appeal	Definition	Time Limit from Determination	Address
First Redetermination	The first appeal level after the initial determination. A redetermination must be submitted to the carrier in writing.	120 days from initial or revised initial determination	Connecticut Medicare Part B Appeals First Coast Service Options, Inc. P.O. Box 45041 Jacksonville, FL 32232-5041
Second Hearings	The second level of appeal for redeterminations made prior to 01/01/06. These appeals should be submitted to the carrier as instructed in your redetermination notice	Six months from the redetermination	Connecticut Medicare Part B Hearings First Coast Service Options, Inc. P.O. Box 45041 Jacksonville, FL 32232-5041
New Second Reconsideration	The new second level of appeal for redeterminations made on or after 01/01/06. These appeals should be submitted to the qualified independent contractor (QIC) as instructed in your redetermination notice.	180 days from redetermination	Connecticut Q2 Administrators, LLC Part B QIC East Operations P.O. Box 183092 Columbus, Ohio 43218-3092 Attn: Administration Manager

Appeals of Connecticut Claims and Appeal Decisions for Medicare Part B, continued

Appeal Process

If you are dissatisfied with the determination made on your case you should file an appeal with the appropriate entity. The appropriate entity depends on the level of appeal and the completion date of the determination you are appealing. The name and address for the next level of appeal will appear on your decision notice. Providers, physicians, and other suppliers are responsible for submitting all required documentation with the appeal request.

REMINDER: Unprocessable claims (CO16 denial code) result when the provider submits an incomplete or invalid Medicare claim (EMC or paper). Claims denied as unprocessable because information is incomplete, missing, invalid or non-linked (diagnosis code reference number) cannot be corrected over the telephone or via written appeal. The provider must determine what information is missing or incomplete, correct the billing error and file a new claim to the carrier. Example: A claim submitted with an invalid modifier.

Telephone Reopening Process

Did you know…

Minor errors or omissions could be corrected outside of the appeals process?

How…

- A clerical error reopening may be initiated via the telephone or in writing; or
- In most cases, the denied service (s) may simply be resubmitted.

Prior to requesting a telephone reopening you must provide the following three items:

- The provider's/physician's/supplier's name and identification number
- Beneficiary last name, first initial
- Medicare health insurance number (HICN).

When you call, please have your remittance advice and any other documentation on hand. We will only handle three reopening requests during each call.

The hours of operations for requesting a reopening are:

Monday – Friday 8:00 a.m. – 4:00 p.m.
1-866-535-6790

Examples of minor clerical errors or omissions that can be handled via a telephone clerical reopening are as follows:

- Number of services/units billed
- Submitted charge amount
- Date of service (DOS)
- Add, change or delete certain modifiers (**excluding** 22, 24, 25, 52, 53, 58, 62, 66, 78, and 79)
- Transposed procedure or diagnosis codes.

Non-Acceptable items via Telephone Clerical Reopenings

- Limitation of liability
- Potential overpayments
- Medical necessity denials and reduction
- Denials requiring manual review of medical documentation
- Year of service, which result in overpayment
- Provider number/name
- Utilization denials.

A written redetermination must be requested for the type of denials above.

Resubmission of Minor Clerical Errors

Resubmitting denied lines on a claim that are the result of a minor clerical error or omission reduces processing delays and saves you time and money!

Examples of minor clerical errors or omissions that may be corrected and resubmitted via a new claim are as follows:

- Changes of diagnosis codes
- Addition, changes, or deletion of modifiers (e.g., 24, 25, 50, 59, 78, 79, RT, LT)
- Incorrect place of service.

***Resubmit ONLY the denied service (s)! Resubmitting the entire claim may result in a duplicate denial.**

Redetermination Request

Redetermination requests should be submitted on the Redetermination form with documentation attached to support the service(s) rendered. The redetermination forms are located at *http://www.connecticutmedicare.com*.

Reconsideration Request

Reconsideration requests should be submitted on the reconsideration form attached to your redetermination notice.

Source: CMS Pub 100-04, Transmittal 1069, Change Request 4147
CMS Pub 100-04, Chapter 29, Section 310

Appeals of Florida Claims and Appeal Decisions for Medicare Part B

Effective January 1, 2006, the Medicare claim appeals process was amended. The reconsideration process has been added as the new second level of appeal. In addition, it is no longer necessary to appeal a claim if a minor error or omission was made which caused the claim to deny. In these cases, the provider can request that the claim be reopened and the error or omission corrected.

Appeals of Florida Claims and Appeal Decisions for Medicare Part B, continued

Definitions

Levels of Appeal	Definition	Time Limit from Determination	Address
First Redetermination	The first appeal level after the initial determination. A redetermination must be submitted to the carrier in writing.	120 days from initial or revised initial determination	Florida Medicare Part B Claims Review P.O Box 2360 Jacksonville, FL32231-2100
Second Hearings	The second level of appeal for redeterminations made prior to 01/01/06. These appeals should be submitted to the carrier as instructed in your redetermination notice.	Six months from the redetermination	Florida Medicare Hearings Post Office Box 45156 Jacksonville FL 32232-5156
New Second Reconsideration	The new second level of appeal for redeterminations made on or after 01/01/06. These appeals should be submitted to the qualified independent contractor (QIC) as instructed in your redetermination notice.	180 days from redetermination	Florida Q2 Administrators, LLC Part B QIC East Operations P.O. Box 183092 Columbus, Ohio 43218-3092 Attn: Administration Manager

Appeal Process

If you are dissatisfied with the determination made on your case you should file an appeal with the appropriate entity. The appropriate entity depends on the level of appeal and the completion date of the determination you are appealing. The name and address for the next level of appeal will appear on your decision notice. Providers, physicians, and other suppliers are responsible for submitting all required documentation with the appeal request.

REMINDER: Unprocessable claims (CO16 denial code) result when the provider submits an incomplete or invalid Medicare claim (EMC or paper). Claims denied as unprocessable because information is incomplete, missing, invalid or non-linked (diagnosis code reference number) cannot be corrected over the telephone or via written appeal. The provider must determine what information is missing or incomplete, correct the billing error and file a new claim to the carrier. Example: A claim submitted with an invalid modifier.

Telephone Reopening Process

Did you know…

Minor errors or omissions could be corrected outside of the appeals process?

How…

- A clerical error reopening may be initiated via the telephone or in writing; or,
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Prior to requesting a telephone reopening you must provide the following three items:

- The provider's/physician's/supplier's name and identification number,
- Beneficiary last name, first initial
- Medicare health insurance number (HICN).

When you call, please have your remittance advice and any other documentation on hand. We will only handle three reopening requests during each call.

The hours of operations for requesting a reopening are:

Monday – Friday 8:00 a.m. – 4:00 p.m.
1-866-454-9007

Examples of minor clerical errors or omissions that can be handle via a telephone clerical reopening are as follows:

- Number of services/units billed
- Submitted charge amount
- Date of service (DOS)
- Add, change or delete certain modifiers (e.g., 79,91,50,58, RT, LT)
- Procedure code; excluding codes requiring documentation on the initial submission or codes being upcoded
- Diagnosis Code

Note: It may take up to 60 days to process a telephone clerical reopening.

Non-Acceptable items via Telephone Clerical Reopenings

- Limitation of liability
- Potential overpayments
- Medical necessity denials and reduction
- Analysis of documents such as operative reports, clinical summaries
- Year of service which result in overpayment
- Provider number/name
- Utilization denials.

A written redetermination must be requested for the type of denials above.

Appeals of Florida Claims and Appeal Decisions for Medicare Part B, continued

Resubmission of Minor Clerical Errors

Resubmitting denied lines on a claim that are the result of a minor clerical error or omission reduces processing delays and saves you time and money!

Examples of minor clerical errors or omissions that may be corrected and resubmitted via a new claim are as follows:

- Changes of diagnosis codes
- Addition, changes, or deletion of modifiers (e.g., 24, 25, 50, 59, 78, 79, RT, LT)
- Incorrect place of service

***Resubmit ONLY the denied service (s)! Resubmitting the entire claim may result in a duplicate denial.**

Redetermination Request

Redetermination requests should be submitted on the Redetermination form with documentation attached to support the service(s) rendered. The redetermination forms are located at: *http://www.floridamedicare.com*.

Reconsideration Request

Reconsideration requests should be submitted on the reconsideration form attached to your redetermination notice.

Source: CMS Pub 100-04, Transmittal 1069, Change Request 4147
CMS Pub 100-04, Chapter 29, Section 310

FRAUD

New Contractors Help Identify Fraud in the Medicare Part D Prescription Drug Program—Connecticut Only

This notice is to inform you that the Centers for Medicare & Medicaid Services (CMS) has contracted Medicare Drug Integrity Contractors (MEDICs) to investigate any complaints or allegations (within their jurisdiction) of potential fraud, waste and abuse related to the Medicare prescription drug benefit.

MEDIC North jurisdiction includes Montana, Wyoming, North Dakota, South Dakota, Nebraska, Minnesota, Iowa, Wisconsin, Illinois, Indiana, Michigan, Kentucky, Ohio, West Virginia, Pennsylvania, New York, Vermont, Maine, New Hampshire, Massachusetts, Rhode Island, **Connecticut**, New Jersey, Delaware and Maryland, the District of Columbia, and the U.S. Virgin Islands

You are invited to learn more about the role of the MEDIC at *http://www.edssafeguardservices.eds-gov.com/*, which will be available December 1, 2006.

MEDIC North is interested in receiving complaints of potential fraud, waste or abuse from Medicare providers, suppliers and other concerned parties.

Some examples of these types of complaints may include:

- Situations where the prescriber is offered or paid to write prescriptions for certain drugs or products.
- Situations known where the provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs.
- Situations where the prescriber falsifies information (not consistent with medical record) submitted through a prior authorization or other formulary oversight mechanism in order to justify coverage.
- Theft of prescriber 's Drug Enforcement Administration (DEA) number or prescription pad. This information could illegally be used to write prescriptions for controlled substances or other medications.
- Suspicions of inappropriate relationships between pharmaceutical manufacturers and physicians that may include:
- "Switching" arrangements, when manufacturers offer physicians cash payments or other benefits each time a patient's prescription is changed to the manufacturer's product from a competing product.
- Incentives offered to physicians to prescribe medically unnecessary drugs.
- Illegal promotion of off-label drug usage through marketing, financial incentives, or other promotional campaigns.
- Providing free samples to physicians knowing and expecting those physicians to bill the federal health care programs for the samples.

Please report your complaint to **1-877-7SafeRx or** 1-877-772-3379 to report complaints that you think may indicate fraud.

Source: Program Safeguard Contractor

NATIONAL PROVIDER IDENTIFIER

Reporting the National Provider Identifier on Physician Claims for Clinical Diagnostic Services Purchased Outside of the Local Carrier's Jurisdiction

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

Provider Types Affected

Physicians billing Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for diagnostic services purchased outside the local carrier or A/B MAC's jurisdiction.

Background

This article relates to change request (CR) 5289, in which the Centers for Medicare & Medicaid Services (CMS) provides specific instructions for physicians to modify their current reporting guidelines and requires physicians to begin **reporting, as of May 23, 2007, a National Provider Identifier (NPI) on claims for clinical diagnostic services purchased outside of the local carrier's jurisdiction**. Previously CMS instructed physicians to report their provider identification number (PIN) on claims when billing for clinical diagnostic services purchased outside of the local carrier 's jurisdiction. (See CR 3630, Transmittal 415, issued on December 23, 2004 at: *http://www.cms.hhs.gov/Transmittals/downloads/R243OTN.pdf* on the CMS website).

As of May 23, 2007, physicians must begin using their NPI to bill the local carrier for a clinical diagnostic service purchased outside of the jurisdiction of the local carrier or A/B MAC. As of May 23, 2007, remember the following:

- When reporting the 2400 PS1 segment (Purchased Service Information) of the ANSI X12 837 electronic claim format, version 4010A, the billing physician must report their NPI.
- When submitting paper claims, physicians must report their NPI for both the purchased portion of the test and the portion of the test that they performed.
- Physicians may no longer report a PIN after May 22, 2007.

Prior to May 23, 2007, physicians may report the PIN, the NPI, or both PIN and the NPI.

Additional Information

For complete details, please see the official instruction issued to your Medicare carrier or A/B MAC, regarding this change. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R243OTN.pdf* on the CMS website.

To learn more about the NPI and how to apply for one, visit *http://www.cms.hhs.gov/NationalProvIdentStand/* on the CMS website.

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

MLN Matters Number: MM5289	Related Change Request (CR) #: 5289
Related CR Release Date: October 27, 2006	Effective Date: April 1, 2007
Related CR Transmittal #: R243OTN	Implementation Date: April 2, 2007

Electronic Claims Submitted Without the Medicare Legacy Number During the Stage 2 Transition Period

In previous provider educational notifications addressing the national provider identifier (NPI) initiative, Medicare has strongly recommended that providers, clearinghouses, and billing services continue to submit the Medicare fee-for-service legacy number during the stage 2 implementation of the NPI transition period that started on October 1, 2006.

During the stage 2 NPI transition period of October 1, 2006, through May 22, 2007, Medicare is recommending that providers submitting Medicare fee-for-service claims send in **both** NPIs and legacy provider numbers. Electronic claims must be submitted either by using:

- **Only** the provider's Medicare legacy number, such as a provider identification number (PIN), NSC number, OSCAR number or UPIN; or
- **Both** the provider's NPI and legacy number.

If providers submit Medicare claims with only an NPI, the following may occur:

- Claims may be processed and paid, or
- Claims for which Medicare systems are unable to properly match the incoming NPI with the Medicare legacy number (e.g., PIN, OSCAR number) may be returned to the provider as unprocessable, and then the provider will need to resubmit the claim with the appropriate Medicare legacy number.

Based on the above guidelines, **effective for claims processed on or after October 1, 2006,** and until further notice, claims submitted with only an NPI will be returned to the provider as unprocessable if a properly matching Medicare legacy number cannot be found.

Action Required by Providers

Providers must resubmit claims with the appropriate Medicare legacy number when a claim is denied as unprocessable because of a missing legacy number. The same means of submission **must** be used to refile the claim (e.g.; providers that submitted electronically shall resubmit electronically). Please note that NPIs cannot be submitted on paper claims until the implementation of the revised Form CMS-1500 (08/05) on January 2, 2007.

Source: CMS Pub. 100-20, Transmittal 249, CR 5378

National Provider Identifier—Just 6 Months Remaining

NPI: Get It. Share It. Use It.

Over 1.4M national provider identifiers (NPIs) have been issued. Do you have yours?
Think you don't need an NPI? Think again, and be sure. If you are a health care provider who bills for services, you probably do need an NPI. If you bill Medicare for services, you definitely do!

The bad news is that as of November 23. 2006, only six months remain until the NPI compliance date. The implementation of the NPI is a complex process that will impact all business functions of your practice, office or institution including billing, reporting and payment. This is why providers are urged to get, share, and use their NPI NOW to avoid a disruption in cash flow.

If you don't have an NPI, get one. If you have one, start the testing process with your health plan and use it on your claims and other transactions.

The Center for Medicare & Medicaid Services (CMS) continues to urge providers to include legacy identifiers on their NPI applications. This information is critical for health plans and health care clearinghouses in the development of crosswalks to aid in the transition to the NPI.

Key NPI Facts

The CMS along with the Workgroup for Electronic Data Interchange (WEDI) and other industry health plans would like to remind providers of the following key NPI facts:

Every covered health care provider must get and use the NPI; and even if a health care provider is an individual and is not conducting electronic transactions and is, therefore, not a covered provider, he or she may be required by health plans or employers to obtain an NPI.

The NPI is not just a number. It does affect internal and external business and systems operations and can affect the appropriate payment of claims in a timely manner.

It is estimated that use of the NPI can require a transition period of no less than 120 days.

Providers should begin to test and use their NPIs in electronic health care transactions no later than January 31, 2007.

May 23, 2007 is not when the process starts, but when the process must be completed.

Providers may be requested to communicate their NPIs to health plans, clearinghouses, and other providers well before the compliance date.

A health care provider who is a sole proprietor is considered an individual and can only have ONE NPI.

Sharing NPIs

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business, and with health plans that request it. In fact, as outlined in current regulation, all providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes – including designation of ordering or referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their numbers for them.

National Provider Identifier—Just 6 Months Remaining, continued

NPIs are FREE!

Health care providers should know that getting an NPI is free. You do not need to pay an outside source to btain your NPI for you. All CMS education on the NPI is also free. CMS does not charge for its education or materials.

NPI Questions

CMS continues to update our Frequently Asked Questions (FAQs) to answer many of the NPI questions we receive on a daily basis. Visit the following link to view all NPI FAQs:
http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=Qjr3YRYh&p_lva=&p_li=&p_page=1&p_cv=&p_pv=&p_prods=0&p_cats=&p_hidden_prods=&prod_lvl1=0&p_search_text=NPI&p_new_search=1&p_search_type=answers.search_nl

Providers should remember that the NPI Enumerator can **only** answer/address the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application .

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203.

Upcoming WEDI Events

WEDI has several NPI events scheduled in the upcoming month. Visit *http://www.wedi.org/npioi/index.shtml* to learn more about these events. Please note that there is a charge to participate in WEDI events.

Important Information for Medicare Providers

Communicating NPIs to Medicare

Medicare providers should know that there is no "special process" or need to call to communicate NPIs to the Medicare program. NPIs can be shared with the Medicare program in three different ways, as part of the following standard procedures:

- Medicare providers should use their NPI, along with appropriate legacy identifiers, on their Medicare claims
- For new Medicare providers, an NPI must be included on the CMS-855 enrollment application
- Existing Medicare providers must provide their NPIs when making any changes to their Medicare enrollment information

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found at the CMS NPI page *www.cms.hhs.gov/NationalProvIdentStand* on the CMS website. Providers can apply for an NPI online at *http://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Getting an NPI is free - not having one can be costly.

Source: CMS Learning Resource, Message 200611-15

GENERAL INFORMATION

Application Update to Medicare Deductible, Coinsurance and Premium Rates for 2007

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and Part A/B MACs for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5345, which announces the 2007 Medicare rates and instructs your Medicare contractors to make necessary updates to their claims processing systems.

Background

There are beneficiary-related costs for using certain services under Parts A and B of Medicare, typically in the form of deductibles, co-payments, and/or premium payments. Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61-90 day spent in the hospital.

An individual has 60 lifetime reserve days (LRDs) of coverage, which they may elect to use after the 90 day in a spell of illness. The coinsurance amount for these LRDs is equal to one-half of the inpatient hospital deductible.

For skilled nursing facility (SNF) services furnished during a spell of illness, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21 through the 100 day.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium.

Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment occurs more than 12 months after the date a person is initial eligibility to enroll, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under supplementary medical insurance (SMI) or Part B, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When SMI enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

Medicare Part A for 2007

For calendar year (CY) 2007, the following rates are applicable for Medicare Part A deductible, coinsurance, and premium amounts:

Deductible
$992.00 per benefit period

Coinsurance
$248.00 a day for days 61-90 in each period
$496.00 a day for days 91-150 for each LRD used
$124.00 a day in a SNF for days 21-100 in each benefit period

Premium
$410.00 per month for those who must pay a premium
$451.00 per month for those who must pay both a premium and a 10 percent increase
$226.00 per month for those who have 30-39 quarters of coverage
$248.60 per month for those who have 30-39 quarters of coverage and must pay a 10 percent increase

Medicare Part B for 2007

For CY 2007, the following rates are applicable for Medicare Part B deductible and coinsurance.

Deductible	$131.00 per year
Coinsurance	20 percent

Application Update to Medicare Deductible, Coinsurance and Premium Rates for 2007, continued

CMS updates the Part B premium each year. These adjustments are made according to formulas set by statute. By law, the monthly Part B premium must be sufficient to cover 25 percent of the program's costs, including the costs of maintaining a reserve against unexpected spending increases. The federal government pays the remaining 75 percent.

Below are the annual Part B premium amounts from calendar year (CY) 1996 to 2006. For these years, and years prior to 1996, the Part B premium is a single established rate for all beneficiaries.

Year	Premium	Year	Premium	Year	Premium
1996	$42.50	2000	$45.50	2004	$66.60
1997	$43.80	2001	$50.00	2005	$78.20
1998	$43.80	2002	$54.00	2006	$88.50
1999	$45.50	2003	58.70		

Beginning on January 1, 2007, the Part B premium will be based on the income of the beneficiary. Below are the CY 2007 Part B premium amounts based on beneficiary income parameters.

Income Parameters for Determining Part B Premium

Premium/mon	Individual Income	Combined Income (Married)
$ 93.50	$ 80,000.00 or less	$160,000.00 or less
$105.80	$ 80,000.01 - $100,000.00	$160,000.01 - $200,000.00
$124.40	$100,000.01 - $150,000.00	$200,000.01 - $300,000.00
$142.90	$150,000.01 - $200,000.00	$300,000.01 - $400,000.00
$161.40	$200,000.01 or more	$400,000.01 or more

Implementation

The implementation date for CR 5345 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC,DME MAC, intermediary, RHHI, or A/B MAC regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R41GI.pdf* on the CMS website.

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

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

MLN Matters Number: MM5345
Related CR Release Date: October 27, 2006
Related CR Transmittal #: R41GI
Related Change Request (CR) #: 5345
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Carrier Jurisdiction for Ambulance Supplier Claims

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

Provider Types Affected

Ambulance suppliers who submit claims to Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for ambulance services furnished to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

Effective for claims processed January 1, 2008 and later, a claim for an ambulance service furnished by a supplier must be filed with the carrier or A/B MAC having jurisdiction for the "point of pickup" (POP).

CAUTION – What You Need to Know

Effective April 1, 2007, each carrier will begin processing applications from ambulance suppliers that are rendering services in their jurisdiction. For claims with dates of service January 1, 2008 and later, carriers will return claims as unprocessable any claim for a ground or air ambulance service where the POP is not within its jurisdiction.

GO – What You Need to Do

Be sure your staff knows to file Medicare claims with the carrier or A/B MAC having jurisdiction for the POP to assure prompt and accurate payment.

Carrier Jurisdiction for Ambulance Supplier Claims, continued

Background

The Medicare claims filing jurisdiction rule for ambulance services has been that an ambulance must file the claim with the carrier or A/B MAC having jurisdiction for where the service was furnished. When the ambulance fee schedule policies and systems changes were being developed, most carriers interpreted this rule to mean that a claim for an ambulance service must be filed with the carrier or A/B MAC having jurisdiction for the area where the vehicle is garaged or hangered. When the ambulance fee schedule was implemented beginning January 1, 2000, CMS determined that this de facto interpretation of the claims filing jurisdiction rule would not be changed during the fee schedule transition period, which was completed on January 1, 2006. (See Program Memorandum [PM] AB-00-88, Change Request [CR] 1281, dated September 18, 2000 which was re-issued as PM AB-01-185 dated December 14, 2001. CR 1281 can be found at the following link *http://www.cms.hhs.gov/Transmittals/Downloads/AB01185.pdf* on the CMS website.)

Currently all ambulance services are paid under the fee schedule which is based on the location from which the beneficiary is transported, i.e., the "point of pickup" (POP). Because the basis for payment under the fee schedule is based on the POP, it is reasonable for the claims filing jurisdiction rule to also be based on the POP.

Changing the claims filing jurisdiction to the POP will ensure jurisdictional congruence between the policies for payment and claims filing. It will additionally ensure that the ambulance supplier meets the State and local requirements where the service was furnished, which was the original intent of the claim filing jurisdiction rule. This change will:

- Bring administrative practice into congruence with the longstanding regulatory standards at 42 C.F.R. section 410.41;
- Avoid having federal administrative practice undercut appropriate state and local regulatory standards; and
- Promote an appropriate level of service for all Medicare beneficiaries.

For dates of service of January 1, 2008, or later, ground and air ambulance supplier claims for a POP not rendered in the carrier's (or A/B MAC's) jurisdiction will be returned to the supplier as "unprocessable", accompanied by the following remittance advice message:

- "N104 This claim/service is not payable under our claims jurisdiction area. You can identify the Medicare contractor to process this claim/service through the CMS website at *http//:www.cms.hhs.gov*."

Carriers and A/B MACs will not apply this rule to:

- Ambulance claims submitted to the carrier that processes indian health service ambulance claims, or
- Any future ambulance demonstration claims unless CMS so directs that this policy applies.

As a consequence of changing the claims filing rule to the POP, ambulance suppliers (including those who operate in multiple states) must be enrolled with the carrier in each jurisdiction where they furnish services to Medicare beneficiaries. This is the case even if that supplier does not garage or hanger its vehicles in each state in which the supplier operates (Required by 42 C.F.R. section 410.41 located at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410_41.pdf* on the Centers for Medicare & Medicaid (CMS) website).

Note: As early as April 1, 2007, each carrier or A/B will begin processing applications from ambulance suppliers that are rendering services in their jurisdiction.

Exception: Where the POP is outside the United States, the claim for an ambulance service furnished by a supplier must be filed in accordance with the instructions in Publication 100-4, The Medicare Claims Processing Manual, Chapter 1 section 10.1.4.1. Carrier jurisdiction is defined in Publication 100-04, Chapter 1 section 10.1.4.2. These instructions can be found at *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the CMS website.

Additional Information

CR 5203 is the official instruction issued to your Medicare carrier or A/B MAC regarding changes mentioned in this article. CR 5203 may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1100CP.pdf* on the CMS website.

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

MLN Matters Number: MM5203
Related Change Request (CR) #: 5203
Related CR Release Date: November 3, 2006
Effective Date: January 1, 2008
Related CR Transmittal #: R1100CP
Implementation Date: January 1, 2008

HMO Information Available on the Interactive Voice Response Unit

Effective November 1, 2006, the interactive voice response unit (IVR) began voicing Health Maintenance Organization (HMO) information under Option 3, and Option 7. When HMO information is offered, you will hear the following script, depending on the selected HMO Option:

Option 3 - Eligibility, HMO and Deductible Information

- HMO Option A B C
- For this patient, Medicare is responsible only for dialysis services. For all other services, this patient is currently on an HMO.

Afterward, the system will allow you to hear specific information by pressing *1* on the keypad. The following HMO information is voiced on the requested beneficiary:

- HMO number
- Name and address of the HMO
- Effective date of the HMO

Option 7 – HMO name and address

Under Option 7, you may enter an HMO number, and the system will voice the name and address of the HMO, which has been recorded from the HMO list on the CMS website. For example: If you enter HMO number *H1036* (Humana Medical Plan), the IVR will voice "Humana Medical Plan" as the name of the HMO, and will also voice Humana's address.

For your convenience, the IVR hours of operation for patient eligibility and claims status information are Monday through Friday 6:00 a.m.- 6:00 p.m. Eastern Time.

Laboratory Competitive Bidding Demonstration

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

Note: This article was previously published as MM5205, based on CR 5205, which discussed the initial phase of implementing this demonstration.

Provider Types Affected

Physicians and all providers who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites

Background

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory

Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

Key Points

This article and change request (CR) 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this article and CR 5359 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the zip code of the beneficiary's residence.
- Hospital inpatient testing is covered by Medicare Part A and is therefore exempt from the demonstration.
- Physician office laboratory (POL) testing and hospital outpatient testing are not included in the demonstration, except where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.
- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

Required Bidders

Laboratory firms with $100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for "demonstration tests" provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located)

Laboratory Competitive Bidding Demonstration, continued

will be required to bid in the demonstration.

These laboratory firms will be referred to as "required bidders."

Passive Laboratories

Small laboratories or laboratory firms with less than $100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will not be required to bid in the demonstration. These laboratories are considered "passive" laboratories." Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of $100,000.

Passive laboratory firms exceeding the annual ceiling of $100,000 will be:

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.
- Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considers "passive-ESRD" laboratories. Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration tests provided to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007 through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

Winners

Both required and non-required bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled "winners."

Non-Winners

Both required and non-required bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled "non-winners."

Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Non-winner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, non-winner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

Although non-winner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Demonstration Sites

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's zip code of residence

CMS will provide the contractors with a list of zip codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Implementation

CR 5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

During the first quarter of 2007, CMS will provide Medicare carriers, FIs, and A/B MACs with a national zip code pricing

Laboratory Competitive Bidding Demonstration, continued

file identifying the zip codes included in the first CBA. Also, in that same timeframe, CMS will provide to the carriers, FIs, and A/B MACs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

Claims submitted by non-winner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code 96 (noncovered charges);
- Remark code M114 (This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.); and
- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Using these same reason and remark codes, Medicare will reject any laboratory claims with a date of service between April 1, 2007, and March 31, 2010 with a modifier "90" submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA, regardless of the referring laboratory's participation status.

Medicare will pay claims during the demonstration period submitted by non-demonstration laboratories for beneficiaries residing in the CBA who receive services outside of those areas (e.g., "snow birds") according to the laboratory competitive bidding demonstration.

Non-winning laboratories should know that advance beneficiary notices (ABNs) and Notices of Beneficiary Exclusion from Medicare Benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at non-winner laboratories.

Line items for demonstration services and for non-demonstration services may be submitted on the same claim.

A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

Medicare contractors will be prepared to begin processing claims under the laboratory competitive bidding demonstration in the first CBA on April 1, 2007. The tentative start date for the demonstration in the second CBA is April 1, 2008.

Remember that required and non-required bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

Implementation

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

Additional Information

The official instructions issued to your Medicare carrier, FI, or A/B MAC regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R50DEMO.pdf* on the CMS website.

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

MLN Matters Number: MM5359
Related CR Release Date: November 1, 2006
Related CR Transmittal #: R50DEMO

Related Change Request (CR) #: 5359
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

1. Please note that the demonstration design described in Transmittals R49DEMO and R50DEMO, which provide instructions to Medicare contractors for the implementation of a CMS laboratory competitive bidding demonstration, is a proposed design and has not yet received final approval from the Office of Management and Budget.

2. 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.

Laboratory Competitive Bidding Demonstration

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the October 2006 Medicare B Update! pages 33-35.

Note: This article has been superseded by *MLN Matters* article MM5359. Please review MM5359 for more current information regarding this demonstration effort. The new article is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5359.pdf* on the CMS site.

MLN Matters Number: MM5205 *Revised*
Related CR Release Date: August 1, 2006
Related CR Transmittal #: R49DEMO

Related Change Request (CR) #: 5205
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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.

National Influenza Vaccination Week: November 27 – December 3, 2006

November 27 to December 3 is National Influenza Vaccination Week. The Centers for Disease Control and Prevention has designated the week after Thanksgiving as national influenza vaccination week.

This week long event is designed to raise awareness of the importance of continuing influenza (flu) vaccination, as well as foster greater use of flu vaccine through the months of November, December and beyond. Since flu activity typically does not peak until February or later, November and December still provide good opportunities to get vaccinated. The Centers for Medicare & Medicaid Services (CMS) invites you to join in this event as an opportunity to ensure that people with Medicare get their flu shot.

The flu vaccine is the best way to protect your patients from the flu. Though Medicare provides coverage for the flu vaccine and its administration, there are still many beneficiaries who don't take advantage of this benefit. If you have Medicare patients who have not yet received their flu shot, we ask that you encourage these patients to protect themselves from the risk and severity of the flu virus. – And don't forget to immunize yourself and your staff.

Protect yourself, your patients, and your family and friends. Get Your Flu Shot.

Remember: Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf.*

Source: CMS Provider Education Resource 200611-16

Flu Shot Reminder

Flu season is here! Medicare patients give many reasons for not getting their flu shot, including:

"It causes the flu" "I don't need it"
"It has side effects" "It's not effective"
"I didn't think about it" "I don't like needles!"

The fact is that out of the average 36,000 people in the U.S. who die each year from influenza and complications of the virus, greater than 90 percent of deaths occur in persons 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk to your Medicare patients about the importance of getting their annual flu shot—and don't forget to immunize yourself and your staff.

Protect yourself, your patients, and your family and friends. **Get Your Flu Shot!**

Remember: Influenza vaccination is a covered Medicare Part B benefit.

Note: Influenza vaccine is not a Medicare Part D covered drug.

For information about Medicare's coverage of adult immunizations and educational resources, go to CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf*.

Source: CMS Provider Education Resource 200611-01

Revision to the Electronic Funds Transfer Authorization Agreement (Form CMS-588)

The Centers for Medicare & Medicaid Services (CMS) issued revisions to the CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement. EFT deposits your Medicare payments directly into your bank account. *CMS requires that all providers that are enrolling in the Medicare program or making any changes to their Medicare enrollment file, must sign up for EFT.* Effective December 1, 2006, First Coast Service Options, Inc. can only accept Form CMS 588 (08/06) version of the Electronic Funds Transfer (EFT) Authorization Agreement.

To sign up, you must complete Form CMS-588 (08/06) version available at *http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf*. The completed form must be signed and dated by the provider or authorized/delegated official (for groups or organizations). For existing Medicare providers, the authorized delegated official must be the same authorized delegated the contractor has on file. **The signature must be original and cannot be a copy or stamped signature.**

Under the Physician/Provider/Supplier Information section, the form asks for "Medicare Identification Number." In this field, please indicate your Medicare provider identification number (PIN) (also known as Medicare legacy number). This field can be left blank if you are submitting the EFT authorization agreement with an initial enrollment application. The national provider identifier (NPI) must be included in the "National Provider Identifier (NPI)" field.

Include a copy of a voided check or deposit ticket containing your preprinted name with the Form CMS-588 (08/06).

Medical groups under the Medicare Part B do not need to submit an EFT authorization agreement for each of its members. Only the group submits the form and indicates the group PIN in the Medicare identification number field.

Action Required by Providers

Providers must submit Form CMS-588 (08/06) version of the Electronic Funds Transfer (EFT) Authorization Agreement **beginning December 1, 2006,** when enrolling in the Medicare program or making any changes to their existing provider file.

Source: CMS Joint Signature Memorandum 06684, September 21, 2006

CONNECTICUT MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised local 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 coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text LCDs on our provider education website, *http://www.connecticutmedicare.com*. Final LCDs, draft LCDs available for comment, LCD statuses, and 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 LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new 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 LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Medical Review Table of Contents

Advance Notice Statement

Advance beneficiary notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity (see page 4).

REVISIONS TO LCDS

EPO: Epoetin alfa—LCD Revision

This local coverage determination (LCD) was last updated on October 1, 2006. Since that time, the LCD has been revised. A correction has been made to the list of ICD-9-CM codes that support medical necessity.

Revision 1

With the 2007 annual ICD-9-CM update, several new ICD-9-CM codes were included in the diagnosis range 235.0-238.9, that were not appropriate for the myelodysplastic syndrome (MDS) indication found in the LCD. Therefore, the range of ICD-9-CM codes that support medical necessity has been broken down to individual diagnosis ranges/codes in order to correctly identify the appropriate ICD-9-CM codes for MDS. The new diagnosis ranges/codes will appear as follows in the LCD:

235.0-235.9	Neoplasm of uncertain behavior of digestive and respiratory systems
236.0-236.99	Neoplasm of uncertain behavior of genitourinary organs
237.0-237.9	Neoplasm of uncertain behavior of endocrine glands and nervous system
238.0	Neoplasm of uncertain behavior of bone and articular cartilage
238.1	Neoplasm of uncertain behavior of connective and other soft tissue
238.2	Neoplasm of uncertain behavior of skin
238.3	Neoplasm of uncertain behavior of breast
238.4	Neoplasm of uncertain behavior of polycythemia vera
238.5	Neoplasm of uncertain behavior of hystiocytic and mast cells
238.6	Neoplasm of uncertain behavior of plasma cells
238.72	Low grade myelodysplastic syndrome lesions
238.73	High grade myelodysplastic syndrome lesions
238.74	Myelodysplastic syndrome with 5q deletion
238.75	Myelodysplastic syndrome, unspecified
238.8	Neoplasm of uncertain behavior of other specified sites
238.9	Neoplasm of uncertain behavior of site unspecified

This revision is effective for claims processed on or after November 22, 2006 for services rendered on or after October 1, 2006.

Revision 2

In addition to this revision, a request was received to allow for several off-label dosing schedules for indication #2, anemia in Chronic Kidney Disease (CKD), #4, anemia in cancer patients receiving chemotherapy for non-myeloid malignancy, # 5, anemia related to MDS and #7, anemia associated with malignancy.

The following off-label dosing schedule was added as medically reasonable for indication #2: Extended (maintenance dosing) for patients not requiring dialysis, who already receive EPO and have a stable Hgb level greater than or equal to 11:

- 20,000 units subcutaneously once every two weeks to maintain target Hgb level
- 30,000 units subcutaneously once every three weeks to maintain target Hgb level
- 40,000 units subcutaneously once every four weeks to maintain target Hgb level

The following off-label dosing schedule was added as medically reasonable for indications # 4, #5 and #7:

Maintenance dosing – 120,000 units subcutaneously once every three weeks to maintain target Hgb. This dosing schedule should not be used as initial dosing. The patient should already be receiving EPO and responding to the drug as evidenced by the patients Hgb increasing at least 2g/dl.

This revision is effective for services rendered on or after October 17, 2006.

The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

J9000: Antineoplastic Drugs – LCD Revision

This local coverage determination (LCD) for antineoplastic drugs was last updated on October 30, 2006. Since that time, the following revision was made based on new approved Federal Drug Administration (FDA) indications for Rituximab (J9310).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for rituximab (J9310), the following indications were added:

- For the first-line treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in combination with CVP chemotherapy.
- For the treatment of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma in patients with stable disease or who achieve a partial or complete response following first-line treatment with CVP chemotherapy.

Effective Date

This revision is effective for services rendered on or after September 29, 2006. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

NESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—LCD Revision

This local coverage determination (LCD) was last updated on October 1, 2006. Since that time, the LCD has been revised. A correction has been made to the list of ICD-9-CM codes that support medical necessity. With the 2007 Annual ICD-9-CM update, several new ICD-9-CM codes were included in the diagnosis range 235.0-238.9 that were not appropriate for the Myelodysplastic Syndrome (MDS) indication found in the LCD. Therefore, the range of ICD-9-CM codes that support medical necessity has been broken down to individual diagnosis ranges/codes in order to correctly identify the appropriate ICD-9-CM codes for MDS. The new diagnosis ranges/codes will appear as follows in the LCD:

235.0-235.9	Neoplasm of uncertain behavior of digestive and respiratory systems
236.0-236.99	Neoplasm of uncertain behavior of genitourinary organs
237.0-237.9	Neoplasm of uncertain behavior of endocrine glands and nervous system
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238.1	Neoplasm of uncertain behavior of connective and other soft tissue
238.2	Neoplasm of uncertain behavior of skin
238.3	Neoplasm of uncertain behavior of breast
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238.74	Myelodysplastic syndrome with 5q deletion
238.75	Myelodysplastic syndrome, unspecified
238.8	Neoplasm of uncertain behavior of other specified sites
238.9	Neoplasm of uncertain behavior of site unspecified

Effective Date

This revision is effective for claims processed on or after November 22, 2006 for services rendered on or after October 1, 2006. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

62263: Epidural—LCD Revision

The local coverage determination (LCD) for epidural was last revised October 1, 2006. At that time, the LCD was updated based on the 2007 ICD-9-CM code changes.

Since that time, First Coast Service Options, Inc. (FCSO) has determined that additional ICD-9-CM code updates to the LCD would be appropriate. Since ICD-9-CM code V58.49 is no longer appropriate for this LCD, it has been deleted and replaced with ICD-9-CM codes 338.21, 338.22, 338.29, 338.3 and 338.4.

Effective Date

This LCD revision is effective for claims processed on or after November 22, 2006 for services rendered on or after October 1, 2006. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

94010: Spirometry—LCD Revision

The latest revision for local coverage determination (LCD) spirometry was effective October 1, 2006. Since that time, this LCD has been revised to add ICD-9-CM code 277.02 (Cystic fibrosis with pulmonary manifestations) and the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD has been revised accordingly.

This revision is effective for services rendered on or after December 4, 2006. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

ADDITIONAL INFORMATION

Lucentis Claims Processing Issues

First Coast Service Options, Inc. (FCSO) has identified claims processing issues that are impacting claims being billed for Lucentis (ranibizumab injection), a drug used in the treatment of age-related macular degeneration (AMD). Claims for this drug billed with HCPCS codes J3490 (unclassified drugs) or J3590 (unclassified biologic) are generating a second additional development request letter (ADR) for billing providers who have already submitted documentation in response to an initial ADR. A problem with inconsistent pricing of this drug is occurring as well.

FCSO is working to correct the problems, and will make claim adjustments as appropriate. We apologize for any inconvenience.

Are You Getting the Correct Reimbursement when Billing for Unclassified Drugs Using HCPCS Codes J3490, J3590, or J9999?

There may be some confusion on how to appropriately bill for drugs using Healthcare Common Procedure Coding System (HCPCS) codes for unclassified drugs. Inappropriate billing methods are resulting in inconsistent payments.

When a new drug is approved by the Food and Drug Administration (FDA), there is normally a delay in assigning a national HCPCS code to that drug. When a code has not been assigned to a drug, it is necessary for the biller to provide Medicare with additional information to identify the specific drug. In addition, because drugs are administered in various dosages, this information must be provided to ensure that the appropriate reimbursement is made. Once a HCPCS code has been assigned by the Centers for Medicare & Medicaid Services (CMS), it is no longer necessary to supply this information; simply list the HCPCS code and the number of units. Reimbursement for codes J3490 (unclassified drugs [NOC]), J3590 (unclassified biologics), or J9999 (not otherwise classified, antineoplastic drug) is *always* based on the information provided in item 19 on Form CMS-1500.

Please note that Medicare does not process claims using the national drug code (NDC) number.

Please follow the instructions below when filing claims to Medicare Part B for HCPCS codes J3490, J3590, and J9999.

Item 19

- Name of the drug
- Total dosage administered to the patient

Item 24

- **24D** HCPCS code (J3490, J3590, or J9999)
- **24G** Enter number of units as **1**

Frequently Asked Questions

Q Does including the NDC number of the unlisted drug on the claim assist Medicare in identifying the drug and processing the claim correctly?

A No, Medicare does not use the NDC number in processing claims.

Q If I indicate a number of units in item 24G other than 1 and do not list the total dosage administered to the patient in item 19, will my claim pay according to the units in item 24G?

A No, Your claim will only be paid according to the total dosage administered to the patient, which is listed in item 19.

Q Is it acceptable to list name, strength and dosage in item 24 below my line item services?

A No, this is an incorrect billing method and will cause your claim to be denied.

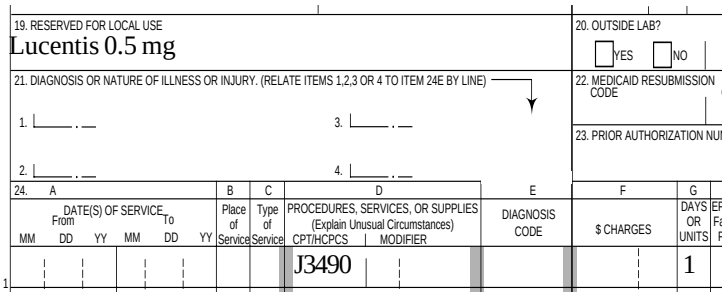
We hope this information is helpful. If you have any questions in reference to this notice, you may call the Medicare Customer Service department toll-free at 1-866-419-9455.

Please see examples on the next page...

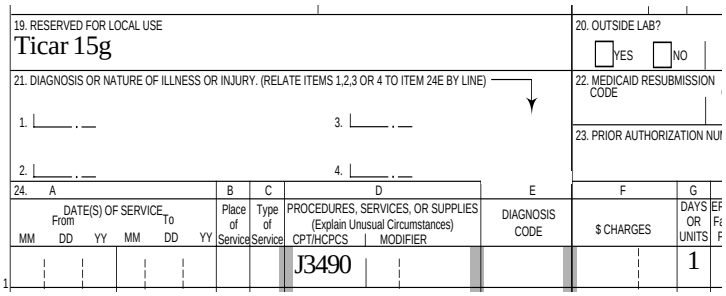
Are You Getting the Correct Reimbursement When Billing for Unclassified Drugs Using HCPCS Codes J3490, J3590, or J9999?, continued

Examples: The following are only examples of drug dosages. Actual drug dosages may vary, depending on how supplied, patient weight, type of disease, other drugs, etc.

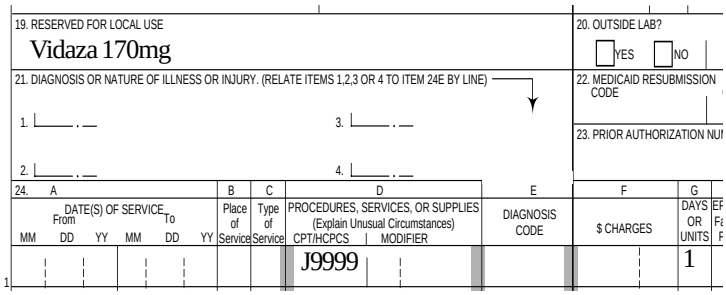
1. Patient was given a total dosage of 0.5 milligrams of Lucentis :



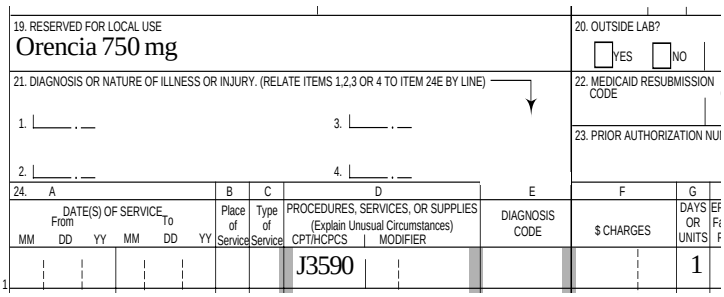
3. Patient was given a total dosage of 15 grams of Ticar:



2. Patient was given a total dosage of 170 milligrams of Vidaza:



4. Patient was given a total dosage of 750 milligrams of Orencia :



CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

December 2006 – February 2007

NPI CMS Module-3, Sub-Parts

When: December 13, 2006
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Provider Outreach & Education Advisory Group (POE AG) Meeting

When: December 14, 2006
Time: 8:30 a.m. – 10:30 a.m.
Type of Event: Teleconference

For membership information, visit the POE AG Web page on *http://www.connecticutmedicare.com*

NPI CMS Modules – 4 & 5

When: January 18, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Hot Topics Teleconference – Topics based on data analysis and "What's New" in Medicare as of January 1, 2007

When: January 24, 2007
Time: 10:30 a.m. – 12:00 p.m.
Type of Event: Teleconference

Ask the Contractor Teleconference (ACT) – Topics to be determined

When: February 7, 2007
Time: 12:00 p.m. – 1:00 p.m.
Type of Event: Teleconference

More events will be planned soon for this quarter. Keep checking our website, *www.connecticutmedicare.com*, or listening to information on the FCSO Provider Education Registration Hotline, 1-203-634-5527, for details and newly scheduled events!

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to event advertisement.
- For event and registration details, check our website (*www.connecticutmedicare.com*) or call our registration hotline at (203) 634-5527 a few weeks prior to the event.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, Zip Code: _____

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

Connecticut Medicare Part B welcomes any questions that you may have regarding the Medicare Part B program. Always be sure to clearly explain your question or concern. This will help our staff to know exactly what issues to address when developing a response to your inquiry.

Please submit your questions to the appropriate department. This will ensure that your concerns are handled in a proper and timely manner. This can be achieved by including an Attention Line below the address on the envelope. Listed below is a directory of departments that includes the issues that you would address to their attention.

With the exception of Redeterminations and Medicare EDI, please submit all correspondence with the appropriate attention line to:

Attention: (insert dept name)
Medicare Part B CT
P.O. Box 45010
Jacksonville, FL 32232-5010

Attention: Correspondence

The Correspondence attention line is used for inquiries pertaining to general issues regarding Medicare Part B. Some examples of these issues are deductibles, assignment, and beneficiary address changes. Do not use words such as *REVIEW* or *RECHECK* when sending general correspondence.

Attention: Financial Services

Use this attention line to return duplicate payments or overpayment refunds.

Attention: Fraud and Abuse

If you encounter what you believe is suspected, potential, or possible fraud or abuse of the Medicare program, we encourage you to contact this department.

Attention: Freedom of Information (FOIA)

This department handles requests for information available under the Freedom of Information Act.

Attention: Medical Review

Questions regarding LMRPs/LCDs and correct documentation for evaluation and management services are handled by this department. Documentation for off-label chemotherapy use should also be submitted to the Medical Review Department.

Attention: MSP

Write to the Medicare Secondary Payer (MSP) department when submitting an Explanation of Benefits from a primary insurance, Exhaust letters from Auto Liability claims, and MSP calculation review requests.

Attention: Pricing/ Provider Maintenance

Address your envelope to this department to apply for a new provider number, change a business or billing address of a provider, or to make any changes in the status of a provider. This department also handles fee schedule requests and inquiries, participation requests, and UPIN requests.

Attention: Resolutions

Use the Resolutions attention line when inquiring or submitting information regarding dates of death, incorrect Medicare (HIC) numbers, incorrect beneficiary information, etc.

MAILING ADDRESS EXCEPTIONS

We have established special P.O. boxes to use when mailing your redeterminations and hearings requests, paper claims, or to contact Medicare EDI:

Redeterminations/Appeals

Please mail only your requests for redeterminations to this P.O. Box. *DO NOT* send new claims, general correspondence, or other documents to this location; doing so will cause a delay in the processing of that item.

If you believe the payment or determination is incorrect and want a claim to be reconsidered, then send it to the attention of the review department. Requests for redeterminations must be made within 120 days of the date of the Medicare Summary Notice. These requests should not include redetermination requests on Medicare Secondary Pay calculations. Claims that are denied for return/reject need to be resubmitted and should **not** be sent as a redetermination. These resubmitted claims should be sent in as new claims.

Hearings

If you believe that your redetermination was incorrect and want it reviewed by a Hearing Officer, send your inquiry to the attention of the Hearing Department. A request for a hearing must be made within six months of the date of the Review Department determination and at least $100.00 must remain in controversy from this decision.

Post Office Box for Appeals/Hearings:

Medicare Part B CT Appeals/Hearings
First Coast Service Options, Inc.
P.O. Box 45041
Jacksonville, FL 32232-5041

Electronic Media Claims/EDI

The Electronic Data Interchange department handles questions and provides information on electronic claims submission (EMC).

Post Office Box for EDI:

Medicare Part B CT Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Claims

The Heath Insurance Portability and Accountability Act (HIPAA) requires electronic submission of mpst types of Medicare claims. We realize, however, that on occasion it is necessary to submit a paper claim. When this happens, submit your claims on the approved red-and-white Form CMS-1500 to:

Medicare Part B CT CLaims
P.O. Box 44234
Jacksonville, FL 32231-4234

CONNECTICUT MEDICARE PHONE NUMBERS

Provider Services
First Coast Service Options, Inc.
Medicare Part B
1-866-419-9455 ***(toll-free)***

Beneficiary Services
1-800-MEDICARE ***(toll-free)***
1-866-359-3614 *(hearing impaired)*

Electronic Data Interchange (EDI)
Enrollment
1-203-639-3160, option 1

PC-ACE® PRO-32
1-203-639-3160, option 2

Marketing and Reject Report Issues
1-203-639-3160, option 4

Format, Testing, and Remittance Issues
1-203-639-3160, option 5

Electronic Funds Transfer Information
1-203-639-3219

Hospital Services
Empire Medicare Services
Medicare Part A
1-800-442-8430

Durable Medical Equipment
HealthNow NY
DMERC Medicare Part B
1-800-842-2052

Railroad Retirees
Palmetto GBA
Medicare Part B
1-877-288-7600

Quality of Care
Peer Review Organization
1-800-553-7590

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

American Association of Retired Persons (AARP)
1-800-523-5800

To Report Lost or Stolen Medicare Cards
1-800-772-1213

Health Insurance Counseling Program
1-800-994-9422

Area Agency on Aging
1-800-994-9422

Department of Social Services/ConnMap
1-800-842-1508

ConnPace/ Assistance with Prescription Drugs
1-800-423-5026

MEDICARE WEBSITES

PROVIDER
Connecticut
http://www.connecticutmedicare.com
Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov

BENEFICIARIES
Centers for Medicare & Medicaid Services
http://www.medicare.gov

FLORIDA MEDICAL REVIEW

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In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text LCDs on our provider education website, *http://www.floridamedicare.com*. Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part B Medical Policy section.

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Electronic Notification

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http://www.floridamedicare.com , click on the "eNews" link on the navigational menu and follow the prompts.

More Information

If you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

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

Medical Review Table of Contents

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238.3	Neoplasm of uncertain behavior of breast
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In addition to this revision, a request was received to allow for several off-label dosing schedules for indication #2, anemia in Chronic Kidney Disease (CKD), #4, anemia in cancer patients receiving chemotherapy for non-myeloid malignancy, # 5, anemia related to MDS and #7, anemia associated with malignancy.

The following off-label dosing schedule was added as medically reasonable for indication #2: Extended (maintenance dosing) for patients not requiring dialysis, who already receive EPO and have a stable Hgb level greater than or equal to 11:

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- 40,000 units subcutaneously once every four weeks to maintain target Hgb level

The following off-label dosing schedule was added as medically reasonable for indications # 4, #5 and #7:

Maintenance dosing – 120,000 units subcutaneously once every three weeks to maintain target Hgb. This dosing schedule should not be used as initial dosing. The patient should already be receiving EPO and responding to the drug as evidenced by the patients Hgb increasing at least 2g/dl.

This revision is effective for services rendered on or after October 17, 2006.

The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J1745: Infliximab (Remicade®)—LCD Revision

This local coverage determination (LCD) was last updated on March 21, 2006. Since that time, the LCD has been revised. A request was received to add the new Food and Drug Administration (FDA) indication for plaque psoriasis. The indications and limitations section of the LCD was revised to allow for the new indication, plaque psoriasis, and the language for indication number one and number three was revised to align with the FDA-approved drug label. In addition to these revisions, the list of ICD-9-CM codes that support medical necessity was revised to include ICD-9-CM code 696.1 (Other psoriasis), as medically necessary.

Effective Date

This revision is effective for claims processed **on or after October 23, 2006** for services rendered **on or after September 26, 2006.** The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J9000: Antineoplastic Drugs—LCD Revision

This local coverage determination (LCD) for antineoplastic drugs was last updated on October 30, 2006. Since that time, the following revision was made based on new approved Federal Drug Administration (FDA) indications for Rituximab (J9310).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for Rituximab (J9310), the following indications were added:

- For the first-line treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in combination with CVP chemotherapy.
- For the treatment of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma in patients with stable disease or who achieve a partial or complete response following first-line treatment with CVP chemotherapy.

Effective Date

This revision is effective for services rendered on or after September 29, 2006. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

NESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—LCD Revision

This local coverage determination (LCD) was last updated on October 1, 2006. Since that time, the LCD has been revised. A correction has been made to the list of ICD-9-CM codes that support medical necessity. With the 2007 Annual ICD-9-CM update, several new ICD-9-CM codes were included in the diagnosis range 235.0-238.9 that were not appropriate for the myelodysplastic syndrome (MDS) indication found in the LCD. Therefore, the range of ICD-9-CM codes that support medical necessity has been broken down to individual diagnosis ranges/codes in order to correctly identify the appropriate ICD-9-CM codes for MDS. The new diagnosis ranges/codes will appear as follows in the LCD:

235.0-235.9	Neoplasm of uncertain behavior of digestive and respiratory systems
236.0-236.99	Neoplasm of uncertain behavior of genitourinary organs
237.0-237.9	Neoplasm of uncertain behavior of endocrine glands and nervous system
238.0	Neoplasm of uncertain behavior of bone and articular cartilage
238.1	Neoplasm of uncertain behavior of connective and other soft tissue
238.2	Neoplasm of uncertain behavior of skin
238.3	Neoplasm of uncertain behavior of breast
238.4	Neoplasm of uncertain behavior of polycythemia vera
238.5	Neoplasm of uncertain behavior of hystiocytic and mast cells
238.6	Neoplasm of uncertain behavior of plasma cells
238.72	Low grade myelodysplastic syndrome lesions
238.73	High grade myelodysplastic syndrome lesions
238.74	Myelodysplastic syndrome with 5q deletion
238.75	Myelodysplastic syndrome, unspecified
238.8	Neoplasm of uncertain behavior of other specified sites
238.9	Neoplasm of uncertain behavior of site unspecified

Effective Date

This revision is effective for claims processed on or after November 22, 2006 for services rendered on or after October 1, 2006. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

PULMDIAGSVCS: Pulmonary Diagnostic Services—LCD Revision

The latest revision for local coverage determination (LCD) pulmonary diagnostic services was effective October 1, 2006. Since that time, this LCD has been revised to add ICD-9-CM code 277.02 (Cystic fibrosis with pulmonary manifestations) and the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD has been revised accordingly.

This revision is effective for services rendered on or after December 4, 2006.

The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* on or after this effective date.

62310: Epidural—LCD Revision

The local coverage determination (LCD) for epidural was last revised October 1, 2006. At that time the LCD was updated based on the 2007 ICD-9-CM code changes.

Since that time, First Coast Service Options, Inc. (FCSO) has determined that additional ICD-9-CM code updates to the LCD would be appropriate. Since ICD-9-CM code V58.49 is no longer appropriate for this LCD, it has been deleted and replaced with ICD-9-CM code 338.22. Additional codes that replaced ICD-9-CM code V58.49 include ICD-9-CM codes 338.21, 338.29, 338.3 and 338.4, which were added to the LCD in the previous revision.

Effective Date

This LCD revision is effective for claims processed on or after November 22, 2006 for services rendered on or after October 1, 2006. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

93025: Microvolt-T-wave Alternans—LCD Revision

The local coverage determination (LCD) for Microvolt-T-wave Alternans was last revised March 21, 2006. Since that time, the following ICD-9-CM codes have been added to the "ICD-9 Codes That Support Medical Necessity" section of the LCD:

402.01	Malignant hypertensive heart disease with heart failure
402.11	Benign hypertensive heart disease with heart failure
402.91	Unspecified hypertensive heart disease with heart failure
404.00-404.03	Malignant hypertensive heart and chronic kidney disease
404.10-404.13	Benign hypertensive heart and chronic kidney disease
404.90-404.93	Unspecified hypertensive heart and chronic kidney disease
411.1	Intermediate coronary syndrome
411.81	Acute coronary occlusion without myocardial infarction
411.89	Other acute and subacute forms of ischemic heart disease
412	Old myocardial infarction
414.10	Aneurysm of heart (wall)
414.19	Other aneurysm of heart
426.82	Long QT syndrome
427.42	Ventricular flutter
428.0	Congestive heart failure, unspecified
428.20-428.23	Systolic heart failure
428.30-428.33	Diastolic heart failure
428.40-428.43	Combined systolic and diastolic heart failure
428.9	Heart failure, unspecified
746.89	Other congenital anomalies of heart

This LCD revision is effective for services rendered on or after December 4, 2006. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

ADDITIONAL INFORMATION

Lucentis Claims Processing Issues

First Coast Service Options, Inc. (FCSO) has identified claims processing issues that are impacting claims being billed for Lucentis (ranibizumab injection), a drug used in the treatment of age-related macular degeneration (AMD). Claims for this drug billed with HCPCS codes J3490 (unclassified drugs) or J3590 (unclassified biologic) are generating a second additional development request letter (ADR) for billing providers who have already submitted documentation in response to an initial ADR. A problem with inconsistent pricing of this drug is occurring as well.

FCSO is working to correct the problems, and will make claim adjustments as appropriate. We apologize for any inconvenience.

Are You Getting the Correct Reimbursement when Billing for Unclassified Drugs Using HCPCS Codes J3490, J3590, or J9999?

There may be some confusion on how to appropriately bill for drugs using Healthcare Common Procedure Coding System (HCPCS) codes for unclassified drugs. Inappropriate billing methods are resulting in inconsistent payments.

When a new drug is approved by the Food and Drug Administration (FDA), there is normally a delay in assigning a national HCPCS code to that drug. When a code has not been assigned to a drug, it is necessary for the biller to provide Medicare with additional information to identify the specific drug. In addition, because drugs are administered in various dosages, this information must be provided to ensure that the appropriate reimbursement is made. Once a HCPCS code has been assigned by the Centers for Medicare & Medicaid Services (CMS), it is no longer necessary to supply this information; simply list the HCPCS code and the number of units. Reimbursement for codes J3490 (unclassified drugs [NOC]), J3590 (unclassified biologics), or J9999 (not otherwise classified, antineoplastic drug) is *always* based on the information provided in item 19 on Form CMS-1500.

Please note that Medicare does not process claims using the national drug code (NDC) number.

Please follow the instructions below when filing claims to Medicare Part B for HCPCS codes J3490, J3590, and J9999.

Item 19

- Name of the drug
- Total dosage administered to the patient

Item 24

- **24D** HCPCS code (J3490, J3590, or J9999)
- **24G** Enter number of units as **1**

Frequently Asked Questions

Q Does including the NDC number of the unlisted drug on the claim assist Medicare in identifying the drug and processing the claim correctly?

A No, Medicare does not use the NDC number in processing claims.

Q If I indicate a number of units in item 24G other than 1 and do not list the total dosage administered to the patient in item 19, will my claim pay according to the units in item 24G?

A No, Your claim will only be paid according to the total dosage administered to the patient, which is listed in item 19.

Q Is it acceptable to list name, strength and dosage in item 24 below my line item services?

A No, this is an incorrect billing method and will cause your claim to be denied.

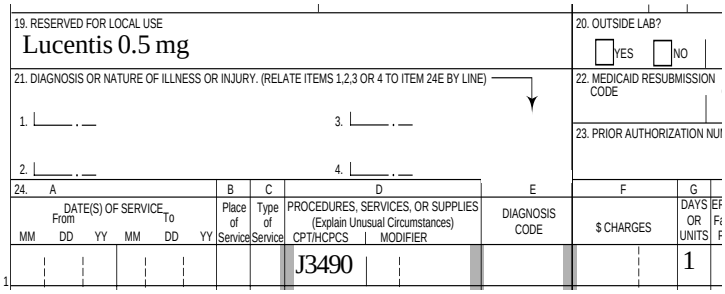
We hope this information is helpful. If you have any questions in reference to this notice, you may call the Medicare Customer Service department toll-free at 1-866-454-9007.

Please see examples on the next page...

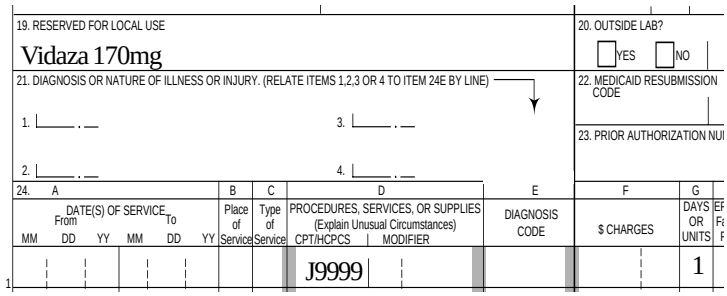
Are You Getting the Correct Reimbursement When Billing for Unclassified Drugs Using HCPCS Codes J3490, J3590, or J9999?, continued

Examples: The following are only examples of drug dosages. Actual drug dosages may vary, depending on how supplied, patient weight, type of disease, other drugs, etc.

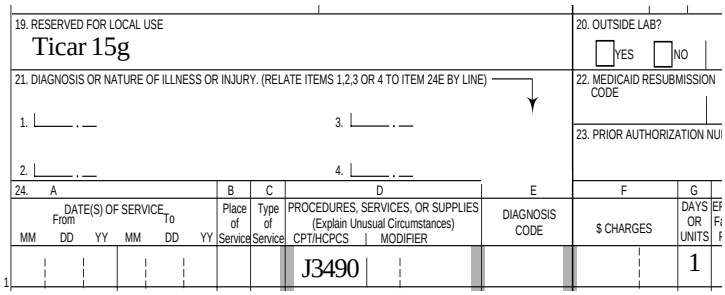
1. Patient was given a total dosage of 0.5 milligrams of Lucentis :



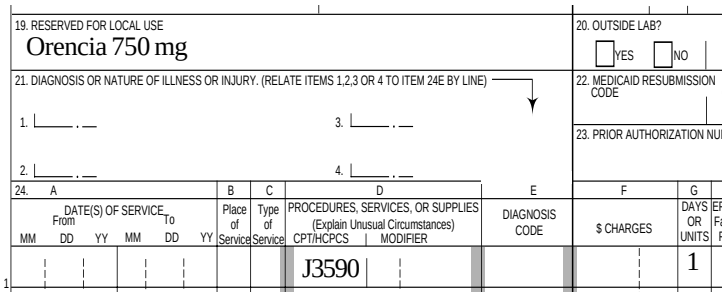
2. Patient was given a total dosage of 170 milligrams of Vidaza:



3. Patient was given a total dosage of 15 grams of Ticar:



4. Patient was given a total dosage of 750 milligrams of Orencia :



FLORIDA EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

December 2006 – February 2007

Appeals and Overpayments

When: December 7, 2006
Time: 12:00 p.m. – 1:00 p.m.
Type of Event: Webcast

NPI CMS Module-3, Sub-Parts

When: December 13, 2006
Time: 11:30 a.m. – 1:30 p.m.
Type of Event: Webcast

Hot Topics Teleconference – Topics to be determined

When: January 11, 2007
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

NPI CMS Modules-4 & 5

When: January 18, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Ask the Contractor Teleconference (ACT) – Topics to be determined

When: February 15, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

More events will be planned soon for this quarter. Keep checking our website, *www.floridamedicare.com*, or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events!

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to event advertisement.
- For event and registration details, check our website (*www.floridamedicare.com*) or call our registration hotline at (904) 791-8103 a few weeks prior to the event.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, Zip Code: _____

FLORIDA MEDICARE PART B MAIL DIRECTORY

CLAIMS SUBMISSIONS

Routine Paper Claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating Providers
Medicare Part B Participating Providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic Claims
Medicare Part B Chiropractic Unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance Claims
Medicare Part B Ambulance Dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare Secondary Payer
Medicare Part B Secondary Payer Dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD Claims
Medicare Part B ESRD Claims
P. O. Box 45236
Jacksonville, FL 32232-5236

COMMUNICATIONS

Redetermination Requests
Medicare Part B Claims Review
P.O Box 2360
Jacksonville, FL 32231-2100

Fair Hearing Requests
Medicare Hearings
Post Office Box 45156
Jacksonville FL 32232-5156

Administrative Law Judge Hearing
Q2 Administrators, LLC
Part B QIC East Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration Manager

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
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For Education Event 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 Education Event Registration (*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
1-866-270-4909

MEDICARE PART A

Toll-Free:
1-866-270-4909

Medicare Websites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com

Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

EDUCATIONAL RESOURCES

Teaching Physicians, Interns and Residents Fact Sheet Available for Ordering

The updated *Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet* is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *www.cms.hhs.gov/mlngeninfo*, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page."

Source: CMS Learning Resource, Message 200610-14

November is American Diabetes Awareness Month

The prevalence of diabetes is a growing health concern in the United States.

Approximately 20.8 million people, or 7.0 percent of the population, have diabetes. It is estimated that 20.9 percent of people age 60 years or older have diabetes. Left undiagnosed, diabetes may lead to severe complications such as heart disease, stroke, blindness, kidney disease, and lower limb amputation as well as premature death.

Millions of people have diabetes and don't know it. However, with early detection and treatment people with diabetes can take steps to control the disease and lower the risk of complications.

The good news is that scientific evidence now shows that treatment of diabetes with diet, physical activity, and new medicines can prevent or delay much of the illness and complications associated with diabetes.

The Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to remind health care professionals that Medicare provides coverage of diabetes screening tests, for beneficiaries at risk for diabetes or those diagnosed with prediabetes.

The diabetes screening benefit covered by Medicare can help improve the quality of life for Medicare beneficiaries by preventing more severe health conditions that can occur without proper treatment from undiagnosed or untreated diabetes.

Coverage includes the following diabetes screening tests:

- A fasting blood glucose test, **and**
- A post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for nonpregnant adults), **or**
- A two-hour post-glucose challenge test alone.

In addition to the diabetes screening service, Medicare also provides coverage for diabetes self-management training, medical nutrition therapy, certain diabetes supplies, and glaucoma screenings for eligible beneficiaries.

We Need Your Help

CMS needs your help in ensuring that people with Medicare are assessed for and informed about their risk factors for diabetes or pre-diabetes, and that those who are eligible take full advantage of the diabetes screening benefit and all preventive services covered by Medicare for which they may be eligible.

For More Information

For more information about Medicare's coverage of diabetes screening services, diabetes self management training, medical nutrition therapy, diabetes supplies, and glaucoma screening:

- See Special Edition *MLN Matters* article SE0660 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0660.pdf*.
- Visit the CMS website: *http://www.cms.hhs.gov/home/medicare.asp*.

CMS has also developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

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

For products to share with your Medicare patients, visit on the Web *http://www.medicare.gov*.

For more information about American Diabetes Month, please visit *http://www.diabetes.org/home.jsp*.

Thank you for joining with CMS during American Diabetes Month to ensure that people with Medicare learn more about diabetes and their risk factors for the disease and that they take full advantage of the diabetes screening services and all other Medicare-covered preventive services and screenings for which they may be eligible.

Source: CMS Provider Education Resource 200611-02

The Great American Smokeout—November 16, 2006

In conjunction with the 30th Anniversary of the Great American Smokeout, the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join us in helping people with Medicare break the smoking habit. This one-day event is designed to encourage 45.1 million adult smokers in the United States to quit. Although smoking rates have significantly declined, 9.3 percent of the population age 65 and older smokes cigarettes. Approximately 440,000 people die annually from smoking related diseases, with the majority of deaths – 68 percent (300,000) – being among people ages 65 and older.

Interest in smoking cessation is increasing. The Centers for Disease Control and Prevention estimated in 2002 that 57 percent of smokers age 65 and over reported a desire to quit. Currently, about 10 percent of elderly smokers quit each year, with one percent relapsing. CMS would like to take this opportunity to remind health care professionals that Medicare provides coverage of smoking and tobacco-use cessation counseling for people with Medicare who:

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

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

How Can You Help

Seniors who quit smoking experience rapid improvements in breathing and circulation. They decrease their risk for heart disease and stroke within one year of quitting. Talk with your patients about the health benefits of smoking cessation. Older smokers have been shown to be more successful in their quit attempts than younger smokers and respond favorably to their health care providers' advice to quit smoking. Your quit smoking recommendation can make a difference in the quality of life for your patients.

For More Information

- For more information about Medicare's coverage of Smoking and Tobacco-Use Cessation Counseling Services:
- See *MLN Matters* articles MM3834 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3834.pdf* and MM4104 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4104.pdf*
- See Smoking and Tobacco-Use Cessation Counseling Services brochure *http://www.cms.hhs.gov/MLNproducts/downloads/smoking.pdf*
- Visit the CMS website: *http://www.cms.hhs.gov/home/medicare.asp*
- CMS has also developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.
- The *MLN* Preventive Services Educational Products Web Page – provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* on the CMS website.
- For products to share with your Medicare patients, visit *www.medicare.gov* on the Web.
- For more information on the Great American Smokeout, please visit *http://www.cancer.org/docroot/PED/ped_10_4.asp** or by telephone: 800-227-2345. Information on how to quit smoking is also available at *www.smokefree.gov* and all 50 states, the District of Columbia, and several U.S. territories now have quit lines, which can be reached by telephone: 800–QUIT–NOW (800–784–8669).

Thank you for joining with CMS in encouraging people with Medicare to break the smoking habit.

Source: CMS Learning Resource, Message 200611-09

ORDER FORM — 2007 PART B MATERIALS

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO with the account number listed by each item.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

QUANTITY	ITEM	ACCOUNT NUMBER	COST PER ITEM
❒	***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Hardcopy or CD-ROM distribution is limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers who meet these criteria must register to receive the *Update!* in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason can be shown why the electronic publication available free of charge on the Internet cannot be utilized. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2006 through September 2007 (back issues will be sent upon receipt of order).	700395	$85.00 (Hardcopy) $20.00 (CD-ROM)
❒	**2007 Fee Schedule –** The revised Medicare Part B Physician and Non-Physician Practitioner Fee Schedule, effective for services rendered January 1, 2007, through December 31, 2007, is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Providers who do not have Internet access may purchase a hardcopy or CD-ROM. The Fee Schedule contains calendar year 2007 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	Hardcopy: $5.00 (CT) $10.00 (FL) CD-ROM: $6.00 (Specify CT or FL)

Please write legibly

Subtotal $ _____

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

Total $ _____

Mail this form with payment to:

First Coast Service Options, Inc.
Medicare Publications
P.O. Box 45280
Jacksonville, FL 32232-5280

Contact Name: _____

Provider/Office Name: _____

Phone: _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Please make check/money order payable to: FCSO Account # (fill in from above)
(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

MEDICARE B UPDATE!

FIRST COAST SERVICE OPTIONS, INC.
P.O. BOX 2078 JACKSONVILLE, FL 32231-0048 (FLORIDA)
P.O. BOX 44234 JACKSONVILLE, FL 32231-4234 (CONNECTICUT)

*** ATTENTION BILLING MANAGER ***