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.

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

Routing Suggestions:

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

_____

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Kimberly McCarron
Millie C. Pérez
Betty Alix

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 has begun distributing the *Medicare B Update!* on a monthly basis. We made this change to better serve our customers to make 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 electronic access.

For additional copies, providers may purchase a separate annual subscription in hardcopy or CD-ROM format (see order form on page 44). 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

CLAIMS

Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500

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 5-6.

Note: This article was revised on October 13, 2006, to reflect that the appropriate NPI must be entered in certain fields on Form CMS-1500. Previously, the article incorrectly stated the NPI of the billing provider. All other information remains the same.

Provider Types Affected

Physicians and suppliers who bill Medicare carriers including durable medical equipment regional carriers (DMERCs) for their services using the Form CMS-1500.

Key Points

- The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the national provider identifier (NPI).
- The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.
- During this transition time there will be a dual acceptability period of the current and the revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the split provider identifier fields.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.
- There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

January 2, 2007 – March 30, 2007

Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version. **Note**: Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08-05) by January 2, 2007.

April 2, 2007

The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used. **Note**: All rebilling of claims should use the revised Form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12-90).

Background

Form CMS-1500 is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The CMS-1500 form is being revised to accommodate the reporting of the NPI.

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Thus, small plans may need to receive legacy provider numbers on coordination of benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

In a related change request (CR) 4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report provider identification numbers (PINs) and unique physician identification numbers (UPINs) as applicable.

There were no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. CR 4293 provided guidance for implementing the revised Form CMS-1500 (08-05). This article, based on CR 5060, provides additional Form CMS-1500 (08-05) information for Medicare carriers and DMERCs, related to validation edits and requirements.

Billing Guidelines

- When the NPI number is effective and required (May 23, 2007, although it can be reported starting January 1, 2007), claims will be rejected (in most cases with reason code 16 – "claim/service lacks information that is needed for adjudication") in tandem with the appropriate remark code that specifies the missing information, if the appropriate NPI is not entered on Form CMS-1500 (08-05) in items:
    - 24J (replacing item 24K, Form CMS-1500 [12-90]);
    - 17B (replacing item 17 or 17A, Form CMS-1500 [12-90]);
    - 32a (replacing item 32, Form CMS-1500 [12-90]); and
    - 33a (replacing item 33, Form CMS-1500 [12-90]).

Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500, continued

Additional Information

The NPI is effective and required May 23, 2007.

To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.

Legacy identifiers are pre-NPI provider identifiers such as:

- PINs
- UPINs
- OSCARs (online survey certification & reporting system numbers)
- NSCs (national supplier clearinghouse numbers) for DMERC claims.

Additional NPI-Related Information

Additional NPI-related information may be found at *http://www.cms.hhs.gov/NationalProvIdentStand/* on the CMS website.

The change log which lists the various changes made to the Form CMS-1500 (08-05) version may be viewed at the NUCC website at *http://www.nucc.org/images/stories/PDF/change_log.pdf*.

MLN Matters article MM4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms," may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf* on the CMS website.

CR 4293, Transmittal Number 899, "Revised Health Insurance Claim Form CMS-1500," provides contractor guidance for implementing the revised Form CMS-1500 (08-05). It may be found at *http://www.cms.hhs.gov/transmittals/downloads/R899CP.pdf* on the CMS website.

MLN Matters article MM4023, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms," may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf* on the CMS website.

CR 5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1058CP.pdf* on the CMS website.

Please refer to your local carrier or DMERC if you have questions about this issue. To find their toll free phone number, please go to: *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: MM5060 *Revised*
Related CR Release Date: September 15, 2006
Related CR Transmittal #: R1058CP
Related Change Request (CR) #: 5060
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Health Professional Shortage Area Listing

The following are counties (all census tracts) designated as geographic HPSAs (and therefore eligible for the HPSA bonus payment) for Primary Care (Connecticut and Florida) and Mental Health (Florida) (as of September 8, 2006) for the states of Connecticut and Florida.

Connecticut—Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Fairfield/Southwest Bridgeport	0702.00, 0703.00, 0704.00, 0705.00, 0706.00, 0707.00, 0708.00, 0709.00, 0710.00, 0711.00, 0712.00	Urban
Fairfield/Central/East Bridgeport	0713.00, 0714.00, 0715.00, 0716.00, 0717.00, 0735.00, 0736.00, 0738.00, 0739.00, 0740.00, 0741.00, 0742.00, 0743.00, 0744.00	Urban
Fairfield/Central Norwalk	0440.00, 0441.00, 0444.00, 0445.00	Urban
Hartford/North Central Hartford	5005.00, 5008.00, 5009.00, 5010.00, 5011.00, 5012.00, 5013.00, 5014.00, 5015.00, 5016.00, 5017.00, 5018.00, 5020.00, 5021.00, 5022.00, 5031.00, 5032.00, 5033.00, 5034.00, 5035.00, 5036.00, 5037.00, 5038.00, 5039.00, 5040.00, 5041.00, 5042.00, 5044.00	Urban
Hartford/Charter Oak Terrace/Rice Heights	5001.00, 5002.00, 5003.00, 5004.00, 5019.00, 5027.00, 5028.00, 5029.00, 5030.00, 5043.00, 5045.00, 5046.00, 5049.00	Urban
New Haven/ Fair Haven	1421.00, 1422.00, 1423.00, 1424.00, 1425.00, 1426.01, 1426.02	Urban

Health Professional Shortage Area Listing, continued

Florida—Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Clay/Keystone Heights		Rural
Collier/Imokalee/Everglades		Rural
Columbia		Rural
Dixie		Rural
Escambia/Atmore (AL/FL)	0038.00, 0039.00, 0040.00	Rural
Gadsden		Urban
Glades		Rural
Hamilton		Rural
Hardee		Rural
Hendry		Rural
Jefferson		Rural
Lafayette		Rural
Liberty		Rural
Madison		Rural
Martin/Indiantown		Rural
Okeechobee		Rural
Palm Beach	0080.01, 0080.02, 0081.01, 0081.02, 0082.01, 0082.02, 0082.03, 0083.01, 0083.02	Rural
Sumter		Rural
Suwannee		Rural
Wakulla		Rural

Florida—Mental Health

County	Type
Bradford	Rural
Calhoun	Rural
Columbia	Rural
Dixie	Rural
Franklin	Rural
Gilchrist	Rural
Gulf	Rural
Hamilton	Rural
Hillsborough. Ruskin CCD/Wimauma-Lithia CCD	Urban
Holmes	Rural
Indian River/Fellsmere	Rural
Jackson	Rural
Lafayette	Rural
Lake	Rural

County	Type
Liberty	Rural
Jefferson	Rural
Madison	Rural
Martin/Indiantown	Rural
Monroe/Upper Keys	Rural
Okeechobee	Rural
Putnam	Rural
St Johns	Urban
Sumter (effective September 8, 2006)	Rural
Suwannee	Rural
Union	Rural
Walton	Rural
Washington	Rural

Source: CMS Atlanta Regional Office Memorandum (Florida), dated July 31, 2006
CMS Boston Regional Office Memorandum (Connecticut), dated August 10, 2006

COMPETITIVE ACQUISITION PROGRAM

Clarification of Requirements for the Competitive Acquisition Program for Part B Drugs and Biologicals

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

Provider Types Affected

Physicians participating in the Competitive Acquisition Program (CAP) for Part B drugs and biologicals

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) has determined, through analysis, common problems with claims submitted by participating CAP physicians for the administration of drugs covered under the CAP.

CAUTION – What You Need to Know

You need to submit claims for drug administration services to your local carrier **within 14 calendar days** of the administration of the CAP drug. The claims **must include a no-pay claim line for the CAP drug including the appropriate CAP modifier(s), the approved CAP vendor provided prescription order number, and a billed charge greater than $0 for the drug. The no-pay claim line for the CAP drug and the claim line for its administration must be included on the same claim.**

GO – What You Need to Do

Read on for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) has issued transmittal 866, change request (CR) 4309, *MLN Matters* article MM4309 and transmittal 761, CR 4064, *MLN Matters* article MM4064 (December 2005), that provided information regarding the new requirements of the final rule for the CAP for Medicare Part B drugs.

This article (SE0672) summarizes key requirements for submission of claims for the administration of drugs under the CAP. Following these requirements will allow correct and timely processing of your claims.

Physician Billing – Key Requirements
Submitting a claim within 14 days

Physicians who have signed the CAP election form have agreed to submit a claim to Medicare within 14 days of the administration of the CAP drug. This facilitates timely payment to the approved CAP vendor.

Payment to the approved CAP vendor for the drug is conditioned on verification that the drug was administered to the Medicare beneficiary. Proof that the drug was administered is established by matching the participating CAP physician's claim for drug administration with the approved CAP vendor's claim for the drug in the Medicare claims processing system by means of a prescription order number on both claims. When they are matched in the claim processing system, the approved CAP vendor can be paid in full. Until drug administration is verified, the approved CAP vendor may not bill the beneficiary and/or his third party insurance for any applicable coinsurance and deductible.

CAP Modifier Codes

The Medicare carrier will deny any physician Part B claims for drugs included in the CAP unless the appropriate CAP modifier codes are included when physicians submit claims to their carriers for the administration of CAP drugs. The CAP modifier codes are:

- J1 – Competitive Acquisition Program, no-pay submission for a prescription order number
- J2 – Competitive Acquisition Program (CAP), restocking of drugs used in an emergency (as defined by the CAP).
- J3 – Competitive Acquisition Program (CAP), drug not available through CAP as written, reimbursed under average sales price (ASP) methodology.

CAP Prescription Order Number

Participating CAP physicians must use a prescription order number to identify each CAP drug administered. This number will be matched to the prescription order number(s) on the approved CAP vendor's claim as verification that the beneficiary received the drug(s) and that the approved CAP vendor may now be paid by Medicare. The prescription order number will be found on the information sent to CAP physicians by the CAP vendor with their drug order.

General Billing Information

When physicians submit claims for the administration of CAP drug(s) to their carriers, they should include:

- A prescription order number for each CAP drug administered. On paper claims, the prescription order number is placed in Item 19 on the CMS-1500 form. If you bill electronically, make sure that billing software is current and transmits this information in the HIPAA 837 claim format;

Clarification of Requirements for the CAP for Part B Drugs and Biologicals, continued

- The HCPCS code for each CAP drug administered along with the "J1" no pay modifier;
- The billed charge for the CAP drug administered which must be greater than $0;
- The HCPCS code(s) that include the administration of each CAP drug should be listed on separate lines; and.
- The *CPT* code for CAP drug administration and/or office visit associated with a CAP drug administration on the same claim as the CAP drug(s). (The administration services and the no-pay lines must be on the same claim or your carrier will return the claim as unprocessable and you will see a remittance advice reason code of 16 denoting "Claim lacks information which is needed for adjudication.")

CAP Drugs Administered in an Emergency Situation

When physicians submit claims for the administration of CAP drug(s) that have been administered from their office stock in an emergency situation and are to be replaced by the approved CAP vendor, the claim should be submitted with the:

- Prescription order number for each CAP drug administered;
- HCPCS code for each administered CAP drug along with the "J1" no-pay modifier and also on that same line, the "J2" modifier denoting "Competitive Acquisition Program, (CAP) restocking of emergency drugs after emergency administration;"
- The billed charge for the CAP drug administered which must be greater than $0; and
- The HCPCS code(s) that include the administration of each CAP drug, which must be entered on, separate lines of the same claim along with the CAP drug administered.

Claims For Drugs Outside the CAP Program

When physicians submit claims for "furnish as written" drugs to be paid outside the CAP program:

- Physicians should use only the "J3" modifier, (no J1or J2 modifier should be submitted in this situation), denoting "Competitive Acquisition Program (CAP) drug not available through CAP as written, reimbursed under the average sales price (ASP) methodology." The J3 modifier must be submitted with the HCPCS code for the drug along with the appropriate HCPCS code for the administration of that drug and the normal billed charges.

Carrier Monitoring

The Medicare carrier will identify physicians who elected to participate in the CAP, will process claims and will make payment for drug administration services. Payment for CAP drugs will be made to the approved CAP vendor and not to the physician. Additionally, unless claims for CAP administration include the CAP drug no-pay, restocking, or "furnish as written" modifier, the claim will be denied and you will see a remittance advice message N348 stating that "You chose that this service/supply/drug be rendered/supplied and billed by a different practitioner/supplier." Carriers will also monitor drugs:

- Obtained using the "furnish as written" provision to ensure that the participating CAP physician is complying with Medicare payment rules; and
- Ordered under the emergency replacement provision to ensure that the participating CAP physician is complying with Medicare payment rules, including the CAP definition of "emergency situation."

Dedicated CAP Listserv

CMS is in the process of establishing a specific CAP listserv, called CMS-CAP-PHYSICIANS-L, so that CAP physicians can receive pertinent and timely information regarding the CAP program. Please check back on the "Information for Physicians CAP Web page" *www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp* where you will be able to sign up for this listserv shortly.

Additional Information

Physician billing information on the CAP may be found at:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp
A CAP Specific Billing Tip Sheet may be found at:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/cap_billtips.pdf
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/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: SE0672	Related Change Request (CR) #: CR4309, CR4064
Related CR Release Date: N/A	Effective Date: N/A
Related CR Transmittal #: N/A	Implementation Date: N/A

CONSOLIDATED BILLING

2007 Annual Update of HCPCS Codes for Skilled Nursing Facility Consolidated Billing

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) or DME Medicare administrative contractors (DME MACs), and fiscal intermediaries (FIs) for services provided to Medicare beneficiaries in skilled nursing facilities (SNFs)

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5283, which provides the 2007 annual update of HCPCS codes for skilled nursing facility (SNF) consolidated billing (CB) and how the updates affect edits in Medicare claims processing systems.

CAUTION – What You Need to Know

CR 5283 provides updated to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manua*l (Publication 100-04), Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

GO – What You Need to Do

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

Background

Medicare's claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, DMERCs/ DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*. These edits only allow services that are excluded from CB to be separately paid by carriers and\or FIs.

- For physicians and providers billing carriers: By the first week in December 2006, new code files will be posted at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* on the CMS website.
- For those providers billing FIs: By the first week in December 2006, new Excel® and PDF files will be posted at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* on the CMS website.

Note: It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* on the CMS website in order to understand the major categories including additional exclusions not driven by HCPCS codes.

Implementation

The implementation date for CR 5283 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC or intermediary regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1068CP.pdf* on the CMS website.

If you have any questions, please contact your carrier, DMERC, DME MAC, or intermediary at their toll-free number, which may be 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: MM5283
Related Change Request (CR) #: 5283
Related CR Release Date: September 29, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1068CP
Implementation Date: January 2, 2007

INDEPENDENT DIAGNOSTIC TESING FACILITY

Incorrect Denials for IDTF services

Independent diagnostic testing facility (IDTF) claims submitted from October 02, 2006 through October 11, 2006 may have incorrectly denied with the following message:

"PR-170- Payment is denied when performed/billed by this type of provider"

We are working to resolve the issue as quickly as possible.

No Action Required by Providers

Providers do not need to take action at this time. First Coast Service Options, Inc. (FCSO) will perform adjustments on all affected claims.

We apologize for any inconvenience this may have caused.

LABORATORY/PATHOLOGY

Termination of Healthcare Common Procedure Coding System Code G0107, Colorectal Cancer Screening, Fecal-Occult Blood Tests, 1-3 Simultaneous Determinations

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

Provider Types Affected

All providers who bill Medicare carriers or fiscal intermediaries (FIs), including Part A/B Medicare administrative contractors (A/B MACs) for fecal occult blood tests administered to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Do not use HCPCS G0107 for screening fecal occult blood tests (FOBT) on or after January 1, 2007. As of that date, that code is being deleted and replaced by *current procedural terminology (CPT) 82270*.

CAUTION – What You Need to Know

Effective January 1, 2007, HCPCS G0107 for screening FOBT is being terminated and replaced by *CPT 82270*. If you use HCPCS G0107 for FOBT on or after this date, your reimbursement could be impacted, as the claim will be returned as unprocessable.

GO – What You Need to Do

Make sure that your billing staffs are aware of this coding change for FOBT.

Background

HCPCS G0107 will be retired at the next annual release of the clinical diagnostic laboratory fee schedule effective January 1, 2007, and replaced with *CPT 82270*.

Prior to January 1, 2007 use G0107 for billing Medicare for screening FOBT; however on or after January 1, 2007 (the effective date of the 2007 clinical diagnostic lab fee schedule) use *CPT 82270* for billing Medicare for screening FOBT.

Additional Information

The official instruction issued to you carrier, FI, or A/B MAC is CR 5292, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1062CP.pdf* on the CMS website. Revised Medicare *Claims Processing Manual* (Publication 100.04), Chapter 18 (Preventive and Screening Services), Section 60 (Colorectal Cancer Screening), Subsections 60.1-60.7 are included 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* 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: MM5292
Related Change Request (CR) #: 5292
Related CR Release Date: September 22, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1062CP
Implementation Date: January 2, 2007

MEDICARE PHYICIAN FEE SCHEDULE DATABASE

October Update to the 2006 Medicare Physician Fee Schedule Database

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

Provider Types Affected

Physicians and other providers who bill Medicare for professional services paid under the Medicare physician fee schedule (MPFS).

What you need to know

CR 5272, from which this article was taken, amends the payment files (based upon the November 21, 2005 MPFS final rule) that were previously issued to your carriers.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. Carriers, in accordance with the *Medicare Claims Processing Manual* (Publication 100-4), Chapter 23, Section 30.1, give providers 30 days notice before implementing the revised payment amounts, which (unless otherwise stated in the CR 5272) will be retroactive to January 1, 2006.

You should be aware that carriers will adjust claims that you bring to their attention, but are not required to search their files to either retract payment for claims already paid or to retroactively pay claims. The changes made as a result of CR 5272 are as follows:

CPT/HCPCS	Action
15000	Assistant at Surgery Indicator = 0
15001	Assistant at Surgery Indicator = 0
47145	Global Period = XXX Preoperative Time = 0.00 Intraoperative Time = 0.00 Postoperative Time = 0.00
52402	Endoscopic Base Code = 52000
G0289	Multiple Surgery Indicator = 0

In addition, some types of service (TOS) codes have been adjusted, effective for services on or after July 1, 2006. Specifically, carriers will apply TOS 4 to the category III codes of *0159T*, *0159T*-TC, and *0159T*-26 and they will apply TOS 6 to the category III codes of *0160T* and 0 161T.

Additional Information

You can find the official instruction about the October update to the 2006 MPFS database by going to CR 5272, which is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1047CP.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.

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: MM5272
Related Change Request (CR) #: 5272
Related CR Release Date: September 1, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R1047CP
Implementation Date: October 2, 2006

PSYCHIATRY SERVICES

Psychological and Neuropsychological Tests

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

Provider Types Affected

Providers who bill Medicare carriers or fiscal intermediaries (FIs) for the provision of diagnostic psychological and neuropsychological tests.

Provider Action Needed

STOP – Impact to You

Effective January 1, 2006, carriers and FIs will pay (under the Medicare physician fee schedule (MPFS) database) for diagnostic psychological and neuropsychological tests that are within the *CPT* code range of *96101* through *96120*.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) announces the revision of the *CPT* codes for psychological and neuropsychological tests (codes *96101* through *96120*) to include tests performed by technicians and computers (*CPT* codes *96102, 96103, 96119* and *96120*) in addition to those performed by physicians, clinical psychologists, independently psychologists and other qualified non-physician practitioners (as described in Background, below).

GO – What You Need to Do

Make sure that your billing staffs are aware of the *CPT* code changes.

Background

Medicare Part B coverage of psychological tests and neuropsychological tests is authorized under section 1861(s)(2)(C) of the Social Security Act, and payment for these tests is authorized under section 1842(b)(2)(A) of the Social Security Act.

The CPT codes for these tests are included in the range of codes from *96101* to *96120*. The appropriate codes when billing for psychological tests are: *96101, 96102, 96103*, *96105*, *96110*, and *96111*, and when billing for neuropsychological tests are: *96116*, *96118, 96119* and *96120*. All of the tests under this *CPT* code range *96101-96120* are covered and indicated as active codes under the MPFS database.

More specifically, CR 5204, from which this article is taken, provides that (effective January 1, 2006) the *CPT* codes for psychological and neuropsychological tests include tests performed by technicians and computers (*CPT* codes *96102, 96103, 96119* and *96120*) in addition to tests performed by physicians, clinical psychologists, independently practicing psychologists and other qualified nonphysician practitioners.

These changes, made in accordance with the final physician fee schedule regulation, were published in the *Federal Register* on November 21, 2005, at 70 FR *70279* and *70280* under Table 29 (AMA, Relative Value Update Committee (RUC) and Health Care Professional Advisory Committee (HCPAC) Recommendations and CMS Decisions for New and Revised 2006 *CPT* Codes).

You should be aware of some supervision requirements for diagnostic psychological and neuropsychological tests. First, under the diagnostic tests provision, all diagnostic tests are assigned a certain level of supervision. Generally, regulations governing the diagnostic tests provision allow only physicians to provide the assigned level of supervision for such tests; however, for diagnostic psychological and neuropsychological tests, there is a regulatory exception that allows either a clinical psychologist (CP) or a physician to perform the assigned general supervision.

Moreover, nonphysician practitioners such as nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs), who personally perform diagnostic psychological and neuropsychological tests are excluded from having to perform these tests under the supervision requirements of the diagnostic psychological and neuropsychological tests benefit, that is, under the general supervision of a physician or a CP.

In fact, rather than providing them under the requirements for diagnostic psychological and neuropsychological tests, NPs and CNSs must perform such tests under the requirements of their respective benefit. Therefore, NPs and CNSs must perform them in collaboration (as defined under Medicare law at section 1861(aa)(6) of the Act) with a physician. Likewise, PAs must perform these tests under the general supervision of a physician as required for services furnished under the PA benefit.

To continue, physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs) are authorized to bill three test codes (*96105, 96110*, and *96111*) as "sometimes therapy" codes. However, when PTs, OTs and SLPs perform these three tests, they must do so under the general supervision of a physician or a CP.

You should also note that expenses for diagnostic psychological and neuropsychological tests are not subject to the outpatient mental health treatment limitation, which is the payment limitation on treatment services for mental, psychoneurotic and personality disorders as authorized under Section 1833(c) of the Social Security Act. Further, the payment amounts that are billed for tests performed by a technician or a computer reflect a site of service payment differential for the facility and nonfacility settings.

Psychological and Neuropsychological Tests, continued

Remember that CPs, NPs, CNSs and PAs are required by law to accept assigned payment for psychological and neuropsychological tests. And although Independently Practicing Psychologists (IPPs) are not required to accept assigned payment for these tests, they must report the name and address of the physician who ordered the test on the claim form when billing for tests. (An IPP is any psychologist who is licensed (or certified) to practice psychology in the State or jurisdiction where furnishing services or, if the jurisdiction does not issue licenses, if provided by any practicing psychologist. Examples of psychologists (other than CPs) whose psychological and neuropsychological tests are covered under the diagnostic tests provision include, but are not limited to, educational psychologists and counseling psychologists.) Additionally, there is no authorization under Medicare law for payment for diagnostic tests when performed on an "incident to" basis.

Following is a summary of who may bill for diagnostic psychological and neuropsychological tests, and references for the review of qualifications, when appropriate.

Providers that May Bill for Diagnostic Psychological and Neuropsychological Tests	
CPs	Chapter 15, section 160 of the Medicare *Benefits Policy Manual*.
NPs –to the extent authorized under State scope of practice.	Chapter 15, section 200 of the Medicare *Benefits Policy Manual*.
CNSs –to the extent authorized under State scope of practice.	Chapter 15, section 210 of the Medicare *Benefits Policy Manual*.
PAs – to the extent authorized under State scope of practice.	Chapter 15, section 190 of the Medicare *Benefits Policy Manual*.
Independently Practicing Psychologists (IPPs)	
PTs, OTs and SLPs	Chapter 15, sections 220-230.6 of the Medicare *Benefits Policy Manual*.

The Medicare *Benefits Policy Manual* is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Here are some other important things that you should know.

- The technician and computer *CPT* codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Therefore, *CPT* psychological test code *96101* will not be paid if you include it in the bill for the same tests or services performed under psychological test codes *96102* or *96103*.

  Similarly, *CPT* neuropsychological test code *96118* will not be paid when included in the bill for the same tests or services performed under neuropsychological test codes *96119* or *96120*. Note, however, *CPT* codes *96101* and *96118* can sometimes be paid separately, when billed on the same date of service for different and separate tests from *96102, 96103, 96119* and *96120*.

- Under the MPFS, there is no payment for services performed by students or trainees. Accordingly, Medicare does not pay for services represented by *CPT* codes *96102* and *96119*, when performed by a student or a trainee. However, the presence of a student or a trainee while the test is being administered does not prevent a physician, CP, IPP, NP, CNS or PA from performing and being paid for the psychological test under *96102* or the neuropsychological test under *96119*.

- Fiscal intermediaries will continue to pay claims from providers of outpatient Part B therapy services (including physical therapy, occupational therapy, and speech-language pathology) for *CPT* codes *96105*, *96110* and *96111* with revenue codes and corresponding therapy modifiers (42x with GP, 43x with GO, and 44x with GN, respectively).

- Finally, your carriers and fiscal intermediaries do not have to search their files to either retract payment for claims already paid, or to retroactively pay claims to January 1, 2006; they will adjust claims that you bring to their attention.

You may find more information about psychological and neuropsychological tests by reading CR 5204, located at *http://www.cms.hhs.gov/Transmittals/downloads/R55BP.pdf* on the CMS website. As an attachment to this CR, you will find updated relevant portions of Publication 100.02 (Medicare *Benefit Policy Manual*), Chapter 15 (Covered Medical and Other Health Services), Section 80.2 (Psychological Tests and Neuropsychological Tests)

If you have any questions, please contact your carrier or fiscal intermediary 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).

Psychological and Neuropsychological Tests, continued

MLN Matters Number: MM5204
Related Change Request (CR) #: 5204
Related CR Release Date: September 29, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R55BP
Implementation Date: December 28, 2006

SURGERY

Holding of Pancreas Transplant Alone Claims—Amendment to MLN Matters Article MM5093

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

Provider Types Affected

Providers who bill Medicare fiscal intermediaries (FIs) or A/B Medicare administrative contractors (MACs) for pancreas transplant alone (PA) services to Medicare beneficiaries.

Key Points

- The held PA claims, described above, **will not process correctly** through the claims processing system beginning on October 2, 2006.
- **Until further notice, PA claims will be held**. Once the PA claims may be released for processing you will be notified.

Background

The Centers for Medicare & Medicaid Services (CMS) is publishing this special edition (SE) article to amend a prior notice to providers on May 19, 2006, change request (CR) 5093 (see *Additional Information* section for the web address). That prior notice announced that PA claims for discharges on or after April 26, 2006 through September 30, 2006, would be held until further notice. The PA claims **were scheduled** to be released October 2, 2006.

Additional Information

If you have questions, please contact your Medicare 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).

The MLN Matters article on CR 5093 may be found at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5093.pdf* on the CMS website

MLN Matters Number: SE0674
Related Change Request (CR) #:5093
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Pancreas Transplants Alone

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2006 Medicare B Update! page 37.

Note: This article was revised on October 5, 2006; to include this statement alerting affected providers to review *MLN Matters* article SE0674 for important information regarding the continued hold of affected claims. This article is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0674.pdf* on the CMS website.

Provider Types Affected

Physicians and providers billing Medicare fiscal intermediaries (FIs) and carriers for PA

Background

Medicare covers whole organ pancreas transplantation when it is performed in conjunction with or after kidney transplantation (*National Coverage Determination (NCD) Manual*, Section 260.3). However, Medicare does not cover PA in diabetes patients without end-stage renal failure because of a lack of sufficient evidence, based in large part on a 1994 Office of Health Technology Assessment report.

Pancreas Transplants Alone, continued

Key Points

This article is based on information contained in Change Request (CR) 5093, which informs physicians and providers that, effective for services performed on or after April 26, 2006, Medicare will cover PA for beneficiaries in the following limited circumstances:

- Facilities must be Medicare-approved for kidney transplantation (Approved centers are found at *http://www.cms.hhs.gov/ESRDGeneralInformation/02_Data.asp#TopOfPage* on the CMS website).
- Patients must have a diagnosis of type I diabetes:
- The patient with diabetes must be beta cell autoantibody positive; or
- The patient must demonstrate insulinopenia, defined as a fasting C-peptide level that is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method. Fasting C-peptide levels will be considered valid only with a concurrently obtained fasting glucose ≤225 mg/dL.
- Patients must have a history of medically uncontrollable labile (brittle) insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require hospitalization.
- These complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks.
- An endocrinologist must have optimally and intensively managed patients for at least 12 months with the most medically recognized advanced insulin formulations and delivery systems.
- Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immunosuppression.
- Patients must otherwise be suitable candidates for transplantation.

Billing and Claims Processing

- The following ICD-9 CM codes will be recognized by FIs and carriers for pancreas transplantation alone for beneficiaries with type I diabetes when billed with *CPT 48554*:

  25001, 25003, 25011, 25013, 25021, 25023, 25031, 25033, 25041, 25043, 25051, 25053, 25061, 25063, 25071, 25073, 25081, 25083, 25091, and 25093.

- Carriers and FIs who receive claims for PA services that were performed in an unapproved facility should use the following messages upon the reject or denial:
- Medicare summary notice (MSN) message - MSN code 16.2 (This service cannot be paid when provided in this location/facility)
- Remittance advice message - Claim adjustment reason code 58 (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service)
- Carriers and FIs who receive claims for PA services that are not billed using the covered diagnosis/procedure codes listed above should use the following messages upon the reject or denial:
- MSN message – MSN code 15.4 (The information provided does not support the need for this service or item)
- Remittance advice message – Claim adjustment reason code 50 (These are non-covered services because this is not deemed a 'medical necessity' by the payer)
- Modification of the current coverage policy on pancreas transplants may be found in Publication 100-03, Section 260.3 and claims processing information is located in Publication 100-04, Chapter 3, Section 90.5.1. The location of this information is listed in the "Additional Information" section of this article.

Note: Carriers and FIs will hold any PA claims with dates of service on or after April 26, 2006, until the claims can be processed in their systems. For FIs this date is October 2, 2006, and for carriers the date is July 3, 2006.

Implementation

The implementation date for this instruction is no later than July 3, 2006, for carriers; and October 2, 2006, for FIs.

Additional Information

The official instructions issued to your Medicare FI or carrier regarding this change may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R56NCD.pdf* for the NCD manual revision and *http://www.cms.hhs.gov/Transmittals/downloads/R957CP.pdf* for changes to the *Medicare Claims Processing Manual*.

If you have questions, please contact your Medicare FI or carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf* 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: MM5093 *Revised*
Related Change Request (CR) #: 5093
Related CR Release Date: May 19, 2006
Effective Date: April 26, 2006
Related CR Transmittal #: R56NCD and R957CP
Implementation Date: July 3, 2006 for carriers; October 2, 2006 for FIs

OTHER SERVICES AND PROCEDURES

Update to the Place of Service Code Set to Add a Code for Prison/ Correctional Facility

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

Provider Types Affected

Providers, physicians, and suppliers that submit claims to Medicare carriers, for services rendered in a prison/correctional facility.

Key Points

New Place of Service (POS) Code

A new place of service (POS) code "09" for prison/correctional facilities was added effective July 1, 2006. This POS code is described in the *Medicare Claims Processing Manual*, Chapter 26, Section 10.5 as:

> "**09 Prison/Correctional Facility (July 1, 2006)** - A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either federal, state or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders."

Claims Paid at Nonfacility Rate

Claims for covered services on the Medicare physician fee schedule in this POS/setting, if payable by Medicare, will be paid at the nonfacility rate, and Medicare carriers will develop policies as needed to adjudicate claims containing this new code.

New Code Does Not Supercede Medicare Policy

The addition of code 09 to the POS code set for a prison/correctional facility setting and Medicare claims processing reflects Medicare's compliance with HIPAA laws and regulations and in no way supersedes existing Medicare policy.

Carriers will continue to abide by current policy that does not allow for payment for Medicare services in a penal institution in most cases. This policy is supplied in the *Medicare Claims Processing Manual*, Chapter 1, Section 10.4, located at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the Centers for Medicare & Medicaid Services (CMS) website.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a POS code from the POS code set maintained by the CMS. As a payer, Medicare must be able to recognize as valid any valid code from the POS code set that appears on the HIPAA standard claim transaction.

Additional Information

The POS code set provides setting information necessary to appropriately pay Medicare and Medicaid claims. At times, Medicaid has had a greater need for specificity than has Medicare, and many of the new codes developed over the past few years have been developed to meet Medicaid's needs.

While Medicare does not always need this greater specificity to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

Note: Medicare's durable medical equipment regional carriers (DMERCs) and durable medical equipment Medicare administrative contractors (DME MACs) will implement this change at a later date and a separate notice will be provided when that implementation is scheduled.

CR 4316 is the official instruction issued to your carrier, regarding changes mentioned in this article. CR 4316 may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1049CP.pdf* on the CMS website.

Please refer to your local carrier if you have questions about this issue. To find their toll free phone number, go to *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: MM4316
Related Change Request (CR) #: 4316
Related CR Release Date: September 1, 2006
Effective Date: July 1, 2006
Related CR Transmittal #: R1049CP
Implementation Date: January 2, 2007

HIPAA - The Health Insurance Portability and Accountability Act

Ending the Contingency Plan for Remittance Advice and Charging for PC Print, Medicare Remit Easy Print, and Duplicate Remittance Advices

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

Impact on Providers

This change request (CR) updates the *Medicare Claims Processing Manual* (Publication 100-04) for ending the contingency plan for electronic remittance advice (ERA), and instructs contractors about charging for PC Print, Medicare Remit Easy Print (MREP), and duplicate remittance advice (RA).

Background

This article is based on CR 5308 which:

- Updates the *Medicare Claims Processing Manual* (Chapters 22 and 24) to include the end of the contingency period for ERA effective October 1, 2006; and
- Provides instructions to Medicare contractors (A/B MACs, carriers, DMERCs, DME MACs, FIs, and RHHIs) regarding charging for:
  - Generating and mailing provider requested duplicate RAs. There is no current CMS instruction for contractors to charge for generating duplicate RA (when provider has already been sent a RA – either in electronic or paper format) and mailing in case of paper RA. Therefore, CR 5308 informs Medicare contractors that they are now allowed to charge to recoup their cost to generate a duplicate RA if the request comes from a provider or any entity working on behalf of the provider.
  - Making PC Print or MREP software available to providers by CD/DVD or any other means when the requested software is available for free to download. Contractors may charge up to $25.00 for each mailing to cover their cost(s).

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, an ERA sent to a provider on or after October 16, 2003 is required to be a standard HIPAA compliant ERA, and the ERA standard adopted under HIPAA was ANSI ASC X12N transaction 835, version 004010A1.

CMS implemented a contingency plan (as of October 16, 2003) to continue to accept and send HIPAA-compliant and non HIPAA-compliant transactions from/to trading partners beyond October 16, 2003, for a limited time.

CMS ended the contingency period for claims in October 2005, and in a joint signature memorandum (JSM/TDL-06518) issued on June 28, 2006, CMS instructed Medicare contractors that it is ending the contingency period for ERAs on September 30, 2006.

CR 5308 instructs Medicare Contractors that, on or after October 1, 2006, all ERAs must be provided in the standard HIPAA (ANSI ASC X12N 835 version 004010A1) format.

Implementation

The implementation date for CR 5308 is October 23, 2006.

Additional Information

For complete details, please see the official instruction issued to your A/B MAC, carrier, intermediary regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1063CP.pdf* on the CMS website. The revised sections of the *Medicare Claims Processing Manual* are attached to CR 5308.

If you have any questions, please contact your carrier, intermediary, 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: MM 5308
Related CR Release Date: September 22, 2006
Related CR Transmittal #: R1063CP
Related Change Request (CR) #: CR 5308
Effective Date: October 1, 2006
Implementation Date: October 23, 2006

Duplicate Remittance Advice—Change Request 5308

The Centers for Medicare & Medicaid Services (CMS) has released change request (CR) 5308, which offers contractors the option to charge for generating duplicate remittance advice (when a provider has already been sent a remittance advice, either in electronic or paper format) and mailing in case of paper remittance advice (RA).

First Coast Service Options, Inc. (FCSO) has not opted at this time to charge for generating duplicate RAs.

If FCSO decides to charge for generating duplicate RAs, the information will be posted to the website. Please do not contact our customer service call center regarding this issue.

Source: Publication 100-04, Transmittal 1063, Change Request 5308

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Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Connecticut and Florida Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education websites *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com*. It's very easy to do. Simply go to the website, click on the "***eNews***" link on the navigational menu and follow the prompts.

MEDICARE SECONDARY PAYER

Medicare Secondary Payer Recovery Contractor Addresses

The Centers for Medicare & Medicaid Services (CMS) has notified Medicare fee-for-service contractors of the new addresses for the national Medicare Secondary Payer Recovery Contractor (MSPRC). The MSPRC accepts mail for the following addresses since **September 25, 2006.**

Address all liability insurance or no-fault insurance MSP recovery inquiries to:

MSPRC Auto, No-fault and Liability
P O Box 33828
Detroit, MI 48232-3828

Address Group Health Plan insurance MSP recovery inquiries to:

MSPRC GHP
P O Box 33829
Detroit, MI 48232-3829

Address Workers' Compensation MSP recovery inquiries to:

MSPRC WC
P O Box 33831
Detroit, MI 48232-3831

The MSPRC's dedicated call center toll-free telephone number is 1-866-MSP-RC20 (1-866-677-7220), available from 8:00 a.m. to 8:00 p.m. Eastern Standard Time, Monday through Friday, with the exception of holidays. For the hearing and speech impaired, the toll-free telephone number is 1-866-677-7294.

Additional information regarding the national Medicare Secondary Payer Recovery Contractor initiative may be found on the CMS website at *http://www.cms.hhs.gov/MSPRGenInfo/.*

Source: CMS Update to Joint Signature Memorandum 06686, September 21, 2006

NATIONAL PROVIDER IDENTIFIER

National Provider Identifier—Will You Be Ready?

Get It

The compliance date, May 23, 2007, is only **eight months** away. It's every provider's responsibility to make sure that a national provider Iientifier (NPI) is obtained if the provider is required to do so. If you're not sure, it's time to investigate. Get your NPI now so you have time to prepare **before** the compliance date. This includes sharing your NPI and appropriately testing it with payers to avoid a disruption in cash flow. To learn more on how to apply visit *http://www.cms.hhs.gov/NationalProvIdentStand/* on the CMS website.

Share It

Have your NPI and don't know what to do with it? Share it with health plans you bill and the colleagues who rely on having your NPI to submit their claims (e.g. those who bill for ordered or referred services). You should also share it with your billing service, vendor, or clearinghouse, if you have any of them as business associates. Find out when and how the health plans with which you do business will begin accepting the NPI in claims and other standard transactions.

Use It

Once your health plans have informed you that they are ready to accept NPIs, begin the testing process. It is important to test **before** May 23, 2007 to avoid a disruption in your cash flow. Consider sending only a few claims at first as you test the ability of plans to accept the NPI. Fewer claims will make it easier to keep track of status and payment, as well as troubleshooting any potential problems that may arise during the testing process.

Information on Covered Entities Under HIPAA

CMS has posted a new "Frequently Asked Question" to the CMS website that addresses whether a health care provider is a covered entity under HIPAA if they receive health information electronically (e.g. an electronic remittance advice), but do not transmit any health information electronically. The link is listed below or you may go to the CMS.gov website and click on "Questions" in the blue banner.

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?%20p_faqid=7906&p_created=1158786931&p_sid=fYkZcii&p_accessibility=0&p_lva=&p_sp=cF9zcmNoPSZwX3NvcnRfYnk9JnBfZ3JpZHNvcnQ9MjoyJnBfcm93X2Nud

National Provider Identifier—Will You Be Ready?, continued

New NPI Information for Medicare Providers

Clarification of the Taxonomy Requirement Outlined in CR 5243
Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a taxonomy code on all claims submitted to their Fiscal Intermediary. CMS posted a FAQ that clarifies this requirement. The link is listed below or you may go to the CMS.gov website and click on "Questions" in the blue banner.
http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=7896&p_created=1158064263&p_sid=KiZrwii&p_accessibility=0&p_lva=&p_sp=cF9zcmNoPTEmcF9zb3J0X2J5PSZwX2dyaWRzb3J0PSZwX3Jvd19jbnQ9M

Reminder to Supply Legacy Identifiers on NPI Application

CMS continues to urge providers to include legacy identifiers on their NPI applications. This will help all health plans, including Medicare, to get ready for May 23, 2007. If reporting a Medicaid legacy number, include the associated state name. If providers have already been assigned NPIs, CMS asks them to consider going back into the NPPES and updating their information with their legacy identifiers if they did not include those identifiers when they applied for NPIs. This information is critical for health plans and health care clearinghouses in the development of crosswalks to aid in the transition to the NPI.

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

Source: CMS Learning Resource, Message 200609-13

Message to Medicare Providers, Billers, Clearinghouse, and Vendors

NPI: Get It. Share It. Use It

As noted in previous announcements by the agency and our contractors, CMS plans to begin testing the new software that has been developed to use the national provider identifier (NPI) in the existing Medicare fee-for-service claims processing systems. Providers have until May 23, 2007, before you are required to submit claims with only an NPI.

Until testing is complete within the Medicare processing systems, CMS urges providers to continue submitting Medicare fee-for-service claims in one of two ways:

- Use your legacy number, such as your provider identification number (PIN), NSC number, OSCAR number or UPIN; or
- Use **both** your NPI **and** your legacy number.

Until testing of the new software that uses the NPI in the Medicare systems is complete and until further notice from CMS, the following may occur if you submit Medicare claims with only an NPI:

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

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 *https://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 200609-15
CMS Joint Signature Memorandum 06701, dated September 28, 2006

New National Provider Identifier Educational Products Available

NPI: Get It. Share It. Use It.

NPI Training Package: Module 5 Available Now

Module 5, Medicare Implementation, provides the NPI requirements specific to Medicare providers. This module will be updated as new requirements are announced or changes are made. Module 5 is now posted at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Training_Package.pdf* on the CMS NPI Page.

As always, more information and education on the NPI may be found at the CMS NPI page *www.cms.hhs.gov/NationalProvIdentStand* on the CMS website. Providers may apply for an NPI online at *https://nppes.cms.hhs.gov* or may 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 200610-07

GENERAL INFORMATION

New Qualified Independent Contractor Awards

The following chart indicates the new qualified independent contractor (QIC) jurisdictions by state and the date each QIC will become fully operational.

States in QIC Jurisdiction	Effective Date
Q2 Administrators South: Colorado, Connecticut, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, Florida, North Carolina, South Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands	January 1, 2007
First Coast Service Options North: Alaska, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, District of Columbia, New York, Pennsylvania, New Jersey, Delaware, Maryland, Ohio, Kentucky, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Missouri, Iowa, Kansas, Nebraska, South Dakota, North Dakota, Wyoming, Montana, Idaho, Washington, Oregon, California, Nevada, Arizona, Utah, Hawaii, Guam, Northern Mariana Islands, American Samoa	November 15, 2006
RiverTrust Solutions DME: Nationwide	December 1, 2006

Source: CMS Joint Signature Memorandum 07037, October 24, 2006

CMS Strengthens Emergency Preparedness Communication

The Centers for Medicare & Medicaid Services (CMS) is working to strengthen its emergency preparedness communications infrastructure for the nation's health care providers. As part of this emphasis, CMS is encouraging all health care providers to subscribe to their contractor's listserv in order to remain informed in case of either a regional or national emergency.

You may access First Coast Service Options, Inc. (FCSO) *eNews* mailing lists through the provider educational website (*www.connecticutmedicare.com* or *www.floridamedicare.com*). Click on the "eNews" on the top navigational menu of the home page. Select "FCSO eNews Lists/Interest Groups" on the FCSO eNews Electronic Mailing List Service main page, or use the following link:

http://lb.bcentral.com/ex/manage/subscriberprefs.aspx?customerid=8380

Providers should have a designated employee subscribed to monitor the Medicare listserv and a contingency plan in effect on how to deliver the necessary information throughout the provider's organization. CMS also recommends that there be at least one alternate employee who also subscribes to serve as a backup.

This communication tool is an effective and rapid way to disseminate critical information in the case of a regional or national emergency.

Source: CMS Pub. 100-20, Transmittal 239, CR 5336

"Own Your Future": Long-Term Care Campaign

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

Provider Types Affected

Physicians, providers, and their staff who provide health care to individuals between the ages of 45 - 65.

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to inform you about the Long-Term Care (LTC) Awareness Campaign 'Own Your Future' - the first effort of its kind designed to increase public awareness about the need to plan for future long-term care needs. Providers in Georgia, Massachusetts, Michigan, Nebraska,

"Own Your Future": Long-Term Care Campaign, continued

South Dakota, and Texas, may want to take special note as consumers in those States will receive letters over the next year alerting them of the campaign to promote LTC planning and of the availability of a free long-term care planning kit. You may want to reinforce the importance of such planning as you counsel your patients.

Background

Components of the U.S. Department of Health and Human Services (HHS), including the Office of the Assistant Secretary for Planning & Evaluation (ASPE), the Centers for Medicare & Medicaid Services (CMS),and the Administration on Aging (AoA), are working with the National Governors Association to sponsor the Long-Term Care (LTC) Awareness Campaign, "Own Your Future." The LTC Awareness Campaign represents a unique partnership between the federal government and the states to offer an important message to consumers about planning ahead for long-term care.

The LTC Awareness Campaign is an effort to increase public awareness of the need to plan for future long-term care needs. Many people today do not think about their future long-term care needs and therefore fail to plan appropriately. It is strongly felt that if individuals and families are more aware of their potential need for long-term care, they will be more likely to take steps to prepare for the future and determine how they would like their needs to be met.

The LTC Awareness Campaign includes evaluation activities designed to identify communication strategies that prove most effective in increasing awareness and promoting increased long-term care planning activities. The lessons learned from this campaign will be used in the design of future long-term care awareness campaigns in other states.

The campaign is now entering a third phase and builds upon the successes achieved in the first two phases in which nine states participated (Arkansas, Idaho, Kansas, Maryland, Nevada, New Jersey, Rhode Island, Virginia and Washington). It is supported with additional funds made available by Congress under the Deficit Reduction Act of 2005.

Additional Information

The LTC Awareness Campaign uses long-term care awareness materials that were designed, tested, and approved as part of an earlier awareness effort, and the materials include the following:

- Brochure (with business reply card) offering the Long-Term Care Planning Kit.
- Long-Term Care Planning Kit featuring:
  - A brochure describing what is, and what is not, covered by public programs related to long-term care. The brochure also describes several ways to plan ahead, addressing legal issues, assessing services, and assessing private financing options.
  - An audio CD with interviews of persons engaged in several different types of long-term care planning activities. Consumers in campaign states may order the free planning kit by telephone (1-866-PLAN LTC), business reply card, or at a newly-created consumer website (*http://www.aoa.gov/ownyourfuture*). Individuals outside the LTC Awareness Campaign states can download the planning kit at the consumer website (*http://www.aoa.gov/ownyourfuture*), or they can order and receive the free "Own Your Future" Planning Kit by calling 1-866-PLAN-LTC.

Additional important materials associated with the "Own Your Future" campaign are available at *http://www.cms.hhs.gov/center/longtermcare.asp* on the CMS website. The materials present issues and decisions that anyone thinking about long-term care may encounter such as:

- Home modification(s),
- Family care-giving dynamics, and
- Financing of care.

MLN Matters Number: SE0671 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

Medicare Part B Provider Call Center Holiday Closures

The Medicare Part B Call Center will be closed on the holidays listed below.

Date	Holiday Observed
Friday, November 10, 2006	Veterans' Day (Observance)
Thursday, November 23, 2006	Thanksgiving
Friday, November 24, 2006	Thanksgiving
Monday, December 25, 2006	Christmas
Tuesday, December 26, 2006	Christmas
Monday, January 1, 2007	New Year
Monday, January 15, 2007	Martin Luther King, Jr. Day
Monday, February 19, 2007	President's Day
Friday, April 6, 2007	Good Friday
Monday, May 28, 2007	Memorial Day
Wednesday, July 4, 2007	Independence Day
Monday, September 3, 2007	Labor Day
Monday, October 8, 2007	Columbus Day
Monday, November 12, 2007 (Observance)	Veterans' Day
Thursday, November 22, 2007	Thanksgiving
Friday, November 23, 2007	Thanksgiving
Monday, December 24, 2007	Christmas
Tuesday, December 25, 2007	Christmas

GENERAL MEDICAL REVIEW

Articles in this section apply to both Florida and Connecticut.

Billing Compounded Drugs, Update

In an effort to streamline the submission of compounded drug claims, this article addresses and provides clarification for the billing and reimbursement of compounded drugs.

Background

Compounded medications created/processed by a pharmacist in accordance with the Federal Food, Drug, and Cosmetic Act may be covered under Medicare when their use meets all other criteria for services incident to a physician's service. Since the compounded medications do not have an individual NDC (national drug code) number, the specific HCPCS Level II "J" codes may not be used. Instead, providers must use J3490 (unclassified drugs) as appropriate for reimbursement of the drug(s).

The use of compounded medications has been especially prevalent in the refilling of implantable infusion pumps, (*CPT* codes *95990* or *95991*). Whether a single agent or a combination of agents is used, the compounded medication must be billed under HCPCS code J3490 with the KD modifier (Drug/biological DME infused) even though the compound was similar to a specific HCPCS code (e.g., J2275 for preservative free morphine). Of course, providers who document and use the true "off-the-shelf" product from their office supply may continue to use the specific HCPCS code.

Definitions

Compounded Drug: A compounded drug is a blend of other drugs mixed (compounded) by a pharmacist. This mixture is delivered to the physician or qualified nonphysician provider ready to instill into an implantable pump. At times, the pharmacist may reconstitute only one substance and deliver it to the provider in a ready to instill form. An example of reconstituting is adding saline solution to a medication that is supplied as a powder and then turning it into a liquid. A drug that is reconstituted outside the provider's office and is delivered to her/him for instillation into an implantable pump is a compounded drug. In summary, any agent that has been processed by a pharmacist outside the provider's office is a compounded drug.

Off the Shelf Drug: An off-the-shelf drug is a drug that a physician or qualified nonphysician provider stores in the office in the original vial or other packaging form, as supplied by the manufacturer. Any such agent that is mixed or reconstituted in the provider's office, (i.e. taken off-the-provider's shelf), will be considered an off-the-shelf drug.

Invoice price: Invoice price includes **only** the price of the compounded drugs.

Procedure Codes

HCPCS J3490*:* Unclassified drugs.

***CPT* Code *95990*:** Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular).

***CPT* Code *95991*:** Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician.

Effective for services rendered on or after October 1, 2006, the following guidelines should be followed:

EMC/Paper Claims

The following information should be reported in Item 19 of the CMS 1500 claim form or comment screen for electronic billers.

- Invoice price for that individual patient
- Name(s) and dose(s) of drug(s) administered into the implantable pump

Claims for infusion drugs furnished via implanted DME, with dates of service on or after January 1, 2004, shall be identified using the "**KD**" modifier. Units billed should be (1) in the quantity billed (QB) field (Item 24G) on CMS 1500 form

Please bill the compounded drugs with the refilling and maintenance of implantable pump or reservoir procedure codes.

Helpful Hints for Item 19 of the CMS–1500 claim form or comment screen for electronic billers

- Indicate invoice price by INV$ as the first entry (i.e., INV$200)
- Use abbreviations as much as possible to allow the maxium information to be submitted to the FCSO in block 19 or its electronic equivalent (i.e., Clon for Clondine, MS for morphine sulfate)
- Enter names/doses of drugs in an abbreviated, but still generally understandable and distinguishable format. (This recommendation applies only to the claim, which represents a billing record. Such abbreviations should not be used in the clinical setting, as this may contribute to or cause medical errors.)

Billing Compounded Drugs, Update, continued

- The entry in Item 19 of the CMS 1500 claim form or comment screen for electronic billers could look like this "INV$200 Clon100mg MS100mg"

Note: If any of the above information is omitted from the initial claim, the claim will have to be developed. In that situation, First Coast Service Options, Inc. will request specific documentation by means of an additional documentation request (ADR) letter. This will slow down processing and payment.

Coverage of Less Than 500 cc of Dextrose 5% in Water (D5W) or 250 cc of Normal Saline

Providers are incorrectly billing unlisted procedure code (J3490) for less than 500 cc of D5W or 250 cc of normal saline. When less than 500 cc of D5W or 250 cc of normal saline is provided to a patient, it should always be bundled in the other services billed on the same day, by the same physician, and is not billed separately.

- If less than 500 cc of D5W is provided to a patient, it is always bundled in the other services billed.
- If less than 250 cc of normal saline is provided to a patient, it is always bundled in the other services billed.
- If between 250 cc and 500 cc of normal saline is provided to a patient, it is appropriate to bill J7040, Infusion, normal saline solution sterile (500 ml = 1 unit).

Emerging Diagnostic Technology—NC-stat System, NeuroMetrix®

NC-stat by NeuroMetrix® is an automated nerve conduction testing system marketed as an alternative to conventional nerve conduction testing. The NC-stat system is marketed as hand held and offers rapid turn around of test results, to perform non-invasive point of service testing for the assessment of nerves in the upper and lower extremities.

Nerve conduction studies performed with this device should not be billed to Medicare with the current *CPT* codes *95900*, *95903*, or *95904*. The procedure code descriptor must precisely describe the service billed. Therefore, until a specific code for this service is established by *CPT* that describes automated testing, this procedure must be billed with procedure code *95999* (*Unlisted neurological or neuromuscular diagnostic procedure*).

Currently, First Coast Service Options, Inc. (FCSO) does not have a local coverage determination that addresses when this automated diagnostic test is covered, and if covered, the criteria for coverage; so claims will be administered on an individual consideration basis.

As with any diagnostic test, the test should only be considered for patients with signs and symptoms and used in clinical decision-making when current established diagnostic tests are not indicated. There is no Medicare screening benefit for this type of automated nerve conduction study. The test should only be performed by physicians with training and expertise in the evaluation and treatment of peripheral nerve disorders. This expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty that diagnoses and treats patients with nerve conduction problems. This type of training is generally included in the residency or fellowship programs of physicians who specialize in physical medicine and rehabilitation (physiatrists) or neurology (neurologists).

If a claim is submitted to Medicare, a letter will be sent to the performing provider requesting records that document a description of the test, indications for the test (patient specific signs or symptoms) as outlined in a prior E&M evaluation), a copy of the test results with interpretation and an outline of how the results are used for specific patient decision making. Also, the physician should submit peer-reviewed literature that supports the use of this modality in lieu of established testing for the specific patient's condition.

More often than not, new services or technologies do not meet all the standards for coverage by Medicare. Any time there is a question whether Medicare's medical reasonableness and necessity criteria would be met; we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed *CPT* codes (*95999* in this situation). For further details about the Centers for Medicare & Medicaid Services (CMS) Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*.

Ground Ambulance Services—Beneficiary Deceased

It has come to our attention that some ambulance providers are incorrectly billing for transports for deceased beneficiaries. According to *Medicare Benefit Policy Manual*, reimbursement of ambulance services provided to a deceased Medicare beneficiary depends on when the beneficiary is pronounced deceased by an individual authorized to do so.

- If the beneficiary is pronounced deceased at the scene by an authorized individual after the ambulance is dispatched and prior to loading, the claim is billed with a QL modifier and no mileage is billed.
- If the beneficiary is dead at the scene but has not been pronounced by an authorized individual, services are not paid unless the ambulance waits at the scene for an authorized individual to arrive and pronounce death. The claim is billed with a QL modifier and no mileage is billed.

Medicare reimbursement for the above situations is based on the appropriate basic life support rate using HCPCS codes A0428 or A0429.

- When the beneficiary is dead at the scene but has not been pronounced by an authorized individual and the ambulance transports the body to the hospital for pronouncement of death, services are billed and reimbursed at the appropriate level of service furnished.
- If the beneficiary is pronounced deceased by an authorized individual prior to ambulance being dispatched no payment is made.

Source: Publication 100-02, Chapter 10, Section 10.2.6

Impacted Cerumen Removal—Clarification of Billing

Impacted cerumen removal (procedure code *69210*) is considered bilateral in nature and, therefore, has a bilateral tag = 2 on the Medicare physician fee schedule database (MPFSDB).

150 percent payment adjustment for bilateral procedure does not apply. Relative value units (RVUs) are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier 50 or is reported twice on the same day by any other means (e.g., with modifiers RT and LT, with a 2 in the units field), base payment for both sides on the lower of:

- the total actual charges by the physician for both sides, or
- 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because:

- the code descriptor specifically states that the procedure is bilateral;
- the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or
- the procedure is usually performed as a bilateral procedure.

Since procedure code *69210* is considered bilateral in nature, the proper way to bill procedure code *69210* would be to report it on one detail line (modifiers RT and LT should not be billed). In addition, due to the nature of this service, the use of modifier 76 is inappropriate.

Reporting Critical Care Services

Though the *CPT* codes used to report critical care (codes *99291* and *99292*) are considered evaluation and management (E/M) codes, they differ from other E/M codes, in that critical care codes are time-based.

A physician should use *CPT* code *99291* to report the first 30-74 minutes of critical care provided to a critically ill or injured patient on a given date of service. The time spent providing critical care does not have to be continuous; therefore, *99291* may be used to report the accumulation of smaller blocks of time totaling 30-74 minutes of critical care rendered to a given patient on a given date. A physician may report *99291* only once for a given patient on a given date of service.

CPT code *99292* is used to report additional blocks of time, up to 30 minutes each, of critical care for a given patient on a given date. Since *CPT* code *99292* is an "add-on code," it cannot be reported by a physician unless that physician has reported *CPT* code *99291* on that same date of service. Critical care of less than 30 minutes duration on a given date should be reported with the appropriate E/M code. Because critical care codes are time-based, physicians should document the time spent rendering critical care in the patient's medical record.

Any number of physicians may provide and bill critical care for the same patient on the same date, if the services are medically necessary and the patient's condition and the care rendered meet the definition of critical care.

Reporting Critical Care Services, continued

- If two physicians of the same specialty, in the same group, provide critical care to the same patient on the same date, they must bill as if they were one physician, combining their time and reporting *99291* and (if applicable) the appropriate number of units of *99292*.
- If physicians are of different groups and/or different specialties, they may each provide and bill critical care services to the same patient on a given date, if:
  - the services are medically necessary
  - the condition each physician is treating and the care rendered meet the definition of critical care, and
  - the services are not duplicative.

Each physician should report *99291* for the first 30-74 minutes of critical care provided to the patient on a given date, and *99292* for each additional block of time of up to 30 minutes on that date.

If a service does not meet the definition of critical care, either an inpatient hospital visit or an inpatient consultation, as appropriate, should be reported.

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Connecticut and Florida Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education websites *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com*. It's very easy to do. Simply go to the website, click on the "***eNews***" link on the navigational menu and follow the prompts.

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

J1950: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs—LCD Revision

First Coast Service Options, Inc. (FCSO) implemented the local coverage decision (LCD) for Lutenizing Hormone Releasing Hormone (LHRH) Analogs on August 7, 2006. Since that time, a special release article has been posted on August 15, 2006 clarifying the intent of the "grandfathering" provision defined in the LCD for HCPCS code J3315 (triptorelin pamoate). In addition, the article described how providers were to submit claims meeting the grandfathering provision. The coding guideline for this LCD was also revised at that time, providing the detailed instructions for meeting the grandfathering provision.

FCSO has received several requests asking that the grandfathering clause be removed from the LCD. After reviewing these requests, FCSO has decided to remove the grandfathering clause for HCPCS code J3315. The Least Costly Alternative (LCA) policy states that the agents covered in this LCD are medically comparable to each other and will be paid at the least costly amount. The least costly alternative outlined in this LCD does not prevent providers from administering the drug of their choice. Providers are given the opportunity to submit documentation that supports the patient receiving the more costly drug. The supporting documentation is usually found in the office/progress notes, medication record or letter of medical necessity stating why the patient cannot receive the least costly drug. When the documentation supports the patient receiving the more costly drug, FCSO will reimburse the provider at the higher amount for the drug given. Patient or provider preference for drug or route of administration is not justification enough to support medical necessity for the higher priced drug.

When seeking reimbursement for the higher priced drug, providers must populate block 19 of the CMS 1500 claim form (or the electronic equivalent) with the following: "Documentation of medical necessity available for review". Providers will receive a request for documentation and then must submit the documentation per the instructions received with the development request. Providers who are seeking reimbursement at the LCA price, not a higher amount, should not populate block 19 of the CMS 1500 claim form.

Effective Date

This revision is effective for services rendered on or after December 27, 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.

J2430: Pamidronate (Aredia®)—LCD Revision

This local coverage determination (LCD) was last updated on April 10, 2006. Since that time, the LCD has been revised. A request was received to allow for the off-label coverage of Pamidronate IV for the treatment of postmenopausal osteoporosis and for the prevention of glucocorticoid-induced osteoporosis.

A review of current literature supported this request and the LCD was revised to allow for the off-label treatment of postmenopausal osteoporosis and for the prevention of glucocorticoid-induced osteoporosis when there has been a failed attempt of treatment with oral biphosphonates or when there is a valid medical reason to use parenteral administration over oral administration. The indications and limitations section of this LCD was revised to reflect the new off-label coverage mentioned above. In addition, the "Documentation Requirements" and "Utilization Guidelines" sections were revised to reflect these coverage additions. The ICD-9-CM codes that support medical necessity were revised to include ICD-9-CM codes 733.01 and 733.09.

Effective Date

This revision is effective for services rendered on or after September 25, 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

The local coverage determination (LCD) for antineoplastic drugs was last updated on October 1, 2006. Since that time, the following revisions were made based on reconsiderations for carboplatin and paclitaxel and the USP DI.

Additional indications were added under the "Indications and Limitations of Coverage and/or Medical Necessity" section for the following HCPCS codes:

J9045 (carboplatin)

- Added the off-label indication of malignant neoplasm of the pleura (mesothelioma).

J9170 (docetaxel)

- Added additional off-label indications to ovarian carcinoma stating "after platinum-based therapy has failed, or as first-line treatment in combination with carboplatin."

J9000: Antineoplastic Drugs—LCD Revision,continued

J9206 (irinotecan)

- Added additional off-label indications to small-cell lung carcinoma stating "extensive-stage small-cell lung cancer, first line treatment, in combination with cisplatin."

J9265 (paclitaxel)

- Added the off-label indication of when "used in combination with carboplatin for the treatment of malignant melanoma."

In addition to the above, references were updated and the following HCPCS codes had additional ICD-9-CM codes added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD:

J9045 (carboplatin)

- Added ICD-9-CM code range 163.0-163.9 (Malignant neoplasm of pleura (mesothelioma)

J9265 (paclitaxel)

- Added ICD-9-CM code range 172.0-172.9 (Malignant melanoma of skin)

Effective Date

These revisions are effective for services rendered on or after October 16, 2006. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this

Medicare Guidelines for Independent Diagnostic Testing Facilities—Specialty Manual Revision

The latest revision for the Medicare guidelines for Independent Diagnostic Testing Facilities (IDTFs) was effective in January 2006. Since that time, this specialty manual has been revised in cooperation with a national IDTF workgroup, facilitated by the Centers for Medicare & Medicaid Services (CMS).

In evaluating the information to be revised in the Specialty Manual, the procedure codes contained in the manual were evaluated. It has been determined that not all diagnostic testing is considered appropriate for inclusion in the listing of IDTF codes. IDTFs may not perform therapeutic, intra-operative or ablation procedures. It is not an extension of any outpatient facility and should not perform procedures such as removal of foreign body from the esophagus, placement of gastrointestinal tubes, dilatation of strictures, pain management or trans-catheter therapies to name a few. Therefore, any physician services and/or surgical procedures best provided in acute care facilities, ambulatory surgical centers, or a physician's office are not included in the *CPT* codes for IDTFs. Therefore, this notification serves as a 45-day notice that the following *CPT* codes will no longer be allowed when billed by an IDTF:

59020, 71090, 74235, 74340, 74350, 74355, 74360, 74363, 74475, 74480, 74485, 75893, 75894, 75896, 75898, 75900, 75940, 75945, 75946, 75960, 75961, 75962, 75964, 75966, 75968, 75970, 75978, 75980, 75982, 75984, 75989, 75992, 75993, 75994, 75995, 75996, 76012, 76013, 76355, 76362, 76394, 76930, 76932, 76936, 76941, 76945, 76948, 76950, 76965, 76986, 78890, 78891, 93501, 93505, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533, 93555, 93556, 93561, 93562, 93571, 93572, 93600, 93602, 93603, 93609, 93610, 93612, 93613, 93615, 93616, 93618, 93619, 93620, 93621, 93622, 93623, 93624, 93631, 93640, 93641, 93642, 93724, 95829, 95955, 95961, 95962, 96102

In addition, it has been determined that the following *CPT* codes should be allowed as medically necessary and reasonable when billed by an IDTF:

75635, 76006, 76101, 91132, 91133, 92597, 93010, 93014, 93018, 93226, 93790, 94016, 94452, 94453, 95830, 0067T, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T and *0151T.*

As a reminder, Medicare may reimburse IDTFs only for procedure codes for which they are approved, based on equipment and personnel requirements. IDTFs are required to submit to Medicare Provider Enrollment a list of all procedure codes performed by the facility. The codes and equipment should be listed on Attachment 2, Section 1 of Enrollment Application Form CMS-855B.

There are indications that some IDTFs may have billed for procedures that have not been reviewed and approved by Medicare Provider Enrollment. The Medicare carrier may deny these services, even if the IDTF has the appropriate equipment and personnel. It is the responsibility of the IDTF to provide any changes to its list of procedures on an updated Form CMS-855B (with Attachment 2) to each Medicare contractor with which it does business.

The full text of this specialty manual may be viewed on the provider education website at *http://www.connecticutmedicare.com* when it becomes available.

76514: Ocular Corneal Pachymetry—LCD Revision

The local coverage determination (LCD) for ocular corneal pachymetry was last revised April 11, 2006. Ocular corneal pachymetry is the ultrasonic measurement of corneal thickness. Measurement of corneal thickness in individuals presenting with increased intraocular pressure assists in determining if there is a *risk* of glaucoma or if increased eye pressure is the result of abnormal corneal thickness. Presently, coverage does not include patients who are currently diagnosed and under treatment for glaucoma.

Since that time, First Coast Service Options, Inc. (FCSO) has determined that this service may be beneficial to patients who have a current diagnosis and receiving treatment for glaucoma. Therefore, the indications have been expanded to include patients diagnosed and under treatment for glaucoma when there is documented worsening of glaucoma and ocular corneal pachymetry is integral to the medical management decision-making of the patient. In addition, the "ICD-9 Codes that Support Medical Necessity" section of the LCD has been updated to expand ICD-9-CM diagnosis codes 365.00-365.04 and 365.51 to include ICD-9-CM diagnosis code range 365.00-365.9.

Effective Date

This LCD revision is effective for claims processed on or after October 20, 2006 for services rendered on or after June 21, 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.

81000: Urinalysis—LCD Revision

This local coverage determination (LCD) was last updated on October 1, 2005. Based on change request 5142 (Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM]), dated June 23, 2006, ICD-9-CM code 995.2 is no longer valid. Therefore, the "ICD-9 Codes that Support Medical Necessity" section of the LCD was updated to add ICD-9-CM codes 995.20 and 995.29.

Effective Date

This LCD revision is effective 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.

92552: Audiometry—LCD Revision

The local coverage determination (LCD) for audiometry was last revised, effective October 1, 2006. Since that time, language changes have been made to the "Documentation Requirements" section of the LCD to clarify language in this section.

Effective Date

This LCD revision is effective 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.

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Connecticut Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *http://www.connecticutmedicare.com* . It's very easy to do. Simply go to the website, click on the "***eNews***" link on the navigational menu and follow the prompts.

CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

November – December 2006

Ask the Contractor Teleconference – Revised Form CMS-1500 (08/05)

When: November 15, 2006
Time: 12:00 p.m. – 1:00 p.m.
Type of Event: Teleconference

Ask the Contractor Teleconference – NPI CMS Module-2, Electronic File Interchange (EFI)

When: November 16, 2006
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Educational Webcast (A/B)– 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*

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

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.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.

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.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

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).

NEW LCDs

77520: Proton Beam Radiotherapy—New LCD

Proton beam radiotherapy is a type of particle beam radiation therapy that delivers high dose radiation to a localized site. Proton beams theoretically deposit less radiation in normal non-targeted tissues than conventional radiation therapy and have been used to escalate the radiation dose to diseased tissues while minimizing damage to adjacent normal tissues. Historically, proton beam radiotherapy has most commonly been used for tumors that are difficult or dangerous to treat with surgery or for tumors that are located next to vital structures, where administration of adequate doses of conventional radiation is difficult or impossible.

In general, proton beam radiotherapy is not indicated for cancers that are widely disseminated, such as leukemias, have hematogenous metastases or as a short term palliative procedure. The intent of treatment should be curative. If proton beam radiotherapy is used for a patient with metastatic disease, evidence should be provided to justify the expectation of a long-term benefit (>2 years), as well as evidence of a dosimetric advantage for proton beam radiotherapy over other forms of radiation therapy.

This new local coverage determination (LCD) has been developed to provide indications and limitations of coverage and/or medical necessity and documentation requirements for CPT codes 77520, 77522, 77523, and 77525.

Effective Date

This new LCD is effective for services rendered on or after January 8, 2007. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

REVISIONS TO LCDs

J1950: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs—LCD Revision

First Coast Service Options, Inc. (FCSO) implemented the local coverage decision (LCD) for Lutenizing Hormone Releasing Hormone (LHRH) Analogs on August 7, 2006. Since that time, a special release article has been posted on August 15, 2006 clarifying the intent of the "grandfathering" provision defined in the LCD for HCPCS code J3315 (triptorelin pamoate). In addition, the article described how providers were to submit claims meeting the grandfathering provision. The coding guideline for this LCD was also revised at that time, providing the detailed instructions for meeting the grandfathering provision.

FCSO has received several requests asking that the grandfathering clause be removed from the LCD. After reviewing these requests, FCSO has decided to remove the grandfathering clause for HCPCS code J3315. The Least Costly Alternative (LCA) policy states that the agents covered in this LCD are medically comparable to each other and will be paid at the least costly amount. The least costly alternative outlined in this LCD does not prevent providers from administering the drug of their choice. Providers are given the opportunity to submit documentation that supports the patient receiving the more costly drug. The supporting documentation is usually found in the office/progress notes, medication record or letter of medical necessity stating why the patient cannot receive the least costly drug. When the documentation supports the patient receiving the more costly drug, FCSO will reimburse the provider at the higher amount for the drug given. Patient or provider preference for drug or route of administration is not justification enough to support medical necessity for the higher priced drug.

When seeking reimbursement for the higher priced drug, providers must populate block 19 of the CMS 1500 claim form (or the electronic equivalent) with the following: "Documentation of medical necessity available for review". Providers will receive a request for documentation and then must submit the documentation per the instructions received with the development request. Providers who are seeking reimbursement at the LCA price, not a higher amount, should not populate block 19 of the CMS 1500 claim form.

Effective Date

This revision is effective for services rendered on or after December 27, 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.

J2430: Pamidronate (Aredia®)—LCD Revision

This local coverage determination (LCD) was last updated on April 10, 2006. Since that time, the LCD has been revised. A request was received to allow for the off-label coverage of Pamidronate IV for the treatment of postmenopausal osteoporosis and for the prevention of glucocorticoid-induced osteoporosis.

A review of current literature supported this request and the LCD was revised to allow for the off-label treatment of postmenopausal osteoporosis and for the prevention of glucocorticoid-induced osteoporosis when there has been a failed attempt of treatment with oral biphosphonates or when there is a valid medical reason to use parenteral administration over oral administration. The indications and limitations section of this LCD was revised to reflect the new off-label coverage mentioned above. In addition, the documentation requirements and utilization guidelines sections were revised accordingly for these coverage additions. The ICD-9-CM codes that support medical necessity were revised to include ICD-9-CM codes 733.01 and 733.09.

Effective Date

This revision is effective for services rendered on or after September 25, 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

The local coverage determination (LCD) for antineoplastic drugs was last updated on October 1, 2006. Since that time, the following revisions were made based on reconsiderations for carboplatin and paclitaxel and the USP DI.

Additional indications were added under the "Indications and Limitations of Coverage and/or Medical Necessity" section for the following HCPCS codes:

J9045 (carboplatin)

- Added the off-label indication of malignant neoplasm of the pleura (mesothelioma).

J9170 (docetaxel)

- Added additional off-label indications to ovarian carcinoma stating "after platinum-based therapy has failed, or as first-line treatment in combination with carboplatin."

J9206 (irinotecan)

- Added additional off-label indications to small-cell lung carcinoma stating "extensive-stage small-cell lung cancer, first line treatment, in combination with cisplatin."

J9265 (paclitaxel)

- Added the off-label indication of when "used in combination with carboplatin for the treatment of malignant melanoma."

In addition to the above, references were updated and the following HCPCS codes had additional ICD-9-CM codes added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD:

J9045 (carboplatin)

- Added ICD-9-CM code range 163.0-163.9 (Malignant neoplasm of pleura (mesothelioma)

J9265 (paclitaxel)

- Added ICD-9-CM code range 172.0-172.9 (Malignant melanoma of skin)

Effective Date

These revisions are effective for services rendered on or after October 16, 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.

Medicare Guidelines for Independent Diagnostic Testing Facilities—Specialty Manual Revision

The latest revision for the Medicare guidelines for Independent Diagnostic Testing Facilities (IDTFs) was effective in January 2006. Since that time, this specialty manual has been revised in cooperation with a national IDTF workgroup, facilitated by the Centers for Medicare & Medicaid Services (CMS).

In evaluating the information to be revised in the Specialty Manual, the procedure codes contained in the manual were evaluated. It has been determined that not all diagnostic testing is considered appropriate for inclusion in the listing of IDTF codes. IDTFs may not perform therapeutic, intra-operative or ablation procedures. It is not an extension of any outpatient facility and should not perform procedures such as removal of foreign body from the esophagus, placement of gastrointestinal tubes, dilatation of strictures, pain management or trans-catheter therapies to name a few. Therefore, any physician services and/or surgical procedures best provided in acute care facilities, ambulatory surgical centers, or a physician's office are not included in the *CPT* codes for IDTFs. Therefore, this notification serves as a 45-day notice that the following *CPT* codes will no longer be allowed when billed by an IDTF:

59020, 71090, 74235, 74340, 74350, 74355, 74360, 74363, 74475, 74480, 74485, 75893, 75894, 75896, 75898, 75900, 75940, 75945, 75946, 75960, 75961, 75962, 75964, 75966, 75968, 75970, 75978, 75980, 75982, 75984, 75989, 75992, 75993, 75994, 75995, 75996, 76012, 76013, 76355, 76362, 76394, 76930, 76932, 76936, 76941, 76945, 76948, 76950, 76965, 76986, 78890, 78891, 93501, 93505, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533, 93555, 93556, 93561, 93562, 93571, 93572, 93600, 93602, 93603, 93609, 93610, 93612, 93613, 93615, 93616, 93618, 93619, 93620, 93621, 93622, 93623, 93624, 93631, 93640, 93641, 93642, 93724, 95829, 95955, 95961, 95962, 96102

Medicare Guidelines for Independent Diagnostic Testing Facilities—Specialty Manual Revision, continued

In addition, it has been determined that the following *CPT* codes should be allowed as medically necessary and reasonable when billed by an IDTF:

75635, 76006, 76101, 91132, 91133, 92597, 93010, 93014, 93018, 93226, 93790, 94016, 94452, 94453, 95830, 0067T, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T and *0151T.*

As a reminder, Medicare may reimburse IDTFs only for procedure codes for which they are approved, based on equipment and personnel requirements. IDTFs are required to submit to Medicare Provider Enrollment a list of all procedure codes performed by the facility. The codes and equipment should be listed on Attachment 2, Section 1 of Enrollment Application Form CMS-855B.

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The full text of this specialty manual may be viewed on the provider education website at *http://www.floridamedicare.com* when it becomes available.

76514: Ocular Corneal Pachymetry—LCD Revision

The local coverage determination (LCD) for ocular corneal pachymetry was last revised April 11, 2006. Ocular corneal pachymetry is the ultrasonic measurement of corneal thickness. Measurement of corneal thickness in individuals presenting with increased intraocular pressure assists in determining if there is a *risk* of glaucoma or if increased eye pressure is the result of abnormal corneal thickness. Presently, coverage does not include patients who are currently diagnosed and under treatment for glaucoma.

Since that time, First Coast Service Options, Inc. (FCSO) has determined that this service may be beneficial to patients who have a current diagnosis and receiving treatment for glaucoma. Therefore, the indications have been expanded to include patients diagnosed and under treatment for glaucoma when there is documented worsening of glaucoma and ocular corneal pachymetry is integral to the medical management decision-making of the patient. In addition, the "ICD-9 Codes that Support Medical Necessity" section of the LCD has been updated to expand ICD-9-CM diagnosis codes 365.00-365.04 and 365.51 to include ICD-9-CM diagnosis code range 365.00-365.9.

Effective Date

This LCD revision is effective for claims processed on or after October 26, 2006 for services rendered on or after June 21, 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.

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- 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 32231-0018

Fair Hearing Requests
Medicare Part B Fair Hearings
P. O. Box 45156
Jacksonville, FL 32232-5156

Administrative Law Judge Hearing
Administrative Law Judge Hearing
P. O. Box 45001
Jacksonville, FL 32231-5001

Status/General Inquiries
Medicare Part B Correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B Financial Services
P. O. Box 44141
Jacksonville, FL 32231-4141

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims
Palmetto GBA Medicare
DMERC Operations
P. O. Box 100141
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

MISCELLANEOUS

Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
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

Educational Articles in this section apply to both Florida and Connecticut.

CMS Announces Part D Low Income Subsidy Redetermination Information

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

Provider Types Affected

Physicians, suppliers, providers, and their staff who serve Medicare beneficiaries.

Background

The purpose of this Special Edition (SE) article is to alert providers that Medicare and Social Security are making decisions about whether some people who qualify for extra help (also referred to as the low-income subsidy or LIS) in 2006 will continue to qualify in 2007. People affected by these changes will receive information from Medicare or Social Security. The information provided in this SE is intended to help you counsel your patients affected by these changes and help them understand their options for getting help paying for Medicare prescription drug coverage.

Key Points

Changes in Qualifying For Extra Help in 2007

A person will no longer **automatically** qualify for extra help in 2007 if he or she no longer:

- Has both Medicare and Medicaid (full-benefit dual-eligible),
- Belongs to a Medicare Savings Program (partial dual-eligible), or
- Receives Supplemental Security Income (SSI) benefits.

People who will no longer automatically qualify for extra help in 2007 will receive a notice and an application for extra help in the mail from Medicare by the end of September.

If in the coming months a person's situation changes so that they again automatically qualify for extra help, Medicare will send them another notice letting them know that they qualify.

Medicare is also mailing notices to people who will continue to automatically qualify for extra help in 2007 but whose copayment levels will change as of January 1, 2007. Medicare will mail these notices by early October to let people know their new copayment level. A change in co-payment level could result when there is a change in someone's Medicaid eligibility.

For example, if someone with both Medicare and Medicaid no longer resides in a nursing home, then he or she will no longer qualify for a $0 co-payment effective January 1, 2007.

People with no changes who continue to automatically qualify for extra help as of January 1, 2007, will not receive a notice.

Beneficiaries Might Still Save on Their Medicare Prescription Drug Coverage Costs Even if They Don't Qualify For Extra Help

The good news is, even if a person no longer automatically qualifies for extra help, they may still be able to save on Medicare prescription drug coverage costs. A person who no longer automatically qualifies may still qualify for extra help based on their income and resources, but will need to apply to Social Security or their State Medical Assistance (Medicaid) office to find out. Applying early is important so their extra help can be effective as early as January 1, 2007. Social Security's application for extra help and a self-addressed postage free envelope will be included in the mailing they receive. And if they don't qualify, there are still other ways to save on drug costs, as mentioned below. A person should apply and qualify for extra help if

- Yearly income is less than $14,700 (single) or $19,800 (married and living with their spouse), and
- Resources are less than $11,500 (single) or $23,000 (married and living with their spouse). Resources include savings and stocks but not home or car.

The above amounts are for 2006 and may change in 2007. If a beneficiary lives in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How to Apply For Extra Help

Use the web, phone, mail, or in person but apply as soon as possible:

- Apply for extra help online through Social Security at: *http://www.socialsecurity.gov/* on the Web. To apply by phone, get a paper application mailed, or make an appointment at the local Social Security office, call 1-800-772-1213. TTY users should call 1-800-325-0778.
- To apply for extra help through the State Medical Assistance (Medicaid) office, visit *http://www.medicare.gov/* or call 1-800-MEDICARE (1-800-633-4227) for their telephone number. TTY users should call 1-877-486-2048.
- Remind beneficiaries to apply or reapply for extra help if income and/or resources change.

If patients still don't qualify for extra help, encourage them to review the following options for lowering prescription drug coverage costs:

- The state may have programs that provide help paying prescription drug costs. The patient should contact their state medical assistance (Medicaid) office for more information. They can call 1-800-MEDICARE or visit *http://www.medicare.gov/* for the Medicaid telephone number.
- There may be Medicare drug plans available in your area for 2007 with no premiums and no deductibles. Encourage patients to compare these plans to their current plan. New Medicare drug plans can begin advertising as of October 1. Beneficiaries have the opportunity to switch Medicare drug plans from November 15 through December 31 each year. New coverage would begin January 1 of the following year.

CMS Announces Part D Low Income Subsidy Redetermination Information, continued

Encourage patients to enroll early. If they're switching plans, joining the new Medicare drug plan as soon as possible gives the plan time to mail a membership card, acknowledgement letter, and welcome package before the new coverage becomes effective.

People who applied and qualified for extra help in 2006

The Social Security Administration (SSA) is reviewing the eligibility of people who applied and qualified for extra help prior to May 2006. This review will ensure these people are still eligible and receiving the appropriate amount of extra help. SSA mailed these individuals a letter at the end of August telling them what Social Security's records show for their income, resources and household size. A cost of living increase in their Social Security benefit will not be considered a change in their situation.

- People who have no changes to their income, resources or household size should do nothing.
- People who have any changes to their income, resources, or household size will need to return a one-page letter (L1026) in the envelope enclosed with the mailing within 15 days. SSA will then mail them a form called "Social Security Administration Review of Your Eligibility for Extra Help" (Form 1026B). If these individuals fill out and return the form within 30 days, any change to the amount of extra help they qualify for will be effective in January 2007 unless their marital status changed. Changes in marital status may result in changes to the amount of extra help in the following month.

SSA will also send the eligibility review form (1026B) directly to some people to complete because SSA already has information about a change in their income, resources or household composition. The Medicare beneficiary needs to return that form to the SSA within 30 days.

SSA will review the eligibility review form (1026B) and send the person a letter explaining its decision. SSA may decide a person has:

- no change in the amount of extra help they receive
- an increase in the amount of extra help they receive
- a decrease in the amount of extra help they receive, or
- No longer qualifies for extra help.

If a beneficiary believes that SSA's decision is incorrect, they have the right to appeal it. The decision letter will explain their appeal rights. The following Web links at the SSA website provide more information:

- Fact Sheet – *http://www.socialsecurity.gov/pubs/10111.html*
- Mailing (L1026) *http://www.ssa.gov/prescriptionhelp/LL1026%20Passive%20Redetermination%20English%20SAMPLE%20_08-25-06%20Systems_.pdf* on the Social Security website.
- "Social Security Administration Review of Your Eligibility for Extra Help" (1026B) *http://www.ssa.gov/prescriptionhelp/SSA-1026B-OCR-SM-INST.pdf*

Additional Information

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/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).

The bulletins and sample notices that will be sent to Medicare beneficiaries can be reviewed by looking at the following documents at:

Changes in Qualifying for Extra Help in 2007:Materials for Partners and People with Medicare [PDF, 47KB] *http://www.cms.hhs.gov/MyHealthMyMedicare/Downloads/LIS%20package%201.pdf* on the CMS website.

Re-deeming Notice: Loss of (Extra Help) Status Version [PDF, 58KB] *http://www.cms.hhs.gov/partnerships/downloads/11198.pdf* on the CMS website.

Re-deeming Notice: Change in (Extra Help) Copayment Level Version [PDF, 55KB] *http://www.cms.hhs.gov/partnerships/downloads/11199.pdf* on the CMS website.

Information Partners Can Use on: Changes in Qualifying for Extra Help in 2007 [PDF, 48KB] *http://www.cms.hhs.gov/partnerships/downloads/07LISchanges.pdf* on the CMS website.

You might still save on your Medicare prescription drug coverage costs even if you don't automatically qualify for extra help [PDF, 427KB] *http://www.medicare.gov/Publications/Pubs/pdf/11215.pdf* on the CMS website.

MLN Matters Number: SE0668
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

A Reminder About Medicare Preventive Services Education Products

An Overview of Medicare Preventive Services Video

The *Medicare Learning Network* is pleased to announce the availability of the latest provider education resource on Medicare's coverage of preventive benefits, *An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* video program. This educational video program provides an overview of preventive services covered by Medicare including the newest preventive services that became effective January 2005 as a result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This program provides information on risk factors associated with various preventable diseases and highlights the importance of prevention, detection, and early treatment of disease. The information presented in this program is useful for physicians, providers, suppliers, and other health care professionals involved in providing preventive services to Medicare beneficiaries. The program runs approximately 75 minutes in length.

(CMS has approved this educational video program for .1 International Association for Continuing Education and Training (IACET) CEU for successful completion. This program is appropriate for use by a single individual or may be shown to a large group. To order your DVD or VHS copy of the video program, go to *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*)

Preventive Services Web-Based Training Course

The updated *Medicare Preventive Services Series: Part 1 Adult Immunizations* Web-based training course is now available on the Medicare Learning Network (MLN) Product Ordering Page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* The course provides information about Medicare coverage for the following adult immunizations:

- Influenza;
- Pneumococcal; and
- Hepatitis B.

(CMS has approved this web-based training course for .1 IACET CEU for successful completion. The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized Provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington, DC 20006. The authors of these programs have no conflicts of interest to disclose. These courses were developed without the use of any commercial support.)

Flu Season Resources for Health Care Professionals

The *Medicare Learning Network* has developed the **2006 - 2007 Influenza (Flu) Season Educational Products and Resources** online PDF document. This online document includes links to flu-related educational products developed by CMS for provider use and links to other resources where clinicians may find useful information and tools for the 2006 - 2007 flu season. The resource document will be updated as new flu information becomes available. **The 2006 - 2007 Influenza (Flu) Season Educational Products and Resources** online document can be accessed by going to the Downloads section of the *MLN Preventive Services Educational Products* Web page, located at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*

Source: CMS Learning Resource, Message 200610-10

Flu Shot Reminder

Flu season is upon us! Begin now to take advantage of each office visit as an opportunity to talk with your patients about the flu virus and their risks for complications associated with the flu, and encourage them to get their flu shot. It's their best defense against combating the flu this season. *(Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)* And don't forget, health care professionals need to protect themselves also.

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

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 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf*.

Source: CMS Provider Education Resource 200610-01

October is National Breast Cancer Awareness Month

In conjunction with National Breast Cancer Awareness Month (NBCAM), the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join with us in helping to promote increased awareness of the importance of early detection of breast cancer, and ensure that all eligible women with Medicare know that Medicare provides coverage of screening mammograms and clinical breast exams for the early detection of breast cancer.

Next to skin cancer, breast cancer is the most common form of cancer diagnosed in women in the U.S., and it is the second leading cause of cancer death in women. According to the American Cancer Society, in 2006 about 212,920 women in the U.S. will be found to have invasive breast cancer and about 40,970 will die from the disease. The earlier breast cancer is detected, the better the treatment outcome. Regular screening mammograms can help women detect breast cancer early.

Although screening mammograms and clinical breast exams are services covered by Medicare, the data indicates that these services are being underutilized. There are eligible women with Medicare who have never taken advantage of these preventive benefits and others who do not get screening mammograms and/or clinical breast exams at regular intervals.

Barriers to Getting Mammograms*

The top four barriers, in women's words, are:

- "I don't need a mammogram because my doctor has never recommended I have one."
- "I've never thought about it."
- "I have no breast problems, so mammography isn't necessary."
- "I don't have enough time."

Other barriers include:

- Fear about pain from the procedure.
- Fear of a diagnosis of breast cancer.
- Concerns about screening costs.
- Living a distance from the screening site.

Source: *The Manual of Intervention Strategies to Increase Mammography Rates*, Centers for Disease Control and Prevention with the Prudential Center for Health Care Research.

Medicare Coverage

The good news is that mammography rates for women age 50 and older are increasing and breast cancer deaths are in decline. The U.S. Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination, every one-two years for women aged 40 and older.

Medicare provides coverage of an annual screening mammogram for all female beneficiaries age 40 and older. Medicare also provides coverage of clinical breast exams, (the clinical breast exam is a Medicare-covered service which is included as part of the pelvic screening exam) every 12 or 24 months depending on risk level for the disease.

How Can You Help?

As a trusted source, your recommendation is the most important factor in increasing utilization of breast cancer screening services among eligible women with Medicare. CMS needs your help to ensure that all women with Medicare take full advantage of the preventive services and screenings for which they may be eligible. These services could save their lives.

- Help your patients understand the nature of breast cancer, benefits of breast cancer screening and encourage them to get screening mammograms at regular intervals.
- Encourage your patients to talk about any barriers that may keep them from obtaining mammography services on a routine basis and help them overcome those barriers.

For More Information

For more information about Medicare's coverage of screening mammography, visit the CMS website at *http://www.cms.hhs.gov/Mammography/*.

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 Matters article "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*.
- The CMS website provides information for each preventive service covered by Medicare. Click on *http://www.cms.hhs.gov*, select "Medicare", and scroll down to "Prevention."

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

For more information about NBCAM, please visit *http://www.nbcam.org*.

Thank you for joining with CMS to promote increased awareness of early breast cancer detection and mammography and clinical breast exam services covered by Medicare.

Source: CMS Provider Education Resource 200610-02

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 ***