Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue…

Features

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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 _____

_____

TABLE OF CONTENTS

Medicare B Update!

Vol. 4, No. 3
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Publications Staff
Terri Drury
Kimberly McCaw
Millie C. Pérez

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

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

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

A PHYSICIAN'S FOCUS

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria

In addition to national and local coverage determinations (NCDs and LCDs), there are certain principles that apply to all Medicare claims. These are rooted in the Medicare laws and regulations. By drawing the attention of our provider community to these topics, we anticipate reducing the claim payment error rate and reimbursing for medically necessary services correctly and expeditiously. This is not an all-inclusive list, but it does represent frequent observations from our Medical Review and Medical Policy departments. The focus of this article is on professional services that are usually but not always billed to the carrier (Part B funds) as opposed to the fiscal intermediary (FI – Part A and B funds). However, the principles apply to FI services unless specific differences are noted in the Medicare manuals. We hope that this publication will be useful to our providers and their teams by facilitating the correct filing of claims and the submission of supportive information.

Documentation

General Information

Below are some key points:

- Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24-48 hrs.) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
- The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.
- Every note must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered. They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.
- If the provider elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter must be documented in the medical record. Generally, the time must be documented when billing for all time-based codes, such as critical care, prolonged services, hospital discharge services, and others.
- All entries must be legible to another reader to a degree that a meaningful review may be conducted. All notes should be dated, preferably timed, and signed by the author. In the office setting, initials are acceptable as long as they clearly identify the author. If the signature is not legible and does not identify the author, a printed version should be also recorded.

Responding to Additional Documentation Request Letters and Requests from the Comprehensive Error Rate Testing Contractor

Although the terminology of these letters may vary, it is important to send all information that will support the claim. For non-laboratory services, this is the billing provider's responsibility, regardless if she or he has created it. For example, when seeking reimbursement for a diagnostic test, the performing (billing) provider should not only submit the report but also the order and the referring provider's office notes that document the medical necessity for the study. If the information received fails to support the coverage or coding of the claim, in full or in part, the contractor must deny the claim, in full or in part (CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 3, Section 3.4.1.2A).

There are situations where test reports or other elements of the documentation are housed at a different location from the performing provider's office, for instance an EKG or X-ray read in the hospital. Because it is the performing provider who is required to submit this documentation upon request, it would be best practice if providers kept a copy of this information in their records so that it is readily available. This is a very important issue, as it continues to generate a high error rate in CMS' CERT (comprehensive error rate testing) program and results in numerous recoupments of payments already made.

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)

Cloning of Medical Notes

Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Evaluation and Management Coding

Procedure Code/Diagnosis Code Linking

It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical signs/symptoms must be present for the procedure to be paid.

Volume of Documentation vs. Medical Necessity

The Social Security Act, Section 1862 (a)(1)(A) states: "No payment will be made … for items or services …not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member." This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare. Providers frequently "over document" and consequently select and bill for a higher-level E/M code than medically reasonable and necessary. Word processing software, the electronic medical record, and formatted note systems facilitate the "carry over" and repetitive "fill in" of stored information. Even if a "complete" note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient's situation at that specific time cannot be counted.

Shared Visits

Shared visits with non-physician providers (NPPs) may be reported as one visit, if each provider sees the patient separately and each documents separately. Each component of the visit must be medically necessary.

In the office/clinic setting:

- Providers may bill under the physician's provider identification number (PIN), if all "incident to" requirements are met (follow-up visit, direct supervision, etc.).
- The service must be billed under the non-physician provider's PIN if any of the "incident to" requirements are not met (example: new patient and/or physician not in the office suite).

In the hospital inpatient/outpatient/ER setting:

- Providers may bill under the physician's or NPP's PIN if the physician provides any face-to-face portion of the E/M encounter with the patient.
- The services must be billed under the NPP's PIN if there is no face-to-face encounter by the physician.

The medical necessity of a service is the overarching criterion of payment. All interventions must be aimed at benefiting the patient and not only satisfying a billing requirement. It must be apparent that the face-to-face encounter with the physician is medically necessary and benefits the patient (impacts evaluation, treatment, and outcome). Shared visits cannot be reported in the skilled nursing facility (SNF) or nursing facility (NF) settings.

Scribing

If a nurse or non-physician practitioner (PA, NP) acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note "written by xxxx, acting as scribe for Dr. yyyy." Then, Dr. yyyy should co-sign, indicating that the note accurately reflects work and decisions made by him/her.

It is inappropriate for an employee of the physician to make rounds at one time and make entries in the record, and then for the physician to make rounds several hours later and note "agree with above," unless the employee is a licensed, certified provider (PA, NP) billing Medicare for services under his/her own name and number.

Record entries made by a "scribe" should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement. Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to be the one delivering the services and creating the record. There is no carrier Part B "incident to" billing in the hospital setting (inpatient or outpatient). Thus, the scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently, and there is no payment for this activity.

It is acceptable for a physician to use a scribe, but current documentation guidelines must be followed. The physician is ultimately accountable for the documentation, and should sign and note after the scribe's entry the affirmation above that the note accurately reflects work done by the physician.

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)

Provider Qualification

Training and Expertise

CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 13, Section 5.1 (*http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf*) outlines that "reasonable and necessary" services are "ordered and/or furnished by qualified personnel." Services will be considered medically reasonable and necessary only if performed by appropriately trained providers.

This training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty or must reflect extensive continued medical education activities. If these skills have been acquired by way of continued medical education, the courses must be comprehensive, offered or sponsored or endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States, and designated by the American Medical Association (AMA) as category I credit.

Drugs and Biologicals

General

In order to be covered under Medicare, use of a drug or biological must be safe and effective and otherwise reasonable and medically necessary. The medical reasonableness and necessity of drugs and biologicals are extensively discussed in the Medicare manuals.

First Coast Service Options, Inc. (FCSO) has published numerous local coverage determinations (LCDs) and educational articles about drugs and biologicals, specifically anti-cancer agents. Please refer to these publications for more detailed information. The training requirements listed under "Provider Qualification" apply.

Dosage and Frequency

Drugs or biologicals approved for marketing by the FDA are considered safe and effective when used for indications specified on the labeling. The labeling lists the safe and effective, i.e. medically reasonable and necessary dosage and frequency. Therefore, doses and frequencies that exceed the accepted standard of recommended dosage and/or frequency, as described in the package insert, are considered not medically reasonable and necessary and, therefore, not reimbursable.

Route of Administration

CMS Online Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.1 addresses medical reasonableness and necessity based on the FDA approval and labeling: "Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling." This statement extends to the mode of administration that is considered safe and effective, i.e., medically reasonable and necessary by Medicare's criteria. Furthermore, the CMS Online Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.2 K – Reasonable and Necessary, stipulates that "carriers and fiscal intermediaries will make the determination of reasonable and necessary with respect to the medical appropriateness of a drug to treat the patient's condition. Contractors will continue to make the determination of whether the intravenous or injection form of a drug is appropriate as opposed to the oral form."

Based on the above, for agents administered parenterally, the mode of administration (IV, IM, SQ) must be in keeping with the instructions in the package insert, as approved by the FDA. If a drug is available in both oral and injectable forms and both forms are equally effective, the oral preparation shall be used, unless there is a medical reason not to do so.

Wastage

CMS Online Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 17, Section 40, Discarded Drugs and Biologicals addresses wastage as: "CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered.

Note: The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drug."
Payment for wastage will only be made when single-use vials have to be utilized. No reimbursement will be made for wastage in the case of multi-use vials.

Place of Service and Patient Safety

In situations when life threatening and other severe adverse reactions could be expected as a result of the administration of certain drugs or the performance of other services, the administration/performance of these services must take place in a facility equipped and staffed for cardiopulmonary resuscitation and where the patient can be closely monitored by qualified personnel for an appropriate period of time based on his or her health status. For specific services, FCSO may proscribe a place of service (POS) by way of an LCD or other publication.

Unit Dose and Decimal Point Errors

The number of billable units may not be equal to the dose administered. For example, if a HCPCS code descriptor calls for 100 mg of a given agent, the number of units for 1000 mg administered would be 10 and not 1000. Similarly, if the descriptor reads 50 mg and 100 mg are administered, the correct number of units to bill is 2.

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)

Diagnostic Tests

Medical Necessity and Documentation

Code of Federal Regulations (CFR), Title 42, part 410.32, specifies that all diagnostic tests must be ordered by a provider who is the treating provider for the patient and who will use the test results in the patient's care (in regards to the treating provider, there may be exceptions for the diagnostic radiologist in certain institutional inpatient or outpatient patient settings). For laboratory tests, additional documentation of medical necessity may be requested of the referring (treating) provider (CMS Online Manual System, Pub. 100-08, Chapter 3, Section 3.4.1.2).

Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. Like with any service reimbursed by Medicare, to support medical necessity there must be documentation in the medical record as to why a certain modality was chosen/performed. This entire documentation - not just the test report or the finding/diagnosis on the order – must be available to Medicare upon request (please see also under "Responding to Additional Documentation Request (ADR) Letters and Requests from the Comprehensive Error Rate Testing (CERT) Contractor" in this article).

Portable Diagnostic Equipment

Medicare recognizes that the miniaturization of electronic devices is an on-going trend that may be associated with either improved or diminished test performance. Hand-carried diagnostic equipment ranges in complexity and capability from lightweight pocket-sized units completely contained within the examiner's hand, to complex equipment systems where only a part, such as the ultrasonic probe itself, is hand-held. The appropriate assignment of a specific ultrasound CPT code is not solely determined by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure. To be reimbursable by Medicare, a diagnostic ultrasound test must meet at least these minimum criteria (this is not an all inclusive list):

- It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.
- It should be done for the same purpose as a reasonable physician would order a standard ultrasound examination.
- It must be billed using the CPT code that accurately describes the service performed.
- The technical quality of the exam must be in keeping with accepted national standards and not require a follow-up ultrasound examination to confirm the results.
- The study must be performed and interpreted by qualified individuals.
- The medical necessity, images, findings, interpretation and report must be documented in the medical record.

Purchased Interpretations

According to the CMS Online Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 1, Section 30.2.9.1 "A person or entity that provides diagnostic tests may submit the claim, and (if assignment is accepted) receive the Part B payment, for diagnostic test interpretations which that person or entity purchases from an independent physician or medical group if:

- The tests are initiated by a physician or medical group, which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;
- The physician or medical group providing the interpretations does not see the patient; and
- The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary."

Furthermore, it is noted in the Final Rule of 2005 that "Arrangements involving reassignment must not violate any other applicable Medicare laws or regulations governing billing or claims submission, including, but not limited to, those regarding "incident to" services, payment for purchased diagnostic tests, and payment for purchased test interpretations."

Consequently, a provider who initiates (orders) a test cannot purchase the interpretation and bill it to Medicare as professional component. For example, if a physician or a group perform testing on their patients with their own ultrasound equipment, and a radiologist, who is not a member of the practice, reads the tests, the group can bill only for the technical component (modifier TC). The radiologist must bill Medicare separately for the interpretation (professional component, modifier 26).

Eugene J. Winter, M.D.
Medical Director

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

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

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

Who Receives the *Update?*

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

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

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

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

Clear Identification of State-Specific Content

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

Publication Format

The *Update!* is arranged into distinct sections.

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

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

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

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

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

Advance Beneficiary Notices (ABNs)

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

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

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

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

New Patient Liability Notice

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

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

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

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

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

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

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

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

OR

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

Distribution of the *Medicare B Update!*

Use of the Internet has become an accepted standard of communication throughout the world. Publications produced by First Coast Service Options, Inc. (FCSO) for our Connecticut Medicare Part B and Florida Part A and B customers are available on our provider education websites (*http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*).

We post our Medicare publications to our provider education website in PDF (portable document format) and you may view, print, or download them free of charge. By contrast, hardcopy publications cost the Medicare program a substantial amount of money for printing and postage nationally. Reducing the number of hardcopies produced is one way Medicare contractors can reduce costs that may be better used elsewhere. In addition, enhancements to online publications can be made that are not possible in print.

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

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

If you believe you meet these criteria, you must complete and return the "Medicare B Update! Hardcopy/CD ROM Registration Form" to receive hardcopies or CD-ROMs. (See page xx.)

You are required to re-register annually.

Do not complete the form if you are able to receive the *Update!* electronically from the Internet. Providers and other entities that do not meet the above criteria and desire a hardcopy or CD-ROM may purchase an annual subscription to the *Update!* (please see the "Part B Materials" order form on the last page of the Educational Resource section).

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

Features of the Electronic Publication

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

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

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

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

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *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 B Update! Hardcopy/CD-ROM Registration Form

To receive the *Medicare B Update!* in hardcopy or CD-ROM format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. **To receive a hardcopy or CD-ROM of the Fourth Quarter 2006 *Medicare B Update!* your form must be faxed or postmarked on or before July 1, 2006.**

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

Provider/Professional Association Name:

Medicare Provider Identification Number (PIN):

Address:

City, State, ZIP Code:

Contact Person/Title:

Telephone Number:

Rationale for needing a hardcopy:

Does your office have Internet access? YES ☐ NO ☐

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

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

Mail your completed form to:

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

or fax to 1 (904) 791-6292

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

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

CLAIMS

Change Payment Floor Date for Paper Claims

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

Provider Types Affected

Physicians, providers, and suppliers who use paper claims to bill Medicare carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)

Important Points to Remember

- CR 4284 changes the payment floor date for paper claims from the 27th day to the 29th date after receipt of a claim.
- Effective January 1, 2006, Medicare carriers, DMERCs, FIs, and RHHIs will not pay paper claims prior to the 29th day after receipt of the claim.

Background

The Social Security Act Section 1816b (c) (3) (B) (ii) and Section 1842 (c) (3) (B) (ii) provides for payment waiting periods for Medicare claims before a claim is paid by the Medicare contractor. Congress has amended the Social Security Act to extend the waiting period for paper claims from 27 to 29 days, effective January 1, 2006.

Implementation

The implementation date for this instruction is March 13, 2006.

Additional Information

The official instructions issued to your carrier regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R850CP.pdf* on the CMS website.

If you have questions, please contact your Medicare carrier, DMERC, FI, or RHHI at their toll-free number which may be found at *http://www.cms.hhs.gov/apps/contacts/* 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: MM4284	Related Change Request (CR) #: 4284
Related CR Release Date: February 10, 2006	Effective Date: January 1, 2006
Related CR Transmittal #: R850CP	Implementation Date: March 13, 2006

Full Replacement for CR 4266, Revision for HPSA and PSA Bonus Billing for Some Globally Billed Services

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

Provider Types Affected

Physicians billing Medicare carriers for the Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) bonus

Provider Action Needed

This article is based on Change Request (CR) 5015, which will allow physicians to submit global services and receive the HPSA and PSA bonuses without having to submit the professional component and technical component (PC/TC) separately.

Background

Currently, components of services with a professional component/technical component of four must be submitted separately in order to receive the HPSA and PSA bonus payments. CR 5015 is similar to CR 4266 (Transmittal 834) in that it also allows you to submit the global service and receive the bonus payment on all professional component/technical component (PC/TC) 4 codes.

However, CR 5015 further instructs that payment is excluded for the following Current Procedural Terminology (CPT) code:

CPT Code *93015* (cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision; with interpretation and report)

Note: The "technical component" of services relates to facilities, equipment, and technical staff required for the delivery of those services, and the "professional component" consists of fees paid to the physician for providing those services. When combined, the "professional and technical" components of a service are referred to as "global" service.

CR 5015 instructs that, effective for claims received on or after July 1, 2006:

- When your carrier receives a claim for a service with a PC/TC of 4, **except for CPT Code *93015***; and
- The service is provided in a HPSA or PSA bonus payment area; then
- Your claim will be accepted.

The bonus payment amount is calculated based on the payment amount for the associated professional component code.

Your carrier will make any necessary revision to their systems to be able to calculate the bonus payment just for the professional component of the service.

This action will be taken for bonuses paid automatically as well as bonuses paid based on the submission of the QB, QU, AR, or AQ modifiers.

Because there are two associated professional components to *93015*, your carrier will follow the instructions in the *Medicare Claims Processing Manual* and **return claims for *93015* as unprocessable**. The services must then be resubmitted as separate components in order to receive the bonus on the appropriate professional component.

Carriers will continue to allow the option of withholding HPSA/PSA bonuses if that is requested by physicians and the carriers will not pay the bonus on PCTC 4 to physicians who have already notified them of their decision to not receive HPSA/PSA bonuses.

Note: CR 5015 does not affect current HPSA or PSA payment policy.

Implementation

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

Additional Information

The revised *Medicare Claims Processing Manual* - Publication 100.4, Chapter 12 (Physician Practitioner Billing), Section 90.4.5 (Services Eligible for HPSA and Physician Scarcity Bonus Payments), is attached to CR 5015, which is the official instruction issued to your carrier regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R906CP.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/apps/contacts/* 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: MM5015 — Related Change Request (CR) #: 5015
Related CR Release Date: April 14, 2006 — Effective Date: July 1, 2006
Related CR Transmittal #: R906CP — Implementation Date: July 3, 2006

Instructions for the Payment of Health Professional Shortage Area and Physician Scarcity Area Bonuses When the Place of Service Is Home

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

Provider Types Affected

Physicians billing carriers for services provided in the home of Medicare beneficiaries in Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs)

Provider Action Needed

This article is based on Change Request (CR) 4275, which provides instructions for the payment of HPSA/PSA bonuses when the place of service (POS) is home.

This change is necessary to allow bonuses to be paid correctly on HPSA/PSA claims eligible for bonuses that are provided in the POS "Home," when the address of where the service was rendered does not match what is on the beneficiary's file.

Background

When a physician provides services to a Medicare beneficiary and the POS is "home," carriers have been instructed to use the home address they have recorded in the beneficiary's file to determine eligibility for physician bonuses.

However, sometimes this address is a representative payee address or mailing address that does not reflect the physical location of that beneficiary. This can cause incorrect payment/non-payment of the bonuses.

CR 4275 indicates that this issue should be resolved when the next version of the ANSI X12 N837 Implementation Guide is published, because physicians will be required to enter where the service was performed on the claim, even when the POS is "home." CR 4275 also instructs carriers to investigate a claim (to determine the address where the service was actually performed) when they receive a notification from a physician that they have not received a HPSA/PSA bonus for which they are eligible, and the service was provided in the POS "home." If the carrier determines that the address where the service was

actually performed is in an HPSA/PSA eligible bonus payment area (even if it does not match the address on the beneficiary file), they will pay the bonus on the claim.

The physician will also be instructed to submit future claims for this beneficiary, when provided at that address, using the appropriate HPSA or PSA modifier so that the bonus shall be paid.

Implementation

The implementation date for this instruction is February 21, 2006.

Additional Information

An overview of the HPSA/PSA physician bonuses including HPSA and PSA modifiers can be found at *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/* on the CMS website.

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at *http://new.cms.hhs.gov/Transmittals/downloads/R813CP.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.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: MM4275	Related Change Request (CR) #: 4275
Related CR Release Date: January 20, 2006	Effective Date: February 21, 2006
Related CR Transmittal #: R813CP	Implementation Date: February 21, 2006

Modifier 50 – Bilateral Procedures

First Coast Service Options, Inc. (FCSO) Provider Contact Center has been receiving numerous inquiries regarding the usage of modifier 50. The purpose of this article is to provide clarification on how modifier 50 should be billed.

Bilateral surgery is defined as a procedure performed on both sides of the body at the same operative session or on the same day. This definition does not include procedures that are bilateral in nature or include the terms “bilateral” or “unilateral/bilateral” in their descriptors.

When submitting claims for bilateral surgery, use modifier 50 with the procedure code. Claims for bilateral surgical procedures should be billed on a single claim detail line with the appropriate procedure code and modifier 50.

When billing for claims that are bilateral in nature, whether the services are performed unilaterally or bilaterally, providers should bill the surgical procedure code as a single claim detail line item without the 50 modifier.

To determine if a procedure can be billed with the modifier 50 as a bilateral procedure, providers may access the on-line Medicare Physician Fee Schedule Database (MPFSDB) at *http://www.cms.hhs.gov/physicians/apps/pfslookup/*.

Moving to a Paperless Claim Processing Environment

As the CMS continues to seek new and innovative methods of reducing the cost of administering the Medicare Program, one immediate focus is on the reduction of paper handling. In an effort to prepare for future changes and to proactively support our provider population, First Coast Service Options, Inc. (FCSO) is initiating a campaign to help providers help us reduce the volume of paper claim submissions. Generally speaking, for Part B claims submissions, FCSO receives a significant volume of their total claims in a paper format.

In the next few months you will be receiving frequent communications in almost every medium available to us. We will continue to reinforce the benefits of filing claims electronically and offer any assistance we can to help you make the transition. So look for updates on the Web and on remits, and listen for information on the IVR.

ASCA – Required Electronic Submission

One current CMS initiative that already supports this effort is ASCA (Administrative Simplification and Compliance Act). Some providers have already received letters from our office requiring that documentation be provided to attest to your qualifications relative to meeting one of the exception criteria to be excluded from filing paper. If you have received a letter, we strongly encourage you to respond timely in order to avoid unnecessary paper claim denials (beginning 90 days from the date of the initial letter) as a result of “no reply” situations. *http://www.floridamedicare.com/edi_local_asca.asp#TopOfPage.*

1500 CLAIM FORM CHANGES /THERE IS NO BETTER TIME TO CONVERT TO ELECTRONIC CLAIM SUBMISSION

As you are aware, the 1500 claim form will be changing fairly significantly in October to accommodate the new National Provider Identifier (NPI) requirements. If you submit paper claims currently and are considering converting to electronic filing, we strongly encourage you to do so prior to October 1, 2006. If you do not convert prior to that date, you will have to implement all of the changes necessary for the new 1500 claim form to your existing programs/systems. Then if you decide (or are required) to convert to electronic submission at a later date, you will incur those expenses as well. Why go through two separate conversions? Let us help you convert to electronic submission prior to October 1, 2006.

GETPAID FASTER/MORE EFFICIENTLY

Of significant benefit to you, in converting from paper to electronic claims submissions, is the difference in payment schedules between paper claims and electronic claims. As you know, the CMS recently made a change to increase the paper claims payment floor by 2 additional days, from 27 to 29 days. This will result in checks being mailed 2 days later than they were previously. At the same time, the CMS removed the contractor performance requirement to process all clean paper claims in 30 days. This could result in additional delays in processing paper claims. If you file electronic claims you are held to a different payment floor of 14 days. This results in a much faster turn-around on claims payments.

In summary, our world, as we know it, is changing very quickly. FCSO is committed to helping our providers by keeping them updated on changes as quickly as possible. We would also like to partner with you to make the necessary changes to processes and systems that are mutually beneficial. If you need additional information on what you need to do to convert to electronic claims filing, please contact our EDI department at (904) 791-8767 or visit the EDI section of the Florida Part B website at *http://www.floridamedicare.com/EDI.asp#TopOfPage*

We look forward to working with you on this very important change!

Quarterly Update to Correct Coding Initiative Edits, Version 12.1, Effective April 1, 2006

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

Provider Types Affected

Physicians billing Medicare carriers

Provider Action Needed

This is a reminder for physicians to note the quarterly updates to the coding initiatives. The next round of CCI edits will be effective on April 1, 2006.

Physicians may view the current Correct Coding Initiative (CCI) edits and the current Mutually Exclusive Code (MEC) edits at *http://www.cms.hhs.gov/physicians/cciedits* on the Centers for Medicare & Medicaid (CMS) website. The website will be updated with the version 12.1 edits as soon as they are effective.

Background

The National CCI developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on the following:

- Coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practice; and
- Review of current coding practice.

The latest package of CCI edits, version 12.1, is effective on April 1, 2006. This version will include all previous versions and updates from January 1, 1996, to the present and will be organized in two tables:

- Column 1/Column 2 Correct Coding Edits table; and
- MEC Edits table.

Additional Information

The CCI and MEC file formats will be maintained in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 20.9, which can be found at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Medlearn Matters Number: MM4308
Related Change Request (CR) #: 4308
Related CR Release Date: February 1, 2006
Effective Date: April 1, 2006
Related CR Transmittal #: R824CP
Implementation Date: April 3, 2006

AMBULANCE SERVICES

Ambulance Fee Schedule - CY 2006 Update: Correction to CR 4061

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

Provider Types Affected

Providers and suppliers of ambulance services billing Medicare carriers and fiscal intermediaries (FIs) for those services

Provider Action Needed

This article is for your information only. It references CR 4362, which provides the correct Ambulance Fee Schedule File for Calendar Year (CY) 2006.

Background

CR 4061, "Ambulance Inflation Factor for CY 2006" (released November 25, 2005), contained an incorrect file name for the CY 2006 Ambulance Fee Schedule File. CR 4362, from which this article is taken, corrects that file name. It also amends the *Medicare Claims Processing Manual*, Chapter 15 (Ambulance), Section 20.6 (Update Charges), Subsection 20.6.1 (Ambulance Inflation Factor [AIF]), to reflect this correction.

Your carriers and FIs will use this corrected file to determine the payment limit for ambulance services that you furnish during CY 2006. Of most importance to providers/suppliers, rather than process CY 2006 ambulance service claims using the incorrect file name contained in CR 4061, the carriers and FIs will hold these claims until the corrected file can be downloaded and used. In the event they processed any CY2006 ambulance claims using the incorrect file, the carriers and FIs will do mass adjustments of those claims to correct the payments.

Additional Information

You can find more information about the corrected Ambulance Inflation Factor file name by going to the official instruction (CR 4362) issued to your carrier/intermediary. That instruction is available at *http://www.cms.hhs.gov/Transmittals/downloads/R852CP.pdf* on the CMS website. In addition, you can learn more about the Ambulance Inflation Factor for CY 2006 in MedLearn Matters article MM4061, which you can find by going to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm4061.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4362
Related Change Request (CR) #: 4362
Related CR Release Date: February 10, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R852CP
Implementation Date: February 24, 2006

Collection and Verification of Ambulance Crew Member Information

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

Provider Types Affected

Providers and suppliers who bill Medicare carriers for ambulance services

Key Points

- Effective February 9, 2006, the Centers for Medicare & Medicaid Services (CMS) will no longer require enrolled ambulance suppliers to report ambulance crew member changes in Attachment 1 of the provider enrollment application CMS-855B.
- This policy change only applies to ambulance companies already enrolled with Medicare.
- Ambulance suppliers that are enrolling in the Medicare program for the first time or are submitting a new enrollment application are required to report ambulance crew member information in Attachment 1 of the provider enrollment application (CMS-855B).
- This change should reduce the paperwork burden imposed on ambulance suppliers and reduce the number of ambulance supplier changes processed by contractors.

Background

On January 27, 2006, CMS published a Federal Register notice requesting public comments on revisions to the provider enrollment applications. While CMS is seeking comments regarding proposed changes to its Medicare enrollment applications, it is also adopting a policy change that affects ambulance suppliers effective immediately with regard to reporting ambulance crew member information as noted above.

Relevant Links

The Medicare Federal Health Care Provider/Supplier Enrollment Application Form CMS-855B can be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/cms855b.pdf* on the CMS website.

If you have any questions regarding this issue, contact your carrier at their toll free number, which is available at *http://www.cms.hhs.gov/apps/contacts/* 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: SE0610 Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: February 9, 2006
Related CR Transmittal #: N/A Implementation Date: N/A

CARDIOLOGY SERVICES

Modification to Modifier QR Edit for Automatic Implantable Cardiac Defibrillator Services

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

Provider Types Affected

Providers who bill carriers or fiscal intermediaries (FIs) for ICD services rendered to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

The modifier QR is not required to process claims with ICD-9-CM codes 996.04 (Mechanical complication of cardiac device, implant, and graft, due to automatic implantable cardiac defibrillator) or for V53.32 (Fitting and adjustment of other device, automatic implantable cardiac defibrillator) for ICD services with dates of service on or after April 1, 2005. The modifier QR should continue to be used on all claims for ICD device implants when the beneficiary is enrolled in a data collection system such as a registry.

CAUTION – What You Need to Know

The modifier QR is required on claims for primary prevention ICD device implantations (QR signifies that data is being reported on the patient and data reporting is a requirement of primary prevention device insertion).

However, claims submitted for replacement devices do not carry the patient's previous arrhythmic diagnoses; therefore, these claims look like claims for primary prevention clinical indications. CR 4273, from which this article is taken, adds two new ICD-9-CM codes (addressing ICD replacement due to instrument recall or device complication) to the list of codes that do not require the use of the modifier QR for claims processing (effective on or after April 1, 2006, for claims with dates of service on and after April 1, 2005).

GO – What You Need to Do

Make sure that your billing staffs continue to bill ICD implantation and replacement services appropriately according to professional coding guidelines. If claims with dates of service on or after April 1, 2005, were inappropriately denied, they should be brought to the attention of the local Medicare contractor.

Background

The modifier QR identifies services that are being covered under a clinical study(e.g., patients enrolled in a registry), and effective January 27, 2005, is required as a condition for payment on claims for ICD services rendered in the primary prevention of cardiac arrest.

CR3604, Transmittal 497 (released March 8, 2005), provides guidance for the coverage of ICD services under newly expanded coverage. One of the requirements for covering the new ICD indications (effective January 27, 2005) is that the patient be enrolled in a data collection system as indicated by the presence of the modifier QR on the claim, which identifies services being covered under a clinical study.

A *MLN Matt*ers article on CR 3604 is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3604.pdf* on the CMS website.

Again, the modifier is used to identify patients, who meet the coverage requirement for any indication that is for the primary prevention of sudden cardiac arrest (i.e., no history of induced or spontaneous arrhythmias).

It is not required for ICD services rendered for the secondary prevention of cardiac arrest as documented by the secondary prevention diagnosis codes noted in the table below. (Note, however, that you can use the modifier QR for secondary prevention diagnoses if you deem it to be appropriate, i.e., in order to report the data to the data collection system, when this reporting applies).

Two New Diagnosis Codes Added

Since CR3604 was published, the Centers for Medicare & Medicaid Services (CMS) has become aware that there are other clinical situations for ICD services in which the diagnoses show neither primary nor secondary prevention of cardiac arrest. Such a situation could occur when the patient is having his/her ICD replaced, perhaps due to ICD recall, or to a device complication (such as the end of battery-life).

Since it would be incorrect to deny such claims because they lacked the QR modifier, in CR4273, CMS is adding two new ICD-9-CM diagnosis codes to the list of those that do not require it:

- **996.04, Mechanical complication of cardiac device, implant, and graft; due to automatic implantable cardiac defibrillator** Use this diagnosis code when the patient is having his/her ICD replaced due to a mechanical complication, as could occur due to ICD recall.
- **V53.32, Fitting and adjustment of other device; automatic implantable cardiac defibrillator** Use this diagnosis code when there is a fitting or an adjustment, including device removal or replacement; it would be used when the ICD reaches its natural end-of-battery life.

The table below displays the new list of diagnoses that do not require a QR modifier for ICD services in order to be paid (both those indicating the secondary prevention of cardiac arrest, and ICD replacement).

Diagnoses Not Requiring the Modifier QR

ICD-9-CM Code	Secondary Prevention Diagnosis
427.1	Ventricular Tachycardia
427.41	Ventricular fibrillation
427.42	Ventricular flutter
427.5	Cardiac arrest
427.9	Cardiac dysrhythmia, unspecified
	New "Replacement" Diagnoses
996.04	Mechanical complication of cardiac device, implant, and graft, due to automatic implantable cardiac defibrillator
V53.32	Fitting and adjustment of other device, automatic implantable cardiac defibrillator

Remember: Carriers and FIs will adjust, as appropriate, claims brought to their attention (with dates for service on or after April 1, 2005) that were denied because the diagnosis code was 996.04 or V53.32, and lacked a modifier QR.

Additional Information

More information about the use of the Modifier QR for Automatic Implantable Cardiac Defibrillator (ICD) Services is available in the official instruction (CR 4723) issued to your carrier/intermediary. That instruction is available at *http://www.cms.hhs.gov/Transmittals/downloads/R819CP.pdf* on the CMS website. Another good source for additional information is *MLN Matters* article MM3604, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm3604.pdf* on the CMS website.

Finally, if you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/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: MM4273 Related Change Request (CR) #: 4273
Related CR Release Date: January 27, 2006 Effective Date: April 1, 2005
Related CR Transmittal #: R819CP Implementation Date: April 3, 2006

Expansion of Coverage for Percutaneous Transluminal Angioplasty

CMS has issued the following "MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the January 2006 Medicare B Update! Special Issue pages 42-44.

Note: This article was revised on April 3, 2006, to clarify that reporting of both 433.30 and 433.10, in either diagnosis position, needs to be done in the same claim as noted in the "Note" box at the top of page 5 of this article. All other information remains the same.

Provider Types Affected

Hospitals, physicians, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for Percutaneous Transluminal Angioplasty (PTA) services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

MM3811 and related CR3811 announce the expansion of Medicare coverage for PTA of the carotid artery.

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

Expanded Coverage

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

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

Significant Comorbidities

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

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

Carotid Artery Stenosis

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

The appropriate documentation confirming that a patient is at high risk for CEA and records of the patient's symptoms of carotid artery stenosis should be available in the patient medical records prior to performing any procedure.

The degree of carotid artery stenosis should be measured by duplex Doppler ultrasound or carotid artery angiography and recorded in the patient medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. If the stenosis is determined to be less than 70% by angiography, the CAS should not proceed.

- Carotid artery stenting with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes.
- All facilities must at least meet the minimum standards outlined in Pub 100-03, Section 20.7 of the NCD Manual in order to receive coverage for CAS for highrisk patients. Briefly, facilities must have high quality X-ray imaging equipment, device inventory, staffing, and infrastructure to support a dedicated CAS program.
- Advanced physiologic monitoring, including real time and archived physiologic, hemodynamic, and cardiac rhythm monitoring equipment, and associated support staff capable of interpreting findings and responding appropriately.
- Readily available emergency management equipment and systems, such as resuscitation equipment, a defibrillator, vasocative and antiarrhythmic drugs, endotracheal intubation capability, and anesthesia support.
- A clearly delineated program for granting CAS privileges and for monitoring the quality of the individual interventionists and the program as a whole. The oversight committee for this program is encouraged to apply published standards from national specialty societies recognized by the American Board of Medical Specialties to determine appropriate physician qualifications.

Examples of standards and clinical competence guidelines include those published in the December 2004 edition of the *American Journal of Neuroradiology* and those published in the August 18, 2004, *Journal of the American College of Cardiology.*

- A data collection system maintained by the facility or its contractor on all CAS procedures done at that facility. The data must be analyzed routinely to ensure patient safety (to be determined by the facility but should not be less frequent than 6-month intervals), will be used in re-credentialing the facility, and must be made available to CMS upon request.

Written Documentation

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

- Was an FDA-approved site that enrolled patients in prior CAS IDE trials, such as SAPPHIRE, and ARCHER;
- Is a FDA-approved site that is participating and enrolling patients in ongoing CAS IDE trials, such as CREST;
- Is a FDA-approved site for one or more FDA post-approval studies; or
- Has provided a written affidavit to CMS affirming that the facility meets the minimum facility standards. The affidavit must include the facility's name and complete address, Medicare provider number, point-of-contact name and telephone number, CAS procedure data collection mechanism, and a senior facility administrative official's signature. (Note that a new affidavit is required every two years.)

  The affidavit should be sent to:

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

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

Additional Information

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

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

Note: Providers must also bill V70.7 (Exam – clinical trial) as a secondary diagnosis for claims with "From" dates before October 1, 2005. Providers must bill V70.7 in order to avoid unintentional Medicare Code Editor (MCE) editing. For claims that have "From" dates on or after October 1, 2005, hospitals are not required to bill V70.7 as the unintentional MCE editing will be corrected.

Coding for Carotid Artery Stents

In the American Hospital Association's (AHA's) publication *Coding Clinic for ICD-9-CM*, First Quarter 2002, page 10 (and corrected in Second Quarter 2002, page 19), there is a Q&A regarding coding of bilateral carotid artery stenosis. The answer said, "Assign only code 433.10, (Occlusion and stenosis of precerebral arteries, Carotid artery, without mention of cerebral infarction) as the principal diagnosis." The correction notice changed that advice to use code 433.30 (Occlusion and stenosis of precerebral arteries, multiple and bilateral, without mention of cerebral infarction) instead of 433.10. In an effort to reduce the confusion, CMS has decided to allow hospitals to be able to code both 433.30 and 433.10, in any diagnosis positions, on the same claim. Code 433.30 will identify the bilateral condition, while 433.10 will specifically identify the carotid vessel.

You may also want to review the following MLN Matters article MM3489 and CR 3489 for additional information relating to Medicare coverage of PTA. They are available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R314CP.pdf* on the CMS website.

The official instruction issued to your carrier/FI regarding this change may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R33NCD.pdf* on the CMS website. That site contains the NCD manual revision. The changes to the *Medicare Claims Processing Manual* are at *http://www.cms.hhs.gov/Transmittals/downloads/R531CP.pdf* on the CMS website.

If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at *http://www.cms.hhs.gov/apps/contacts/* 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: MM3811 *Revised* — Related Change Request (CR) #: 3811
Related CR Release Date: April 22, 2005 — Effective Date: March 17, 2005
Related CR Transmittal #: R33NCD and R531C — Implementation Date: July 5, 2005

Nesiritide for Treatment of Heart Failure Patients

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

Provider Types Affected

Providers and physicians that submit claims to Medicare fiscal intermediaries (FIs) and carriers for nesiritide when provided as a treatment for chronic heart failure.

Key Points

- Effective for dates of service **on or after March 2, 2006,** the Centers for Medicare & Medicaid Services (CMS) will deny coverage of nesiritide for the treatment of chronic heart failure in Medicare beneficiaries. For billing guidelines about the noncovered use of nesiritide, please refer to the *Additional Information* section of this article.
- CMS has determined that there is insufficient evidence to conclude that the use of nesiritide for the treatment of chronic heart failure is reasonable and necessary for Medicare beneficiaries in any setting.
  This determination does not change local contractor discretion for treatment of acute(ly) decompensated heart failure consistent with the FDA labeled indication in Medicare beneficiaries who may have underlying chronic heart failure. Nor does it affect local contractor discretion for other off-label uses of nesiritide in Medicare beneficiaries who may have underlying chronic heart failure.
- For claims submitted to FIs, the requirement to deny nesiritide for chronic heart failure will only affect type of bill (TOBs) 13x and 85x. TOBs 11x and 12x will be rejected.
  CMS recommends that FIs create medical policy parameters to deny outpatient claims for nesiritide for chronic heart failure in the absence of acutely decompensated heart failure.
  CMS recommends that FIs reject inpatient claims where the primary diagnosis is chronic heart failure in the absence of acutely decompensated heart failure (TOBs 11x and 12x) when billed with nesiritide for chronic heart failure.
- For inpatient claims where the beneficiary is admitted with a primary diagnosis other than heart failure and nesiritide is administered under a DRG (diagnosis related group) payment, the administration of nesiritide should not be the sole basis for denial of the entire inpatient claim.
- The provider will be held liable unless occurrence code 32 is present on the claim or modifier GA is present on the line on an outpatient bill.
- All other indications for the use of nesiritide not otherwise indicated as noncovered (other off-label uses or use consistent with the current Food and Drug Administration (FDA) indication for intravenous treatment of patients with acutely decompensated congestive heart failure (CHF) who have dyspnea at rest or with minimal activity) are left to local contractor (carrier or FI) discretion.
- This addition to Chapter 1, Section 200.1, of the *Medicare National Coverage Determinations Manual* (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act (the Act).
- NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1064, effective May 1, 2005).
- An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Act.)

Background

Nesiritide is FDA-approved for the short-term intravenous treatment of patients with acutely decompensated CHF who have dyspnea (shortness of breath) at rest or with minimal activity.

Recent published studies of nesiritide have highlighted safety concerns, specifically increased mortality and decreased renal function in patients treated with nsiritide.

In addition, an independent advisory panel of cardiac experts sponsored by Scios, manufacturer of Natrecor® (nesiritide), recommends that nesiritide be restricted to the treatment of acute decompensated heart failure in the inpatient hospital setting.

Additional Information

Claims submitted with Healthcare Common Procedure Coding System (HCPCS) code J2325 (Injection, nesiritide, 0.1 mg) with International Classification of Diseases (ICD-9) codes of:

428.0, 428.1, 428.20, 428.22, 428.30, 428.32, 428.40, 428.42, or 428.9; **and not accompanied by:**
428.21, 428.23, 428.31, 428.33, 428.41, or 428.43, **will be denied.**

Denied claims will be returned with the following claims adjustment codes:

- Reason code: These are noncovered services because the payer does not deem this a 'medical necessity'.
- Remark code M76: Missing/incomplete/invalid diagnosis or condition.

Contractors must apply the following Medicare summary notice messages:

- **15.20** – The following policy [NCD 200.1] was used when we made this decision.
- **15.4**: – The information provided does not support the need for this service or item.

Contractors will not search for, but may adjust, claims brought to their attention with dates of service March 2, 2006, through implementation.

Relevant Links

CR 4312 is the official instruction issued to your FI or carrier, regarding changes mentioned in this article, MM4312. There are two transmittals related to CR 4312.

One is transmittal number R51NCD, which relates to the NCD and it may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R51NCD.pdf*.

The second transmittal, R218OTN, relates to Medicare claims processing instructions, and it may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R218OTN.pdf*.

Please refer to your local FI or carrier if you have questions about this issue. To find the toll free phone number, go to CMS website at *http://www.cms.hhs.gov/apps/contacts/*.

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: MM4312
Related Change Request (CR) Number: 4312
Related CR Release Date: April 7, 2006
Related CR Transmittal Number: R218OTN and R51NCD
Effective Date: March 2, 2006
Implementation Date: May 22, 2006

External Counterpulsation Therapy

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

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare contractors (fiscal intermediaries (FIs) and carriers) for external counterpulsation (ECP) therapy services

Key Points

- The Centers for Medicare & Medicaid Services (CMS) initiated a reconsideration of the National Coverage Determination (NCD) for ECP therapy in response to a request to reconsider that policy and expand coverage to certain additional cardiac conditions.
- Effective March 20, 2006, CMS decided to continue current coverage for ECP therapy, and not to expand coverage to additional cardiac indications.
- The CMS determined that the evidence is **not** adequate to conclude that ECP therapy is reasonable and necessary for (1) Canadian Cardiovascular Society Classification (CCSC) II angina, (2) heart failure (New York Heart Association (NYHA) Class II/III stable heart failure symptoms with an ejection fraction of = 35%, NYHA Class II/III stable heart failure symptoms with an ejection fraction of = 40%, NYHA Class IV heart failure, and acute heart failure), (3) cardiogenic shock, or (4) acute myocardial infarction.
- Continuing with current policy, effective for services performed on or after July 1, 1999, ECP therapy is considered reasonable and necessary relative to cardiac conditions **only when** the conditions for coverage identified in Publication 100-3, Section 20.20 of the *Medicare National Coverage Determinations Manual* (NCD Manual) are met.
- All other cardiac conditions that are not otherwise specified as nationally covered for the use of ECP remains nationally noncovered.

Background

Prior to July 1999, ECP therapy was non-covered for all indications. The coverage policy was amended, effective July 1, 1999, to allow coverage for ECP therapy under certain circumstances. Coverage for ECP was provided only for patients who were diagnosed with disabling angina (Class III or Class IV, CCSC or equivalent classification) and who, in the opinion of a cardiologist or cardiothoracic surgeon, are not readily amenable to surgical intervention.

Under this policy decision, the therapy was identified as Enhanced External Counterpulsation. Subsequent reconsiderations of the NCD in February 2000 and October 2001:

- Changed the description of the service back to ECP;
- Removed the requirement limiting coverage to specific ECP systems; and
- Clarified that the policy only pertains to ECP devices intended for the treatment of cardiac conditions.

Additional Information

Publication 100-04, *The Medicare Claims Processing Manual*, Chapter 32, Section 130, is updated to manualize current billing and payment requirements for both FIs and carriers. The revised section is attached to CR 4350, which is the official instruction issued to your FI or carrier regarding changes mentioned in this article, MM4350. There are two transmittals related to CR 4350. The first is the transmittal conveying the NCD, which is available at *http://www.cms.hhs.gov/Transmittals/downloads/R50NCD.pdf*, and the second, which revises the *Medicare Claims Processing Manual*, is at *http://www.cms.hhs.gov/Transmittals/downloads/R898CP.pdf* on the CMS website.

Please refer to your local FI or carrier if you have questions about this issue. To find their toll-free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* 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: MM4350
Related Change Request (CR) #: 4350
Related CR Release Date: March 31, 2006
Effective Date: March 20, 2006
Related CR Transmittal #: R50NCD and R898CP
Implementation Date: April 3, 2006

Microvolt T-wave Alternans Diagnostic Testing

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for Microvolt T-wave Alternans (MTWA) diagnostic testing services

Provider Action Needed

This article is based on Change Request (CR) 4351, which announces that effective for dates of service on or after March 21, 2006, MTWA diagnostic testing is covered for the evaluation of patients at risk of sudden cardiac death (SCD), only when the spectral analysis method is used.

Background

MTWA testing is a non-invasive diagnostic test that detects minute electrical activity in a portion of the electrocardiogram (EKG) known as the T-wave. The test is performed by placing highly sensitive electrodes on a patient's chest prior to a period of controlled exercise.

These electrodes detect very small beat-to-beat voltage fluctuations (on the order of one-millionth of volt) in the EKG T-wave. Spectral analysis (a sensitive mathematical method of measuring and comparing time and the EKG signals) is then used to calculate these minute voltage changes. Computer software then analyzes these microvolt changes and produces a report to be interpreted by a physician.

Within patient groups that may be considered candidates for Implantable Cardioverter Defibrillator (ICD) therapy, published literature indicates that a negative MTWA test may be useful in identifying low-risk patients who are unlikely to benefit from, and who may experience worse outcomes from, ICD placement.

Effective for services performed on or after March 21, 2006, the following Current Procedural Terminology (CPT) code will be recognized as nationally payable for MTWA diagnostic testing.

CPT Code	Descriptor
93025	MTWA for assessment of ventricular arrhythmias

This is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act (the Act). NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1064, effective May 1, 2005).

An NCD that expands coverage is also binding on a Medicare Advantage Organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Act.)

Notes: MTWA diagnostic testing is non-covered for the evaluation of patients at risk for SCD if measurement is not performed employing the spectral analysis method.

Prior to March 21, 2006, MTWA diagnostic testing was covered at local carrier/FI discretion. Carrier/FI discretion is no longer applicable.

Implementation

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

Additional Information

For complete details, please see the official instruction (CR 4351) issued to your carrier/FI regarding this change. There are two parts to CR 4351, transmittal R894CP, which includes the Medicare claims processing instructions at *http://www.cms.hhs.gov/Transmittals/downloads/R894CP.pdf* and transmittal R49NCD, which includes the National Coverage Determination Manual revision at *http://www.cms.hhs.gov/Transmittals/downloads/R49NCD.pdf* on the CMS website.

If you have questions, please contact your carrier/FI at their toll-free number, which may be found at *http://www.cms.hhs.gov/apps/contacts/* 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: MM4351
Related Change Request (CR) #: 4351
Related CR Release Date: March 24, 2006
Effective Date: March 21, 2006
Related CR Transmittal #: R894CP and R49NCD
Implementation Date: April 3, 2006

Cardiac Rehabilitation Programs

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 for cardiac rehabilitation services

Provider Action Needed

STOP – Impact to You

Effective on and after March 22, 2006, Medicare has expanded coverage for cardiac rehabilitation programs to include three new indications, and has extended the time frame for performing the services to include up to 36 sessions.

CAUTION – What You Need to Know

CR 4401 updates the *National Coverage Determination (NCD) Manual*, Publication 100-03, Section 20.10, Cardiac Rehabilitation Programs (March 22, 2006), to include three newly covered indications: 1) heart valve repair/replacement; 2) percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; and 3) heart or heart-lung transplant. It also extends the program's possible duration to a total of 36 sessions (generally, two to three sessions per week for 12 to 18 weeks) and lists the services required to provide a comprehensive program. CR4401 also updates the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 32, Section 140 to include billing requirements and language regarding physician supervision.

GO – What You Need to Do

Make sure that your billing staffs are aware of these coverage changes in the cardiac rehabilitation program.

Background

Phase II cardiac rehabilitation, as described by the U.S. Public Health Service, is a comprehensive, long-term program including medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Phase II refers to outpatient, medically supervised programs that are typically initiated 1-3 weeks after hospital discharge and provide appropriate electrocardiographic monitoring.

CR 4401 updates *National Coverage Determinations (NCD) Manual* (100-03), Section 20.10 (effective for cardiac rehabilitation services provided on or after March 22, 2006) to:

- Expand the clinical indications for coverage
- Extend the program's possible duration.
- Simplify the language regarding physician supervision
- List the services required to provide a comprehensive program
- Update the relevant billing and claims related instructions found in the *Medicare Claims Processing Manual* (Publication 100.04).

CMS has historically covered cardiac rehabilitation services for patients who have: (1) a documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months; (2) coronary artery bypass surgery; and /or (3) stable angina pectoris. The updated NCD now provides coverage for these three indications and adds three additional ones.

Expanded Coverage

Effective for services performed on or after March 22, 2006, Medicare covers cardiac rehabilitation exercise programs for patients who meet the following criteria:

- Have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or
- Have had coronory bypass surgery; or
- Have stable angina pectoris; or
- Have had heart valve repair/replacement; or
- Have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
- Have had a heart or heart lung transplant.

Further, the updated policy also now allows up to 18 weeks for a beneficiary to receive their maximum of 36 cardiac rehabilitation services (Patients generally receive two to three sessions per week for 12 to 18 weeks).

Please note that additional services may be covered at the discretion of the local Medicare contractor, but may not exceed 72 sessions within a 36-week period.

Clarification of Physician and Facility Requirements

The updated policy also clarifies language regarding physician supervision and facility requirements and the physician's physical location during the rehabilitation services. Specifically the NCD requires that:

- The program must be staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease.
- The facility must have available for immediate use the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary, e.g., oxygen, cardiopulmonary resuscitation equipment, or defibrillator.

The *Medicare Claims Processing Manual* instructs that:

- Cardiac rehabilitation programs shall be performed incident to physician's services in outpatient hospitals, or outpatient settings such as clinics or offices. Follow the policies for services incident to the services of a physician as they apply in each setting. For example, see Pub. 100-02, chapter 6, section 2.4.1, and Pub. 100-02, chapter 15, section 60.1.

Coding Requirements

This CR also changes the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 32, Section 140, to update the relevant billing and claims related instructions, and points out the following applicable *CPT* codes:

93797 Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)
93798 Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

You should note that your carriers and FIs will apply current payment methodologies, rates, and payments policies for cardiac rehabilitation services when these services are performed according to the new policy stated in this CR.

However, they will not search and adjust claims that have already been processed unless brought to their attention.

Additional Information

The revision of Section 20.10 of the *Medicare National Coverage Determinations Manual* (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act. Remember that:

- NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see 42 CFR 405.1064, effective May 1, 2005).
- An NCD that expands coverage is also binding on a Medicare advantage organization.
- In addition, an administrative law judge may not review an NCD. (See 1869(f)(1)(A)(i) of the Social Security Act.

You may view CR 4401, Transmittal 52, the revised *Medicare National Coverage Determinations Manual*, Chapter 1 – Coverage Determinations, Part 1, Section 20.10 (Cardiac Rehabilitation Programs – effective March 22, 2006), on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R52NCD.pdf*.

You may view CR 4401, Transmittal 909, the revised *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 140 (Cardiac Rehabilitation Programs) and 140.1 (Coding Requirements), on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R909CP.pdf*.

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

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: MM4401	Related Change Request (CR) Number: 4401
Related CR Release Date: April 21, 2006	Related CR Transmittal Number: R909CP and R52NCD
Effective Date: March 22, 2006	Implementation Date: June 21, 2006

DIAGNOSTIC SERVICES

Mammography Facility Certification File—Updated Procedures and Content

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

Provider Types Affected

Providers (facilities certified by the Food and Drug Administration [FDA[), who submit screening and diagnostic mammography claims to Medicare fiscal intermediaries (FIs) and to carriers

Key Points

- This article is related to CR 4303. It provides guidelines for carriers/intermediaries to download the most recent Mammography Quality Standards Act (MQSA) file **on a weekly basis** and use it to adjudicate claims.
- Currently, the FDA file does not contain information on terminated facilities. The Centers for Medicare & Medicaid Services (CMS) will be populating a new file, however, with terminated facilities to enable carriers/intermediaries to pay for services prior to the date of termination and to deny services rendered after the date of termination.

Background

The Mammography Quality Standards Act (MQSA) ensures that all facilities that provide mammography services meet national quality standards.

The FDA, Center for Devices and Radiological Health, is responsible for collecting certificate fees and surveying mammography facilities (screening and diagnostic).

FDA provides CMS with a file containing a list of all facilities that have been issued certificates to perform mammography services. CMS then provides the list to Medicare carriers and FIs, which also contains information about terminated facilities.

Additional Information

Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000, "Modernization of Screening Mammography Benefit," provided new payment methodologies for both diagnostic and screening mammograms that utilize digital technology.

For Medicare to determine whether the mammography facility is certified to perform digital mammography (due a higher payment rate), the FDA sends an updated file via the CMS Mainframe Telecommunications System (CMSTS) on a weekly basis.

Effective July 1, 2006, CMS will be populating a new Mammography Quality Standards Act (MQSA) file with terminated FDA-certified facilities (designated with a "T" value). This will enable carriers/intermediaries to pay for screening and diagnostic mammography services for terminated facilities prior to the date of termination and to deny services furnished after the date of termination. By doing so, it will enable the payment of claims that come into Medicare from a terminated facility if the date of service occurred before the facility was terminated.

Relevant Links

CR 4303 is the official instruction issued to your FI or carrier, regarding this change. CR 4303 may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R828CP.pdf* on the CMS website.

Please refer to your local FI or carrier if you have questions about this issue. To find their toll free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4303
Related CR Release Date: February 2, 2006
Related CR Transmittal #: R828CP
Related Change Request (CR) #: 4303
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

DURABLE MEDICAL EQUIPMENT

Change in the Long Descriptor for HCPCS Code Q4080

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services related to ILOPROST inhalation treatment of Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 4324, which provides information on the revised code dosage descriptor for Q4080. This is a non-systems change CR.

Background

The Centers for Medicare & Medicaid Services (CMS) established HCPCS code Q4080 that was effective July 1, 2005, with a code descriptor that read: **"**ILOPROST, INHALATION SOLUTION, ADMINISTERED THROUGH DME**, 20 MICROGRAMS."**

Effective January 1, 2006, the long code descriptor for HCPCS code Q4080 will read: **"**ILOPROST, INHALATION SOLUTION, ADMINISTERED THROUGH DME**, UP TO 20 MCG"**

The short descriptor for HCPCS code Q4080 will continue to read: "Iloprost inhalation solution."

CR 4324 provides clarification on the change in the long descriptor for HCPCS code Q4080 effective January 1, 2006.

Implementation

The implementation date for the instruction is March 13, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary/RHHI regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R209OTN.pdf* on the CMS website.

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

Medlearn Matters Number: MM4324
Related Change Request (CR) #: 4324
Related CR Release Date: February 10, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R209OTN
Implementation Date: March 13, 2006

April Quarterly Update for 2006 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule

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

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 4335 and provides specific information regarding the quarterly update for the April 2006 DMEPOS Fee Schedule.

Background

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

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

Payment on a fee schedule basis is required for:

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

Changes made in this update include the following:

- The fee schedule amounts for HCPCS code **K0730**, *Controlled dose inhalation drug delivery system,* were added to the fee schedule file on April 1, 2006, and are effective for claims with dates of service on or after April 1, 2005. If processed claims for code K0730 with dates of service on or after April 1, 2005, are resubmitted as adjustments after April 1, 2006, carriers and DMERCs will adjust the claim.
- The fee schedule amounts for HCPCS code **E1010**, *Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest,* were inadvertently dropped from the January fee schedule file and are being added back to the file as part of the April 2006 update.
- The payment categories for codes **E0471 and E0472** are being revised to move Respiratory Assist Devices from the DME category for frequently serviced items to the DME payment category for capped rental items, effective on April 1, 2006.

Implementation

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

Additional Information

The official instructions issued to your intermediary, carrier, or DMERC regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R880CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4335
Related Change Request (CR) #: 4335
Related CR Release Date: March 3, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R880CP
Implementation Date: April 3, 2006

Payment for Power Mobility Device Claims

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

Provider Types Affected

Physicians, providers, and non-physician practitioners billing Medicare carriers, durable medical equipment regional carriers (DMERCs), regional home health intermediaries (RHHIs), and/or fiscal intermediaries (FIs) for power mobility devices (PMD) and services related to prescribing PMDs

Important Points to Remember

Options for Submitting G0372 and Evaluation and Management (E/M) Codes

Providers billing a Medicare carrier have the following options for submitting the G0372 code and the E/M code during January 1, 2006, through March 31, 2006:

- Submit the G0372 code and E/M now on the same claim. Payment for these claims will be held through March 31, 2006.
- Hold all claims containing the G0372 code until after March 31, 2006.
- Submit the E/M service now and bill the G0372 code after March 31, 2006. The E/M service will be paid now. Note that this is not intended to require that Medicare fiscal intermediaries or carriers split claims submitted with both the E/M and G0372 code. Rather, the physician/provider may choose to submit two separate claims for the individual services.

Providers submitting claims on or after April 1, 2006, must bill the E/M and the G0372 code on the same claim.

Critical Access Hospitals billing the FI under Method II have the following options from January 1, 2006, through July 2, 2006, for submitting the G0372 code and the E/M code:

- Submit the G0372 and E/M now on the same claim. Payment for these claims will be held by the FI through July 2, 2006.
- Hold all claims containing the G0372 code until after July 2, 2006.
- Submit the E/M service now and bill the G0372 code after July 2, 2006. The E/M service will be paid now. Note that this is not intended to require the FI or carrier to split claims submitted with both the E/M and G0372 code. Rather, the physician or treating practitioner may choose to submit two separate claims for the individual services.

Method II Critical Access Hospitals submitting claims on or after July 2, 2006, must bill the E/M and the G0372 code on the same claim.

Background

The Centers for Medicare & Medicaid Services (CMS) published an interim final rule on PMDs to conform its regulations to section 302(a)(2)(E)(iv) of the Medicare Modernization Act (MMA), which is codified at section 1834(a)(1)(E)(iv) of the Social Security Act (SSA). The effective date of the rule was October 25, 2005.

For PMDs, the MMA mandated that:

- A face-to-face examination of the individual be conducted by a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist; and
- That payment may not be made for a motorized or power wheelchair unless the physician or treating practitioner has written a prescription for the item.

By defining the practitioners allowed to conduct the face-to-face examination, it also effectively removed the current requirement that a beneficiary must be seen by a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology in order to get a power-operated vehicle (POV).

Submission of Medical Record and Prescription

Apart from the MMA requirements, the other key change made by this regulation is a requirement that the physician or treating practitioner must submit pertinent parts of the medical record (in lieu of the certificate of medical necessity [CMN]), along with the prescription, to the durable medical equipment (DME) supplier within 30 days of the face-to-face examination.

A separate add-on payment (an add-on payment to the office visit billed with the code of G0372) was established by the rule to recognize the additional physician work and resources required for submitting pertinent parts of the medical record.

Payment for the history and physical examination is made through the appropriate E/M code along with the add-on payment (G0372), which goes to the local Medicare FI or carrier. The PMD claim will go to the local durable medical equipment regional carrier (DMERC).

Appropriations Act

Title II, Section 222, of the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 2006 (H.R. 3010) (the Appropriations Act) was signed into law on December 30, 2005. It states, in part:

SEC. 222. None of the funds made available under this Act may be used to implement or enforce the interim final rule published in the Federal Register by the Centers for Medicare & Medicaid Services on August 26, 2005, (70 Fed. Reg. 50940) prior to April 1, 2006.

Although this section of the Appropriations Act does not allow federal funds to implement or enforce the rule, CMS believes that this section does not affect the validity of the rule. Therefore, CMS is instructing DMERCs and/or DME PSCs that, between January 1, 2006 to April 1, 2006, contractors will only pay PMD claims that satisfy the requirements of section 1834(a)(1)(E)(iv) of the SSA.

Based on the Appropriations Act, CMS is instructing FIs and carriers to hold claims that contain G0372. These claims must be held through March 31, 2006. Carriers will begin to release physician claims for processing on April 3, 2006.

Implementation

The implementation date for this instruction is no later than two weeks after release of CR4372 or March 24, 2006.

Additional Information

For additional information regarding PMDs you may want to review the following Medlearn Matters articles:

- MM4121: *MMA - New G Code for Power Mobility Devices (PMDs)* *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4121.pdf*
- MM3952: *MMA - Evidence of Medical Necessity: Power Wheelchair and Power Operated Vehicle (POV)/Power Mobility Device (PMD) Claim* *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3952.pdf*

The official instructions issued to your carrier, DMERC, FI, or RHHI regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R215OTN.pdf* on the CMS website.

If you have questions, please contact your Medicare carrier, DMERC, FI, or RHHI at their toll-free number, which may be found at: *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4372
Related Change Request (CR) #: 4372
Related CR Release Date: March 10, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R215OTN
Implementation Date: No later than March 24, 2006

2006 Jurisdiction List

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare durable medical equipment regional carriers (DMERCs) and Part B local carriers.

Provider Action Needed

STOP – Impact to You

CR 4363 provides notice of the spreadsheet containing the annual updated list of Healthcare Common Procedure Coding System (HCPCS) for DMERC and Part B local carrier jurisdictions.

CAUTION – What You Need to Know

The excel spreadsheet containing these codes is available within the official instructions (CR4363) issued to your DMERC contractor and Part B carrier, which may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R893CP.pdf*.

The list will also be available at *http://www.cms.hhs.gov/center/dme.asp* on the CMS website.

GO – What You Need to Do

The above codes are updated on an annual basis. Be sure your billing staff is aware of these changes.

Background

The HCPCS is updated annually to reflect changes in medical practice and the provision of health care. The Centers for Medicare & Medicaid Services (CMS) provides a file containing updated HCPCS codes to Medicare carriers, DMERCs, and intermediaries and to Medicaid State Agencies 60 to 90 days before the implementation of the annual update.

CMS publishes a recurring update notification annually to notify the DMERCs and Part B carriers that the list has been updated and is available on the CMS website.

Both the DMERCs and the local carriers publish this list to educate providers as to which contractor—the DMERC or local Part B carrier—to bill for codes provided on that list.

Implementation

The implementation date for this instruction is June 26, 2006.

Additional Information

The official instructions issued to your DMERC and Carrier regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R893CP.pdf* on the CMS website.

If you have questions, please contact your Medicare DMERC or carrier at their toll free number, which may be found at *http://www.cms.hhs.gov/apps/contacts/* 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: MM4363
Related Change Request (CR) #: 4363
Related CR Release Date: March 24, 2006
Effective Date: June 26, 2006
Related CR Transmittal #: R893CP
Implementation Date: June 26, 2006

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *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.

2006 Jurisdiction List

HCPCS	DESCRIPTION	JURISDICTION
A0021 - A0999	Ambulance Services	Local Carrier
A4206 - A4209	Medical, Surgical, and Self- Local Carrier if incident to a physician's Administered Injection service (not separately payable). If other Supplies	DME REGIONAL Carrier.
A4210	Needle Free Injection Device	DME REGIONAL Carrier
A4211	Medical, Surgical, and Self	Local Carrier if incident to a physician's Administered Injection service (not separately payable). If other Supplies DME REGIONAL Carrier.
A4212	Non Coring Needle or Stylet	Local Carrier with or without Catheter
A4213 - A4215	Medical , Surgical, and Self Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4216 - A4218	Saline	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4220	Refill Kit for Implantable Pump	Local Carrier
A4221 - A4250	Medical, Surgical, and Self Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4253 - A4259	Diabetic Supplies	DME REGIONAL Carrier
A4261	Cervical Cap for Contraceptive	Local Carrier Use
A4262 - A4263	Lacrimal Duct Implants	Local Carrier
A4265	Paraffin	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4266 - A4269	Contraceptives	Local Carrier
A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME REGIONAL Carrier
A4281 - A4286	Accessory for Breast Pump	DME REGIONAL Carrier
A4290	Sacral Nerve Stimulation Test Lead	Local Carrier
A4300 - A4301	Implantable Catheter	Local Carrier
A4305 - A4306	Disposable Drug Delivery System	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4310 - A4359	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device billed to the DME REGIONAL Carrier.
A4361 - A4434	Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier.

2006 Jurisdiction List

HCPCS	Description	Jurisdiction
A4450 - A4455	Tape;Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4458	Enema Bag	DME REGIONAL Carrier
A4462	Abdominal Dressing	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4465	Non-elastic Binder for Extremity	DME REGIONAL Carrier
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4483	Moisture Exchanger	DME REGIONAL Carrier
A4490 - A4510	Surgical Stockings	DME REGIONAL Carrier
A4520	Diapers	DME REGIONAL Carrier
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME REGIONAL Carrier
A4556 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier
A4570	Splint	Local Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	DME REGIONAL Carrier
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4604	Tubing for Positive Airway Pressure Device	DME REGIONAL Carrier
A4605	Tracheal Suction Catheter	DME REGIONAL Carrier
A4606	Oxygen Probe for Oximeter	DME REGIONAL Carrier
A4608	Transtracheal Oxygen Catheter	DME REGIONAL Carrier
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME REGIONAL Carrier
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other DME Regional Carrier.
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME REGIONAL Carrier.
A4630 - A4640	DME Supplies	DME REGIONAL Carrier
A4641 - A4642	Imaging Agent; Contrast Material	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A4651 - A4932	Supplies for ESRD	DME REGIONAL Carrier

2006 Jurisdiction List

HCPCS	DESCRIPTION	JURISDICTION
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier.
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier.
A5500 - A5513	Therapeutic Shoes	DME REGIONAL Carrier
A6000	Non-Contact Wound Warming	DME REGIONAL Carrier Cover
A6010-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6025	Silicone Gel Sheet	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6154 - A6411	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6412	Eye Patch	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6441 - A6512	Surgical Dressings	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6513	Compression Burn Mask	DME REGIONAL Carrier
A6530 - A6549	Compression Gradient Stockings	DME REGIONA Carrier
A6550	Supplies for Negative Pressure Wound Therapy Electrical Pump	DME REGIONAL Carrier
A7000 - A7039	Accessories for Nebulizers, Aspirators, and Ventilators	DME REGIONAL Carrier
A7040 - A7041	Chest Drainage Supplies	Local Carrier
A7042 - A7043	Pleural Catheter	Local Carrier
A7044 - A7046	Respiratory Accessories	DME REGIONAL Carrier
A7501-A7527	Tracheostomy Supplies	DME REGIONAL Carrier
A9150	Non-Prescription Drugs	Local Carrier

2006 Jurisdiction List

HCPCS	DESCRIPTION	JURISDICTION
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier.
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME REGIONAL Carrier.
A5500 - A5513	Therapeutic Shoes	DME REGIONAL Carrier
A6000	Non-Contact Wound Warming	DME REGIONAL Carrier Cover
A6010-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6025	Silicone Gel Sheet	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6154 - A6411	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6412	Eye Patch	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6441 - A6512	Surgical Dressings	Local Carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME REGIONAL Carrier.
A6513	Compression Burn Mask	DME REGIONAL Carrier
A6530 - A6549	Compression Gradient Stockings	DME REGIONA Carrier
A6550	Supplies for Negative Pressure Wound Therapy Electrical Pump	DME REGIONAL Carrier
A7000 - A7039	Accessories for Nebulizers, Aspirators, and Ventilators	DME REGIONAL Carrier
A7040 - A7041	Chest Drainage Supplies	Local Carrier
A7042 - A7043	Pleural Catheter	Local Carrier
A7044 - A7046	Respiratory Accessories	DME REGIONAL Carrier
A7501-A7527	Tracheostomy Supplies	DME REGIONAL Carrier
A9150	Non-Prescription Drugs	Local Carrier

2006 Jurisdiction List

HCPCS	DESCRIPTION	JURISDICTION
A9180	Lice Infestation Treatment	Local Carrier
A9270	Noncovered Items or Services	DME REGIONAL Carrier
A9275	Home Glucose Disposable Monitor	DME REGIONAL Carrier
A9280	Alarm Device	DME REGIONAL Carrier
A9281	Reaching/Grabbing Device	DME REGIONAL Carrier
A9282	Wig	DME REGIONAL Carrier
A9300	Exercise Equipment	DME REGIONAL Carrier
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier.
A9901	Delivery	DME REGIONAL Carrier
A9999	Miscellaneous DME Supply or Accessory	Local Carrier if used with implanted DME. If other, DME REGIONAL Carrier.
B4034 - B9999	Enteral and Parenteral Therapy	DME REGIONAL Carrier
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME REGIONAL Carrier
E0110 - E0118	Crutches	DME REGIONAL Carrier
E0130 - E0159	Walkers	DME REGIONAL Carrier
E0160 - E0175	Commodes	DME REGIONAL Carrier
E0180 - E0199	Decubitus Care Equipment	DME REGIONAL Carrier
E0200 - E0239	Heat/Cold Applications	DME REGIONAL Carrier
E0240 - E0248	Bath and Toliet Aids	DME REGIONAL Carrier
E0249	Pad for Heating Unit	DME REGIONAL Carrier
E0250 - E0304	Hospital Beds	DME REGIONAL Carrier
E0305 - E0326	Hospital Bed Accessories	DME REGIONAL Carrier
E0350 - E0352	Electronic Bowel Irrigation System	DME REGIONAL Carrier
E0370	Heel Pad	DME REGIONAL Carrier
E0371 - E0373	Decubitus Care Equipment	DME REGIONAL Carrier
E0424 - E0484	Oxygen and Related Respiratory Equipment	DME REGIONAL Carrier
E0485 - E0486	Oral Device to Reduce Airway Collapsibility	DME REGIONAL Carrier
E0500	IPPB Machine	DME REGIONAL Carrier
E0550 - E0585	Compressors/Nebulizers	DME REGIONAL Carrier
E0600	Suction Pump	DME REGIONAL Carrier
E0601	CPAP Device	DME REGIONAL Carrier
E0602 - E0604	Breast Pump	DME REGIONAL Carrier
E0605	Vaporizer	DME REGIONAL Carrier
E0606	Drainage Board	DME REGIONAL Carrier
E0607	Home Blood Glucose Monitor	DME REGIONAL Carrier
E0610 - E0615	Pacemaker Monitor	DME REGIONAL Carrier
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME REGIONAL Carrier
E0618 - E0619	Apnea Monitor	DME REGIONAL Carrier
E0620	Skin Piercing Device	DME REGIONAL Carrier
E0621 - E0636	Patient Lifts	DME REGIONAL Carrier
E0637 - E0642	Standing Devices/Lifts	DME REGIONAL Carrier
E0650 - E0675	Pneumatic Compressor and Appliances	DME REGIONAL Carrier
E0691 - E0694	Ultraviolet Light Therapy Systems	DME REGIONAL Carrier

2006 Jurisdiction List

HCPCS	DESCRIPTION	JURISDICTION
E0700	Safety Equipment	DME REGIONAL Carrier
E0701	Helmet	DME REGIONAL Carrier
E0705	Transfer Board	DME REGIONAL Carrier
E0710	Restraints	DME REGIONAL Carrier
E0720 - E0745	Electrical Nerve Stimulators	DME REGIONAL Carrier
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME REGIONAL Carrier
E0749	Implantable Osteogenic Stimulators	Local Carrier
E0755	Reflex Stimulator	DME REGIONAL Carrier
E0760	Ultrasonic Osteogenic Stimulator	DME REGIONAL Carrier
E0761	Electromagnetic Treatment Device	DME REGIONAL Carrier
E0762	Electrical Joint Stimulation Device	DME REGIONAL Carrier
E0764	Functional Neuromuscular Stimulator	DME REGIONAL Carrier
E0765	Nerve Stimulator	DME REGIONAL Carrier
E0769	Electrical Wound Treatment Device	DME REGIONAL Carrier
E0776	IV Pole	DME REGIONAL Carrier
E0779 - E0780	External Infusion Pumps	DME REGIONAL Carrier
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME REGIONAL Carrier. This item may be billed to the DME REGIONAL Carrier whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME REGIONAL Carrier
E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME REGIONAL Carrier
E0830	Ambulatory Traction Device	DME REGIONAL Carrier
E0840 - E0900	Traction Equipment	DME REGIONAL Carrier
E0910 - E0930	Trapeze/Fracture Frame	DME REGIONAL Carrier
E0935	Passive Motion Exercise Device	DME REGIONAL Carrier
E0940	Trapeze Equipment	DME REGIONAL Carrier
E0941	Traction Equipment	DME REGIONAL Carrier
E0942 - E0945	Orthopedic Devices	DME REGIONAL Carrier
E0946 - E0948	Fracture Frame	DME REGIONAL Carrier
E0950 - E1298	Wheelchairs	DME REGIONAL Carrier
E1300 - E1310	Whirlpool Equipment	DME REGIONAL Carrier
E1340	Repair or Non-routine Service	Local Carrier if repair of implanted DME. If other, DME REGIONAL Carrier.
E1353 - E1392	Additional Oxygen Related Equipment	DME REGIONAL Carrier
E1399	Miscellaneous	DME Local Carrier if implanted DME. If other, DME REGIONAL Carrier.
E1405 - E1406	Additional Oxygen Equipment	DME REGIONAL Carrier
E1500 - E1699	Artificial Kidney Machines and Accessories	DME REGIONAL Carrier
E1700 - E1702	TMJ Device and Supplies	DME REGIONAL Carrier
E1800 - E1841	Dynamic Flexion Devices	DME REGIONAL Carrier

2006 Jurisdiction List

HCPCS	DESCRIPTION	JURISDICTION
E1902	Communication Board	DME REGIONAL Carrier
E2000	Gastric Suction Pump	DME REGIONAL Carrier
E2100 - E2101	Blood Glucose Monitors with Special Features	DME REGIONAL Carrier
E2120	Pulse Generator for Tympanic Treatment of Inner Ear	DME REGIONAL Carrier
E2201 - E2399	Wheelchair Accessories	DME REGIONAL Carrier
E2402	Negative Pressure Wound Therapy Pump	DME REGIONAL Carrier
E2500 - E2599	Speech Generating Device	DME REGIONAL Carrier
E2601 - E2621	Wheelchair Cushions	DME REGIONAL Carrier
E8000 - E8002	Gate Trainers	DME REGIONAL Carrier
G0008 - G9130	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier.
J3590	Unclassified Biologics	Local Carrier
J7030 - J7130	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier.
J7188 - J7195	Antihemophilic Factor	Local Carrier
J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199	Other Hemophilia Clotting Factors	Local Carrier
J7300 - J7306	Intrauterine Copper Contraceptive	Local Carrier
J7308	Aminolevulinic Acid HCL	Local Carrier
J7310	Ganciclovir	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier.
J7317 - J7320	Injection	Local Carrier
J7330	Autologous Cultured Chondrocytes Implant	Local Carrier
J7340 - J7350	Dermal and Epidermal – Tissue of Human Origin	Local Carriers
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier.
J7608 - J7699	Inhalation Solutions	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
J7799	NOC, Other than Inhalation Drugs through DME	Local carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
J8498	Anti-emetic Drug	DME REGIONAL Carrier
J8499	Prescription Drug, Oral, Non Chemotherapeutic	Local carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
J8501 - J8999	Oral Anti-Cancer Drugs	DME REGIONAL Carrier

2006 Jurisdiction List

HCPCS	DESCRIPTION	JURISDICTION
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME REGIONAL Carrier.
K0001 - K0108	Wheelchairs	DME REGIONAL Carrier
K0195	Elevating Leg Rests	DME REGIONAL Carrier
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME REGIONAL Carrier
K0462	Loaner Equipment	DME REGIONAL Carrier
K0552	External Infusion Pump Supplies	DME REGIONAL Carrier
K0601 - K0605	External Infusion Pump Batteries	DME REGIONAL Carrier
K0606 - K0609	Defibrilator Accessories	DME REGIONAL Carrier
K0669	Wheelchair Cushion	DME REGIONAL Carrier
K0730	Inhalation Drug Delivery System	DME REGIONA Carrier
L0100 - L2090	Orthotics	DME REGIONAL Carrier
L2106 - L2116	Orthotics	DME REGIONAL Carrier
L2126 - L4398	Orthotics	DME REGIONAL Carrier
L5000 - L5999	Lower Limb Prosthetics	DME REGIONAL Carrier
L6000 - L7499	Upper Limb Prosthetics	DME REGIONAL Carrier
L7500 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other, DME REGIONAL Carrier.
L7600	Prosthetic Donning Sleeve	DME REGIONAL Carrier
L7900	Vacuum Erection System	DME REGIONAL Carrier
L8000 - L8485	Prosthetics	DME REGIONAL Carrier
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if implanted prosthetic device. If other, DME REGIONAL Carrier.
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME REGIONAL Carrier
L8505	Artificial Larynx Accessory	DME REGIONAL Carrier
L8507 - L8515	Voice Prosthesis	DME REGIONAL Carrier
L8600 - L8699	Prosthetic Implants	Local Carrier
L9900	Miscellaneous Orthotic or Prosthetic Component or device Accessory	Local Carrier if used with implanted prosthetic . If other, DME REGIONAL Carrier.
M0064 - M0301	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardio-kymography	Local Carrier
Q0081	Infusion Therapy	Local Carrier if incident to a physicians service or used in an implanted infusion pump. If other, DME REGIONAL Carrier.
Q0083 - Q0085	Chemotherapy Administration	Local Carrier if incident to a physicians service or used in an implanted infusion pump. If other, DME REGIONAL Carrier.
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier

2006 Jurisdiction List

HCPCS	DESCRIPTION	JURISDICTION
Q0144	Azithromycin Dihydrate	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier
Q0163 - Q0181	Anti-emetic	DME REGIONAL Carrier
Q0480 - Q0505	Ventricular Assist Devices	Local Carrier
Q0510 - Q0514	Drug Dispensing Fees	DME REGIONAL Carrier
Q0515	Sermorelin Acetate	Local Carrier
Q1003 - Q1005	New Technology IOL	Local Carrier
Q2004	Irregation Solution	Local Carrier
Q2009	Fosphenytoin	Local Carrier
Q2017	Teniposide	Local Carrier
Q3001	Radio Elements for Brachytherapy	Local Carrier
Q3014	Telehealth Originating Site Facility Fee	Local Carrier
Q3019 - Q3020	ALS Transport	Local Carrier
Q3025 - Q3026	Vaccines	Local Carrier
Q3031	Collagen Skin Test	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier
Q4079	Natalizumab	Local Carrier
Q4080	Inhalation Drug	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
Q9945 - Q9954	Imaging Agents	Local Carrier
Q9955 - Q9957	Microspheres	Local Carrier
Q9958 - Q9964	Imaging Agents	Local Carrier
R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME REGIONAL Carrier
V2100 - V2513	Lenses	DME REGIONAL Carrier
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
V2530 - V2531	Contact Lenses, Scleral	DME REGIONAL Carrier
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service. If other, DME REGIONAL Carrier.
V2600 - V2615	Low Vision Aids	DME REGIONAL Carrier
V2623 - V2629	Prosthetic Eyes	DME REGIONAL Carrier
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME REGIONAL Carrier
V2781	Progressive Lens	DME REGIONAL Carrier
V2782 - V2784	Lenses	DME REGIONAL Carrier
V2785	Processing--Corneal Tissue	Local Carrier
V2786	Lense	DME REGIONAL Carrier
V2788	Intraocular Lenses	Local Carrier
V2790	Amniotic Membrane	Local Carrier
V2797	Vision Supply	DME REGIONAL Carrier
V2799	Miscellaneous Vision Service	DME REGIONAL Carrier
V5008 - V5299	Hearing Services	Local Carrier
V5336	Repair/Modification of Augmentative Communicative System or Device	DME REGIONAL Carrier
V5362 - V5364	Speech Screening	Local Carrier

2006 Oncology Demonstration Project—Inclusion of Gynecological Oncology

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

Provider Types Affected

Gynecological oncologists who bill Medicare for office-based oncological services

What You Need to Know

CR4347 (from which this article was taken) adds gynecological oncologists to the list of physician specialties qualified to participate in the 2006 Oncology Demonstration Project.

Background

CMS initiated a one-year oncology demonstration project for 2006 designed to identify and assess particular oncology office practice-based services that improve outcomes in the Medicare population (as stated in CR 4219, Transmittal 36, *2006 Oncology Demonstration Project*, issued on December 30, 2005).

That CR included the physician specialties of hematology (82), medical oncology (90), and hematology/oncology (83), as qualifying under the 2006 oncology demonstration.

In CR 4347, CMS adds the specialty of gynecological oncology (98) to this list.

Therefore, unless otherwise noted, the policy, instructions, messages, and business requirements in CR4219 apply equally to gynecological oncology.

Your carriers will not search their records for claims previously submitted for gynecological oncology services in 2006 that were denied payment under the oncology demonstration. They will, however, adjust claims that are brought to their attention.

Additional Information

You can find more information about the inclusion of gynecological oncologists in the 2006 Oncology Demonstration Project by going to *http://www.cms.hhs.gov/Transmittals/downloads/R41DEMO.pdf* on the CMS website.

In addition, you can learn more about the 2006 Oncology Demonstration Project itself by reading *MedLearn Matters* article MM4219. This article is at *http://www.cms.hhs.gov/MedLearnMattersArticles/downloads/MM4219.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/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4347
Related Change Request (CR) #: 4347
Related CR Release Date: March 10, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R41DEMO
Implementation Date: April 3, 2006

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *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.

DRUGS AND BIOLOGICALS

April 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File and Revisions to January 2005, April 2005, July 2005, October 2005, and January 2006 Quarter ASP Medicare Part B Drug Pricing Files

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

Provider Types Affected

All Medicare providers who bill Medicare for Part B drugs

Provider Action Needed

STOP – Impact to You

CR 4319 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective April 1, 2006 through June 30, 2006, as well as revised payment files for the January 2005, April 2005, July 2005, October 2005, and January 2006 Quarter ASP Medicare Part B Drug Pricing Files.

CAUTION – What You Need to Know

Be aware that certain Medicare Part B drug payment limits have been revised and that the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance quarterly. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR 4319.

GO – What You Need to Do

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

Background

According to Section 303 (c) of the Medicare Modernization Act of 2003 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis.

Beginning January 1, 2005, Part B drugs that are not paid on a cost or prospective payment basis) are paid based on **106 percent** of the average sales price (ASP).

Additionally, in 2006, all ESRD drugs furnished by both independent and hospital based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on the ASP methodology. The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are **106 percent** of the ASP.

Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions to General Rule

There are exceptions to this general rule as summarized below:

Blood and Blood Products

For blood and blood products (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003.

The payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.

Infusion Drugs

For infusion drugs furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the DME is implanted.

The payment allowance limits were not updated in 2005. For infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003 (i.e., new drugs), the payment allowance limits are 95 percent of the first published AWP.

Influenza, Pneumococcal, Hepatitis B Vaccines

For influenza, pneumococcal, and hepatitis B vaccines**,** payment allowance limits are 95 percent of the AWP as reflected in the published compendia.

Drugs Not Included in ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File

For drugs (other than new drugs) not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) pricing file**,** payment allowance limits are based on the published wholesale acquisition cost (WAC) or invoice pricing.

In determining the WAC-based payment limit, Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries, including regional home health intermediaries (RHHIs)) will follow the methodology specified in the *Medicare Claims Processing Manual* for calculating the AWP, but substitute WAC for AWP. (See Publication 100-04, Chapter 17, Drugs and Biologicals) at *http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf* on the CMS website. The payment limit is 100 percent of the lesser of the lowest brand or median generic WAC.

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

Radiopharmaceuticals

The payment allowance limits for **radiopharmaceuticals** are not subject to ASP.

Your carrier/FI will determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003.

New Drugs Produced or Distributed under a New Drug Application Approved by the Food and Drug Administration

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

How the ASP is Calculated

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter, CMS will update your carrier payment allowance limits with the ASP files. On or after March 20, 2006, revised January 2005, April 2005, July 2005, October 2005, and January 2006 ASP and NOC payment files and the April 2006 ASP and NOC files will be available for download.

- The revised January 2005 payment allowance limits apply to dates of service January 1, 2005 through March 31, 2005.
- The revised April 2005 payment allowance limits apply to dates of service April 1, 2005 through June 30, 2005.
- The revised July 2005 payment allowance limits apply to dates of service July 1, 2005 through September 30, 2005.
- The revised October 2005 payment allowance limits apply to dates of service October 1, 2005 through December 31, 2005.
- The revised January 2006 payment allowance limits apply to dates of service January 1, 2006 through March 31, 2006.
- The April 2006 payment allowance limits apply to dates of service April 1, 2006 through June 30, 2006.

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The carrier processing your claim will make these determinations.

For any drug or biological not listed in the ASP or NOC drug pricing files, your Medicare contractor will determine the payment allowance limits in accordance with the policies described in CR 4319 and fiscal intermediaries will seek payment allowances from the local Medicare carrier.

Implementation

The implementation date for the instruction is April 3, 2006

Additional Information

The official instructions issued to your carrier/FI/RHHI/DMERC regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R876CP.pdf* on the CMS website.

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

More information is available at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/* on the CMS website.

Medlearn Matters Number: MM4319
Related Change Request (CR) #: 4319
Related CR Release Date: February 24, 2006
Effective Date: April 1, 2006
Related CR Transmittal #: R876CP
Implementation Date: April 3, 2006

Additional 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 and suppliers billing Medicare carriers for Part B drugs and biologicals **not paid on a cost or prospective payment system basis.**

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4309, which provides additional requirement for the CAP for Part B drugs and biologicals.

CAUTION – What You Need to Know

CR 4309 provides additional instructions for the implementation of the CAP program. It builds on CR 4064 through business requirements that were identified through the implementation process of CR 4064 and the development of the final CAP rule published on November 21, 2005.

GO – What You Need to Do

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

Background

Change Request (CR) 4309 provides new requirements that were identified both during the coding process of CR 4064 (*http://new.cms.hhs.gov/transmittals/downloads/R777CP.pdf*) and the publication of the final rule for the CAP for Medicare Part B drugs. It provides additional instructions for the implementation of the CAP program as outlined in CR 4064, and it is tied to the business requirements in CR 4064. CR 4309 is not a stand-alone CR and needs to be understood in conjunction with CR 4064.

The Competitive Acquisition Program (CAP) for Drugs and Biologicals Not Paid on a Cost or Prospective Payment Basis

The Medicare Prescription Improvement and Modernization Act of 2003 (MMA, Section 303 [d]), requires the implementation of a CAP for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system (PPS) basis.

Beginning with drugs administered on or after July 1, 2006, physicians will be given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. For a complete overview of the program, see the MLN Matters article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf* on the CMS website.

Note: For 2006, the first CAP year will run from July 1, 2006, through December 31, 2006. In subsequent years, it will run annually on a calendar year basis. MMA, Section 303 (d) may be found at *http://www.cms.hhs.gov/MMAUpdate/* on the CMS website.

Social Security Act, Section 1861(s) is available at *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm.*

The Centers for Medicare & Medicaid Services (CMS) may exclude drugs from the CAP if competitive pricing will not result in significant savings, or is likely to have an adverse impact on access to such drugs.

Note: Physicians will still be able to continue to purchase and bill Medicare under the average sales price (ASP) system for those drugs that are covered under Medicare Part B but whose HCPCS codes are not provided by the chosen approved CAP vendor.

Providing a Drug from Physician's Stock

Under emergency situations, the CAP will allow a participating CAP physician to provide a drug to a Medicare beneficiary from his or her own stock and obtain the replacement drug from the approved CAP vendor when certain conditions are met.

The local carrier will monitor drugs ordered under the emergency replacement provision to ensure that the participating CAP physician is complying with Medicare payment rules.

Physician Election and Information Transfer between Carriers and the Designated Carrier for CAP Claims

For this first CAP year, by April 17, 2006, CMS will post on its website:

- A list of the vendors that have been selected to participate in the CAP for 2006 and their websites,
- The categories of drugs they will be providing, and
- The geographic areas within which each vendor will operate.

Physicians can then elect the vendors and the categories of drugs they choose to receive drugs from under the CAP program. For this first CAP cycle, there will be one category of drugs and one geographic area.

In subsequent years, the CAP election will take place in the fall of each year and CMS will post on its website the updated list of vendor information. The election process will end each year approximately 45 days after the list of vendors is posted on the CMS website.

Additional Requirements Regarding the CAP

Additional instructions and more complete details about the CAP requirements for Part B Drugs can be found in Change Request (CR) 4309 and its attachments. Some of these important requirements to remember are as follows:

- The CAP is only available to physicians billing Medicare on a fee-for-service basis and is not applicable to United Mine Worker, Railroad Retirement Board, or Medicare Advantage beneficiaries;
- Vendors can only submit claims for drugs provided by physicians who selected that vendor;
- Every claim from a vendor will indicate that all appeals on CAP claims must be adjudicated by the physician's carrier;
- Members of a group must elect to participate in the CAP as a whole group when billing as a group;
- Only members of a group who have prescriptive authority are eligible to participate in the CAP;
- Any carrier that is currently applying a local billing policy for unused drug (waste) that requires a separate detail line with the unused drug modifier (JW) may continue to apply that policy under the CAP, but they must require the addition of the CAP modifier to the line;
- Claims that include the no-pay, restocking, or furnished as written modifier (as noted in CR 4064) will be treated as unprocessable if they contain one of the following invalid modifier combinations:
- J1 and J3
- J2 without J1
- J2 and J3
- The J1 modifier must be on every physician claim for a CAP drug;
- Vendors may petition CMS to add new drugs to their vendor specific drug list on a quarterly basis;
- The UPIN (or NPI) of the ordering physician must be entered on every vendor claim and match the UPIN (or NPI) of a physician that has elected that vendor; and
- All HCPCS codes for the administration of CAP drugs must be billed as assigned.

When physicians or practitioners submit a paper claim with a no-pay modifier on a line, but without a prescription number on that line, the claim will be rejected and returned with remittance advice remark code MA130, indicating "Your claim contains incomplete information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."

Implementation

The implementation date for this instruction is July 3, 2006, except where otherwise indicated in this article.

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R866CP.pdf* on the CMS website. In addition, you may wish to review CR 4064 at *http://www.cms.hhs.gov/Transmittals/downloads/R777CP.pdf* and its related article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.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/apps/contacts/* 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: MM4309	Related Change Request (CR) #: 4309
Related CR Release Date: February 17, 2006	Effective Date: July 1, 2006
Related CR Transmittal #: R866CP	Implementation Date: July 3, 2006, except as otherwise specified in the article.

April Quarterly Update to the 2006 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or 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) 4298, which provides updates to the lists of HCPCS codes that are subject to the Consolidated Billing (CB) provision of the SNF Prospective Payment System (PPS).

CAUTION – What You Need to Know

Services included on the SNF consolidated billing enforcement list will be paid to SNF Medicare providers only. Services excluded from the SNF consolidated billing enforcement list may be paid to Medicare providers other than SNFs. See *Background* and *Additional Information* sections for further explanation.

GO – What You Need to Do

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

Background

The Social Security Act (Section 1888, *http://www.ssa.gov/OP_Home/ssact/title18/1883.htm*) codifies both the SNF PPS and CB. The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes subject to the CB provision of the SNF PPS.

Services that appear on this HCPCS code list (that are submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs)) will not be paid by Medicare to providers (other than an SNF) when included in SNF CB.

For non-therapy services, SNF CB applies only when the services are furnished to an SNF resident during a covered Part A stay. However, SNF CB applies to the following services whenever they are furnished to an SNF resident, regardless of whether Part A covers the stay:

- Physical and occupational therapies; and
- Speech-language pathology.

Services for beneficiaries that are excluded from SNF PPS and CB may be paid to providers (other than SNFs) even when in an SNF stay. To assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

2006 Annual Update

Each January, CMS publishes a combined instruction for FIs and Carriers/DMERCs for the annual notice on SNF CB. The 2006 Annual Update file for FIs can be found at *http://www.cms.hhs.gov/SNFConsolidatedBilling/01a_SNFCBforFIs.asp#TopOfPage* on the CMS website. This 2006 file will be updated with the changes addressed in CR 4298 by March 1, 2006.

Information on the 2006 Annual Update for carriers can be found at *http://cms.hhs.gov/SNFConsolidatedBilling/* on the CMS website.

Note: Quarterly updates apply to FIs and carriers/DMERCs. The update provided by CR 4298 affects claims with dates of service on or after the effective date of CR 4298 unless otherwise indicated. The following HCPCS codes are listed as being added or removed from the Annual Update:

HCPCS Codes Added or Removed from Annual Update

Computerized Axial Tomography (CT) Scans (Major Category I, FI Annual Update, EXCLUSION)

HCPCS Code REMOVED	Descriptor
76375	3D/holograph reconstr add-on

Radiation Therapy (Major Category I, FI Annual Update, EXCLUSION)

HCPCS Code REMOVED	Descriptor
C9722	KV imaging w/ir tracking
G0242	Lultisource photon ster plan
G0338	Linear accelerator stero pln

Angiography, Lymphatic, Venous (Major Category I, FI Annual Update, EXCLUSION)

HCPCS Code ADDED	Descriptor
36598	Contrast injection, radiologic eval of existing cent venous access device

Note: This code should be added to the SNF CB file effective April 1, 2006.

Outpatient Surgery and Related Procedures (Major Category I, FI Annual Update, INCLUSION)

HCPCS Code REMOVED	Descriptor
15810	Salabrasion
15811	Salabrasion
G0345	Intravenous infusion, hydration; initial, up to one hour

Ambulance Trips w/ Application to Major Category II (Major Category I, FI Annual Update, EXCLUSION)

HCPCS Code REMOVED	Descriptor
Q3019	ALS vehicle used, emergency transport, no ALS service furnished
Q3020	ALS vehicle used, non-emergency transport, no ALS service furnished service furnished

Dialysis Supplies (Major Category II, FI Annual Update, EXCLUSION)

HCPCS Code REMOVED	Descriptor
A4656	Needle, any size, for dialysis, each

Chemotherapy Administration (Major Category III, FI Annual Update, EXCLUSION)

HCPCS Code REMOVED	Descriptor
96408	Chemotherapy, push technique
96410	Chemotherapy,infusion method
96412	Chemo, infuse method add-on
96414	Chemo, infuse method add-on
96520	Pump refilling, maintenance
96530	Pump refilling, maintenance
G0357	Intravenous, push technique, single or initial substance/drug
G0358	Intravenous, push technique, each additional substance/drug
G0359	Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
G0360	Each additional hour, one to eight hours
G0361	Initiation of prolonged chemotherapy infusion (more than 8 hours)
G0362	Each additional sequential infusion (different substance /drug), up to one hour

HCPCS Code ADDED	Descriptor
96409	Chemo admin; IV, push; single/initial drug
96411	Chemo admin; IV, push; each add'l drug
96413	Chemo admin; IV, infusion; up to 1 hr; single/initial drug
96415	Chemo admin; IV, infusion; each add'l hr, 1-8 hrs
96416	Chemo admin; IV, infusion; initiation of prolonged chemo, requiring pump
96417	Chemo admin; IV infusion; each add'l sequential infusion, up to 1 hr
C8953	Chemo admin; IV, push
C8954	Chemo admin; IV, infusion; up to 1 hr
C8955	Chemo admin; IV, infusion; each add'l hr

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R826CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4298 Related Change Request (CR) #: 4298
Related CR Release Date: February 1, 2006 Effective Date: January 1, 2006
Related CR Transmittal #: R826CP Implementation Date: April 3, 2006

January 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective January 1, 2006, and Revisions to January 2005, April 2005, July 2005, and October 2005 Quarterly ASP Medicare Part B Drug Pricing Files

CMS has issued the following "MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the HCPCS 2006 January Special Medicare B Update! page 30.

Note: This article was revised on February 17, 2006, to delete references to the revised January 2005 pricing file. CR 4140 was revised by CMS to delete the same references since the revised January 2005 pricing file was not provided as indicated in the original CR 4140. Also, the CR transmittal number, Web address, and release date were also changed. Other Web addresses were changed to conform to the new CMS website. All other information remains the same.

Provider Types Affected

All Medicare providers who bill Medicare for Part B drugs

Provider Action Needed

STOP – Impact to You

CR4140 provides notice of the updated payment allowance limits in the January 2006, April 2005, July 2005, and October 2005 drug pricing files.

CAUTION – What You Need to Know

Be aware that certain Medicare Part B drug payment limits have been revised and that CMS updates the payment allowance on a quarterly basis. The revised payment limits included in the revised average sales price (ASP) and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to this document.

GO – What You Need to Do

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

Background

According to Section 303 (c) of the Medicare Modernization Act of 2003 (MMA), the Centers for Medicare & Medicaid Services (CMS) will update the payment allowances for Medicare Part B drugs on a quarterly basis.

Beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the ASP.

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

On or after December 19, 2005, revised April 2005, July 2005, and October 2005 ASP and NOC payment files and the January 2006 ASP and NOC files will be available for download.

- The revised April 2005 payment allowance limits apply to dates of service April 1, 2005, through June 30, 2005.
- The revised July 2005 payment allowance limits apply to dates of service July 1, 2005, through September 30, 2005.
- The revised October 2005 payment allowance limits apply to dates of service October 1, 2005, through December 31, 2005.
- The January 2006 payment allowance limits apply to dates of service January 1, 2006, through March 31, 2006.

Exceptions

There are, however, exceptions to the general rule and they were summarized in MM3846, effective July 1, 2005, and may be viewed at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3783.pdf* on the CMS website.

Implementation

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

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R856CP.pdf* on the CMS website.

CMS will also update the Microsoft Excel files on the CMS website to reflect these revised payment limits. Those files can be found at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/* on the CMS website.

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

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

Medlearn Matters Number: MM4140 *Revised*
Related CR Release Date: February 15, 2006
Related CR Transmittal #: R856CP
Related Change Request (CR) #: 4140
Effective Date: January 1, 2005
Implementation Date: January 3, 2006

Competitive Acquisition Program for Part B Drugs – Coding, Testing, and Implementation

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

Provider Types Affected

Physicians billing Medicare carriers for Part B drugs and approved Competitive Acquisition Program (CAP) vendors billing the designated carrier

Provider Action Needed

STOP – Impact to You

Beginning in April 2006, Medicare physicians will be given the opportunity to elect to participate in the CAP for claims paid on or after July 1, 2006. Participating CAP physicians will obtain Medicare Part B covered drugs from selected drug categories through the CAP. Until further notice, there is only one drug category in the CAP. (**Note:** Exact dates of the physician election period will be announced on the comp bid website (*http://www.cms.hhs.gov/CompetitiveAcquisforBios*) and via a list serv notice).

CAUTION – What You Need to Know

Participating CAP physicians will receive all of their Part B drugs from the approved CAP vendor for the drug category (ies) they have selected.

The only exception is the **"furnish as written"** situation, in which the participating CAP physician requires that, because of medical necessity, the beneficiary must have a certain brand of a drug or a particular product identified by the product's national drug code (NDC) and that specific drug is not available for the HCPCS code listed on the approved CAP vendor's drug list. This one exception will be identified with the use of the new CAP modifier J3.

Physicians participating in the CAP program should pay particular attention to the discussion in this article concerning the CAP modifiers J1, J2, and J3.

GO – What You Need to Do

In April 2006, the Centers for Medicare & Medicaid Services (CMS) will post on its website a list of the CAP vendors and the drugs they will supply. Physicians wishing to participate in the CAP program in 2006 must elect to do so within 45 days of the date the election information is posted. The election agreement is effective on July 1, 2006. See the Background section of this article for further details regarding these changes.

Background

This article includes information from Change Request (CR) 4064, which provides instructions to Medicare carriers regarding the CAP program. This new CAP program applies to physician-injectable and infused drugs covered under Medicare's supplemental insurance (Part B) program that are commonly provided incident to a physician's service. This program does NOT apply to drugs included in the new Prescription Drug Benefit under Part D, which goes into effect on January 1, 2006.

Physicians (and other practitioners who provide physician services that include the authority to prescribe and order Medicare Part B drugs) wishing to participate in the CAP program in 2006 must elect to do within 45 days of the date that the election information is posted on the CMS website.

The election agreement is effective on July 1, 2006. Each subsequent year, the election period will be in the fall and physicians must make their participation decision within 45 days after CMS publishes the list of vendors and their drug list for the following year on the CMS website. Election decisions will take effect on the following January 1.

How Drugs Are Selected For CAP

The CMS may exclude drugs from the CAP if competitive pricing will not result in significant savings, or is likely to have an adverse impact on access to such drugs.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) gives CMS the authority to:

- Select drugs (or categories of drugs) that will be included in the CAP program,
- Establish geographic competitive acquisition areas, and
- Phase in these elements as appropriate.

How Approved CAP Vendors Are Selected

A competition will be held every three years to award contracts to vendors that will supply drugs and biologicals for the program. A three-year contract will be awarded to qualified approved CAP vendors in each geographic area who have and maintain:

- Sufficient means to acquire and deliver competitively biddable drugs within the specified contract area;
- Arrangements in effect for shipping at least 5 days each week for the competitively biddable drugs under the contract and means to ship drugs in emergency situations;
- Quality, service, financial performance, and solvency standards; and
- A grievance and appeals process for dispute resolution.

Approved CAP vendors must qualify for enrollment as a Medicare supplier, and they will be enrolled as a new provider specialty type.

CMS will establish a single payment amount for each of the competitively bid drugs and areas. For this three year contract cycle there will be one drug category and one geographic area for CAP. After CAP drug prices are determined and vendor contracts are awarded, the information will be posted to a directory at *http://www.cms.hhs.gov/CompetitiveAcquisforBios* on the CMS website.

Obtaining Drugs in the CAP

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 303 (d)) requires the implementation of a CAP for Medicare Part B drugs and biologicals not paid on a cost or Prospective Payment System basis.

You can review the MMA, Section 303(d) at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/303d.pdf* on the CMS website.

Beginning with Part B drugs administered on or after July 1, 2006 incident to a physician service, Medicare physicians will be given a choice between:

- Buying and billing these drugs under the ASP system; or
- Obtaining these drugs from vendors selected in the CAP's competitive bidding process.

Physicians (and other practitioners who provide physician services that include the authority to prescribe and order Medicare Part B drugs) will be given the opportunity to participate in the CAP. Approved CAP vendors will supply the drugs and biologicals for the participants of this program.

Physicians who elect to participate in CAP will continue to bill their local carrier for drug administration.

Participating CAP physicians will receive all of their drugs from the approved CAP vendor for the drug categories they have selected, **with only one exception:**

The exception will be for **"furnish as written"** situations in which the participating CAP physician specifies that, because of medical necessity, the beneficiary must have a certain brand of a drug or a particular product defined by the product's NDC and that drug is not available for the HCPCS codes listed on the approved CAP vendor's drug list.

In those cases, the participating CAP physician may:

- Buy the drug;
- Administer it to the beneficiary; and
- Using the appropriate modifier (see below discussion of modifiers), bill Medicare using the ASP methodology.

In addition, under emergency situations, the CAP will allow a participating CAP physician to provide a drug to a Medicare beneficiary from his or her own stock and obtain the replacement drug from the approved CAP vendor under the emergency replacement provision when certain conditions are met as follows:

- The drug was required immediately;
- The need for the drug could not be anticipated;
- The CAP vendor could not deliver the drug in time;
- The drug was administered in an emergency situation; and
- Documentation is maintained on file to validate these conditions.

Note: Physicians will still be able to continue to purchase and bill Medicare under the ASP system those drugs that are covered under Medicare Part B but whose HCPCS codes are not provided by the chosen approved CAP vendor.

Physician Billing

Physicians will be given the opportunity to participate in the CAP on an annual basis, and those who elect to participate in CAP will continue to bill their local carrier for the drug's administration. They will agree to submit a claim to Medicare within 14 days of the administration of the CAP drug.

The carrier will deny any physician Part B claims for drugs included in the CAP unless the CAP modifier codes are appropriately included. CAP has three modifier codes that will need to be used when physicians submit claims to their carriers for the administration of CAP drugs. The new CAP modifier codes are:

- J1 – Competitive Acquisition Program, no-pay submission for a prescription number
- J2 – Competitive Acquisition Program (CAP), restocking of emergency drugs after emergency administration and a prescription number
- J3 – Competitive Acquisition Program (CAP), drug not available through CAP as written, reimbursed under ASP methodology.

Participating CAP physicians will also 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.

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;
- The HCPCS code for each CAP drug administered along with the new no-pay modifier "J1";
- The HCPCS code(s) that include the administration of each CAP drug on separate lines.

Note: On paper claims, the prescription numbers will be in Item 19.

When physicians submit claims for the administration of CAP drug(s) that have been administered in an emergency situation and required "emergency restocking" from 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 new no-pay modifier J1 and also on that same line, the new modifier J2 denoting "Competitive Acquisition Program, (CAP) restocking of emergency drugs after emergency administration;" and
- HCPCS code(s) that include the administration of each CAP drug on separate lines. When physicians submit claims for **"furnish as written"** drugs to be paid outside the CAP program:
- Physicians should use only the new modifier J3 denoting "Competitive Acquisition Program (CAP), drug not available through CAP as written, reimbursed under the average sales price methodology."

Physicians who elect CAP should note:

- 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.
- The Medicare carrier will identify them as physicians who elected to participate in CAP and who will not be paid for the drugs obtained from the approved CAP vendor.

Additionally, unless claims for CAP administration do not include the CAP drug no-pay, restocking, or "furnish as written" modifier, the claim will be denied and you will see a remittance advice, N348, stating that "You chose that this service/supply/drug be rendered/supplied and billed by a different practitioner/supplier."

Note: The physician's local carrier will monitor drugs that are:

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

Vendor Billing
The approved CAP vendor will bill the:

- Medicare designated carrier for the drug; and
- Beneficiary for any applicable coinsurance and deductible.

The approved CAP vendor will also include a prescription/order number on the claim to identify each CAP drug administered.

Note: 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 shall be 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 number on both claims. When they are matched in the claims processing system, the approved CAP vendor will 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.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R777CP.pdf* on the CMS website.

Also, additional information on the CAP program is available at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/* 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/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4064
Related CR Release Date: December 9, 2005
Related CR Transmittal #: R777CP
Related Change Request (CR) #: 4064
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

2006 Allowances for Administration of Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines

The following are the 2006 allowances for the administration of pneumococcal pneumonia, hepatitis B, and influenza virus vaccines.

Connecticut

G0008	20.77
G0009	20.77
G0010	20.77

Florida

Code	Loc 01/02	Loc 03	Loc 04
G0008	17.90	18.70	19.59
G0009	17.90	18.70	19.59
G0010	17.90	18.70	19.59

Source: Publication 100-20, Transmittal 207, Change Request 4313

HCPCS Procedures J7317, J7318 and J7320

The January 2006 *Medicare B Update!* Special Issue indicates HCPCS J7317 and J7320 as discontinued procedure codes (page 10) for 2006. Additionally this publication referenced HCPCS J7318 as a new code for 2006 (page 6). This information is incorrect; procedures J7317 and J7320 are will remain active codes and J7318 was not activated as a new code for 2006.

Reminder: To determine the appropriate procedure code for services rendered, please refer to your current CPT/HCPCS coding manuals. Using an inappropriate code can result in underpayment/overpayments and subsequent requests for refunds.

We apologize for any inconvenience this may have caused.

Payment for HCPCS G0332

This information was previously published in the Second Quarter 2006 Medicare B Update! page 30.

Medicare will make separate payment for pre-administration related services associated with IVIG (G0332) rendered on the same date of service as the IVIG drug (J1566 - J1567) and a drug administration service.

Procedure G0332 must be billed on the same claim form as the corresponding drug (J1566 and/or J1567). If procedure G0332 is not billed on the same claim for the same date as the corresponding drug code or more than once per day and a drug administration service, code G0332 will be returned as unprocessable.

Source: Publication 100-04, Transmittal 812, Change Request 4244

FEE SCHEDULE/MPFSDB

New 2006 Payment Rate for Services Paid Under the Medicare Physician Fee Schedule

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, regional home health intermediaries (RHHIs), and/or fiscal intermediaries (FIs)) for services paid under the Medicare Physician Fee Schedule (MPFS) provided to Medicare beneficiaries

Important Points to Remember

- This article is based on Change Request (CR) 4313, which states that Congress has amended the physician update from a negative 4.4 percent (- 4.4%) update to a zero-percent (0%) update for services provided on or after January 1, 2006, and paid under the MPFS.
- Within two days of the enactment of the new legislation, Medicare contractors (i.e., carriers, FIs, and RHHIs) will begin to automatically reprocess those claims paid at the -4.4% update.
- New MPFS fees will be posted on the carrier sites as soon as possible after the President signs the bill. Your carrier may charge a reasonable fee for mailing a hardcopy version of the MPFS if you choose not to access the MPFS via the Internet.
- The Centers for Medicare & Medicaid Services (CMS) will create another participation enrollment period that will begin after the President signs the bill and the enrollment period will run for 45 days.

Background

Congress has passed the Deficit Reduction Act (DRA) of 2005, which, among other things, changes the update to the 2006 conversion factor for services paid under the MPFS. The DRA replaces the previously announced -4.4 percent reduction with a zero-percent increase for services paid under the MPFS. The change is effective retroactive for service on or after January 1, 2006.

Because of the change in the 2006 MPFS rates, CMS will create another participation enrollment period that will run for 45 days. More specific information concerning a second participation enrollment period will be appear in a forthcoming CR and related *Medlearn Matters* article.

This CR only addresses the change in payment rates related to the new zero-percent update to the conversion factor and reprocessing of claims that were paid using the -4.4 percent update rates.

Claims processed with the -4.4 percent rates will be reprocessed with the new rates and adjustments will be made. Medicare contractors will complete the necessary adjustments no later than July 1, 2006. In the event your claims are not adjusted by your carrier/FI/RHHI, contact them to bring the issue to their attention and they will make the adjustments.

Note: Services not paid under the MPFS, i.e., DME, Lab, ambulance etc., are not affected by CR 4313.

Implementation

Medicare carriers and intermediaries will have two business days from the date of enactment of the DRA to begin to process claims using the new fees as well as to begin reprocessing claims using those new fees.

Additional Information

The official instructions issued to your Intermediary or Carrier regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R207OTN.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4313
Related CR Release Date: February 1, 2006
Related CR Transmittal #: R207OTN
Related Change Request (CR) #: 4313
Effective Date: January 1, 2006
Implementation Date: See "Implementation" section of article.

April 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, suppliers, and providers billing Medicare carriers, and/or fiscal intermediaries (FIs) for services paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 4399, which informs your carrier/intermediary that payment files were issued to carriers based upon the November 21, 2005, Medicare Physician Fee Schedule Final Rule. CR 4399 amends those payment files and includes new G-codes for the Low Vision Rehabilitation Demonstration Project and new Category II codes *3046F* through *3050F* and *3076F* through *3080F*.

Background

The Social Security Act (Section 1848(c)(4); *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*), authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services. CMS issued payment files to carriers/intermediaries based upon the November 21, 2005, MPFS Final Rule.

Note: CR 4399 amends those payment files and includes new G-codes for the Low Vision Rehabilitation Demonstration Project and new Category II codes *3046F* through *3050F* and *3076F* through *3080F*.

In the October 2005 update to the Medicare Physician Fee Schedule Database (MPFSDB) the multiple procedure indicators were inadvertently changed from a "0" to a "2" for CPT codes *20931*, *20937*, and *20938*. The emergency update to the 2006 MPFSDB reinstated the multiple procedure indicators for these codes to a "0" effective January 1, 2006. Also, in the October 2005 update to the MPFSDB, the bilateral surgical indicators were inadvertently changed from "1" to "0" for *CPT* codes *63035*, *63043*, *63044*, *64480*, and *64484*. This CR reinstates the bilateral surgical indicators for these codes to a "1" effective January 1, 2006.

Your carrier will not search their files for claims paid incorrectly from October 1, 2005, through December 31, 2005, but will adjust claims brought to their attention.

In addition, your carrier will manually adjust their systems and the 2005 MPFSDB to reflect a multiple procedure indicator of a "0" for CPT codes *20931*, *20937*, and *20938* and a bilateral surgical indicator of a "1" for *CPT* codes *63035*, *63043*, *63044*, *64480*, and 64484.

CR 4399 instructs that:

- Your carrier/intermediary should reinstate the bilateral surgical indicators for codes *63035*, *63043*, *63044*, *64480*, and *64484* to a "1" effective January 1, 2006.
- For services performed on or after March 17, 2005, Medicare will not pay for carotid artery stenting (CAS) with embolic protection claims that have procedure code *37216* (Transcatheter placement of intravascular stent(s) without distal embolic protection).
- *CPT* code *43842* (Gastric restrictive procedure, without gastric bypass, for morbid obesity, vertical banded gastroplasty) is non-covered for Medicare effective for services on or after February 21, 2006.
- Your carrier/intermediary should manually update the HCPCS file to reflect a coverage indicator of "C" for category II codes *0001F* through *4018F*.
- The descriptors for Category II modifiers 1P and 2P have been modified, effective for dates of service on or after January, 1, 2006, as follows:
- 1P – Performance Measure Exclusion Modifier due to Medical Reasons
- 2P – Performance Measure Exclusion Modifier due to Patient Reasons
- Effective for dates of service on or after April 1, 2006, the Category II modifier 3P (Performance Measure Exclusion

Modifier due to System Reasons) is recognized. Those system reasons include resources to perform the services were unavailable, insurance coverage/payer-related limitations, and other reasons attributable to the health care delivery system.

Note: Your carrier/intermediary will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, your carrier/intermediary will adjust claims brought to their attention.

Unless otherwise stated in CR4399, changes are retroactive to January 1, 2006.

Implementation

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

Additional Information

Other changes included in the April update of the MPFS are attached to CR4399.

To see that official instruction issued to your carrier/intermediary, go to *http://www.cms.hhs.gov/Transmittals/downloads/R897CP.pdf* on the CMS website.

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

MLN Matters Number: MM4399 Related Change Request (CR) #:4399
Related CR Release Date: March 29, 2006 Effective Date: January 1, 2006
Related CR Transmittal #: R897CP Implementation Date: April 3, 2006

Revision to the 2006 Medicare Physician Fee Schedule–Florida only

The Centers for Medicare & Medicaid Services (CMS) has released a revised Medicare physician fee schedule (MPFS) file for 2006. The Medicare claim-processing systems have been updated with the 2006 revised MPFS file. As of February 10, 2006, First Coast Service Options, Inc. (FCSO) is processing and releasing all affected claims for services provided on or after January 1, 2006, based on the revised fee schedules.

FCSO began to mass adjust previously processed claims on April 19, 2006. All adjustments are scheduled for completion by July 1, 2006. .

No Action Required by Providers at This Time

Providers do not need to take action at this time. FCSO is requesting that providers do not submit appeal or reopening requests, and to refrain from calling the customer services lines in regards to the additional payment of claims that have been affected by this issue. Since the adjustments will be performed systematically, requesting appeals, reopenings and or telephone inquiries will not expedite payments and will result in increased appeal/inquiry backlogs.

FCSO, on behalf of CMS, apologize for any inconvenience this may cause.

Source: Joint Signature Memorandum (JSM) 06280 dated February 8, 2006.

2006 Anesthesia Conversion Factors

The anesthesia conversion factors published on page 8 of the Revised 2006 Medicare Part B Physician and Nonphysician Practitioner Fee Schedule book are incorrect. The correct conversion factors are:

Connecticut

Participants	18.54
Nonparticipants	17.61

Florida

LOCALITY	PARTICIPATING PHYSICIAN	NONPARTICIPATING PHYSICIAN
01/02	18.03	17.13
03	18.82	17.88
04	19.82	18.83

Source: Publication 100-20, Transmittal 207, Change Request 4313

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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 Florida 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.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.

Understanding the Revised 2006 Medicare Physician Fee Schedule

Although Change Request (CR) 4313 indicates that the Medicare Physician Fee Schedule (MPFS) has been revised from a –4.4 percent increase to a 0.0 percent increase for the conversion factor, other factors included in the calculation of the MPFS allowed amount may have increased or decreased. These factor changes will affect the final result of the calculation. Therefore, the MPFS allowed amounts for 2006 may have been increased or decreased as well.

To help our provider community better understand the total calculation involved, the following information is being provided.

MPFS Calculation Method

The information that follows is designed to assist you in understanding how the MPFS is calculated. For the majority of physician services, this calculation is performed by and provided to carriers by the Centers for Medicare & Medicaid Services (CMS). The elements used to calculate the fee schedule amounts are as follows:

- **Resource Based Relative Value Units (RBRVU):** This factor takes into consideration the physician work required for the service, practice expenses, and the malpractice insurance premium. RBRVUs are established at a national level and do not vary among Medicare carriers.
- **Geographic Practice Cost Index (GPCI):** This factor represents the variations in practice costs, which exist in different geographic areas. For MPFS purposes, Connecticut comprises a single geographical area (locality); Florida is comprised of three geographical areas. The GPCI is established for each RBRVU component (work, overhead, and malpractice) in each pricing locality for a given state.
- **Conversion Factor (CF):** This factor is a single number set at a national level and is used by all carriers in calculating the final fee schedule amounts. ***This is the factor that was originally –4.4 percent and was changed to 0.00 percent increase.***

For each fee schedule service, there are three RBRVUs:

- A relative value for physician work (RVUw),
- A relative value for practice expense (RVUpe),
- A relative value for malpractice (RVUm).

Note: For certain services, there are different practice expense RVUs depending on the place of service– facility or non-facility.

For each payment locality, there are three GPCIs:

- A GPCI for physician work (GPCIw),
- A GPCI for practice expense (GPCIpe), and
- A GPCI for malpractice (GPCIm).

The formula for calculating the payment allowance for a given service under the fee schedule is:

Fee Schedule Amount = [(RVUw x GPCIw) + (RVUpe x GPCIpe) + (RVUm x GPCIm)] x CF

The RBRVUs, GPCIs, and the conversion factor are published in a Final Rule in the *Federal Register*, generally on or near November 1 of each year. These calculations *do not* take into account any reductions based on fee schedule payment policies (e.g., pre- post- and intraoperative percentages, professional and technical components, multiple surgery, bilateral surgery, assistant-at-surgery, co-surgery, team surgery, or facility pricing rules). Information regarding fee schedule payment policies may be found at *http://cms.hhs.gov/physicians/mpfsapp/step0.asp*.

Source: Publication 100-04, Chapter 23, Section 30

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *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.

PATHOLOGY

Repeat Tests for Automated Multi-Channel Chemistries for End Stage Renal Disease Beneficiaries

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services provided to Medicare ESRD beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4101 provides details regarding the payment policy for End Stage Renal Disease (ESRD)-related automated multi-channel chemistry (AMCC) tests (i.e., the ESRD 50/50 rule), and clarifies a coding issue concerning repeat tests using the current procedure terminology (CPT) modifier 91.

CAUTION – What You Need to Know

Clinical diagnostic laboratory tests ordered by an ESRD facility must follow accepted CPT guidelines. Specifically, **modifier 91 must be used on any subsequent service** being billed if 1) any single service (same CPT code) is ordered (for the same beneficiary), and 2) the specimen is collected more than once in a single day, and the service is medically necessary. Also, any line item on a claim with a modifier 91 will be included into the calculation of the 50/50 rule, and after the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.

GO – What You Need to Do

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

Background

ESRD 50/50 Rule

The Centers for Medicare & Medicaid Services (CMS) previously issued instructions to Medicare carriers regarding procedures to enforce compliance with the payment policy for End Stage Renal Disease (ESRD)-related automated multi-channel chemistry (AMCC) tests (i.e., the ESRD 50/50 rule). The ESRD 50/50 rule requires a count of AMCC tests ordered to capture:

- The number of tests included in the composite payment rate paid to the ESRD facility; or
- The monthly capitation payment made to the furnishing physician; ***Versus***
- The number of covered non-composite tests performed for the same beneficiary, on the same date of service.

The proportion of the composite payment rate tests **versus** the number of covered non-composite tests calculated by the billing laboratory is used to determine whether separate payment may be made for all tests performed on that day.

In CR 2813, CMS directed Medicare carriers to make the necessary systems changes to implement front-end edits in preparation for the standard system implementation of CR 2813 in the January 2005 release.

Note: The carrier standard system changes needed to implement the new ESRD 50/50 rule compliance guidelines were partially implemented in the October 2004 release. Intermediary billing guidelines for ESRD 50/50 rule compliance have been in effect since October 2003.

CR 2813 also directed the carriers not to post any information concerning the business requirements associated with the implementation of CR 2813 until receiving further guidance from CMS.

Business Requirements Relating to Modifier 91

In June 2005, CMS issued CR 3890, which required the implementation of the ESRD 50/50 rule for Carriers, effective January 2006. During the preparation for implementation, the provider community commented that business requirements relating to the use of modifier 91 (Repeat Clinical Diagnostic Laboratory Test) were ***inconsistent*** with Current Procedural Terminology (CPT) procedures. CMS is adjusting the business requirements for proper use of modifier 91.

A Medlearn Matters article, MM3890, is available for CR 3890 at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3890.pdf* on the CMS website.

Therefore, CR 4101 directs that clinical diagnostic laboratory tests ordered by an ESRD facility must follow accepted CPT guidelines. Specifically, **modifier 91 must be used on any subsequent service** being billed if:

- Any single service (same CPT code) is ordered (for the same beneficiary); and
- The specimen is collected more than once in a single day; and
- The service is medically necessary.

In addition, when using CPT modifier 91, it must be used without regard to whether it is a:

- Composite rate test (healthcare common procedure coding system (HCPCS) modifier CD);
- Composite rate test beyond the normal frequency (HCPCS modifier CE); or

- Non-composite rate test (HCPCS modifier CF).

Note: Any claim with a modifier 91 will be included into the calculation of the 50/50 rule, and after the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.

Implementation

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

Additional Information

For complete details regarding CR 4101, please see the official instruction issued to your carrier or intermediary regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R733CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4101 Related Change Request (CR) #: 4101
Related CR Release Date: October 28, 2005 Effective Date: January 1, 2006
Related CR Transmittal #: R733CP Implementation Date: April 3, 2006

HCPCS Subject to, and Excluded from Clinical Laboratory Improvement Amendments Edits

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

Provider Types Affected

Providers and clinical laboratories that submit claims to Medicare carriers for CLIA-related services

Key Points

The HCPCS codes that are considered laboratory tests under CLIA are subject to change each year. Effective January 1, 2006, there are new HCPCS codes, including modifiers, for 2006 that are either subject to CLIA edits or excluded from CLIA edits.

HCPCS codes subject to or excluded from CLIA edits are described in Change Request (CR) 4321 and in the attachments to that CR which revise the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 16, Laboratory Services.

The new 2006 HCPCS codes are listed in Table 1, Appendix A, of this article.

Please note that this list **does not** include new HCPCS codes for waived tests or provider-performed procedures.

These HCPCS codes are subject to CLIA edits, therefore a CLIA number must be submitted on claims by facilities for these HCPCS codes. The HCPCS codes listed in the Table 1 **require a facility to have** either:

- A CLIA certificate of registration (certificate type code 9);
- A CLIA certificate of compliance (certificate type code 1); **or**
- A CLIA certificate of accreditation (certificate type code 3).

Facilities will not be permitted to bill for the tests listed in Table 1, Appendix A, of this article:

- If they **do not have** a valid, current, CLIA certificate;
- If they **have** a current CLIA certificate of waiver (certificate type code 2); or
- If they **have** a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4).

Effective January 19, 1993, a laboratory that holds a certificate for provider-performed microscopy procedures may perform only those tests specified as provider-performed microscopy procedures and waived tests, and no others. The provider-performed microscopy procedures are described in Table 2, Appendix A of this article.

The following new HCPCS codes for 2006 in the 80000 series are excluded from CLIA edits and **do not require** a facility to have any CLIA certificate:

- *86923* - Compatibility test each unit; electronic;
- *86960* - Volume reduction of blood or blood products (e.g., red blood cells or platelets), each unit; and
- *87900* - Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics.

Relevant Links

For a complete list of the specific HCPCS codes subject to CLIA edits please refer to *http://www.cms.hhs.gov/CLIA/downloads/Subject.to.CLIA.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

For a complete list of the specific HCPCS codes in the 80000 series that are excluded from CLIA edits please refer to *http://www.cms.hhs.gov/CLIA/downloads/cpt4exc.pdf* on the CMS website.

CR 4321 is the official instruction issued to your carrier regarding changes mentioned in this article, MM4321. CR 4321 may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R865CP.pdf* on the CMS website.

Please refer to your local carrier if you have questions about this issue. To find the toll free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

Appendix A

The HCPCS codes listed in the chart below are new for 2006 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. Effective January 1, 2006, the HCPCS codes listed below require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3).

Table 1: 2006 HCPCS Codes Subject to CLIA Edits

Code/Modifier	Description
0103T	*Holotranscobalamin, quantitative*
0111T	*Long-chain (C20 – 22) omega-3 fatty acids in red blood cell (RBC) membranes*
80195	*Sirolimus*
82271	*Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; other sources*
83631	*Lactoferrin, fecal; quantitative*
83695	*Lipoprotein (a)*
83700	*Lipoprotein, blood; electrophoretic separation and quantitation*
83701	*Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (e.g., electrophoresis, ultracentrifugation)*
83704	*Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (e.g., by nuclear magnetic resonance spectroscopy)*
83900	*Molecular diagnostics; amplification of patient nucleic acid, multiplex, first two nucleic acid sequences*
83907	*Molecular diagnostics; lysis of cells prior to nucleic acid extraction (e.g., stool specimens, paraffin embedded tissue)*
83908	*Molecular diagnostics; signal amplification of patient nucleic acid, each nucleic acid sequence*
83909	*Molecular diagnostics; separation and indentification by high resolution technique (e.g., capillary electrophoresis)*
83914	*Mutation identification by enzymatic ligation or primer extension, single segment, each segment (eg, oligonucleotide ligation assay (OLA), single base chain extension (SBCE), or allele-specific primer extension (ASPE))*
86200	*Cyclic citrullinated peptide (CCP), antibody*
86355	*B cells, total count*
86357	*Natural killer (NK) cells, total count*
86367	*Stem cells (i.e., CD34), total count*
86480	*Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response*
87209	*Smear, primary source with interpretation; complex special stain (e.g., trichrome, iron hemotoxylin) for ova and parasites*
88333	*Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site*
88333 TC	*Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), initial site*
88333 26	*Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), initial site*
88334	*Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site*
88334 TC	*Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), each additional site*
88334 26	*Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), each additional site*
88384	*Array-based evaluation of multiple molecular probes; 11 through 50 probes*
88384 TC	*Array-based evaluation of multiple molecular probes; 11 through 50 probes*
88384 26	*Array-based evaluation of multiple molecular probes; 11 through 50 probes*
88385	*Array-based evaluation of multiple molecular probes; 51 through 250 probes*
88385 TC	*Array-based evaluation of multiple molecular probes; 51 through 250 probes*
88385 26	*Array-based evaluation of multiple molecular probes; 51 through 250 probes*
88386	*Array-based evaluation of multiple molecular probes; 251 through 500 probes*
88386 TC	*Array-based evaluation of multiple molecular probes; 251 through 500 probes*
88386 26	*Array-based evaluation of multiple molecular probes; 251 through 500 probes*
89049	*Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report*

Effective January 19, 1993, a laboratory that holds a certificate for provider-performed microscopy procedures may perform only waived tests and those tests specified as provider-performed microscopy procedures in the following table, and no others.

Table 2: Provider-Performed Microscopy Procedures

Code	Description
Q0111	Wet mounts, including preparations of vaginal, cervical, or skin specimens
Q0112	All potassium hydroxide (KOH) preparations
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous
81015	*Urinalysis; microscopic only*
81000	*Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy*
81001	*Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy* (**NOTE**: May only be used when the lab is using an automated dipstick urinalysis instrument approved as waived.)
81020	*Urinalysis; two or three glass test*
89055	*Fecal leukocyte examination*
89190	*Nasal smears for eosinophils*
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner

Medlearn Matters Number: MM4321 Related Change Request (CR) #: 4321
Related CR Release Date: February 17, 2006 Effective Date: January 1, 2006
Related CR Transmittal #: R865CP Implementation Date: July 3, 2006

Changes to the Laboratory National Coverage Determination Edit Software for April 2006

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for clinical diagnostic laboratory services.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4328, which announces the implementation of changes to the list of codes associated with the 23 negotiated laboratory NCDs, and the update of the laboratory edit module for changes in the laboratory NCD code lists for April 2006.

CAUTION – What You Need to Know

The changes to the list of codes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs. Several of the listed changes correct codes to reflect the recent Current Procedural Terminology (CPT) update and are necessary so that the laboratory edit module will appropriately process claims using the most current negotiated laboratory NCDs and code lists.

GO – What You Need to Do

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

Background

In accordance with the Balanced Budget Act of 1997 (Section 4554), the Centers for Medicare & Medicaid Services (CMS) entered into negotiated rulemaking proceedings to develop national coverage determinations (NCDs) for clinical diagnostic laboratory services. Under the negotiations, CMS developed 23 laboratory NCDs, and these NCDs are different than most other Medicare NCDs in that they include lists of ICD-9-CM codes. All codes are included on one of the following lists:

- Covered codes;
- Not covered codes; and
- Codes that do not support medical necessity.

The NCDs were published under the Administrative Procedures Act in the Federal Register of November 23, 2001 (*http://www.access.gpo.gov/su_docs/fedreg/a011123c.html*), and the list of 23 laboratory NCDs is included in the *Additional Information* section of this article. In addition, the CMS website for laboratory NCDs can be found at *http://www.cms.hhs.gov/CoverageGenInfo/05_LabNCDs.asp* on the CMS website.

Nationally uniform software was developed by Computer Sciences Corporation (CSC) and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs are processed uniformly throughout the nation effective January 1, 2003. The laboratory edit module for the NCDs is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

(See the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 16, Section 120.2, at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS web site.)

CMS updates the NCD code list quarterly as necessary to incorporate new codes, correct ministerial errors, incorporate the results of Coding Analysis published elsewhere on this site, and incorporate reconsideration of the NCDs that alter covered indications. The quarterly updates are published in the NCD Coding Policy Manual, and you can download the current and previous coding manuals from this site. Alternatively, you can access individual NCDs from the lab index included on the following CMS website: *http://www.cms.hhs.gov/mcd/index_section.asp?ncd_sections=40*

Change Request (CR) 4238 announces the changes that will be included in the April 2006 release of the edit module for clinical diagnostic laboratory services.

The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs. Several of the listed changes correct codes to reflect the current CPT update. CR 4238 communicates requirements to the laboratory edit module to update it for the following changes in laboratory NCD code lists for April 2006:

Blood Count NCD

Add the following ICD-9-CM code to the list of **codes that do not support medical necessity** for the Blood Count NCD:

Add ICD-9-CM Code Descriptor
V76.51 Special screening for malignant neoplasms, colon

ICD-9-CM Codes Never Covered by Medicare

Delete the following ICD-9-CM code from the list of ICD-9-CM **codes never covered** by Medicare:

Delete ICD-9-CM Code Descriptor
V76.51 Special screening for malignant neoplasms, colon

Fecal Occult Blood Test NCD

Add the following new CPT code to the list of HCPCS/CPT codes covered by Medicare for Fecal Occult Blood Test NCD:

Add CPT Codes Descriptor
82272 Blood occult peroxidase

Delete the following CPT code from the HCPCS/CPT code list for Fecal Occult Blood Test NCD:

Delete CPT Code Descriptor
82270 Fecal occult blood

Hepatitis Panel/Acute Hepatitis Panel NCD

Add the following ICD-9-CM code to the list of ICD-9-CM codes covered by Medicare for Hepatitis Panel/Acute Hepatitis Panel NCD:

Add ICD-9-CM Code Descriptor
790.4 Nonspecific Elevation of Levels of Transaminase or Lactic Acid Dehydrogenase

Lipids Testing NCD

Add the following new CPT codes to the list of HCPCS/CPT codes covered by Medicare for Lipids Testing NCD:

Add CPT Codes Descriptor
83700 Lipoprotein bld, electrophoretic
83701 Lipoprotein bld, hr fraction

Delete the following CPT codes from the HCPCS/CPT code list for Lipids Testing NCD:

Delete CPT Codes Descriptor
83715 Lipoprotein, blood: electrophoretic separation and quantitation
83716 High resolution fractionation and quantitation of lipoprotein cholesterols

Urine Culture, Bacterial NCD

Delete Coding Guideline 1 in the Urine Culture, Bacterial NCD, and renumber the remaining Coding Guidelines.

Note: Changes included in the April 2006 release of the edit module for clinical diagnostic laboratory services become effective for services furnished on or after April 1, 2006.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R864CP.pdf* on the CMS web site.

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

The following table includes the list of all twenty-three (23) Laboratory National Coverage Determinations, and each NCD can be reviewed at *http://www.cms.hhs.gov/mcd/index_section.asp?ncd_sections=40* on the CMS website.

Laboratory National Coverage Determination (NCD)

Alpha-fetoprotein (AFP) (190.25)
Blood Counts (190.15)
Blood Glucose Testing (190.20)
Carcinoembryonic Antigen (CEA) (190.26)
Collagen Crosslinks, any Method (190.19)
Digoxin Therapeutic Drug Assay (190.24)
Fecal Occult Blood Test (FOBT) (190.34)
Gamma Glutamyl Transferase (GGT) (190.32)
Glycated Hemoglobin/Glycated Protein (190.21)
Hepatitis Panel/Acute Hepatitis Panel (190.33)
Human Chorionic Gonadotropin (hCG) (190.27)
Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (190.14)
Human Immunodeficiency Virus (HIV) Testing (Prognosis Including Monitoring) (190.13)
Lipid Testing (190.23)
Partial Thromboplastin Time (PTT) (190.16)
Prostate Specific Antigen (PSA) (190.31)
Prothrombin Time (PT) (190.17)
Serum Iron Studies (190.18)
Thyroid Testing (190.22)
Tumor Antigen by Immunoassay - CA 125 (190.28)
Tumor Antigen by Immunoassay - CA 15-3/CA 27.29 (190.29)
Tumor Antigen by Immunoassay - CA 19-9 (190.30)
Urine Culture, Bacterial (190.12)

Medlearn Matters Number: MM4328
Related CR Release Date: February 17, 2006
Related CR Transmittal #: R864CP
Related Change Request (CR) #: 4328
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

PREVENTIVE SERVICES

Colorectal Cancer: Preventable, Treatable, and Beatable: Medicare Coverage and Billing for Colorectal Cancer Screening

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

Provider Types Affected

Physicians, nurse practitioners, physician assistants, clinical nurse specialists, outpatient hospital departments, community surgical centers

Provider Action Needed

STOP – Impact to You

March is National Colorectal Cancer Awareness Month. The Centers for Medicare & Medicaid Services (CMS) would like to remind providers to encourage their eligible Medicare patients ages 50 and older to get screened for colorectal cancer. This MLN Matters Special Edition issue reviews Medicare coverage and billing processes for colorectal cancer screening.

CAUTION – What You Need to Know

Medicare has covered colorectal cancer screening since 1998, but the benefit is underused. Claims data from 1998-2002 indicate that less than half of Medicare beneficiaries had any screening test during this five-year period, and less than one-third were tested according to recommended intervals.

GO – What You Need to Do

Encourage your patients to be screened, appropriately bill Medicare for the screening test you provide, and follow up with patients, as needed.

Background

Colorectal cancer is the second leading cause of cancer death in the United States and the third most common type of cancer. In 2005, colorectal cancer was expected to account for 56,290 deaths and 145,290 new cases. Colorectal cancer primarily affects men and women ages 50 and older, and risk increases with age. If detected early, colorectal cancer can be treated and cured.

In January 1998, Medicare began covering colorectal cancer screening. The data currently available (1998 - 2002) indicates that the colorectal cancer screening benefit is underused. Less than half of enrollees had any colorectal cancer test during the five-year period and less than one-third were tested according to recommended intervals.

The U.S. Preventive Services Task Force (USPSTF) evaluates the clinical merits of preventive measures, and strongly recommends ("A" rating) that clinicians screen men and women ages 50 and older for colorectal cancer. The choice of screening strategy should be based on patient preferences, medical contraindications, patient adherence, and resources for testing and follow-up. To read the full recommendation, go to the following link: *http://www.ahrq.gov/clinic/uspstf/uspscolo.htm.*

The Partnership for Prevention conducted a systematic assessment of the clinical preventive services recommended by the USPSTF to help decision-makers identify those services that provide the most value based on two criteria—burden of disease prevented and cost-effectiveness. Screening adults for colorectal cancer screening was among the services considered to be of the greatest value.

Colorectal Cancer Screening Methods

There are a variety of methods available for colorectal cancer screening, including fecal occult blood testing, flexible sigmoidoscopy, colonoscopy, and screening barium enema. It is important that practitioners follow the practice guidelines for screening and follow-up.

Two studies published in January 2005 in the *Annals of Internal Medicine* suggest that the office-based single sample screening fecal occult blood test is of limited value, and that many physicians are not following practice guidelines for screening and follow-up. Click on the following link for information on colorectal cancer detection and American Cancer Society screening recommendations and guidelines: *http://www.cancer.org/docroot/CRI/content/CRI_2_6X_Colorectal_Cancer_Early_Detection_10.asp?sitearea=&level.*

Coverage

Medicare covers the following colorectal cancer screening tests and procedures:

Fecal Occult Blood Test (FOBT)

Medicare covers one FOBT annually for beneficiaries 50 and older. A written order from the beneficiary's attending physician is required. Medicare will pay for an immunoassay-based FOBT as an alternative to the guaiac-based FOBT, but will only pay for one FOBT, not both, per year.

Beneficiaries do not have to pay coinsurance for the FOBT, and don't have to meet the annual Medicare Part B deductible.

Screening Flexible Sigmoidoscopy

Medicare covers a screening flexible sigmoidoscopy once every four years for beneficiaries 50 and older. If a beneficiary had a screening colonoscopy in the previous 10 years, then the next screening flexible sigmoidoscopy would be covered only after 119 months have passed following the month in which the last screening colonoscopy was performed. A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist may perform a screening flexible sigmoidoscopy.

Screening Colonoscopy

Medicare coverage for a screening colonoscopy is based on beneficiary risk.

- For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every 10 years, but not within 47 months of a previous screening flexible sigmoidoscopy.
- For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every two years, regardless of age.

A screening colonoscopy must be ordered and provided by a doctor of medicine or osteopathy.

Screening Barium Enema

Medicare covers a screening barium enema as an alternative to a screening flexible sigmoidoscopy or a screening colonoscopy.

- For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening barium enema every four years.
- For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers one screening barium enema every two years regardless of age.

A screening barium enema must be ordered in writing and provided by a doctor of medicine or osteopathy once it is determined that it is the appropriate screening method for a beneficiary. A double contrast barium enema is preferable, but the physician may order a single contrast barium enema if it is more appropriate for the beneficiary.

The beneficiary is liable for paying 20% of the Medicare-approved amount (the coinsurance) for screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema after meeting the annual Medicare Part B deductible.

For a screening flexible sigmoidoscopy or a screening colonoscopy performed in a hospital outpatient department, the beneficiary is liable for paying the Medicare-approved amount (the coinsurance) after meeting the annual Medicare Part B deductible.

Beneficiaries are considered to be at high risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer;
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

How to Bill Medicare

The following Healthcare Common Procedure Coding System (HCPCS) codes should be used to bill for colorectal cancer screening:

HCPCS Code

HCPCS Code	Descriptor
G0104	Colon cancer screening; flexible sigmoidoscopy
G0105*	Colon cancer screening; colonoscopy on individual at high risk
G0106	Colon cancer screening; barium enema as an alternative to G0104
G0107	Colon cancer screening; FOBT, 1-3 simultaneous determinations
G0120	Colon cancer screening; barium enema as an alternative to G0105
G0121	Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk

G0122** Colon cancer screening; barium enema (non-covered)
G0328 Colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations

* When billing for the "high risk" beneficiary, the screening diagnosis code on the claim must reflect at least one of the high risk conditions mentioned previously. Examples of diagnostic codes are in the colorectal cancer screening chapter (page 81) of the Guide to Preventive Services. This guide is available at *http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf* on the CMS website.

Code G0122 should be used when a screening barium enema is performed **not as an alternative to either to G0104 or G0105. This service is denied as non-covered because it fails to meet the requirements of the benefit. **The beneficiary is liable for payment.** Reporting of this noncovered code will also allow claims to be billed and denied for beneficiaries who need a Medicare denial for other insurance purposes.

If billing Medicare carriers, the appropriate HCPCS and corresponding diagnosis codes must be provided on Form CMS-1500 (or the HIPAA 837 Professional electronic claim record).

If billing Medicare intermediaries, the appropriate HCPCS, revenue, and corresponding diagnosis codes must be provided on Form CMS-1450 (or the HIPAA Institutional electronic claim record). Information on the type of bill and associated revenue code is also provided in the colorectal cancer-screening chapter (page 82) of the Guide to Preventive Services. This guide is available at: *http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf* on the CMS website. Reimbursement information is also provided in this guide.

Other Helpful Information

CMS has developed a comprehensive prevention website that provides information and resources for all Medicare preventive benefits. The following link is to the colorectal cancer screening section, and includes website links to information and resources developed by other organizations interested in promoting colorectal cancer screening, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American Cancer Society: *http://www.cms.hhs.gov/ColorectalCancerScreening/*.

Also, visit the Medicare Learning Network (MLN) website at *http://www.cms.hhs.gov/MLN/* to access the *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* as well as other educational resources designed for health care professionals to promote and increase national awareness of Medicare-covered preventive services. Once on the MLN site, scroll to the bottom of the page and click on Products, then click on Preventive Services.

MLN Matters Number: SE0613	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

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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 Florida 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.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.

RADIOLOGY

Billing Requirements for Positron Emission Tomography Scans for Dementia and Neurodegenerative Diseases

CMS has issued the following "MLN Matters... Information for Medicare Providers" article.
This information was previously published in the Third Quarter 2005 Medicare B Update! pages 82-83.

IMPORTANT NOTE: This article has been revised to include web addresses consistent with the new CMS website. Previously, this article was revised on April 22, 2005, to show that Change Request (CR) 3426 was revised by CR 3640 (Transmittal 428, dated January 14, 2005). CR 3640 revised billing requirements in CR 3426 for PET Scans for Alzheimer's Disease (AD) by 1) removing the edit for one scan per beneficiary's lifetime for PET AD Scans, and 2) adding requirements for specifying ICD-9 diagnosis coding. In addition, Section 60.1 of the *Medicare Claims Processing Manual* (Publication 100-04) was updated to include specific payment information for claims for all PET Scans for services submitted by Critical Access Hospitals (CAHs). To see CR 3640, go to *http://www.cms.hhs.gov/Transmittals/downloads/R428CP.pdf* on the CMS website. Also, the MLN Matters article related to CR 3640 is located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3640.pdf* on the CMS website.

Provider Types Affected

Physicians and providers

Provider Action Needed

This instruction notifies physicians and providers that Medicare will provide coverage for 2-deoxy-2- [F-18] fluoro-D-glucose (FDG)-PET scans for beneficiaries with a recent diagnosis of dementia and documented cognitive decline of at least 6 months duration. This service may be covered:

- When the patient meets diagnostic criteria for both fronto-temporal dementia (FTD) and Alzheimer's disease (AD) under specific requirements; **or**
- For use in a Centers for Medicare & Medicaid Services (CMS)-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

Background

Effective for dates of service on or after September 15, 2004, Medicare will provide coverage for FDG Positron Emission Tomography PET for one of the following:

- When the patient meets diagnostic criteria for both fronto-temporal dementia (FTD) and Alzheimer's disease; **or**
- When used in a CMS-approved practical neurodegenerative disease clinical trial.

Clinical trial results are expected to help in determining if PET scans contribute to the effective diagnosis and treatment of Medicare beneficiaries with mild cognitive impairment or early dementia, and add information that will help monitor, evaluate, and improve clinical outcomes of patients with this disease.

Refer to the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 13, Section 60, for general Medicare coverage and billing requirements for PET scans for dementia and neurodegenerative diseases.

Also, refer to the *Medicare National Coverage Determinations* (NCD) *Manual*, Publication 100-03, Section 220.6 for complete coverage policy and clinical trial requirements. The revision to the *NCD Manual*, Section 220.6 is an NCD. NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans.

Under 42 Code of Federal Regulations (CFR) 422.256(b), an NCD that expands coverage is also binding on Medicare Advantage Organizations. In addition, an administrative law judge may not review an NCD. (See §1869(f)(1)(A)(i) of the Social Security Act.)

Key portions of these revised manuals are as follows:

FDG-PET Requirements for Use in the Differential Diagnosis of AD and FTD

According to the NCD on this issue, Medicare covers FDG-PET scans for either a) the differential diagnosis of both FTD and Alzheimer's disease AD under specific requirements **or,** b) its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

For use in the differential diagnosis of FTD and AD, an FDG-PET scan is considered reasonable and necessary for patients with a recent diagnosis of dementia and documented cognitive decline of at least 6 months, who meet diagnostic criteria for both AD and FTD. These patients have been evaluated for specific alternative neurodegenerative diseases or causative factors, but the cause of the clinical symptoms remains uncertain.

The following additional conditions must be met before an FDG-PET scan can be ordered:

- The patient's onset, clinical presentation, or course of cognitive impairment is such that FTD is suspected as an alternative neurodegenerative cause of the cognitive decline. Specifically, symptoms such as social disinhibition, awkwardness, difficulties with language, or loss of executive function are more prominent early in the course of FTD than the memory loss typical of AD;
- The patient has had a comprehensive clinical evaluation (as defined by the American Academy of Neurology (AAN)) encompassing a medical history from the patient and a well-acquainted informant (including assessment of activities of daily living), physical and mental status examination (including formal documentation of cognitive decline occurring over at least 6 months) aided by cognitive scales or neuropsychological testing, laboratory tests, and structural imaging such as magnetic resonance imaging (MRI) or computed tomography (CT);
- The evaluation of the patient has been conducted by a physician experienced in the diagnosis and assessment of dementia;
- The evaluation of the patient did not clearly determine a specific neurodegenerative disease or other cause for the clinical symptoms, and information available through FDG-PET is reasonably expected to help clarify the diagnosis between FTD and AD and help guide future treatment;
- The FDG-PET scan is performed in a facility that has all the accreditation necessary to operate nuclear medicine equipment. The reading of the scan should be done by an expert in nuclear medicine, radiology, neurology, or psychiatry, with experience interpreting such scans in the presence of dementia;
- A brain single photon emission computed tomography (SPECT) or FDG-PET scan has not been obtained for the same indication. The indication can be considered to be different in patients who exhibit important changes in scope or severity of cognitive decline, and meet all other qualifying criteria listed above and below (including the judgment that the likely diagnosis remains uncertain).
- The results of a prior SPECT or FDG-PET scan must have been inconclusive or, in the case of SPECT, difficult to interpret due to immature or inadequate technology. In these instances, an FDG-PET scan may be covered after 1 year has passed from the time the first SPECT or FDG-PET scan was performed.
- The referring and billing provider(s) have documented the appropriate evaluation of the Medicare beneficiary. Providers should establish the medical necessity of an FDG-PET scan by ensuring that the following information has been collected and is maintained in the beneficiary medical record:
- Date of onset of symptoms;
- Diagnosis of clinical syndrome (normal aging; mild cognitive impairment or MCI; mild, moderate or severe dementia);
- Mini mental status exam (MMSE) or similar test score;
- Presumptive cause (possible, probable, uncertain AD);
- Any neuropsychological testing performed;
- Results of any structural imaging (MRI or CT) performed;
- Relevant laboratory tests (B12, thyroid hormone); and
- Number and name of prescribed medications.
- The billing provider must furnish a copy of the FDG-PET scan result for use by CMS and its contractors upon request.
- These services should be billed with HCPCS code of G0336 (Pet imaging, brain imaging for the differential diagnosis of Alzheimer's disease with aberrant features vs. FTD).

FDG-PET Requirements for Use in the Context of a CMS-Approved Neurodegenerative Disease Practical Clinical Trial Utilizing Specific Protocol

With regard to use of the FDG-PET in the context of a CMS-approved clinical trial, the clinical trial must compare patients who do and those who do not receive an FDG-PET scan and have as its goal to monitor, evaluate, and improve clinical outcomes. In addition, it must meet the following basic criteria:

- Written protocol on file;
- Institutional Review Board review and approval;
- Scientific review and approval by two or more qualified individuals who are not part of the research team; and
- Certification that investigators have not been disqualified.

Physicians should note that a **QV** modifier must be used when billing Medicare carriers for a CMS-approved neurodegenerative disease practical clinical trial. In addition, on such claims from trials that are billed to Medicare intermediaries, a second diagnosis code **(ICD-9) of V70, 7,** along with the appropriate principal diagnosis code and **HCPCS code G0336** must be entered on the CMS-1450 or its electronic equivalent. There will be a link on the *http://www.cms.hhs.gov/center/coverage.asp* website that will have a list of all the participating trial facilities once they have been selected.

Implementation

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

Additional Information

As previously mentioned, the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 13 (Radiology Services), Section 60 (Positron Emission Tomography (PET) Scans), is being updated by this instruction. It includes billing and claims processing requirements for PET Scans for beneficiaries with a recent diagnosis of dementia and documented cognitive decline of at least six months duration who meet diagnostic criteria for both FTD and AD, or its use in a CMS-approved practical clinical trial focused on the utility of FDG-PET in the diagnosis or treatment of dementing neurodegenerative diseases.

In addition, the *Medicare NCD Manual* (Publications 100-03), Chapter 1 (Coverage Determinations) Section 220 (Radiology), Subsection 6 (Positron Emission Tomography (PET)) Scans, is being updated by this instruction to include complete coverage policy and requirements for related clinical trials.

These updated manual instructions are included in the official instruction issued to your carrier/intermediary, which can be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R310CP.pdf* on the CMS website.

If you have questions, please contact your intermediary at their toll-free number, which may be found at *http://www.cms.hhs.gov/apps/contacts/* 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: MM3426 *Revised* Related Change Request (CR) #: 3426
Related CR Release Date: October 1, 2004 Effective Date: September 15, 2004
Related CR Transmittal #:24 Implementation Date: October 4, 2004

SURGERY

Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for ultrasound stimulation for nonunion fracture healing.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4085, which supplements CR 3836 - Coverage and Billing Requirements for Ultrasound Stimulation for Nonunion Fracture Healing.

CAUTION – What You Need to Know

Effective for services performed on or after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgery. Please note that there have been changes made to CR 3836 business requirements.

These changes are discussed in the *Additional Information* section of this article.

All other material and information remain the same as in the original CR 3836.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) determined that evidence is adequate to conclude that it is reasonable and necessary to use non-invasive ultrasound stimulation for the treatment of nonunion bone fractures prior to surgical intervention.

Therefore, effective for services performed on or after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgery.

Coverage and Billing for Ultrasound Stimulation for Nonunion Fracture Healing

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

Ultrasonic osteogenic stimulators are not to be used concurrently with other non-invasive osteogenic devices.

Coverage Requirements

Effective for dates of service on and after April 27, 2005, ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgical intervention. In demonstrating nonunion fractures, CMS expects a minimum of **two** sets of radiographs, obtained prior to starting treatment with the osteogenic stimulator, separated by a minimum of 90 days.

Each radiograph set must include multiple views of the fracture site, accompanied with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

For further coverage information, please refer to the Medicare *National Coverage Determinations Manual* (Pub.100-03), Chapter 1, Section 150.2, which can be found at *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf* on the CMS website.

Note: Hospitals should note that there are no covered services for ultrasonic osteogenic stimulation for which hospitals can be paid by the FI. Thus, hospitals cannot bill for ultrasonic osteogenic stimulators.

Bill Types When Billing RHHIs

When billed to RHHIs, ultrasonic osteogenic stimulators must be billed on type of bill 32X, 33X, 34X, and is payable under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

Note: Ultrasonic osteogenic stimulators must be in the patient's home health plan of care if billed on TOBs 32X or 33X.

Billing Instructions When Billing Medicare Carriers

Effective for dates of service on or after April 27, 2005, carriers will allow payment for ultrasonic osteogenic stimulators with the following current procedural terminology (CPT) code:

- ***20979*** - Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative).

Billing Instructions for Durable Medical Equipment Regional Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs)

Effective for dates of service on or after April 27, 2005:

- DMERCs and RHHIs will allow payment for ultrasonic osteogenic stimulators with the following HCPCS codes:
- **E0760** for low-intensity ultrasound (include modifier "KF"); or
- **E1399** for other ultrasound stimulation (include modifier "KF").
- RHHIs will:
- Pay for ultrasonic osteogenic stimulators only when services are submitted on type of bills (TOBs) 32X, 33X, or 34X;
- Pay HHAs on TOBs 32X, 33X, and 34X for ultrasonic osteogenic stimulators on the DMEPOS fee schedule.

Note: Medicare carriers, FIs, and RHHIs will adjust claims with dates of service on and after April 27, 2005, if brought to their attention.

Implementation

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

Additional Information

Some of the differences between CR 3836 and the new CR 4085 include the following:

- A modifier is not needed when billing code *20979* to a carrier as a result of CR 4085.
- Modifier "KF" is now to be used when billing code E0760 or code E1399 to a DMERC or RHHI.

For complete details, please see the official instruction issued to your carrier/DMERC/FI/RHHI regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R816CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4085 Related Change Request (CR) #: 4085
Related CR Release Date: January 20, 2006 Effective Date: April 27, 2005
Related CR Transmittal #: R816CP Implementation Date: April 3, 2006

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THERAPY SERVICES

Therapy Caps Exception Process

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

Provider Types Affected

Providers, physicians, and nonphysician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) under the Part B benefit for therapy services

Key Points

- Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims).

Outpatient rehabilitation services include:

- **Physical therapy –** including outpatient speech-language pathology: Combined annual limit for 2006 is $1,740; and
- **Occupational therapy –** annual limit for 2006 is $1,740.

- In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, **exceptions to therapy caps for services provided during calendar year 2006**, if these services meet certain qualifications as medically necessary services (Section 1833(g)(5) of the Social Security Act).
- The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.
- Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:
    - Meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR 4364) for exception from the therapy cap; or
    - Meet specific criteria for exception, in addition to those listed in the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.
        - Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

You may submit a request, with supporting documentation, for a specific number (not to exceed 15 future treatment days for each discipline of occupational therapy, physical therapy, and speech language pathology services) of additional therapy visits.

- Please refer to the *Additional Information* section of this article for more detailed information about the therapy caps exception process.

Background

Financial limitations on Medicare-covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997. These caps were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005.

The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to these dollar limitations of $1,740 for each cap in 2006 may be made when provision of additional therapy services is determined to be medically necessary.

Additional Information

Billing Guidelines

- **Modifier KX –** You must include modifier KX on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
- **Separate requests –** You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received **before** the cap is exceeded because the patient is liable for denied services based on caps.

- **Subsequent requests during the same episode of care –** To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of additional therapy treatment days, not to exceed 15, **each time** the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.
    - When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using t modifier KX. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

ICD-9 Codes That Qualify for the Automatic Therapy Cap Exception Process Based Upon Clinical Condition or Complexity

CR 4364 transmittal that contains these codes is the one that revises the *Medicare Claims Processing Manual*, available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf.*

You may wish to bookmark that link so you may easily reference these codes.

Documentation

Providers who believe that it is medically necessary for their patient to receive therapy services in excess of the therapy cap limitations (and the patient does not fall into the automatically excepted categories mentioned above) must submit documentation, sufficient to support medical necessity, in accordance with the revised *Medicare Benefit Policy Manual*, Pub.100-02 Chapter 15, Section 220.3; and the revised *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Sections 10.2 and 20, with the request for treatment days in excess of those payable under the therapy cap.

These manual sections contain important definitions, as well as examples of acceptable documentation, and are attached to CR 4364. CR 4364 is in three parts, one each for the revised manuals, i.e.:

- The *Medicare Benefit Policy Manual*, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R47BP.pdf*.
- The *Medicare Claims Processing Manual*, located at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf*.
- The *Medicare Program Integrity Manual*, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf*.

The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

1. **Evaluation and Certified Plan of Care** – 1-2 documents.
2. **Certification** – Physician/NPP approval of the plan required 30 days after initial treatment-or delayed certification.
3. **Clinician-signed Interval Progress Reports** (when treatment exceeds ten treatment days or 30 days) – These must be sufficient to explain the beneficiary's current functional status and need for continued therapy with the request for therapy visits in excess of those payable under the therapy cap. This is not required to be provided daily in treatment encounter notes or for an incomplete interval when unexpected discontinuation of treatment occurs.
4. **Treatment Encounter Notes** – The treatment encounter note is acceptable if it records the name of the treatment; intervention, or activity provided; the time spent in services represented by timed codes; the total treatment time; and the identity of the individual providing the intervention. These may substitute for progress reports if they contain the requirements of interval progress reports at least once every ten treatment days or once in the interval.
5. For therapy caps exceptions purposes, records justifying services over the cap, either included in the above or as a separate document.

Please see the revised Section 220.3 of the *Medicare Claims Processing Manual* located at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf* for more details about the types of documentation required and explanations of what that documentation should contain.

When reviewing documentation, Medicare contractors will:

- Consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary.
- Consider a dictated document to be completed on the day it is dictated if the identity of the qualified professional is included in the dictation.
- Consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing purposes) if it includes a diagnosis, subjective and/or objective condition, and prognosis. This information may be included in or attached to a plan. The inclusion of this information in the documentation does not necessarily constitute a billable evaluation or reevaluation unless it represents a service.
- Accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.

Medicare Contractor Decisions

If determined to be medically necessary, your Medicare contractor will grant additional treatment days for occupational therapy, physical therapy, and speech language pathology.

It is preferable that the request for exception be received before the therapy cap is actually exceeded. However, your Medicare contractor will approve additional therapy treatment days retroactively if they are deemed medically necessary, in the exceptional circumstance where a timely request for exception from the therapy cap is not received before the therapy cap is surpassed.

Your Medicare contractor may also approve additional therapy visits already provided when the request is accompanied by documentation supporting medical necessity of the services.

Please note that outpatient therapy services appropriately provided by assistants or qualified personnel will be considered covered services only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment. Claims for services above the cap that are not deemed medically necessary will be denied as a benefit category denial.

Note: If your Medicare contractor does *not* make a decision within ten business days of receipt of the request and documentation, then the decision for therapy cap exception is considered to be deemed approved as medically necessary for the number of future visits requested (not to exceed 15).

Notification

You will be notified as to whether or not an exception to the cap has been made (and if so, for how many additional future visits) as soon as practicable once the contractor has made its decision.

This notification is not an initial determination and, therefore, does not carry with it administrative appeal rights. For examples of the standard letters from the *Medicare Program Integrity Manual*, 100-8, Section 3.3.1.2, please refer to the Attachments to CR 4364. The examples include:

- Letter #1 – Approved
- Letter #2 – Negative Decision-Medical Necessity
- Letter #3 – Denied-Insufficient Documentation

Revised Medicare Summary Notice (MSN) Messages

The MSN messages (17.13; 38.18) are revised to inform beneficiaries about the therapy caps and approved medically necessary exceptions. These notices are also part of CR4 364.

Once again, there are three transmittals that comprise CR 4364. They are:

- The *Medicare Benefit Policy Manual* revision on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R47BP.pdf*.
- The *Medicare Claims Processing Manual* revision, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf*.
- The *Medicare Program Integrity Manual* revision, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf*.

If you have any questions, contact your Medicare contractor at their toll free number, which is available on the CMS website at *http://www.cms.hhs.gov/apps/contacts/*.

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: MM4364
Related CR Release Date: February 15, 2006
Effective Date: January 1, 2006
Related Change Request (CR) Number: 4364
Related CR Transmittal Number: R47BP, R140PI, R855CP
Implementation Date: No later than March 13, 2006

Guidelines for Therapy Cap Exception Process

The Deficit Reduction Act of 2005 (DRA) directed CMS to create a process to allow exceptions to the therapy caps where continued therapy services are medically necessary services provided **on or after January 1, 2006.**

This article provides:

- Key points of interest to providers submitting claims under the automatic exceptions process.
- Instructions for submitting requests via the manual exceptions process.
- Important tips and reminders.

Key Points of Interest to Providers Submitting Claims Under the Automatic Exceptions Process

- No request is required, simply verify that the patient's records meet all documentation requirements and submit your claim-attaching **modifier KX** to all therapy line items. *(Do not submit documentation unless requested.)*
- The following ICD-9-CM codes and ranges describe the conditions (etiology or underlying medical conditions) that may result in excepted conditions and complexities (marked *) that may cause medically necessary therapy services to qualify for the automatic therapy cap exception. If a diagnosis code is not listed here, then the disorder may still qualify for an exception by approval via the manual exceptions request process. The codes apply to all therapy disciplines, but may be used only when the code is applicable to the condition being actively treated. For example, an exception should not be claimed for a diagnosis of hip replacement when the service provided is for an unrelated dysphagia.

250 – 250.93*	353 – 357	**486***	**724.3***	828.0 – 828.1
278.01 – 278.02*	359.0 – 359.9	**490 – 496***	**724.4***	852.00 – 852.59
290.0 – 290.4*	**386.0 – 386.9***	**707.99 – 707.9***	726.10 – 726.19	853.00 – 853.19
294.0 – 294.9*	**401.0 – 401.9***	710.0 – 710.9	727.61 – 727.62	854.00 – 854.19
311*	**402.00 – 402.91***	**711.00 – 711.99***	733.00	881.0 – 881.2
323.0 – 323.0*	**414.00 – 414.9***	**713.0 – 713.8***	780.93	882.0 – 882.2
331.0 – 331.9	**415.0 – 415.19***	**714.0 – 714.9***	781.2	884.0 – 884.2
332.0 – 332.1	**416.0 – 416.9***	715.09	781.3	887.0 – 887.7
333.0 – 333.99	**427.0 – 427.0***	715.11	781.8	897.0 – 897.7
334.0 – 334.9	**428.0 – 428.9***	715.15	**781.92***	952.00 – 952.9
335.0 – 335.9	430 – 432.9	715.16	784.3 – 784.69	941.00 – 952.9
336.0 – 336.9	433.0 – 434.9	715.91	787.2	959.01
337.20 – 337.29	436	715.96	806.00 – 806.99	V43.64
340	437.0 – 437.9	718.44	810.00 – 810.13	V43.65
342.00 – 342.9	438.0 – 438.9	718.49	811.00 – 811.19	V43.61
343.0 – 343.9	**443.0 – 443.9***	**719.7***	812.00 – 812.59	V49.63 – 49.67
344.00 – 344.9	**453.0 – 453.9***	721.91	813.00 – 813.93	V49.73 – 49.77
348.9 – 348.9	457.0 – 457.1	723.4	820.00 – 820.9	
349.0 – 349.9	478.30 – 478.5	724.02	821.0 – 821.39	

* Complexities

- The following examples are clinical complexities that may also justify an automatic exception to the therapy caps for **any** condition that necessitates skilled therapy services, regardless of whether it is on the list of diagnosis codes. As in all exceptions, the services rendered above the caps must be documented, covered, medically necessary services. The mere existence of one of these complexities **does not assure** that the services were medically necessary. The clinician's documentation must justify the use of **modifier KX.**
- The beneficiary was discharged from a hospital or skilled nursing facility (SNF) within 30 treatment days of starting this episode of outpatient therapy. Indicate date of discharge and name of hospital or SNF.
- The beneficiary has, in addition to another disease or condition being treated, generalized musculoskeletal conditions or conditions affecting multiple sites not listed as automatically excepted by conditions that will directly and significantly impact the rate of recovery.
- The beneficiary has a mental or cognitive disorder in addition to the conditions being treated that will directly and significantly impact the rate of recovery.

  For the above complexities, list in your documentation all relevant disorders or conditions and describe the impact. For example: A sprained ankle does not qualify for exception by condition, but if the patient also has a dysfunctional wrist on the opposite side that precludes the use of a cane, it would cause a direct and significant impact on the patient's need for skilled physical therapy, and might require services that exceed caps.
- The beneficiary requires PT and SLP services concurrently. If the combination of the two services causes the cap to be exceeded for necessary services, the services are excepted from the PT/SLP cap. The OT cap is not affected.
- The beneficiary had a prior episode of outpatient therapy during this calendar year for a **different** condition. The second condition treated in the year may not be on the list of excepted conditions. If services are medically necessary and would be payable under the cap, an exception is allowed if prior use of services for a different condition caused the cap to be exceeded and the medically necessary services to be denied. In cases where the beneficiary was treated in the same year for the same condition, contractor approval is required for use of **modifier KX**.
- The beneficiary requires this treatment in order to return to a premorbid living environment. Document what environment and what is needed to return. For example: Patient is progressing (see FIM scores) and has good potential for completing goals for independent toileting, which is required for discharge from the nursing home setting and return to the assisted living facility where she resided prior to the CVA.

    - The following therapy evaluation services are excepted from the therapy caps. When submitting claims for evaluation services that exceed the caps, providers and suppliers are instructed to attach **modifier KX.**

92506 92597 92607 92608 92610 92611 92612 92614
92616 96105 97001 97002 97003 97004

Instructions for Submitting Requests Via the Manual Exception Process

Providers need to submitt a written request to the contractor for medical review for patients who are expected to exceed the therapy caps, but do **not** meet one of the conditions for the automatic exception.

- You **must** submit in writing and complete in its entirety the "Request for Exception from Therapy Cap" form.
- The following documentation **must** be faxed along with your completed form. If all required documentation is not attached, a decision will be made based solely on the submitted documentation:

- Evaluation and certified plan of care
- Certification
- Clinician's signed progress reports
- Treatment encounter notes
- Medical justification (explanation of medical necessity)

- Requests will only be accepted via the fax number 1-904-791-8006. Requests sent any other way (e.g., mail, appeals etc,) will be returned with instructions on how to correctly submit. In the very near future, the fax number shown above will change to allow for a separate toll free fax number for Florida Part A, Florida Part B and Connecticut Part B. This information will be posted to our website along with a new updated form.

One of the following responses will be faxed within 10 business days of receipt of your request to the fax number provided on the request form:

1. Based on your documentation, the beneficiary does not meet medical necessity requirements for granting the exception.
2. Based on your documentation, the beneficiary meets the medical necessity requirements for granting an exception, for all days requested. You may submit claims using **modifier KX** for the requested number of days.
3. Based on your documentation, the beneficiary meets medical necessity requirements for granting the exception, but not for all days requested. You may submit claims using **modifier KX** for the number of days indicated in this letter.
4. We received your request, but did not meet the 10-day requirement; therefore all days requested are granted. You may submit claims using **modifier KX** for the number of days indicated in this letter.

Important Tips and Reminders

- The automatic exceptions process will be closely monitored via the normal progressive corrective action (PCA) process.
- If you are a Medicare provider currently going through the progressive corrective action process and are on prepayment review due to a high error rate, **you are not allowed** to participate in the therapy cap exception process.
- Due to changes required by the Centers for Medicare & Medicaid Services (CMS) implemented with change request 4364 (transmittals 855, 140 and 47), the local coverage determination (LCD) for Florida providers titled "Therapy and Rehabilitation Services (L6196), and for Connecticut providers titled "Physical Medicine and Rehabilitation (L13920), have been updated. It is your responsibility to be aware of these changes. To view this LCD, access the provider education website *http://www.floridamedicare.com* or *http://www.connecticutmedicare.com*. From the home page, select "Part B" on the top navigational menu. On the next screen, click on "Final" under the local Medical Coverage section on the left navigational menu.
- For all claims submitted with **modifier KX** during the interim process that may have been denied in error (rejected for Part A providers), you may resubmit your claim for reprocessing.
- It is expected that a manual request for therapy cap exceptions will be submitted prior to the beneficiaries meeting the financial limitation. However, a request for exceptions for services already provided may sometimes be necessary. Please provide the appropriate documentation and justification of the medical necessity for the services provided and include the dates with your manual request as retroactive services in the block titled "*First date of denied Services and/or Estimated Date Service Cap is Exceeded"* of the "Request for Exception from the Therapy Caps" form. Providers are cautioned against abuse of this process by routinely requesting exceptions for past services.
- You must continue to use modifiers GN, GP, and GO on all therapy services when using **modifier KX.** There is no specific order that must be followed.

To download the "Request for Exception from Therapy Cap" form, from the home page on the provider education website *http://www.floridamedicare.com* or *http://www.connecticutmedicare.com*, select "Forms" under the "Resources" section on the left navigational menu. On the next screen, click on "Request for Exception from the Therapy Caps" under the "Resource Order Forms" section.

Source: CMS Pub. 100-04, Transmittal 855, CR 4364

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

CMS CENTERS for MEDICARE & MEDICAID SERVICES

REQUEST FOR EXCEPTION FROM THE THERAPY CAPS

Attention Provider

You must submit the following types of documentation of therapy services:

1. Evaluation and Certified Plan of Care
2. Certification
3. Clinician-signed Progress Reports
4. Treatment Encounter Notes
5. Justification (Explanation of Medical Necessity)

If all required documentation is not attached, a decision will be made based solely on information received

You must provide documentation that is sufficient to support medical necessity for the additional treatment days, which shall be in accordance with the revised Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, Section 220.3 and the revised Medicare Claims Processing Manual, Pub 100-04, Chapter 5, Sections 10.2 and 20.

It is preferable that all manual requests for exception be submitted before the therapy cap has actually been exceeded. However, in the exceptional circumstance where a timely request is not made before the cap is surpassed, additional treatment days may be approved retroactively if they are deemed medically necessary.

Date of Request	Date to Start Requested Exception	First Date of Denied Services and/or Estimated Date Service Cap is Exceeded	
Beneficiary Name & HIC#			
Request is for: *(check only one; submit a separate request for each therapy)* Physical Therapy ☐ Occupational Therapy ☐ Speech-language Pathology ☐			
Provider Name			Provider Number
Number of Exceptions Already Requested for this Episode of Care *(If applicable)*	Number of Treatment Days Being Requested *(Not to exceed 15 days)*	**Primary Diagnosis Code (Please list only one)** 1.	Secondary/ Additional Diagnosis Codes 1. 2. 3. 4.
Name, and telephone number of person to contact regarding this request			*Fax number for purposes of receiving a response to this request*

FAX TO:

Florida Part A (904) 791-8006 Florida Part B (904) 791-8006 Connecticut Part B (904) 791-8006

Medical Review and Education 19 Tower, 532 Riverside Ave, Jacksonville, Florida 32202 Form Date March 10, 2006

Annual Update to the Therapy Code List

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

Provider Types Affected

Private practicing therapists, physicians, suppliers, and providers of therapy services billing Medicare carriers and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for rehabilitation therapy services.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4226, which implements policy changes discussed in the outpatient prospective payment system (OPPS) final rule for calendar year (CY) 2006 and the Medicare physician fee schedule (MPFS) final rule for CY 2006.

CAUTION – What You Need to Know

CR 4226 describes changes to, and billing instructions for, payment policies for rehabilitation therapy services, including physical therapy, occupational therapy and speech-language pathology. It also updates the list of codes that sometimes or always describe therapy services and their associated policies.

GO – What You Need to Do

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

Background

The Social Security Act (Section 1834(k)(5)) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system.

The Healthcare Common Procedure Coding System/*Current Procedural Terminology*, 2006 – Fourth Edition (HCPCS/*CPT-4*), is the coding system used for the reporting of these services.

The uniform coding requirement in the Social Security Act is specific to payment for all CORF services and outpatient rehabilitation therapy services that are provided and billed to carriers and FIs including:

- Physical therapy
- Occupational therapy
- Speech-language pathology.

Note: Section 1834(k)(5) of the Social Security Act may be found at *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*.

The Medicare physician fee schedule (MPFS) is used to make payment for these therapy services at the nonfacility rate. The following "providers of therapy services" must bill the FI/RHHI for outpatient rehabilitation services using HCPCS codes:

- Hospitals (to outpatients and inpatients who are not in a covered Part A[1] stay)
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF)
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care[2] [POC])
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Providers of outpatient physical therapy and speech-language pathology services (OPTs), also known as rehabilitation agencies (previously termed outpatient rehabilitation facilities).

[1] The requirements for hospitals and SNFs apply to inpatient Part B and outpatient services only. Inpatient Part A services are bundled into the respective prospective payment system payment; no separate payment is made.

[2] For HHAs, HCPCS/*CPT* coding for outpatient rehabilitation services is required only when the HHA provides such service to individuals that are not homebound and, therefore, not under a home health plan of care.

The following practitioners must bill the carriers for outpatient rehabilitation therapy services using HCPCS/*CPT* codes:

- Physical therapists in private practice (PTPPs)
- Occupational therapists in private practice (OTPPs)
- Physicians, including MDs, DOs, podiatrists and optometrists
- Certain nonphysician practitioners (NPPs), acting within their state scope of practice, e.g., nurse practitioners and clinical nurse specialists.

Change Request 4226 Requirements

- Describes changes to, and billing instructions for, payment policies for rehabilitation therapy services, including physical therapy, occupational therapy and speech-language pathology.
- Updates the list of codes that sometimes or always describe therapy services and their associated policies
- Reflects policy changes implemented in (a) the OPPS final rule for CY 2006 and (b) the Medicare physician fee schedule (MPFS) final rule for CY 2006.

Other policies contained in CR 4226 correct or clarify the previous policy noted in CR 3647 (Transmittal 515 dated April 1, 2005).

The therapy code list and associated policies for CY 2006 is updated by CR4226 as described below.

Note: **CR 3647 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R515CP.pdf*.**

The MLN Matters article that corresponds to CR3647 may be reviewed on the CMS website at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3647.pdf*.

Orthotic Management and Prosthetic Management Services

In order to create a new category under the section for physical medicine and rehabilitation services, HCPCS/*CPT* modified the descriptors of one of these codes, *CPT* code *97504* (2005), and renumbered it as well as two other HCPCS/*CPT* codes.

The new therapy code list removes the CY 2005 CPT codes *97504, 97520 and 97703,* and replaces them with *CPT* codes *97760, 97761 and 97762*, respectively, for use in CY 2006. The following table contains a list of the added CY 2006 CPT codes and the new short descriptor for *CPT* code *97760*:

2006 Code	2006 Short Descriptor	2005 Code
97760	Orthotic management and training	97504
97761	Prosthetic training	97520
97762	C/o for orthotic/prosth use	97703

Active Wound Care Management Services

The therapy code list contains five (5) HCPCS/*CPT* codes that represent active wound care services: *CPT* codes *97602, 97605, 97606, 97597 and 97598.* Three of these *CPT* codes for wound care (*97602, 97605, and 97606*) were previously noted as "bundled" services for payment purposes under the MPFS and represented "always therapy" services.

For CY 2006, these three codes were changed to "sometimes therapy" services. While *CPT* code *97602* remains a bundled service under the MPFS, *CPT* codes *97605* and *97606*, which represent services for negative pressure wound therapy, are now valued and active codes under the MPFS.

Except as noted below for hospitals subject to the OPPS, the requirements for "sometimes therapy" apply. These requirements are described in more detail in Publication 100-04, Chapter 5, Section 20, of the *Medicare Claims Processing Manual*. That manual is available on the CMS website at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*.

A new payment policy for hospitals paid under the OPPS is being implemented for these five wound care HCPCS/*CPT* codes – *97602, 97605, 97606, 97597, and 97598*, and the indicator **"?"** is being added as a note to the code list. The indicator **"?"** signifies that these codes represent "sometimes therapy" services and will be paid under the OPPS when (a) the service is not performed by a therapist (i.e., under the therapy benefit); and (b) it is inappropriate to bill the service under a therapy plan of care.

Wound care provided, which meets these two requirements, should not be billed with a therapy modifier (e.g., GP, G0, or GN) or a therapy revenue code (e.g., 42x, 43x, or 44x). As for other "sometimes therapy" codes, these services are considered therapy services (i.e.; under the therapy benefit) when rendered by a therapist.

They are also considered therapy services when rendered by physicians and nonphysician practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. When such services are therapy services as noted above, the appropriate therapy modifier is required.

2006 Status	HCPCS/*CPT* Code	Short Descriptor	2005 Status
Bundled service for payment purposes under the MPFS; sometimes therapy service.	97602	Wound (s) care, non-selective	Bundled service for payment purposes under the MPFS; always therapy service.
Valued and active code under the MPFS; sometimes therapy service.	97605	Neg press wound tx,< 50 cm	Bundled service for payment purposes under the MPFS; always therapy service.
Valued and active code under the MPFS; sometimes therapy service.	97606	Neg press wound tx, > 50 cm	Bundled service for payment purposes under the MPFS; always therapy service.
Sometimes therapy service.	97597	Active wound care/20 cm or <	Sometimes therapy service.
Sometimes therapy service.	97598	Active wound care > 20 cm	Sometimes therapy service.

Carrier Pricing of Unspecified Therapy Codes

The 2006 policy adds Note **"?"** to HCPCS/*CPT* codes *97039 and 97139* to indicate that the MPFS payment has changed to carrier-pricing and these two codes will no longer be paid using the relative values units previously listed in Addendum B of the 2006 MPFS final rule.

As with other carrier-priced services, where an existing HCPCS/*CPT* code does not accurately describe the services performed, the provider submits information, for the contractor's review, to describe the "unspecified" modality(s) or therapeutic procedure(s) performed.

In addition to a detailed service description for *CPT* code *97039*, information submitted to the contractor must specify the type of modality utilized and, if the modality requires the constant attendance of the therapist, the time spent by the therapist one-on-one with the beneficiary must also be noted.

For *CPT code 97139*, the information supplied to the carrier must specify the procedure furnished and also meet the other requirements for therapeutic procedures, i.e., the process of effecting change, through the application of clinical skills or services that attempt to improve function.

CPT codes *97039 and 97139* remain designated as "always therapy" and require the use of modifier GP or GO, as appropriate.

HCPCS/CPT	Code Short Descriptor
97039	Physical therapy treatment
97139	Physical medicine procedure

Speech, Language, Voice, Communication and/or Auditory Processing

The 2006 policy creates a **"?"** indicator to indicate that the CY 2006 code descriptors were revised for the following *CPT* codes: *92506 and 92507*. *CPT* code *97760* is also flagged with the **"?."** Although this code number is new, it reflects a revision to the descriptor of the code it replaces, *CPT* code *97504*. The revised 2006 descriptors for *CPT* code *95206* and *95207* are the following:

2006 Code	2006 Short Descriptor
92506	Speech/hearing evaluation
92507	Speech/hearing therapy

Microwave Modality

The 2006 policy removes deleted HCPCS/*CPT* codes *96115 and 97020*. *CPT 96115* was deleted for CY 2006. *CPT* code *97020*, for the microwave modality, was combined with CPT code *97024* for diathermy.

2006	Code 2006 Short Descriptor
97024	Diathermy e.g., microwave

Code 0019T

The 2006 policy adds HCPCS/*CPT* code *0019T*, as a "sometimes" therapy service, to replace HCPCS codes G0279 and G0280 that were both deleted for CY2006. This code is carrier priced.

2006 Code	2006 Short Descriptor	2006 Status
0019T	Extracorp shock wv tx, ms nos	Sometimes therapy

Diagnostic Services

The 2006 policy clarifies in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 5, Section 20, Subsection C (Additional HCPCS Codes), that the listed HCPCS/*CPT* codes *95860, 95861, 95863, 95864, 95867, 95869, 95870, 95900, 95903, 95904 and 95934* represent diagnostic services, under MPFS, and do not represent therapy services and cannot be billed as such. Those codes and their short descriptors are in the following table:

CPT	Short Descriptor	Status under MPFS
95860	Muscle trest, one limb	Diagnostic Service
95861	Muscle test, 2 limbs	Diagnostic Service
95863	Muscle test, 3 limbs	Diagnostic Service
95864	Muscle tesl, 4 limbs	Diagnostic Service
95867	Muscle test cran nerv unilat	Diagnostic Service
95868	Muscle test cran nerve bilat	Diagnostic Service
95869	Muscle test, thor paraspinal	Diagnostic Service
95870	Muscle test, nonparaspinal	Diagnostic Service
95900	Motor nerve conduction test	Diagnostic Service
95903	Motor nerve conduction test	Diagnostic Service
95904	Sense nerve conduction test	Diagnostic Service
95934	H-reflex test	Diagnostic Service

CPT* Code *96110

The 2006 policy removes the **"?"** note for *CPT* code *96110*, because it is no longer applicable. The **"?"** note indicated that, effective January 1, 2004, *CPT* code *96110* became an active code on the Medicare physician fee schedule and that carriers no longer priced this code.

HCPCS/CPT Code	Short Descriptor
96110	*Developmental test, lim*

Summary

In summary, CR 4226 instructs your carrier and/or FI/RHHI to change any policies or edits that are not consistent with the policies or list of codes provided in CR 4226.

The changes noted in CR 4226 are effective for services furnished on or after January 1, 2006. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2006 HCPCS/*CPT-4*.

Implementation

The implementation date for the instruction is February 6, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/FI/RHHI regarding this change. That instruction may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R805CP.pdf*.

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

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: MM4226 Related Change Request (CR) Number: 4226
Related CR Release Date: January 6, 2006 Related CR Transmittal Number: R805CP
Effective Date: January 1, 2006 Implementation Date: February 6, 2006

Therapy Caps Effective January 1, 2006

CMS has issued the following "MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the HCPCS 2006 January Special Medicare B Update! pages 40-41.

Note: This article was revised on March 3, 2006, to include clarifying language (***bold, italicized print***) in the STOP section under "Provider Action Needed".

Provider Types Affected

Therapists and providers who bill Medicare carriers or fiscal intermediaries (FIs) for therapy services for their patients

Provider Action Needed

STOP – Impact to You

Beginning January 1, 2006, financial limitation of therapy services (therapy caps) will be implemented. ***The dollar amount for the 2006 limitation on physical therapy and speech-language pathology services from January 1, 2006, through December 31, 2006, will be $1,740.00 both services combined. The limitation on occupational therapy services separately is also $1,740.00. The limits do not apply to outpatient Part B therapy services in outpatient hospital or hospital emergency room settings or to services that meet Medicare criteria for exceptions.***

CAUTION – What You Need to Know

Please be aware of the January 1, 2006, therapy services caps.

GO – What You Need to Do

Remember that services must meet the Medicare policies in the Medicare Benefit Policy Manual (publication 100-02), Chapter 15, Sections 220and 230. This manual is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Background

Financial limitations on therapy services (therapy caps) are currently described in the *Medicare Claims Processing Manual* (Pub. 100-04), chapter 5, section 10.2, which is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website. The dollar amount for the limitations in 2006 is based on the Medicare Economic Index that is published in the final rule for the Medicare Physician Fee Schedule in November 2005.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, required payment under a prospective payment system for outpatient rehabilitation services (physical therapy, including outpatient speech-language pathology, and occupational therapy). Section 4541(c) of the BBA required the application of a financial limitation to all outpatient rehabilitation services (except outpatient departments of hospitals).

These limits were in effect in 1999, but were removed by law in 2000-2002. The statutory limits went back into effect September 1, 2003. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 re-enacted the moratorium and extended it until December 31, 2005.

Additional Information

There is additional information located on the Rehabilitation Therapy Information Resource for Medicare website located at *http://new.cms.hhs.gov/TherapyServices/01_overview.asp#TopOfPage* on the CMS website.

The official instruction issued to your FI or carrier regarding this change may be found by going to *http://www.cms.hhs.gov/transmittals/downloads/R759CP.pdf* on the CMS website.

Please refer to your local FI or carrier if you have any questions. To find the toll-free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

Medlearn Matters Number: MM4115 *Revised*
Related Change Request (CR) #: 4115
Related CR Release Date: November 18, 2005
Effective Date: January 1, 2006
Related CR Transmittal #: R759CP
Implementation Date: January 3, 2006

VISION

Expansion of Glaucoma Screening Services

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

Provider Types Affected

Physicians and providers who submit claims to Medicare fiscal intermediaries (FIs) and carriers for glaucoma screening examinations

Important Points to Remember

- CR 4365 provides notice that beginning January 1, 2006, the definition of an eligible beneficiary in a high-risk category is expanded to include Hispanic Americans age 65 and over.
- Because of this revised definition, Medicare will pay for glaucoma screening examinations for Hispanic Americans age 65 and older when they are furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist who is legally authorized to perform the services under state law.
- If service is denied because the individual does not meet the age-related and/or ethnic-related coverage criteria, Medicare contractors will return Medicare Summary Notice 21.21 (This service was denied because Medicare only covers this service under certain circumstances).
- If service is denied because the individual is not Hispanic-American age 65 or over, the remittance advice claim will show reason adjustment code 96 (Non-covered charge), and existing remark codes M83 (Services not covered unless the patient is classified as at high risk), and N129 (This amount represents the dollar amount not eligible due to patient's age.).
- Your Medicare FI or carrier will not search for or adjust claims with dates of service January 1, 2006, that were processed before the April 3, 2006, implementation date of CR 4365. They will adjust any such claims that you bring to their attention.
- The following HCPCS codes apply for glaucoma screening:
  - G0117– Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist; and
  - G0118– Glaucoma screening for high risk patients furnished under the direct supervision of an optometrist or ophthalmologist.

Background

On January 1, 2002, CMS implemented regulations at 42 CFR, Section 410.23(a)(2). The regulations set conditions for and limitations on coverage of screening for glaucoma, requiring that the term "eligible beneficiary" be defined to include individuals in the following high-risk categories:

- Individuals with diabetes mellitus;
- Individuals with a family history of glaucoma; or
- African-Americans age 50 and over.

The Physician Fee Schedule for calendar year 2006 Final Rule, 70 FR 70270, dated November 21, 2005, expands Medicare coverage of high-risk individuals eligible to receive glaucoma screening services to include Hispanic Americans age 65 and over.

This expansion of coverage is effective for services performed on or after January 1, 2006, and revises 42 CFR, section 410.23(a)(2) accordingly.

Implementation

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

Additional Information

The official instructions (CR 4365) issued to your FI or Carrier regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R48BP.pdf* **and** *http://www.cms.hhs.gov/Transmittals/downloads/R895CP.pdf* on the CMS website.

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/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4365
Related CR Release Date: March 24, 2006
Related CR Transmittal #: R48BP and R895CP
Related Change Request (CR) #: 4365
Effective Date: January 1, 2006
Implementation Date: April 3, 2006

HIPAA - The Health Insurance Portability and Accountability Act

Welcome to the World of Medicare Electronic Data Interchange

Whether you are already a provider who submits electronic claims data to First Coast Service Options, Inc. (FCSO), a provider who submits paper claims, or a new provider, the information below may be of benefit to you. Please read further.

Administrative Simplification and Compliance Act Provision (ASCA)

This mandate dictates that all claims submitted to Medicare should be submitted electronically (with few exceptions). The enforcement of this provision will entail identifying providers who are currently submitting paper claims and contacting them directly to ensure they meet the exception criteria. Providers not meeting the exception criteria will be given a specific period of time to come into compliance, after which time any paper claims received for that provider will be denied. Providers not meeting the criteria should do the following:

- If you are a new provider, **or** a provider who submits only paper claims – Contact our EDI office. We will discuss available options for submitting your claims electronically. Medicare can also provide free software to you that will allow claims to be submitted electronically.
- If you are a provider who submits claims electronically – Many providers have processes in place that do generate some paper claims. Check to ensure that all claims are being submitted electronically.

Health Insurance Portability and Accountability Act (HIPAA)

This law requires that claims submitted electronically be submitted in a standardized/compliant electronic format, currently the ANSI x12 837 4010A1 format. Claims submitted by providers in a non-compliant format are being paid as if they were paper claims (29 days vs. 14 days for electronic claims).

The compliant format requirement also applies to the electronic remittance advice (ERA), which is the ability to receive payment information electronically for auto posting into your practice management system (see electronic applications below for more information).

All Providers – Ensure your electronic software (or your clearinghouse software, if using a clearinghouse) is sending claims (or receiving remittance) in a HIPAA compliant format. Work with your vendor to obtain a compliant format if you are not in compliance.

Other Electronic Applications

Electronic Funds Transfer

Have your Medicare payments deposited directly into your bank account. No waiting for a paper check in the mail, or last minute trips to the bank to make deposits! Combine this with ERA for a paperless environment.

Electronic Remittance Advice

This is a valuable tool for provider offices, allowing individual claim payment information (identical to the paper remittance form) to be electronically retrieved and automatically posted into your account management system. This eliminates both clerical entry errors and entry time in posting this data and allows your staff to concentrate on other office functions. **IMPORTANT** – contact your vendor or Medicare EDI for additional information regarding this application.

Medicare Remit Easy Print (MREP) Software

Free software that enables you to read and print a remittance advice from the HIPAA compliant electronic remittance in a format similar to the standard paper remittance.

Free Software (PC-ACE Pro32)

This is claim submission software, not a practice management system. It creates HIPAA format compliant claims to be transmitted electronically.

Electronic Reject Reports

This is an important report that provides details about your claim transmissions. It contains information reflecting the volume of claims that were submitted during the transmission, the number of claims successfully received, and the number of claims that rejected based on edit criteria. It also provides specific information on the claims that rejected. Your software vendor would need to make this capability available to you.

Electronic Claim Status Request and Verification

Instead of manually researching the status of your outstanding claims via the Interactive Voice Response (IVR) unit, you can obtain your claim status information electronically.

For additional information, please contact our EDI department:

Florida - (904) 791-8767, option 1 or visit our website, *http://www.floridamedicare.com*.
Connecticut – (203) 639-3160,option 4 or visit our website, *http://www.connecticutmedicare.com*.

Medicare Secondary Payer Claims Must Be Sent Electronically

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically, with few exceptions. **MSP claims are not an exception unless the provider submits the claim for Medicare payment after receiving payment from more than one other payer and at least one of those payers reduced their payment due to an Obligated to Accept as payment in Full (OTAF) adjustment.** The 837-4010A1 Implementation Guides, section 1.4.2.1, contain detailed information on how to submit MSP claims electronically. **In the near future MSP paper claims will not be processed for electronic submitters.**

We ask that you contact your vendor, billing service, clearinghouse or internal IT staff to ensure that your software is correctly set up to capture the data required and begin submission of your MSP claims electronically.

For assistance from Medicare Part B EDI, please contact the appropriate support group based on your location:

Medicare Part B Florida (904) 354-5977, option 4
Medicare Part B Connecticut 203-639-3160, option 6

Batch Detail Control Listing Changes—Connecticut Only

Beginning May 1st, 2006, the paper version of the Batch Detail Control Listing Report will only be generated if the transmission contains rejected information (claim or batch rejections that must be corrected and resubmitted). To obtain the full report, we strongly recommend you utilize the electronic version of the report (read more below).

The electronic Batch Detail Control Listing Report contains both accepted and rejected file/claim submission information and is available for retrieval the next business day after file transmission. It will provide you with detailed feedback on the number of claims received and whether they were accepted or rejected.

In order to obtain this electronic application, contact your software vendor to ensure your software is capable of retrieving the report from your mailbox. Unfortunately, not all vendors' software currently provides the capability to retrieve this report electronically: however, your vendor can access our website at *http://www.connecticutmedicare.com* for the Guide to Gateway, which will provide them with script information that allows for the retrieval of the report.

Another alternative, if your vendor does not provide the capability to retrieve the error report, is Medicare's free software (PC-ACE Pro32®) that (in conjunction with a communications program) is able to retrieve this report.

For more information about retrieving the Batch Detail Control Listing electronically, or using the PC-ACE Pro32® software, call EDI Marketing/Operations at (203) 639-3160 Option 4.

Requirements for Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms

CMS has issued the following "MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Second Quarter 2006 Medicare B Update! pages 47-50.

Note: This article was revised on November 29, 2005, to clarify that the end date of the transition period for the revised CMS-1500 form is February 1, 2007. (See the paper claims form section)

Provider Types Affected

Physicians, providers, and suppliers who submit claims for services to Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), to include regional home health intermediaries (RHHIs)

Provider Action Needed

The requirements for Stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are not based on the date of receipt of a transaction, unless otherwise stated in a business requirement.

Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the NPI in Stage 2 is October 1, 2006.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005.

Applications can be made by mail and also online at *https://nppes.cms.hhs.gov*.

NPI and Legacy Identifiers

The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. **Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers**.

Requirements for Use and Editing of NPI Numbers Received in EDI Transactions, via DDE Screens or Paper Claim Forms

Legacy provider identifiers include:

- Online Survey Certification and Reporting (OSCAR) system numbers;
- National Supplier Clearinghouse (NSC) numbers;
- Provider Identification Numbers (PINs); and
- Unique Physician Identification Numbers (UPINs) used by Medicare.

They **do not** include taxpayer identifier numbers (TINs) such as:

- Employer Identification Numbers (EINs); or
- Social Security Numbers (SSNs).

Primary and Secondary Providers

Providers are categorized as either "primary" or "secondary" providers:

- ***Primary providers*** include billing, pay-to, rendering, or performing providers.

In the DMERCs, primary providers include ordering providers.

- ***Secondary providers*** include supervising physicians, operating physicians, referring providers, and so on.

Crosswalk

During Stage 2, Medicare will utilize a crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. Key elements of this crosswalk include the following:

- Each primary provider's NPI reported on an inbound claim or claim status query will be cross-walked to the Medicare legacy identifier that applies to the owner of that NPI.
- The crosswalk will be able to do a two-directional search, from a Medicare legacy identifier to NPI, and from NPI to a legacy identifier.
- The Medicare crosswalk will be updated daily to reflect new provider registrations.

NPI Transition Plans for Medicare FFS Providers

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

Stage	Medicare Implementation
May 23, 2005 - January 2, 2006:	Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.
January 3, 2006 - October 1, 2006:	Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.
October 2, 2006 - May 22, 2007: (*This is stage 2, the subject of CR4023)*	CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.* Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.
May 23, 2007 – Forward:	CMS systems will only accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007.

Requirements for Use and Editing of NPI Numbers Received in EDI Transactions, via DDE Screens or Paper Claim Forms

Claim Rejection

Claims will be rejected if:

- The NPI included in a claim or claim status request does not meet the content criteria requirements for a valid NPI; this affects:
- X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only);
- National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only);
- Claims submitted using Medicare's free billing software;
- Electronic claim status request received via X12 276 or DDE screen; and
- Non-X12 electronic claim status queries;
- An NPI reported cannot be located in Medicare files;
- The NPI is located, but a legacy identifier reported for the same provider in the transaction does not match the legacy identifier in the Medicare file for that NPI;
- Claims include the NPI but do not have a taxpayer identification number (TIN) reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare's free billing software.

Note: If only provider legacy identifiers are reported on an inbound transaction prior to May 23, 2007, pre-NPI provider legacy number edit rules will be applied to those legacy identifiers.

Additional Information

X12 837 Incoming Claims and COB

During Stage 2, an X12 837 claim may technically be submitted with only an NPI for a provider, **but you are strongly encouraged to also submit the corresponding Medicare legacy identifier for each NPI** in X12 837 Medicare claims.

Use of both numbers could facilitate investigation of errors if one identifier or the other cannot be located in the Medicare validation file. When an NPI is reported in a claim for a billing or pay-to provider, a TIN must also be submitted in addition to the provider's legacy identifier as required by the claim implementation guide.

National Council of Prescription Drug Plans (NCPDP) Claims

The NCPDP format was designed to permit a prescription drug claim to be submitted with either **an NPI or a legacy identifier, but not more than one identifier** for the same retail pharmacy or prescribing physician. The NCPDP did provide qualifiers, including one for NPIs, to be used to identify the type of provider identifier being reported.

- For Stage 1, retail pharmacies were directed to continue filing their NCPDP claims with their individual NSC number and to report the UPIN of the prescribing physician.
- During Stage 2, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have the prescribing physician's NPI) in their claims.

When an NPI is submitted in an NCPDP claim, it will be edited in the same way as an NPI submitted in an X12 837 version 4010A1 claim. The retail pharmacy will be considered the primary provider and the prescribing physician as the secondary provider for NPI editing purposes.

Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006 and end February 1, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

Pending the start of submission of the revised CMS-1500 and the UB-04, **providers must continue to report legacy identifiers, and not NPIs**, **when submitting claims on the non-revised CMS-1500 and the UB-92 paper claim forms**.

Provider identifiers reported on those claim forms are presumed to be legacy identifiers and will be edited accordingly. "Old" form paper claims, received through the end of the transition period that applies to each form, may be rejected if submitted with an NPI.

Or, if they are not rejected—since some legacy identifiers were also 10-digits in length—could be incorrectly processed, preventing payment to the provider that submitted that paper claim.

Standard Paper Remits (SPRs)

The SPR FI and carrier/DMERC formats are being revised to allow reporting of both a provider's NPI and legacy identifier when both are available in Medicare's files. If a provider's NPI is available in the data center provider file, it will be reported on the SPR, even if the NPI was not reported for the billing/pay-to, or rendering provider on each of the claims included in that SPR. The revised FI and carrier/DMERC SPR formats are attached to CR 4023:

- CR 4023 Attachment 1: FI Standard Paper Remit (SPR) Amended Format for Stage 2; and
- CR 4023 Attachment 2: Carrier/DMERC SPRAmended Stage 2 Format.

Remit Print Software

The 835 PC-Print and Medicare Remit Easy Print software will be modified by October 2, 2006, to enable either the NPI or a Medicare legacy number, or both, if included in the 835, to be printed during Stage 2.

Free Billing Software

Medicare will ensure that this software is changed as needed by October 2, 2006, to enable reporting of both an NPI and a Medicare legacy identifier for each provider for which data is furnished in a claim, and to identify whether an entered identifier is an NPI or a legacy identifier.

Requirements for Use and Editing of NPI Numbers Received in EDI Transactions, via DDE Screens or Paper Claim Forms

In-Depth Information

Please refer to CR 4023 for additional detailed NPI-related claim information about the following topics:

- Crosswalk
- X12 837 Incoming Claims and COB
- Non-HIPAA COB Claims
- NCPDP Claims
- DDE Screens
- Paper Claim Forms
- Free Billing Software
- X12 276/277 Claim Status Inquiry and Response Transactions
- 270/271 Eligibility Inquiry and Response Transactions
- 835 Payment and Remittance Advice Transactions
- Electronic Funds Transfer (EFT)
- Standard Paper Remits (SPRs)
- Remit Print Software
- Claims History
- Proprietary Error Reports
- Carrier, DMERC, and FI Local Provider Files, including EDI System Access Security Files
- Med A and Med B Translators
- Other Translators
- Stages 3 and 4

CR 4023, the official instruction issued to your FI/ regional home health intermediary (RHHI) or carrier/durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to *http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf* on the CMS website.

You may also wish to review *Medlearn Matters* article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition *Medlearn Matters* Articles on NPI-Related Activities," which is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf* on the CMS website. This article contains further details on the NPI and how to obtain one.

Please refer to your local carrier/DMERC/FI for more information about this issue. To find the toll free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* 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: MM4023 *Revised* — Related Change Request (CR) #: 4023
Related CR Release Date: November 3, 2005 — Effective Date: April 1, 2006
Related CR Transmittal #: 190 — Implementation Date: April 3, 2006

Shared Systems Medicare Secondary Payer Balancing Edit and Administrative Simplification Compliance Act Enforcement Update

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

Provider Types Affected

Physicians, suppliers and providers billing MSP claims to Medicare carriers, fiscal intermediaries (FI), durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs)

Key Points for Providers

Change request (CR) 4261 makes two key changes to Medicare claims processing as follows:

- **First,** CR 4261 states that inbound MSP claims will be rejected if the paid amounts and the adjusted amounts paid by the primary payer do not equal the billed amounts at the line level and if the claim lacks standard claim adjustment reason codes to identify adjustments performed.

While Medicare may be able to handle such a discrepancy because it does not always use this information, it may pass such claims to other payers. Such other payers may then reject the claims because they do not comply with the 837 version 4010A1 institutional and professional implementation guides. As a result, Medicare will not accept such claims in order to be fully compliant with HIPAA.

- **Second,** if a provider's paper claims have been denied due to Administrative Simplification Compliance Act (ASCA) electronic claims provision enforcement by Medicare contractors (carriers, FIs, RHHIs, and DMERCs), the provider may resubmit the paper claims if they submit appropriate documentation that establishes that they meet the criteria for submitting paper claims.

Providers have until the 91st day after the initial ASCA letter to submit documentation that proves eligibility for submission of paper claims. If a provider establishes eligibility later than the 91st day of the initial enforcement letter and then resubmits paper claims, payment will be denied for dates of service between the 91st day and the effective date for submission of claims.

Implementation

The implementation date for the instruction is July 3, 2006

Administrative Simplification Compliance Act Enforcement Update

Additional Information

For details of enforcement of the ASCA, please see related MLN Matters article MM3440, "Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims," on the CMS website at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3440.pdf*.

The official instruction on this change, CR 4261, may be viewed on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R831CP.pdf*.

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

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: MM4261 Related Change Request (CR) Number: 4261
Related CR Release Date: February 2, 2006 Related CR Transmittal Number: R831CP
Effective Date: July 1, 2006 Implementation Date: July 3, 2006

Medicare Remit Easy Print Enhancements, and Clarification of Check Issue/Electronic Funds Transfer Effective Date

Provider Types Affected

Providers and suppliers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), for services to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 4289, which instructs ViPs (the company that maintains the Medicare Remit Easy Print [MREP] software), carriers, and DMERCs to add enhancements to the current version of the MREP software and provides clarification of the check issue/ electronic funds transfer (EFT) effective date.

Background

On October 11, 2005, the Centers for Medicare & Medicaid Services (CMS) made available the MREP software to enable Medicare providers and suppliers to view and print the Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 (Electronic Remittance Advice (RA). Using the HIPAA 835 files, MREP enables providers and suppliers to view and print Medicare Part B and DMERC 835 in a human readable format. The format is on the current standard paper remittance (SPR) format Medicare uses. MREP provides the ability to:

- View the 835
- Search the 835;
- Print the 835 in a format providers are familiar with; and
- View and print special reports.

Providers who use MREP can print reports to reconcile accounts receivable as well as create document(s) that can be included with claim submission to Coordination of Benefits (COB) payers. MREP is available free to Medicare providers and suppliers, and it can be installed on a personal computer or network. Please contact your Medicare contractor to download a copy of the MREP software.

Keeping MREP Up to Date

In order to continuously improve this product, CMS set up a process to collect valuable suggestions and recommendations to improve MREP's functionality and effectiveness from providers, contractors (carriers and DMERCs), and CMS staff.

Using the suggestions and recommendations received before the cutoff date of November 15, 2005, CMS determined enhancements that were needed for MREP, and CR 4289 includes a summary page attachment listing the MREP enhancements to be implemented in the MREP software release in July 2006.

ViPs will update the MREP software to incorporate the listed enhancements.

Enhancement updates to be implemented in October 2006 will include suggestions/recommendations received between November 16, 2005, and the next cut-off date. Annual enhancement updates to MREP will be scheduled for each year in October.

If you are on the contractor list serv, you will be notified when the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) file is updated three times a year, in April, August, and December. This file is the master listing of CARC and RARC used in printing the glossary on the MREP printout. Washington Publishing Company (WPC) publishes updates to this list three times a year. An update to the MREP application will be issued to correspond to the WPC updates. Your Medicare carrier will post a notification when these updates will be available, and a MLN Matters article is usually published to explain the changes in these updates.

MREP Enhancements,and Clarification of Check Issue/Electronic Funds Transfer Effective Date

Clarification of the Check Issue/EFT Effective Date

The providers receiving both electronic and paper remittance advice (RA) reported an issue to contractors.

- The MREP software populates the "Check Issues/EFT Effective Date" from the BPR16 data field (in the 835 transaction).
- The SPR uses the information contained in the "Production Date" from the DTM 02 data field (in the 835 transaction).

These two dates are the same if:

- The qualifier in the BPR 04 data field (in the 835 transaction) is either "CHK" or "NON"

However, if the qualifier in BPR 04 data field is "ACH" (for electronic funds transfer), then the BPR 16 data field may be different than the "Production Date."

This acknowledges the fact that it may take a few days to have the funds electronically moved from the Medicare financial institution to the provider's financial institution.

CMS requires that the paper RA must mirror the electronic RA, and any software reading the electronic RA must have the same information in the output as in the electronic RA.

CR 4289 repeats the instruction originally included in CR1953 (Transmittal B-01-76, dated December 11, 2001, *http://www.cms.hhs.gov/Transmittals/Downloads/B0176.pdf*), which states that **the information for Check Issue /EFT Effective Date must**:

- Be populated from the BPR16 data field, and
- Not from the DTM 02 data field.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R833CP.pdf* on the CMS website. Attached to that instruction is the list of enhancements that will be incorporated in the July 3, 2006, version of the MREP software.

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

Medlearn Matters Number: MM4289 Related Change Request (CR) #: 4289
Related CR Release Date: February 3, 2006 Effective Date: July 1, 2006
Related CR Transmittal #: R833CP Implementation Date: July 3, 2006

Medicare Remit Easy Print Software

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

Provider Types Affected

Providers, physicians, suppliers, and qualified non-physician practitioners billing Medicare carriers, including durable medical equipment regional carriers (DMERCs)

Provider Action Needed

STOP – Impact to You

This article provides an overview of the new Medicare Remit Easy Print (MREP) software developed by the Centers for Medicare & Medicaid Services (CMS), which is now available for you to view and print the Health Insurance Portability and Accountability Act (HIPAA) compliant electronic remittance advice (ERA).

CAUTION – What You Need to Know

With the new MREP software, you can view and print as many or as few claims as needed. This is especially helpful when you need to print only one claim from the remittance advice (RA) when forwarding the claim to a secondary payer.

GO – What You Need to Do

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

Background

In June 2005,CMS announced to carriers (including DMERCs) their Remittance Advice (RA) Initiative, which included plans to reduce the number of standard paper remittance advices (SPRs) printed and mailed as well as increase usage of the ERA.

Medicare Remit Easy Print Software

As part of the RA initiative, CMS developed MREP software to enable physicians and suppliers to read and print the HIPAA-compliant ERA (also known as Transaction 835 or "the 835").

MREP software uses the ERA file that is sent to you by your carrier/DMERC in the HIPAA-compliant 835 format.[1] Other electronic formats cannot be used.

Medicare Remit Easy Print Software, continued

[2]With the new MREP software, you will be able to:

- Navigate and view the ERA using your personal computer;
- Search and find ERA/claims information easily;
- Print the ERA in the SPR format;
- Print and export reports about ERAs including denied, adjusted and deductible applied claims; and
- Archive, restore, and delete imported ERAs.

To utilize the MREP software, you will need to receive a HIPAA-compliant ERA (HIPAA 835). Contact your carrier/DMERC to find out more about MREP and/or for information on how to receive HIPAA compliant ERAs.

MREP software will be revised three times per year to accommodate claim adjustment reason and remittance advice remark code set changes. You can sign up to be notified automatically when a new version of MREP is available at your carrier's/DMERC's website.

[1] Beginning October 1, 2005, new Medicare contractors are called Medicare Administrative Contractors (MACs). Also, from October 2004 through October 2011, all existing fiscal intermediaries (FIs) and carrier contracts will be transitioned into MAC contracts, using competitive procedures. Providers may access the most current Medicare Contracting Reform information to determine the impact of these changes at *http://www.cms.hhs.gov/MedicareContractingReform/* on the CMS website.

[2] CMS plans to end the use of other formats soon.

Availability and Cost

MREP software can save you time resolving Medicare claim issues, and it provides features unavailable with the SPR. MREP is available to you **free of charge**, and further information on the software (including how to obtain a free copy) is available at your carrier's or DMERC's website.

Benefits of Using MREP Software

1. Save Time and Money

You can print remittance information directly from your computer the day the HIPAA 835 is available. No more time is spent waiting for the mail!

2. Create and Print Special Reports

With MREP, you can run several useful reports including:

- **Deductible Service Lines Report**: Shows claim service lines that have a deductible amount.
- **Adjusted Service Lines Report**: Shows claims within a single remittance that have a claim status 22 (reversed claim).
- **Denied Service Lines Report**: Shows only claim service lines that have an allowed amount of zero *and* are associated with a claim that does not have a claim status 22 (reversed claim).

3. Print and Forward Claims for Other Payers

MREP provides the ability to print remittance information for individual or multiple selected claims, and it allows you to forward only those claims that are needed by other payers for secondary payment.

You may view and/or print as many or as few claims as needed. This eliminates the need for you to darken individually identifiable data on the SPR, as you may do today, that does not pertain to the claim for which you are requesting payment.

4. Navigate and View Remittance Information

MREP organizes and presents information in a manner that makes it easy for you to view. It also provides separate tabs to access the following:

- A list of claims
- Details for individually selected claims
- Summary information
- Glossary information containing claim adjustment reason codes, remittance advice remark codes, and their definitions
- A data view that allows you to look at the various loops and segments containing data in the HIPAA 835
- A search function to find claims containing specific information.

5. Search for Claim(s) Information Quickly and Easily

MREP's search function can help you find a claim (or multiple claims) based on your customized search criteria. Using it, you can search by names, numbers, and even portions of information such as:

- Health Insurance Claim Number (HICN)
- Beneficiary Last Name
- Internal Control Number (ICN)
- Beneficiary Account Number
- Procedure Code
- Service Date
- Rendering Provider Number.

Note: MREP's search capability provides a powerful way to save time and money when examining remittance information.

Medicare Remit Easy Print Software, continued

6. Eliminate Need for Physical Filing and Storage Space

MREP software imports a HIPAA 835 (once you have received it from your carrier/DMERC) and saves the information as a separate Import file to help ensure that the original HIPAA 835 file remains intact.

It also provides an easy-to-use method to archive, restore, and delete these import files as you maintain your remittance records (further reducing the need for physical filing of printed copies and additional storage space).

As you gain familiarity with the MREP software, you will be able to take advantage of the numerous keystroke shortcuts designed to streamline use of the software and save you time while viewing your remittance information.

Installing and Using MREP Software

To install and use the MREP software, your computer system(s) must meet the following minimum criteria:

- IBM-compatible PC
- Windows XP (Recommended), Windows 2000, Windows NT, or Windows 98 SE
- 2.0 GHz processor
- 256 MB RAM
- 3 MB hard disk space
- NET Framework version 1.1 or higher.

Additional Information

For more information about the MREP software and how to receive the HIPAA 835, please contact your carrier/DMERC. Medicare Part B Electronic Data Interchange (EDI) Helpline phone numbers are available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/* on the CMS website.

MLN Matters Number: SE0611	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 Remit Easy Print Software Is Available from Medicare Carrier or DMERC Website

In an effort to advance toward an electronic environment, the Centers for Medicare & Medicaid Services (CMS) has developed software called Medicare Remit Easy Print that enables physicians, providers, suppliers, and qualified nonphysician practitioners that bill Medicare carriers and durable medical equipment regional carriers (DMERCs), to view and print Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 835s from their own computer. Remittance advices printed from the MREP software mirror the current standard paper remittance advice (SPR) format.

Before using the MREP software, physicians and suppliers must have access to HIPAA 835 files. For your reference, a Special Edition Medlearn Matters article – SE0611 is available at: *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0611.pdf*.

Physicians and suppliers can save time and money with MREP! Benefits for physicians and suppliers include the ability to:

- View, search, and print remittance information.
- Print and export reports of denied, adjusted and deductible service lines.
- Print remittance information for individual or multiple selected claims, which allows physicians/suppliers to forward only those claims that are needed by other payers for secondary/tertiary payment. This eliminates the need for physicians and suppliers darkening individually identifiable data on the SPR, as they may do today, that does not pertain to the claim for which they are requesting payment.
- Receive updates to claim adjustment reason codes and remittance advice remark codes three times a year. Physicians and suppliers can sign up on their carrier or DMERC website to be notified of these updates.
- Eliminates physical filing and storage space needs.

Providers using MREP have told CMS:

"I am very impressed with the free easy print software. It works great - and I am finding it is a great timesaver for billing secondaries to denial management. Thank you."

"We love our Easy Print Software and so do our other 17 providers that this business office supports."

"With the latest update we like the claim detail printing when we print the EOB."

MREP software information (including how to obtain a free copy) is available on Medicare contractor websites. To learn more about the new MREP software and how to receive the HIPAA 835, physicians and suppliers should contact their Medicare carrier or DMERC. Medicare Part B Electronic Data Interchange (EDI) helpline phone numbers are available on the CMS website at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/*.

The toll-free number for First Coast Service Options, Inc. Electronic Data Interchange helpline is

FL: 1-904-791-8767, option 1
CT: 1-203-639-3160, option 1

Source: Provider Education Resources Listserv, Message 200603-02

Medicare Remit Easy Print Version 1.7 Available to Download!

Version 1.7 includes the latest version of the claim adjustment reason codes and the remittance advice remark codes, as well as fixes for importing 835 files. These fixes help you specifically identify any problems encountered while importing your 835 with an Import Exception Summary report!

In addition, there are some documentation changes to the user guide. Remember you can save time and money by taking advantage of **FREE** Medicare Remit Easy Print (MREP) software now available to view and print the HIPAA compliant 835!

In order to use the latest version of MREP (Version 1.7), you must click on the link and download the software in its entirety: *http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp#TopOfPage*

Source: CMS Joint Signature Memorandum 06422, dated May 1, 2006

2005 Revised American National Standards Institute X12N 837 Professional Health Care Claim Companion Document

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

Provider Types Affected

Physicians and suppliers who submit electronic X12N 837 claim forms to Medicare carriers, including durable medical equipment regional carriers (DMERCs).

Background

The Centers for Medicare & Medicaid Services (CMS) is updating the current inbound 837 Professional companion document to provide revisions, correct errors, and implement additional language to cover the new national provider identifier (NPI).

This companion document, attached to CR 4260, supplements (but does not contradict) the X12N 837 Professional Implementation Guide and clarifies Medicare carrier and DMERC expectations regarding data/claim submission, processing, and adjudication. The revised companion guide will be available through your Medicare carrier and DMERC via their newsletter, website, and and/or list serve postings.

Key Points

The most important changes to the X12N 837 Professional Health Care Claim Companion Document clarify the specific processing or adjudication of the X12 837, and include the following:

Additions

- New NPI information statement – "The National Provider Identifier (NPI) must be submitted in the NM109 segment (NM108 = XX)";
- Revised taxonomy code set statement for an updated Washington Publishing Company URL, which is http://www.wpc-edi.com/codes/taxonomy;
- New "Application Receiver Code" title to GS03 statement;

Corrections/Clarifications

- Corrected qualifier statement to show that only valid qualifiers may be submitted and qualifiers submitted for Medicare processing that are not defined for use by Medicare could result in claim/transaction rejection;
- Correction of the SV104 anesthesia value statement - changing "units" to "minutes" and correcting the implementation guide page reference from "400" to "403";
- Clarification of the SV104 and PS102 language to show that negative values submitted in these fields could result in claim rejection.

Additional Information

Please note the following message, which will be included in the revised X12N 837 companion document:

"The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. The implementation guides for each X12 transaction adopted as a HIPAA standard are available electronically at *http://www.wpc-edi.com*. This companion document supplements, but does not contradict any requirements in the X12N 837 Professional Implementation Guide."

Relevant Links

CR 4260 is the official instruction issued to your carrier, including your DMERC, regarding this change. CR 4260 may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R871CP.pdf* on the CMS website.

Please contact your local carrier or DMERC if you have questions about this issue.

To find the toll free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* 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: MM4260	Related Change Request (CR) #: 4260
Related CR Release Date: February 24, 2006	Effective Date: March 24, 2006
Related CR Transmittal #: R871CP	Implementation Date: March 24, 2006

Attestation Form for Conducting Real Time Eligibility Inquiries with Medicare

CMS has issued the following "MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Second Quarter 2006 Medicare B Update! pages 50-51.

Note: This article was revised on January 31, 2006, to change the effective date from October 1, 2006, to October 1, 2005. All other information remains the same.

Provider Types Affected

Providers who access the 270/271 health care eligibility inquiry and response application in real time

Provider Action Needed

STOP – Impact to You

Beginning September 1, 2005, an on-line attestation form (*Trading Partner Agreement for Submission of 270s to Medicare on a Real-Time Basis)* must be completed by submitters authenticated by the Centers for Medicare & Medicaid Services (CMS) to conduct 270/271 transactions with CMS before providers may access the real-time 270/271 health care eligibility inquiry and response application.

CAUTION – What You Need to Know

Submitters requesting access to the Medicare beneficiary database must follow the procedure outlined in the *Additional Information* section below.

GO – What You Need to Do

Please be sure to fill out this new agreement form located at *http://www.cms.hhs.gov/it* so you can conduct 270/271 transactions with Medicare.

Background

The purpose of Change Request (CR) 4093 is to alert Medicare providers to the revision in the *Medicare Claims Processing Manual*, Chapter 31 (ANSI X12N Formats Other than Claims or Remittance).

This revision addresses the standards for Medicare beneficiary eligibility inquiries, and creates the database and infrastructure needed to provide a real-time, centralized Health Insurance Portability and Accountability Act (HIPAA) compliant Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

Additional Information

Access Process for Clearinghouses/Provider

Beginning September 1, 2005:

- The Medicare Eligibility Integration Contractor (MEIC) will e-mail the on-line attestation form outlining security and privacy procedures for submitters already submitting authenticated 270 transactions on a real time basis.
- Each Submitter should complete the form in its entirety and transmit it back via e-mail to *MCAREHD@emdeon.com.*

Beginning October 1, 2005:

- Submitters will be able to access the appropriate forms for the CMS 270/271 Medicare Eligibility transaction at: *http://www.cms.hhs.gov/AccessToDataApplication*
- The submitter must provide the information requested on the form electronically and click on the appropriate assurances. If the submitter does not consent to the terms of the agreement, by appropriately completing the form, the access process will be terminated.
- A copy of the appropriately completed form must be electronically submitted to CMS. Once CMS has the completed form, it will be authenticated, at which time the submitter will then be directed to complete an Medicare Data Communications Network (MDCN) connectivity form and submit it electronically in order to be connected to the 270/271 eligibility database.

CMS staff will make sure that all of the necessary information is provided on the form, and will ensure the complete connectivity to the 270/271 application.

A CMS contractor known as the Medicare Eligibility Integration Contractor (MEIC) will contact the submitter in order to authenticate the accessing entity's identity.

Once authentication has been completed, the MEIC will provide the Clearinghouses, Providers, and Trading Partners with a submitter identification (ID) that must be used on all 270/271 transactions.

The MDCN extranet application is suitable for many providers that can create, send, and receive complete X12 eligibility transactions. CMS will soon offer a second solution for providers that desire to conduct the transaction using the Direct Data Entry (DDE) version. The DDE version will allow all approved providers to conduct eligibility transactions over the public Internet at no cost to the provider.

Please note that in order to access the MDCN, an entity must obtain the necessary telecommunication software from the AT&T reseller on its own. AT&T Resellers and contact cumbers include the following:

- IVANS: *http://www.ivans.com*; Telephone: 1-800-548-2675
- McKesson: *http://www.mckesson.com*; Telephone: 1-800-782-7426; Key option 5, then key option 8

MEIC Helpdesk Support

You may also contact the MEIC help desk for connectivity issues on Monday through Friday, 7:00 a.m. - 9:00 p.m. EST; Telephone: 1-866-324-7315; E-mail address: *MCARE@cms.hhs.gov*.

Related Links

The official instruction issued to your fiscal intermediary (FI), regional home health intermediary (RHHI), carrier, or durable medical equipment regional carrier (DMERC) regarding this change may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R700CP.pdf* on the CMS website.

Please refer to your local FI, RHHI, Carrier or DMERC for more information about this issue. To find the toll free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4093 *Revised*
Related Change Request (CR) #: 4093
Related CR Release Date: October 7, 2005
Effective Date: October 1, 2005
Related CR Transmittal #: 700
Implementation Date: November 7, 2005

FRAUD AND ABUSE

An Open Letter to Health Care Providers from the Inspector General

This open letter discusses certain of my perspectives on compliance, the resolution of health care fraud cases, corporate integrity agreements (CIAs), and the OIG's provider self-disclosure protocol (SDP). I am also announcing an initiative that promotes the use of the SDP to resolve civil monetary penalty (CMP) liability under the physician self-referral and anti-kickback statutes for financial arrangements between hospitals and physicians.

In addition to working with our law enforcement partners to sanction companies and individuals who violate the law, OIG also commits substantial resources to promote voluntary compliance by the health care industry. Our guidance to the industry, in the form of advisory opinions, special fraud alerts, special advisory bulletins, and compliance program guidance, offers substantive assistance to program participants committed to promoting ethical and lawful conduct in their organizations. Examples of recent guidance include a special advisory bulletin in concerning patient assistance programs for Medicare Part D enrollees, and a supplemental compliance program guidance for hospitals. All of our compliance materials may be found at OIG's website, *http://www.oig.hhs.gov*.

When a health care provider is alleged to have violated the law, OIG's first priority is to protect the Department's programs and their beneficiaries. OIG has several tools available for pursuing this goal, including program exclusion, CMPs, and integrity agreements. We will continue to seek the exclusion of providers that demonstrate a lack of integrity, or that provide substandard care to beneficiaries. For those providers that demonstrate the requisite level of trustworthiness and that also have in place, or are willing to develop, an effective compliance program, OIG will waive its exclusion authority concurrent with resolution of monetary liability under the False Claims Act and the CMP Law. Typically, these settlements include an integrity agreement between OIG and the provider.

Effective compliance systems are key to strengthening the integrity of the health care system. OIG integrity agreements have been a catalyst for change in corporate culture, and can result in the development of comprehensive internal control systems. Our communications with providers during the course of our compliance monitoring efforts have also enhanced compliance within their organizations.

While we are committed to working collaboratively with providers operating under integrity agreements, some providers fail to demonstrate a commitment to compliance even while operating under such agreements. Integrity agreements typically include contractual remedies for breach of the agreement, including stipulated penalties and exclusion from federal health care programs. Since 1999, OIG has imposed stipulated penalties totaling about $300,000 in 21 cases where providers have failed to meet explicit requirements of their integrity agreements. In a recent case involving repeated and flagrant violations of a CIA, we excluded a hospital.

The OIG's November 2001 "Open Letter to Health Care Providers" continues to guide decisions about whether to require an integrity agreement and the specific terms of these agreements. Many providers have independently developed robust and effective compliance programs, which include internal auditing mechanisms. In appropriate cases, we have agreed to reduce the obligation on providers settling health care fraud matters by entering into certification of compliance agreements (CCAs), rather than more extensive CIAs. CCAs require providers to certify that they will continue to operate their existing compliance programs for a fixed term, typically three years, rather than enter into a more extensive CIA with a five-year term. CCAs do not require independent review organizations to conduct or verify audits or claims reviews.

A provider's self-disclosure of conduct continues to be an important factor in determining whether a CCA is appropriate, because detection and prompt disclosure of potential fraud are evidence of an effective compliance program. The OIG's 1998 SDP (available on OIG website) sets forth a mechanism for providers to investigate, quantify, and resolve potential fraud matters. Consistent with the 2001 open letter, we have required CIAs in only 27 of the 136 self-disclosures resolved with a monetary payment.

OIG has heard from hospitals that, through their compliance programs, they are discovering improper arrangements under the physician self-referral law (42 U.S.C. section 1395nn) and are seeking a way to resolve violations. The SDP is one vehicle to resolve this type of administrative liability. OIG has the authority to impose CMPs of up to $15,000 for each service billed in knowing violation of the physician self-referral law, and assessments of up to three times the amount claimed for such services (see 42 U.S.C. section 1395nn(g)(3)). Hospitals and physicians also have potential liability for these arrangements under OIG's anti-kickback CMP (see 42 U.S.C. section 1320a-7a(a)(7)), which authorizes a penalty of $50,000 for each kickback, plus an assessment of not more than three times the total amount of remuneration offered, paid, solicited, or received. In addition to CMPs, OIG may also seek exclusion under these authorities.

An Open Letter to Health Care Providers from the Inspector General, continued

We are now seeking to increase awareness in the hospital and physician communities of a way to resolve conduct that may result in liability under the OIG's CMP authorities for physician self-referral and anti-kickback violations. This new initiative supplements the SDP by providing guidance on how these types of disclosures will be resolved. The initiative incorporates the SDP process, whereby OIG confers with the Department of Justice (DOJ) to ensure that it is aware of each disclosure and has an opportunity to opine before OIG accepts a provider into the Protocol and is presented with the results of OIG's review of the SDP matter before it is resolved under OIG's CMP authorities. It is important to stress that OIG's agreement to resolve an SDP matter is not binding upon DOJ.

The initiative is limited to matters that, in the provider's reasonable assessment, involve conduct that subjects the provider to CMP liability under the OIG's physician self-referral and anti-kickback authorities-in particular, situations involving a financial benefit knowingly conferred by a hospital upon one or more physicians. The financial benefit conferred upon a physician may take various forms, for example, an arrangement under which the physician pays the hospital below fair market value for a good or service (e.g., lease of office space).

Because multiple OIG authorities are implicated, a provider's liability in these cases typically falls along a continuum—the CMP damages calculation for physician self-referral violations is based on the number and dollar value of improper claims, while the CMP damages calculation for kickbacks is based on the number and dollar value of improper payments or remuneration. Subject to the facts and circumstances of the case, OIG will generally settle SDP matters for an amount near the lower end of this continuum, i.e., a multiplier of the value of the financial benefit conferred by the hospital upon the physician(s).

A provider's participation in the SDP is contingent upon full cooperation and complete disclosure of the facts and circumstances surrounding the violation. Providers will be removed from participation in the initiative unless they disclose in good faith and timely perform the required self-assessment, including quantifying the financial benefits conferred upon the physician(s) and quantify the full amount of the overpayment. The degree of the provider's cooperation is considered when determining the appropriate terms of an administrative settlement. OIG will also consider the provider's existing compliance program when evaluating whether a CIA, CCA, or no additional compliance measures will be required.

This new self-disclosure initiative will serve as an additional opportunity for providers to work collaboratively with OIG and to tae responsibility for further strengthening the integrity of our health care system. I look forward to continuing our joint efforts to promote compliance in the federal health care programs. ❖

Source: Mr. Daniel L. Levinson, Inspector General, April 24, 2006

Revised CMS-1500 Claim Form

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

Provider Types Affected

Physicians, providers, and suppliers who are excluded from the mandatory electronic claims submission requirements and submit claims to Medicare carriers using the CMS-1500 paper claim form

Important Points to Remember

CR4293 describes the claim form **CMS-1500 (12-90)** that is being revised to accommodate the reporting of the National Provider Identifier (NPI) and will then be named **CMS-1500 (08-05).** The following timeline outlines the schedule for using the revised CMS-1500 claim form:

- October 1, 2006: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised CMS-1500 (08/05) claim form.
- October 1, 2006 – January 31, 2007: Providers can use either the current CMS-1500 (12/90) version or the revised CMS-1500 (08/05) version of the claim form.
- February 1, 2007: The current CMS-1500 (12/90) version of the claim form is discontinued; only the revised CMS-1500 (08/05) form is to be used. All rebilling of claims should use the revised CMS-1500 (08/05) form from this date forward, even though earlier submissions may have been on the current CMS-1500 (12/90) claim form.

Background

The Form CMS-1500 form answers the needs of many health insurers. It is the basic form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program and is accepted only from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

The CMS-1500 (12-90) claim form is being revised to accommodate the reporting of the National Provider Identifier (NPI). The intent of the new form is to best accommodate the NPI with minimal changes to the current claim form. The CMS-1500 (08-05) version will be effective October 1, 2006, but will not be mandated for use until February 1, 2007. Therefore, there will be a period when the current and the revised forms will both be acceptable.

The change log that lists the various changes made to the CMS-1500 (08-05) version can be viewed at the National Uniform Claim Committee (NUCC) website at *http://www.nucc.org/images/stories/PDF/change_log.pdf.*

Implementation

The implementation date for the instruction is October 2, 2006

Additional Information

The official instructions issued to your Intermediary regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R899CP.pdf* on the CMS website.

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

You may also wish to review MLN Matters articles:

- **SE0555**, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI Related Activities" available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf* on the CMS website; and/or
- **SE0528**, "CMS Announces the National Provider Identifier (NPI) Enumerator Contractor and Information on Obtaining NPIs" available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0528.pdf* on the CMS website.

MLN Matters Number: MM4293
Related Change Request (CR) #: 4293
Related CR Release Date: March 31, 2006
Effective Date: October 1, 2006
Related CR Transmittal #: R899CP
Implementation Date: October 2, 2006

NATIONAL PROVIDER IDENTIFIER

NPI – Medicare Policy on Subpart Designation

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

Provider Types Affected

Provider types affected include organization health care providers and suppliers who are covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and who are enrolled in the Medicare program. These are certified providers and suppliers, supplier groups and supplier organizations, and suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).

(This information does not apply to health care providers who are enrolled in Medicare as individual practitioners, such as physicians and nurse practitioners, nor does it apply to sole proprietors.)

Key Points

- Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions to the new National Provider Identifier, or NPI.
- For Medicare organization health care providers, the current identifiers could include:
- Online Survey Certification and Reporting (OSCAR) system numbers;
- National Supplier Clearinghouse (NSC) numbers;
- Provider Identification Numbers (PINs); and
- Unique Physician Identification Numbers (UPINs) used by Medicare.

These numbers are now considered legacy identifiers or legacy numbers.
Medicare is transitioning from these legacy identifiers to **National Provider Identifiers**, or **NPIs**.

Note: When applying for an NPI, Medicare providers are urged to include their legacy numbers, particularly their Medicare legacy number, on the NPI application form.

- By regulation, Medicare organization health care providers who are HIPAA covered entities must obtain NPIs. The NPIs will replace the identifiers currently in use in standard transactions with Medicare and with other health plans. Additionally, these **health care providers must determine if they have subparts that need to be uniquely identified** in standard transactions with their own NPIs.

Background

Organization health care providers are corporations, partnerships, or other types of businesses that are considered separate from an individual by the state in which they exist. Subparts of such organization health care providers are also organizations. All of these health care providers would apply for NPIs as organizations (Entity Type 2).

Note: In terms of NPI assignment, an Individual is an Entity Type 1 (Individual), and is eligible for a single NPI. As an individual, a physician or nurse practitioner, for example, as well as a sole proprietor/sole proprietorship, cannot have subparts and cannot designate subparts.

Most Medicare organization health care providers (Entity Type 2 providers) send electronic claims to Medicare (standard transactions), making them covered health care providers (HIPAA covered entities).

Subpart Designation Guidelines

Covered organization health care providers are responsible for determining if they have "subparts" that need to have NPIs. If they do, the covered organization health care providers must ensure that the subparts obtain their own unique NPIs, or they must obtain them for them.

Below are some guidelines to help determine if an enrolled Medicare organization health care provider has a subpart, which will need its own unique NPI.

Regarding all of the entities that could be considered subparts:

- A subpart is not itself a separate legal entity, but is a part of a covered organization healthcare provider that is a legal entity. (All covered entities under HIPAA are legal entities.)
- A subpart furnishes health care as defined at 45 CFR 160.103. (This information can be found at *http://www.hhs.gov/ocr/regtext.html* on the Department of Health and Human Services (DHHS) website.)

Regarding some or all of the entities that a Medicare covered organization health care provider could consider as subparts:

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.
- A subpart may or may not have a Taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part.

NPI – Medicare Policy on Subpart Designation, continued

Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI Final Rule. If such statutes or regulations exist, the health care providers to whom they apply would need NPIs in order to ensure they can continue to be uniquely identified.

- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.

Medicare Organization Subpart Examples

Enrolled Certified Providers and Suppliers

An enrolled provider (a hospital) owns 10 home health agencies, all operating under the TIN (Tax Identification Number) of the hospital. Because the hospital and each of the 10 home health agencies is separately surveyed and enters into its own provider agreement with Medicare, Medicare encourages that the hospital mirror its Medicare enrollment and obtain a total of 11 unique NPIs in order to help avoid claims processing delays (one NPI for the hospital, and one for each of the 10 home health agencies).

Enrolled Supplier Group or Supplier Organization

An enrolled Independent Diagnostic Testing Facility (IDTF) has four different locations, and each one must be separately inspected by the carrier. All four locations operate under a single TIN. Because each location is separately inspected in order to enroll in Medicare, Medicare encourages the IDTF to mirror its Medicare enrollment and obtain a total of four unique NPIs in order to help avoid claims processing delays (one NPI for each location).

Enrolled Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI. Federal regulations require that each location of a Medicare DMEPOS supplier have its own unique billing number.

In order to comply with that regulation, each location must have its own unique NPI.

Please note that regardless of how subparts are determined and NPIs obtained, Medicare payments, by law, may be made only to an enrolled Medicare provider or supplier.

Important Medicare NPI Implementation Dates

January 3, 2006 - October 1, 2006

Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI.

Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

October 2, 2006 - May 22, 2007

CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim.

Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.

Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.

May 23, 2007 – Forward

CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

Final Notes About NPIs

With regard to enrolled organization health care providers or subparts who **bill more than one** Medicare contractor:

- An enrolled organization health care provider or subpart is expected to use a
- single (the same) NPI when billing more than one Medicare contractor.
- For example, a physician group practice billing a Maryland carrier and also billing a Pennsylvania carrier would use a single (the same) NPI to bill both carriers.

With regard to enrolled organization health care providers or subparts who bill **more than one type** of Medicare contractor:

- Generally, the type of service being reported on a Medicare claim determines the type of Medicare contractor who processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type (fiscal intermediary, carrier, RHHI, DMERC) of Medicare contractor.
- In certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as **more than one type of provider**.

For example, an ambulatory surgical center enrolls in Medicare as a Certified Supplier, and bills its services to a carrier. If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a Supplier of DME and bill the DME to a DMERC. This ambulatory surgical center would obtain a single NPI and use it to bill the carrier and the DMERC.

NPI – Medicare Policy on Subpart Designation, continued

- Medicare expects that this ambulatory surgical center would report two different taxonomies when it applies for its NPI:
- Ambulatory Health Care Facility—Clinic/Center - Ambulatory Surgical (261QA1903X); and
- Suppliers—Durable Medical Equipment & Medical Supplies (332B00000X) or the appropriate sub-specialization under the 332B00000X specialization.

With regard to enrolled organization health care providers who determine subparts for **reasons unrelated to** Medicare statutes, regulations or policies:

- Consistent with the NPI Final Rule, covered organization health care providers may designate subparts for reasons that are not necessarily related to Medicare statutes or regulations.
- If a Medicare organization health care provider designates as subparts entities **other than** those who are enrolled Medicare providers, and those subparts obtain their own NPIs and use those NPIs to identify themselves in HIPAA standard transactions with Medicare, **those NPIs will not identify enrolled Medicare providers**. Medicare is not required to enroll them.

NPI Final Rule, page 3441 says the following: "If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls."

Additional Information

Medicare's NPI Responsibilities

Medicare will:

- Use NPIs to **identify** health care providers and subparts in HIPAA standard transactions; NPI Final Rule, page 3469: section 162.412(a): "A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider's identifier is required."
- Ensure that the NPIs it receives in HIPAA standard transactions are valid;
- Reject HIPAA standard transactions that contain invalid NPIs.

Valid NPIs, however, like the provider identifiers used today, must be "known" to Medicare. Medicare is not permitted to make payments for services rendered by non-Medicare providers, nor is it permitted to reimburse providers who are not enrolled in the Medicare program. Medicare will return, with appropriate messages, any HIPAA standard transactions containing valid but unrecognizable NPIs.

Related Links

In preparation for the release of the Electronic File Interchange (EFI) system, CMS released several documents on the EFI process. EFI, also referred to as "bulk enumeration," is a process by which a health care provider or group of providers can have a particular organization (the "EFIO") apply for NPIs on their behalf.

EFI documents posted to the Web include a summary, user's guide, and technical companion manual. Visit *http://www.cms.hhs.gov/NationalProvIdentStand/07_efi.asp* to download these new items.

NPI-related information, including how to apply for an NPI and a new fact sheet for health care providers who are individuals, is available at *http://www.cms.hhs.gov/NationalProvIdentStand/* on the CMS website.

The NPI Final Rule can be found at: *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf* on the CMS website.

MLN Matters Number: SE0608	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

NPI Applications Through the Electronic File Interchange Capability Starts May 1, 2006

Beginning May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) announces the capability for health industry organizations to submit health care providers' applications for National Provider Identifiers (NPIs) to the National Plan and Provider Enumeration System (NPPES) via Electronic File Interchange (EFI). With EFI, a CMS-approved health industry organization can submit a health care provider's NPI application data, along with the application data of many other health care providers, in a single electronic file in a CMS-specified format.

EFI is an alternative to health care providers having to apply for their NPI via the Web based or paper application process.

After the NPPES processes a file, it makes available to the organization a downloadable file containing the NPIs of the enumerated health care providers.

NPI Applications Through the Electronic File Interchange Capability, continued

Interested health industry organizations should avail themselves of the EFI materials available from the CMS NPI page (*http://www.cms.hhs.gov/NationalProvIdentStand/*) and from the NPPES page (*https://nppes.cms.hhs.gov*) before downloading and completing the certification statement (available at *https://nppes.cms.hhs.gov*) and registering as EFI organizations. A completed certification statement must be approved by CMS before an interested health industry organization can participate in EFI.

Source: CMS Provider Education Resources Listserv, Message 200605-04

NPI Tip

When applying for your NPI, CMS urges you to include your legacy identifiers, not only for Medicare but also for all payers. If reporting a Medicaid number, include the associated State name. This information is critical for payers in the development of crosswalks to aid in the transition to the NPI CMS has released three new educational products on the National Provider Identifier (NPI):

- **"Guidance for Organization Health Care Providers Who Apply for National Provider Identifiers (NPIs) for Their Health Care Provider Employees" Tip Sheet**— contains helpful information for organization health care providers who wish to apply for NPIs, or submit updates using the NPPES Web-based process, on behalf of their employed health care providers. This is NOT the EFI process.
- **"Tips for Health Care Professionals - Preparing Your Office Staff for NPI" Tip Sheet** - provides basic steps to prepare your office staff, and your business, for NPI implementation.
- **"NPI Overview" PowerPoint Presentation** - this presentation was presented by a CMS staff member at a recent WEDI meeting and contains basic information on the NPI that is suitable for self-education, as well as training purposes.

Visit the Educational Resources page on CMS' NPI website at http://www.cms.hhs.gov/NationalProvIdentStand/04_education.asp to view these new products.

Source: CMS Provider Education Resources Listserv, Message 200604-17

Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or Paper Claim Forms

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare carriers, including durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)

Provider Action Needed

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began accepting applications for and issuing NPIs on May 23, 2005.

Applications can be made by mail, and online at *https://nppes.cms.hhs.gov* on the CMS website.

CMS has endorsed the Workgroup for Electronic Data Interchange (WEDI) Dual NPI-Legacy Identifier strategy for cross-health care industry implementation of the NPI.

The *Dual Use of NPI & Legacy Identifiers* paper is available at: *http://www.wedi.org/snip/public/articles/.* (Once at the site, scroll down and look for the paper issued on Janury 22, 2006.)

The remainder of this article describes CMS' current plans for a staged process leading to full implementation of the adoption of the NPI in Medicare transactions involving providers.

Background

Implementation involves acceptance and processing of transactions that use the NPI in lieu of the previously used OSCAR, UPIN, PIN, and National Supplier Clearinghouse (NSC) numbers. The WEDI strategy provides for four stages during which system change schedules of trading partners will occur independently of each other.

Medicare fee-for-service (FFS) transaction implementation for NPI will occur in the following stages:

Stage 1 (January 1, 2006 – October 1, 2006)

During this stage, the NPI will be accepted on inbound claims, other than NCPDP claims, and other transactions but will not be used for Medicare processing.

CR 4320 focuses primarily on Stage 1 of the NPI implementation process. During stage 1:

- The "Legacy Identifier" (pre-NPI provider identifiers) will be used to identify providers while Medicare carriers, DMERCs, and intermediaries make sure that X12 837 version 4010A1 claims and other X12 HIPAA adopted transactions are not rejected due to the presence of an NPI. (Transactions may be submitted with or without an NPI during stage 1, as long as the Medicare legacy identifier is still reported.)
- Additionally, NPIs will be edited to verify that they meet basic structure requirements established for NPIs.

Stage 1 Use and Editing of NPI Received in EDI Transactions, continued

- Medicare will allow NPIs on the X12 270 version 4010A1 eligibility inquiry and the 276 claim status inquiry and return them in the respective X12 271 or 277 response, as long as the legacy identifier is also reported in the 270 or the 276.
- NPIs, as well as legacy identifiers, will be reported in coordination of benefit claims sent to trading partners when submitted on claims submitted to Medicare.
- NPIs will NOT be reported in the following outbound transactions during Stage 1, even if an NPI was submitted on related claims:

- X12 835 claims; or
- SPRs (standard paper remittance) formats.
- Medicare carriers, DMERCs, and intermediaries must **reject the following transactions if submitted with NPIs**, since it is not possible to report both NPIs and legacy identifiers for providers in these transactions:
- NCPDP claims;
- DDE claims, claim status and eligibility inquiries;
- UB-92 (CMS-1450) paper claims (the National Uniform Billing Committee [NUBC] announced that the use of the UB-04, which is able to report the NPI and a legacy identifier for each provider involved with a claim, will begin March 1, 2007, and that May 22, 2007, is the last day that a payer should accept a UB-92 form). Since it is not possible to report both a legacy identifier and an NPI on the UB-92, submitters of the UB-92 will be limited to reporting of their legacy identifier on those claims; and
- CMS-1500 paper claims until the National Uniform Claim Committee implements a revised 1500 and CMS announces its implementation of that revised form.

  The NUCC has approved a revised CMS-1500 form and has announced that payers should begin to accept the revised form effective October 1, 2006. Between October 1, 2006, and January 31, 2007, payers should accept either the current or the revised CMS-1500 form. Effective February 1, 2007, and later, payers should accept only the revised CMS-1500 form. Both the NPI and the legacy identifier can be reported on the revised CMS-1500 form, but not on the form currently in use. Until a provider begins to use the revised form, that provider will be limited to submission of legacy identifiers on the non-revised CMS-1500 form.

Stage 2: (October 2, 2006 – May 22, 2007)
During this stage:

- Providers, clearinghouses, and billing services will be directed to provide a Medicare legacy identifier as a secondary identifier when NPIs are submitted as the primary provider identifiers in their X12 837 claims.
- The Legacy Identifier alone can still be used to identify those providers that have not yet obtained an NPI.
- The transitional Dual NPI-Legacy Identifier strategy includes the development of a crosswalk between Medicare legacy numbers and their associated NPIs. The crosswalk should help Medicare validate most NPIs to ascertain that they were actually issued to the providers for which reported, and will help to identify transcription errors in a reported NPI. The Crosswalk will begin operating at the onset of stage 2.
- If you use free billing software supplied by your carrier, DMERC, or intermediary/RHHI, it will be modified for stage 2 to permit reporting of your NPI, once received, and your legacy Medicare provider identifier. You will need to download the new version of the software when notified it is available.
- The 835 PC-Print and Easy Print software for printing of remittances will also be updated for stage 2 to permit reporting of NPIs as well as legacy numbers when both are reported in an 835 transaction. Be sure to download the new version of that software when notified it is available.
- DDE screens will be modified for this stage to accept and return both NPIs, when available, and legacy identifiers.
- NPIs, when available in Medicare provider files, as well as legacy identifiers will be returned in 835 transactions and SPRs during stage 2.

Stage 3 (May 23, 2007 – and Later)

Stage 3 involves the transition to full use of the NPI for acceptance and processing of transactions, **except** for coordination of benefits (COB) claims that Medicare sends to small trading partners.

- HIPAA prohibits the reporting of any provider legacy identifiers to other than small health plans during this period (e.g., plans with less than $5 million in annual receipts).
- All claims, including NCPDP claims, and 270, 276, and 277 attachment transactions sent to Medicare, must contain the NPI in lieu of the legacy identifier (please see Stage 4 below regarding claims). Those that do not are to be rejected.
- Legacy identifiers will no longer be sent to coordination of benefits (COB) trading partners or on outbound electronic or paper Medicare transactions or correspondence.

Stage 4 (May 23, 2007 – May 22, 2008)

Stage 4 involves completion of transition to the full use of NPI by all small trading partners. NPIs, rather than legacy identifiers, will be reported in all 837 version 4010A COB and NCPDP claims sent to small trading partners.

Additional Information

CR 4320 is the official instruction issued to your FI, including RHHI, or carrier, including DMERC, regarding changes mentioned in this article. CR 4320 can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf* on the CMS website.

Stage 1 Use and Editing of NPI Received in EDI Transactions, continued

You may also want to review *Medlearn Matters* Special Edition SE0555, concerning the NPI. That article is available at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0555.pdf* on the CMS website.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find their toll free phone number, go to: *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4320 Related Change Request (CR) #: 4320
Related CR Release Date: February 1, 2006 Effective Date: January 1, 2006
Related CR Transmittal #: R204OTN Implementation Date: January 3, 2006

NPI Outreach Initiative

NPI Tip

When applying for your National Provider Identifer (NPI), CMS urges you to include your legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

New Educational Products

CMS has released three new educational products on the NPI:

Suitable for All Health Care Providers

- A Subparts Fact Sheet that contains high-level information on Medicare's guidance on subpart designation. Although the guidance is geared toward Medicare organization providers, non-Medicare organization providers may find it helpful.
- An Electronic File Interchange (EFI) Fact Sheet that contains basic information and links to helpful resources that will prepare providers and their staff for the release of the EFI system. This information is essential for organizations that wish to submit electronic files for bulk enumeration, and may be of interest to any health care provider for whom an organization will be submitting NPI application data.

Suitable for Medicare Providers

- A MLN Matters Article (SE0608) that takes a detailed look at Medicare's guidance on subpart designation and the impact on Medicare providers.

Visit the Educational Resources link at *http://www.cms.hhs.gov/NationalProvIdentStand/* to view these new products, as well as existing products such as four ***MLN Matters*** articles, two fact sheets and the NPI Viewlet.

For more information on private industry NPI outreach, including upcoming meetings, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at *http://www.wedi.org/npioi/index.shtml* on the Web.

Source: Source: Provider Education Resources Listserv, Message 200603-06

GENERAL INFORMATION

Medicare to Stop Mailing Standard Paper Remittance for Providers/ Suppliers Receiving An Electronic Remittance Advice

Beginning June 1, 2006, the standard paper remittance (SPR) received through the mail will no longer be available to providers/suppliers who also receive an electronic remittance advice (ERA), whether the ERA is received directly or through a billing agent, clearinghouse, or other entity representing a provider/supplier.

In response to the provider/supplier communities continued need for SPRs, the Centers for Medicare & Medicare Services (CMS) has developed free software called Medicare Remit Easy Print (MREP) that gives providers/suppliers a tool to read and print a remittance advice (RA) from the HIPAA compliant Health Care Claim Payment/Advice (835) file. The MREP software was designed to incorporate new functionality to save providers/suppliers time and money. The paper output generated by MREP is similar to the SPR format. CMS has worked with other payers to ensure their acceptance of the SPR generated by the MREP software for coordination of benefit claim submission.

Additionally, CMS has worked with clearinghouses to assure similar software is available to read and print an electronic remittance advice (ERA) for those providers/suppliers that utilize clearinghouse services.

We encourage providers/suppliers currently receiving the ERA, who don't use software to read and print RAs from these files, to begin using MREP or other similar software before the June 1st cutoff.

Medicare to Stop Mailing SPR for Providers/Suppliers Receiving An ERA, continued

Additional information is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf*

For further information regarding MREP software, please go to:

Florida: *http://www.floridamedicare.com/edi_getstarted_edepl.asp#TopOfPage*.

Connecticut: *http://www.connecticutmedicare.com/edi_getstarted_edepl.asp#TopOfPage*.

Source: Pub 100-04, Transmittal 885, Change Request 4376
CMS Joint Signature Memorandum (JSM) 06422, dated May 1, 2006

Suppression of Standard Paper Remittance Advice to Providers and Suppliers Also Receiving Electronic Remittance Advice for 45 Days or More

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

Provider Types Affected

All Medicare providers, physicians, suppliers, and qualified non-physician practitioners billing Medicare carriers and durable medical equipment regional carriers (DMERCs)

Provider Action Needed

STOP – Impact to You

CR 4376 provides notice that beginning June 1, 2006, carriers and DMERCs will stop sending standard paper remittance (SPR) advices to you (or a billing agent, clearinghouse, or other entity representing you) if you have been receiving 835s or electronic remittance advice (ERA) transactions, either directly or through a billing agent, clearinghouse, or other entity representing you, for 45 days or more.

CAUTION – What You Need to Know

If you need a paper copy of a remittance advice for accounts reconciliation or to forward to secondary/tertiary payers, be aware that the Centers for Medicare & Medicaid Services (CMS) has developed software that gives you a tool to view and print an 835 in a readable format locally on your computer. This software is called Medicare Remit Easy Print (MREP). See the *Additional Information* section of this article to learn how to access MREP software. Your clearinghouse may also offer software that allows you to view and print your remittance advice.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes. Try MREP software to view and print your own remittance and see the benefits for yourself. Or, check with your clearinghouse to see if it provides similar software.

Background

The *Medicare Claims Processing Manual*, Chapter 22, Section 40.1, Remittance Advice, describes the instructions issued by CMS to carriers and DMERCs. The section instructs carriers and DMERCs to eliminate SPRs to those providers/suppliers who were receiving ERA transactions for 45 days or more.

MREP was developed in response to comments CMS received from the provider/supplier community that they need a paper document for accounts reconciliation, and claim submission for secondary/tertiary payments.

Providers/suppliers who use the MREP software package have the ability to print paper remittances and reports that can be used to reconcile accounts receivable, as well as to create document(s) that can be included with claim submissions to secondary/tertiary payers. The output of MREP is similar to the current SPR format.

Benefits of using MREP software include the ability to:

Save Time and Money

You can print remittance information directly from your computer the day the HIPAA 835 is available. No more time is spent waiting for the mail.

Create and Print Special Reports

With MREP, you can run, export, or print several useful reports including:

- **Deductible Service Lines Report**: Shows claim service lines that have deductible amount.
- **Adjusted Service Lines Report**: Shows claims within a single remittance that have a claim status 22 (reversed claim).
- **Denied Service Lines Report**: Shows only claim service lines that have an allowed amount of zero and are associated with a claim that does not have a claim status 22 (reversed claim).

Print and Forward Claims for Other Payers

MREP provides the ability to print remittance information for individual or multiple selected claims, and it allows you to forward only those claims that are needed by other payers for secondary payment. You may view and/or print as many or as few claims as needed. This eliminates the need for you to darken individually identifiable data on the SPR, as you may do today, that does not pertain to the claim for which you are requesting payment.

Suppression of SPR to Providers and Suppliers Also Receiving ERA for 45 Days or More, continued

Navigate and View Remittance Information

MREP organizes and presents information in a manner that makes it easy for you to view. It also provides separate tabs to access the following:

- A list of claims;
- Details for individually selected claims;
- Summary information;
- Glossary information containing Claim Adjustment Reason Codes, Remittance Advice Remark Codes, and their definitions;
- A data view that allows you to look at the various loops and segments containing data in the HIPAA 835; and
- A search function to find claims containing specific information.

Note: MREP software will be revised three times per year to accommodate claim adjustment reason and remittance advice remark code set changes. You can sign up to be notified automatically when a new version of MREP is available at your carrier's/DMERC's website.

Search for Claim(s) Information Quickly and Easily

MREP's search function can help you find a claim (or multiple claims) based on your customized search criteria. Using it, you can search by names, numbers, and even portions of information such as:

- Health Insurance Claim Number (HICN);
- Beneficiary Last Name;
- Internal Control Number (ICN);
- Beneficiary Account Number;
- Procedure Code;
- Service Date; and
- Rendering Provider Number

Note: **MREP's search capability provides a powerful way to save time and money when examining remittance information.**

Eliminate Need for Physical Filing and Storage Space

MREP software imports a HIPAA 835 (once you have received it from your carrier/DMERC) and saves the information as a separate import file to help ensure that the original HIPAA 835 file remains intact.

It also provides an easy-to-use method to archive, restore, and delete these Import files as you maintain your remittance records (further reducing the need for physical filing of printed copies and additional storage space).

As you gain familiarity with the MREP software, you will be able to take advantage of the numerous keystroke shortcuts designed to streamline use of the software and save you time while viewing your remittance information.

Implementation

The implementation date for this instruction is June 1, 2006

Additional Information

To learn about more MREP benefits, download the brochure available at *http://www.cms.hhs.gov/MLNProducts/downloads/remit_easy_print.pdf* on the CMS website.

Or, you can view Special Edition MLN Matters article SE0611 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf* on the CMS website.

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

For more information about the MREP software and how to receive the HIPAA 835, please contact your carrier/DMERC. Medicare Part B Electronic Data Interchange (EDI) helpline phone numbers are available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/* on the CMS website.

The official instructions issued to your carrier/DMERC regarding this change can be found at *http://www.cms.hhs.gov/transmittals/downloads/R885CP.pdf* on the CMS website.

Medlearn Matters Number: MM4376
Related Change Request (CR) #: 4376
Related CR Release Date: March 10, 2006
Effective Date: March 15, 2006
Related CR Transmittal #: R885CP
Implementation Date: June 1, 2006

Options for Providers/Suppliers Affected by CR4376: Suppression of Standard Paper Remittance Advice to Providers and Suppliers Also Receiving Electronic Remittance Advice for 45 Days or More

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

Provider Types Affected

Physicians, suppliers, qualified non-physician practitioners, and other providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs).

Provider Action Needed

STOP – Impact to You

This article reminds providers that as of June 1, 2006, if you have been receiving **both** an electronic remittance advice (ERA), either directly from your Medicare carrier/DMERC or indirectly from a clearinghouse, billing agent, or other entity representing you, **and** a standard paper remittance (SPR) from your carrier/DMERC for 45 days or more, that **you will no longer be mailed an SPR** by your carrier/DMERC, in accordance with Change Request (CR) 4376.

This article outlines some of the options available to providers who will no longer receive the SPR directly from their carrier/DMERC.

CAUTION – What You Need to Know

Are you receiving an ERA? Make sure you know if and how you receive the ERA. You may be receiving your ERA directly from your carrier/DMERC or you may be receiving your ERA indirectly through a billing agent, clearinghouse, or other entity representing you. No matter how you receive your ERA, if you are also receiving an SPR from your carrier/DMERC in addition to receiving an ERA for 45 days or more, after June 1, 2006, your carrier/DMERC will no longer mail you an SPR. **If you still need both, take appropriate action now.**

GO – What You Need to Do

If you need the SPR, take action **NOW** so you can avoid any business disruption associated with the June 1, 2006, cutoff of the SPR. If your clearinghouse, billing agent, or other entity cannot offer a way (e.g. print software) for you to receive or generate a paper remittance, it may be beneficial to explore other options.

Determine which of the following scenarios represents your situation:

You are receiving the ERA directly from your carrier in the HIPAA compliant 835 format:

Use the Medicare Remit Easy Print (MREP) software. * MREP requires that you import ERAs in the HIPAA-compliant 835 format. (See the *Additional Information* section of this article for further information.). MREP is **free** software that allows you to:

- Print the ERA for individual or multiple selected claims in a format mirroring the SPR, so you can forward your remittance to secondary/tertiary payers;
- Easily navigate and view remittance information;
- Quickly access claim information;
- Print and export useful reports about ERAs including denied, adjusted, and deductible service lines;
- Receive the latest version of claim adjustment reason and remittance advice remark code sets, three times a year;
- Archive, restore, and delete imported ERAs; and
- Eliminate physical filing and storage space needs.

*This software was developed by the Centers for Medicare & Medicaid Services (CMS) for use by Medicare providers/suppliers to view and print a Health Insurance Portability and Accountability (HIPAA)-compliant Medicare 835. Medicare has no liability and takes no responsibility for any other use of this software.

You are receiving a HIPAA-compliant 835 from a billing agent, clearinghouse, or other entity:

Use MREP or software offered by the billing agent, clearinghouse, or other entity representing you to view and print your paper remittance advice.

You are receiving the ERA directly in a format that is not the HIPAA compliant 835-format:

Transition to the HIPAA-compliant 835 format now, so you can begin using MREP. CMS ended the contingency plan for non-HIPAA claims, i.e., 837-transaction, in 2005. CMS will be ending the contingency plan for the non-HIPAA remittance advice, i.e., the 835, next.

You are receiving an ERA that is not the HIPAA-compliant 835 format from your billing agent, clearinghouse, or other entity representing youand they do not offer software or other means that allows you to view and print your remittance advice:

Work with them so that they will send you a HIPAA-compliant 835, so you can use MREP.

You have a need for the paper remittance advice and your clearinghouse, billing agent, or other entity representing you is receiving the ERA on your behalf, but does not currently forward the ERA to you:

Work with your clearinghouse, billing agent, or other entity to receive the ERA and use MREP. This may be your situation if the clearinghouse, billing agent, or other entity representing you receives the ERA for you, but until now there has been no business reason to forward the ERA to you.

Options for Providers/Suppliers Affected by CR4376, continued

Background

CMS has an initiative for moving to a more electronic transaction environment and reducing the cost associated with producing and mailing the paper remittances sent by CMS contractors. The *Medicare Claims Processing Manual*, Chapter 22, Section 40.1, Remittance Advice, describes the instructions issued by CMS to carriers and DMERCs. The section instructs carriers and DMERCs to eliminate SPRs to those providers/suppliers who were receiving ERA transactions for 45 days or more.

Implementation

The implementation date is June 1, 2006

Additional Information

To learn about more MREP benefits, download the brochure available at *http://www.cms.hhs.gov/MLNProducts/downloads/remit_easy_print.pdf* on the CMS website. Or, you can view Special Edition MLN Matters article SE0611 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf* or a related MLN Matters article (MM4376) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4376.pdf* on the CMS website.

For more information about the MREP software and how to receive the HIPAA 835, please contact your carrier/DMERC. Medicare Part B Electronic Data Interchange (EDI) helpline phone numbers are available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/* on the CMS website.

If you have other questions, please contact your Medicare carrier/DMERC 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).

The official instructions (CR4376) issued to your carrier/DMERC regarding this change can be found at *http://www.cms.hhs.gov/transmittals/downloads/R885CP.pdf* on the CMS website.

Note: CMS issued reminders of this change via the Contractor Provider Education Resources Listserv on: April 21, 2006, posted to our provider education website on April 25, 2006. and April 28, 2006, posted to our provider education website on April 28, 2006.

MLN Matters Number: SE0627 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

Source: CMS Special Edition Article SE0627, Provider Education Resources Listserv, Messages 200604-12 & 200604-15

Provider Enrollment in the Medicare Program

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

What You Need To Know

- You must enroll in the Medicare program in order to receive Medicare payment for covered services that you provide to Medicare beneficiaries.
- The Medicare enrollment application and process are used to collect information about you and to secure the necessary documentation to ensure you are qualified and eligible to enroll in the Medicare program.
- This article contains helpful information about the Medicare enrollment process.

Background

Physicians, providers, and suppliers must enroll in the Medicare program in order to receive Medicare payment for services provided to its beneficiaries.

You can accomplish this enrollment by completing the Medicare enrollment application, in which you provide the information and supporting documentation needed to ascertain your qualifications for, and your eligibility to enroll in, the Medicare program.

When submitted, a designated Medicare fee-for-service contractor (known as a carrier or fiscal intermediary [FI]) will process your application and verify the information that you have provided.

To ensure timely processing of your application, make certain to completely fill out the application and provide all required supporting documentation at the time of filing. Section 17 of the Medicare enrollment application lists the types of supporting documentation that you will need to submit with your enrollment application

To obtain a list of specific supporting documentation that you must submit with your enrollment application, call or visit the Medicare fee-for-service contractor serving your area (see *Additional Information* section below.)

Be aware that, at any time during the enrollment process, your carrier or FI may request documentation to support or validate information that you have reported on your application.

Provider Enrollment in the Medicare Program, continued

Applicants are responsible for providing this documentation in a timely manner.
Failure to provide documentation in a timely manner may delay your enrollment into the Medicare program.

Additional Information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit *http://www.cms.hhs.gov/MedicareProviderSupEnroll* 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: SE0612 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

Creation of a Second Participation Enrollment Period for 2006

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

Provider Types Affected

Physicians who bill Medicare carriers for their services

Key Points

- The Centers for Medicare & Medicaid Services (CMS) is offering a second participation enrollment period for 2006 for physicians.
- This second enrollment period will run for 45 days. It will begin on February 15, 2006, and end on March 31, 2006. Your Medicare carrier will accept any participation enrollment changes for 2006 that are received or post-marked by March 31, 2006.
- Any revisions to the participation election during this new enrollment period will be **retroactive to January 1, 2006**.
- This second enrollment period will allow you to reconsider your decisions in light of the revised 0 percent update stemming from the Deficit Reduction Act of 2005, and the related revision to the 2006 Medicare Physician Fee Schedule (MPFS).
- If you choose to submit your participation election (or withdrawal request) during this second enrollment period, you must begin to bill claims in accordance with your decision once the election is submitted to your local carrier.
- If you do not wish to change your current participation, or non-participation status, you do not need to do anything.

Additional Information

Enrollment Information

- To enroll, please use the **Medicare Participating Physician or Supplier Agreement** (Form CMS-460). A copy of this form is attached to Change Request (CR) 4051, Transmittal R730CP, *Calendar Year (CY) 2006 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures*. This CR can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R730CP.pdf* on the CMS website.
- If you are unable to access the Internet, please contact your Medicare carrier (toll-free telephone numbers are available through the link below) to request a hard copy of the **Medicare Participating Physician or Supplier Agreement** (Form CMS-460).
- The Medicare fee-for-service contractor that serves your state is responsible for processing your **participation election (or withdrawal request).** To locate the mailing address for the Medicare fee-for-service contractor for your state and provider type, please use the link to your carrier's toll free phone number located below.

Note: To avoid processing delays, do *not* mail your application to the Centers for Medicare & Medicaid Services in Baltimore, Maryland.

- Your carrier will not automatically adjust any claims paid for services on or after January 1 based on any participation change made during this second period. However, the carrier will adjust such claims if you bring the claims to their attention.

CR 4346 is the official instruction issued to your carrier regarding changes mentioned in this article. CR 4346 may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R210OTN.pdf* on the CMS website.

Please refer to your local carrier if you have questions about this issue. To find your carrier's toll free phone number, go to: *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4346 Related Change Request (CR) #: 4346
Related CR Release Date: February 10, 2006 Effective Date: January 1, 2006
Related CR Transmittal #: R210OTN Implementation Date: February 15, 2006

Rescind Change Request 4177 – Eliminate the Use of Surrogate UPINs on Medicare Claims

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

Provider Types Affected

Physicians, non-physician practitioners, suppliers, and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs) for diagnostic, radiology, consultation services, and equipment

Provider Action Needed

This article is based on Change Request (CR) 5019, which rescinds CR 4177.

CR 4177 eliminated the use of the surrogate Unique Physician Identification Number (UPIN) OTH000 on claims submitted by billers, suppliers, physicians and non-physician practitioners. CR 5019 instructs Medicare contractors to discontinue all work to eliminate the use of the Surrogate UPIN "OTH000" in claims processing, and continue to use Surrogate UPIN "OTH000" for submitted claims and other internal purposes.

Background

The Social Security Act (Section 1833(q); *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) requires that:

- All physicians meeting the definition of a physician (Section 1861(r); *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*) must have a UPIN, **and**
- All claims for services ordered or referred by one of these physicians must include the names and UPINs of the ordering/referring physician.

Currently, durable medical equipment (DME) suppliers, physicians, and nonphysician practitioners are allowed to use a surrogate UPIN to bill for the following:

- Diagnostic services;
- Radiology services;
- Consultation services; and
- Durable medical equipment

CR 4177 (Transmittal R752CP, dated November 10, 2005) instructed Medicare affiliated contractors (carriers, DMERCs, FIs, and RHHIs) not to accept the Surrogate UPIN "OTH000" on Medicare claims submitted by billers, suppliers, physicians, and non-physician practitioners.

However, because of the possibility that this will adversely impact the ability of providers to bill the Medicare program, the Centers for Medicare & Medicaid (CMS) is rescinding CR 4177.

Surrogate UPINs are intended to be used during an interim period when a UPIN has been requested but has not yet been received. Currently, durable medical equipment (DME) suppliers, physicians, and non-physician practitioners are allowed to use a surrogate UPIN to bill for:

- Diagnostic services;
- Radiology services;
- Consultation services; and
- Durable medical equipment.

CR 5019 instructs your Medicare contractor(s) to:

- Discontinue all work to eliminate the use of the surrogate UPIN "OTH000" in claims processing; and
- Continue to use surrogate UPIN "OTH000" for submitted claims and other internal purposes.

Implementation

The implementation date for CR5019 is April 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/FI/RHHI regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R145PI.pdf* on the CMS website.

Inquirers can obtain providers' UPINs *at http://www.upinregistry.com/*.

If you have any questions, please contact your carrier/DMERC/FI/RHHI at their toll-free number, which may be found at *http://www.cms.hhs.gov/apps/contacts/* 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: MM5019
Related Change Request (CR) #: 5019
Related CR Release Date: March 31, 2006
Effective Date: April 1, 2006
Related CR Transmittal #: R145PI
Implementation Date: April 3, 2006

Eliminate the Use of Surrogate Unique Physician Identification Numbers on Medicare Claims

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

Note: This article was rescinded on March 21, 2006, because CR4177 was rescinded. A new CR will be released on this issue in the future.

MLN Matters Number: MM4177
Related CR Release Date: November 10, 2005
Related CR Transmittal #: R752CP
Related Change Request (CR) #: 4177
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Appeals of Claims Decisions: Administrative Law Judge; Departmental Appeals Board; U.S. District Court Review

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

Provider Types Affected

Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare for services

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a *reconsideration*. It is different from the previous first level of appeal for Part A claims performed by fiscal intermediaries (FIs). Reconsiderations will be processed by Qualified Independent Contractors (QICs).

The purpose of this article is to notify you about changes to the manual provisions that address Administrative Law Judge, Departmental Appeals Board, and U.S District Court review levels of appeal.

Key Points

Administrative Law Judge (ALJ) - The Third Level of Appeal

Parties to an appeal who are not satisfied with decisions made by the QIC at the second level of appeal (reconsideration), have the right to request an ALJ hearing as long as all of the ALJ hearing request requirements are met (see *Medicare Claims Processing Manual*, Chapter 29, Section 330 for details). Outlined below is some pertinent information about the ALJ level of the appeal process.

ALJ Hearing Amount in Controversy

Parties requesting an ALJ hearing must meet the amount in controversy requirements:

- The amount remaining in controversy requirement for requests made before January 1, 2006 is $100.
- The amount remaining in controversy will increase to $110 for requests made on or after January 1, 2006.
- Beginning in 2005, for requests made for an ALJ hearing or judicial court review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Time Limits and Responsibilities

Decisions: The official ALJ decision is a signed copy of the ALJ decision. When issuing decisions, the ALJ will either:

- Issue a decision based on the request for ALJ hearing; or
- Issue an order of dismissal of the appellant's request for ALJ hearing.

Effectuation (No Agency Referral): Often, the ALJ's decision will require an effectuation action (payment of the claim) on the Medicare contractor's part.

Contractors will effectuate ALJ decisions within 30 days of the receipt of the official ALJ decision if:

- The decision is partially or wholly favorable;
- The decision gives a specific amount to be paid; and
- There is no agency referral to the DAB.

Computation of the Amount (No Agency Referral): If the amount must be computed by the Medicare contractor, the decision must be effectuated within 30 days after the contractor computes the amount to be paid to the appellant. The computation should be done as soon as possible, but no later than 30 calendar days of the date of receipt of the official ALJ decision or effectuation notice.

Clarification (No Agency Referral): If clarification from the ALJ is necessary, then the date of the clarification is considered to be the final determination for purposes of effectuation. If clarification is needed from the physician/supplier (e.g., splitting charges), this clarification should be requested as soon as possible and the amount payable should be computed within 30 calendar days after the receipt of the necessary clarification. The date of receipt of the clarification is considered to be the final determination for purposes of effectuation.

Departmental Appeals Board (DAB) - The Fourth Level of Appeal

The DAB evaluates requests for review, and makes final decisions whether to review, or to decline to review, decisions of ALJs as well as orders of dismissal by ALJs.

DAB Effectuation Time Limits: DAB decisions requiring contractor effectuation must be initiated within 30 days of receipt of a DAB decision. Effectuation must be completed within 60 days.

U.S. District Court: The Fifth Level of Appeal

A party may request court review of the DAB's decision. Medicare contractors are not responsible for reviewing ALJ decisions issued by the Department of Health and Human Services (HHS) ALJs to determine if an agency referral is appropriate, and will not accept a request for U.S District Court review by a party.

Appeals of Claims Decisions: ALJ; Departmental Appeals Board; U.S. District Court Review, continued

Relevant Links

The official instruction issued to your FI including Regional Home Health Intermediaries (RHHIs), or carrier including DMERCs, regarding this change may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R862CP.pdf* on the CMS website. The new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR 4152.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find the toll free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* 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: MM4152
Related CR Release Date: February 17, 2006
Related CR Transmittal #: R862CP
Related Change Request (CR) #: 4152
Effective Date: May 1, 2005
Implementation Date: March 17, 2006

Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Date May 1, 2005)

CMS has issued the following "MLN Matters... Information for Medicare Providers" article.
This information was previously published in the Second Quarter 2006 Medicare B Update! pages 59-60.

Note: This article was revised on February 21, 2006, to update the language regarding the appeals process. In addition, the article now contains Web addresses that conform to the new CMS website.

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare for services

Provider Action Needed

The new second level in the administrative appeals process is called a **"reconsideration."** Reconsiderations are processed by Qualified Independent Contractors (QICs).

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, now requires a new second level in the administrative appeals process called a reconsideration.

Requests for reconsideration of appeal decisions (redeterminations) should go either to the Qualified Independent Contractor (QIC), or the Hearing Officer (HO), when the redetermination was issued by a carrier prior to January 1, 2006.

Time Limit for Filing a Request for Reconsideration

A request for reconsideration must be filed within 180 days of the date of receipt of the notice of redetermination. For requests filed in writing - the date received is defined as the date received by the QIC in the corporate mailroom.

Please refer to the following table for clarification.

Appeal Rights for Requests for Reconsideration
The Second Level of Appeal

Medicare Claims	Medicare Contractor Issuing Redetermination	Date Redetermination Issued and Mailed	Where to Appeal the Redetermination*
Part A/Part B	FI	On or after May 1, 2005	QIC
Part B	Carrier	On or after January 1, 2006	QIC
Part A	FI	Before May 1, 2005	ALJ
Part B	FI	Before May 1, 2005	HO
Part B	Carrier	Before January 1, 2006	HO

*Qualified Independent Contractor (QIC); Administrative Law Judge (ALJ); Hearing Officer (HO)

Appeals of Claims Decisions: Redeterminations and Reconsiderations, continued

Additional Information

Medicare Claims Processing Manual, Chapter 29 - Appeals of Claims Decisions, 310.2, 310.3, can be found at *http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf* on the CMS website.

Medlearn Matters article MM3530 - "MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries **Revised: 4/12/2005"** (CR Title - Appeals Transition - BIPA 521 Appeals), can be found at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3530.pdf* on the CMS website.

Change Request CR3530 "Revisions to Medicare Appeals Process for Fiscal Intermediaries **Revised: 4/12/2005**" (CR Title-Appeals Transition – BIPA 521 Appeals), can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R146OTN.pdf* on the CMS website.

The official instruction issued to your FI, DMERC, or carrier regarding this change may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R697CP.pdf* on the CMS website. The new sections of Chapter 29 of the Medicare Claims Processing Manual are attached to CR3942.

Please refer to your local carrier/DMERC/FI for more information about this issue. To find the toll free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Related Change Request (CR) #: 3942 — Medlearn Matters Number: MM3942 *Revised*
Related CR Release Date: October 7, 2005 — Related CR Transmittal #: 697
Effective Date: May 1, 2005 — Implementation Date: January 9, 2006

Appeals of Claims and Appeal Decisions for Medicare Part B

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

Definitions

Levels of Appeal	Definition	Time Limit from Determination	Address
1st - Redetermination	The first appeal level after the initial determination. A redetermination must be submitted to the carrier in writing.	120 days from initial or revised initial determination	**Connecticut** Medicare Part B Appeals First Coast Service Options, Inc. P.O. Box 45041 Jacksonville, FL 32232-5041 **Florida** Medicare Part B Claims Review P.O Box 2360 Jacksonville, FL 32231-2100
2nd - Hearings	The second level of appeal for redeterminations made **prior to 01/01/06**. These appeals should be submitted to the **carrier** as instructed in your redetermination notice.	Six months from the redetermination	**Connecticut** Medicare Part B Hearings First Coast Service Options, Inc. P.O. Box 45041 Jacksonville, FL 32232-5041 **Florida** Medicare Hearings Post Office Box 45156 Jacksonville, FL 32232-5156
New 2nd - Reconsideration	The new second level of appeal for redeterminations made **on or after 01/01/06**. These appeals should be submitted to the **Qualified Independent Contractor** (QIC) as instructed in your redetermination notice.	180 days from redetermination	**Connecticut/Florida** Q2 Administrators, LLC Part B QIC East Operations P.O. Box 183092 Columbus, Ohio 43218-3092 Attn: Administration Manager

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

Appeal Process

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

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

Telephone Reopenings

If you feel your office has made a minor clerical error or omission, (that did not deny as unprocessable) you may request that we reopen the claim to correct the error.

Florida Contact Provider Customer Service - 8:00 a.m. – 4:00 p.m. Monday through Friday at 1-866-419-9455

Connecticut Contact Telephone Reopening - Monday – Friday at 1-866-535-6790 (9:00 a.m. – 4:00 p.m.)

Continue to contact Provider Services Monday – Friday (8:00a.m. and 4:00p.m).at 1-866-419-9455 if you feel that Medicare has processed your claim incorrectly.

The provider must be able to provide the beneficiary's:

- Date of Birth;
- Name;
- Medicare HICN

When you call, please have your Remittance Advice and any other documentation on hand. We will only be able to handle three different claims during each call. The following information will be verified during the call.

- Caller's Name
- Caller's Phone Number
- Provider's Name
- Date(s) of Service
- Item(s) or Service(s) at issue

Examples of minor omissions or clerical errors are as follows:

- Diagnosis code changes
- Number of Services changes
- Place of Service change
- Submitted charge correction
- Date of Service correction
- Add, Change or Delete modifiers excluding 22, 24, 25, 52, 53, 58, 59, 62, 66, 78 and 79
- Procedure code changes excluding codes requiring documentation on the initial submission or codes now being upcoded.

Telephone reopenings are generally inappropriate for the following issues:

- ❑ Limitation of liability;
- ❑ Medical necessity denials and reductions, or
- ❑ Denials requiring manual review of medical documentation

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

Redetermination Request

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

- Connecticut - *http://www.connecticutmedicare.com*
- Florida - *http://www.floridamedicare.com*.

Reconsideration Request

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

Source: CMS Pub 100-4, Chapter 29, Section 310

Denial of Claims Not Timely Filed

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

Provider Types Affected

Providers billing fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) for services provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

This article is based on information contained in CR4041, which clarifies that a determination relating to the untimely submission of a Medicare claim by a provider or supplier is not an initial determination and cannot be appealed.

CAUTION – What You Need to Know

Claims that are filed after the "timely filing period" will be denied as specified in the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 1, Section 70.1. When a claim is denied because it was filed after the timely filing period, the denial will not constitute an "initial determination." As such, the determination that a claim was not filed timely cannot be appealed.

GO – What You Need to Do

Be aware of the time limits for filing Medicare claims and the consequences of untimely filing.

Background

The Centers For Medicare & Medicaid Services (CMS) issued a technical correction to the June 30, 2005 Federal Register, Interim Final Rule, "Medicare Program: Changes to the Medicare Claims Appeal Procedures (42 CFR Parts 401 and 405)," that clarified that a determination regarding the untimely submission of a Medicare claim is not an initial determination and cannot be appealed.

Specifically, 42 CFR Section 405.926(n) indicates that a determination that a provider or supplier failed to submit a claim timely or failed to submit a timely claim, despite being requested to do so by the beneficiary or the beneficiary's subrogee, is not an initial determination and cannot be appealed.

CR4041 informs all Medicare providers of the above technical correction to the June 30, 2005 interim final rule, "Medicare Program: Changes to the Medicare Claims Appeal Procedures" and revises the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 1 (General Billing Requirements), Sections 70.4 and 70.8.6 to incorporate these changes.

Additional Information

For complete details, including the revised sections of the *Medicare Claims Processing Manual* and a table that illustrates the timely filing limit for dates of service in each calendar month, please see the official instruction issued to your carriers, FIs, DMERCS, or RHHIs regarding this change. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R830CP.pdf* on the CMS website.

If you have any questions, please contact your Medicare contractor (carrier, FI, etc.) at their toll-free number, which may be found at *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4041
Related CR Release Date: February 2, 2006
Related CR Transmittal #: R830CP
Related Change Request (CR) #: 4041
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

Hold on Medicare Payments

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

Provider Types Affected

Providers and physicians who bill Medicare contractors—fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and carriers—for their services

Provider Action Needed

STOP – Impact to You

A brief hold will be placed on Medicare payments for all claims for the last nine days of the Federal fiscal year, i.e., September 22, 2006 - September 30, 2006. Claims held as a result of this one-time policy will be paid on October 2, 2006. No interest or late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.

CAUTION – What You Need to Know

Additionally, Medicare contractors will continue to apply the Centers for Medicare & Medicaid Services (CMS) regulations for the 14-day electronic claim payment floor and the 29-day paper claim payment floor.

GO – What You Need to Do

Please note that this policy applies only to claims subject to payment. It does not apply to full denials and no-pay claims.

Essentially, no payments on claims will be made from September 22-30, 2006, and providers should be aware of these payment delays, which are mandated by section 5203 of the Deficit Reduction Act of 2006.

Additional Information

CR 4349 is the official instruction issued to your FI, RHHI, or carrier regarding changes mentioned in this article. CR 4349 may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R847CP.pdf* on the CMS website.

Please refer to your local FI/RHHI or carrier if you have questions about this issue.

To find their toll free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4349	Related Change Request (CR) #: 4349
Related CR Release Date: February 10, 2006	Effective Date: September 22, 2006
Related CR Transmittal #: R847CP	Implementation Date: July 3, 2006

Update of the Medicare Claims Processing Manual to Show New CMS Website URL References

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims for services to the Centers for Medicare & Medicaid Services (CMS) Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and durable medical equipment regional carriers [DMERCs])

Background

This article, based on CR 4398, highlights the fact that the *http://www.cms.hhs.gov* website has been completely redesigned. Currently, Chapter 24 (EDI Support Requirements) of the *Medicare Claims Processing Manual contains* URLs that no longer direct the user to the new CMS website. If used, the following message will appear. '*We're sorry. The page you requested cannot be found. CMS has recently launched a website redesign and many addresses have changed.*'

This instruction updates the URLs that are currently in Chapter 24, removes the URLs that no longer apply, and replaces them with the new URLs.

Key Points

The key new Web addresses are as follows:

- The new address for accessing and downloading the CMS EDI instructions is *http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp*.
- The X12N 837 implementation guide (IG) version 4010A1 for Institutional (I) and Professional (P) claims is now at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp* on the CMS website.
- The implementation guide for coordination of benefits (COB) with other payers is at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/12_COB.asp* on the CMS website.
- The NCPDP Telecommunications Standard Specifications and IG version 5.1 and Batch Standard 1.1 for retail prescription drug claims (Billed to Medicare DMERCs only) and COB are at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp* on the CMS website.

Update of the Medicare Claims Processing Manual to Show New CMS Website URL References, continued

- The X12 835 IG version 4010A1 for Remittance Advice is at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp* on the CMS website.
- The X12 276/277 IG version 4010A1 for Claim Status Inquiry and Response is located at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp* on the CMS website.
- Information on the X12 270/271 IG version 4010A1 transactions for Beneficiary Eligibility Inquiry and response are at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/09_Eligibility.asp* on the CMS website.
- HIPAA IG "companion documents" are available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans* on the CMS website.

Once at that site, select the specific transaction desired from the left side of the screen and you will then get a link to the companion document at the bottom of the page for that transaction.

Additional Information

The official instructions issued to your carrier or intermediary regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R900CP.pdf* on the CMS website.

If you have questions, please contact your Medicare FI/RHHI or carrier/DMERC at their toll-free number, which may be found at *http://www.cms.hhs.gov/apps/contacts/* 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: MM4398	Related Change Request (CR) #: 4398
Related CR Release Date: April 7, 2006	Effective Date: May 8, 2006
Related CR Transmittal #: R900CP	Implementation Date: July 7, 2006

New Skilled Nursing Facility Consolidated Billing Website Address

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

Provider Types Affected

Physicians, non-physician practitioners, institutional providers, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for services provided to skilled nursing facility (SNF) patients.

Provider Action Needed

The purpose of the instruction in CR 4297 is to inform affected providers of the new Web address for SNF consolidated billing information. The new address corresponds to the new website from the Centers for Medicare & Medicaid Services (CMS), and this new address is also being placed in the *Medicare Claims Processing Manual.*

Background

The purpose of Change Request (CR) 4297 is to place the following new Skilled Nursing Facility (SNF) Consolidated Billing (CB) website address into the CMS *Medicare Claims Processing Manual* (Pub. 100-04): *http://www.cms.hhs.gov/SNFConsolidatedBilling/*.

Information regarding SNF consolidated billing at this Web page includes the following:

- Services Beyond the Scope of the Part A SNF Benefit
- Edit for Therapy Services Separately Payable When Furnished by a Physician
- Annual Update Process for SNF CB
- Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a Non-covered SNF Stay

Additional Information

For complete details, please see the official instruction issued to your carrier/FI regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R846CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4297	Related Change Request (CR) #: 4297
Related CR Release Date: February 10, 2006	Effective Date: December 15, 2005
Related CR Transmittal #: R846CP	Implementation Date: March 13, 2006

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Medicare carriers including durable medical equipment regional carriers (DMERCs)

Key Points

- Effective December 29, 2005, **Remark Code MA02** was updated to reflect the following narrative:

"If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days."

- Within 30 days of release of CR 4326, **Remark Code MA03** will not be used for Medicare Fee for Service (FFS) and Medicare will update the current narrative of remark code MA02 in the same timeframe.
- Please use the text posted on the Washington Publishing Company (WPC) website if there are discrepancies between any code text included in this article and the corresponding text on the WPC website: *http://www.wpcedi.com/codes*.

Background

There are two code sets that must be used to report payment adjustments, appeal rights, and related information for transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice. These code sets, updated on a regular basis, include:

- Claim Adjustment Reason Code (CARC); and
- Remittance Advice Remark Code (RARC)

Additionally, for transaction 837 COB, CARC must be used.

Additional Information

CR 4326 is the official instruction issued to your FI/RHHI or your carrier/DMERC regarding changes mentioned in this article, MM4326. CR 4326 may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R860CP.pdf* on the CMS website

Please refer to your local FI/RHHI or your carrier/DMERC if you have questions about this issue. To find their toll free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4326	Related Change Request (CR) #: 4326
Related CR Release Date: February 17, 2006	Effective Date: May 17, 2006
Related CR Transmittal #: R860CP	Implementation Date: May 17, 2006

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs)) for services.

Provider Action Needed

STOP – Impact to You

The complete list, including changes made from July 1, 2005, through October 30, 2005, of X12N 835 Remittance Advice Remark Codes (RARC) and X12N 835 Claim Adjustment Reason Codes (CARC) have been posted. The most current and complete code list will be found at *http://www.wpc-edi.com/codes*.

CAUTION – What You Need to Know

Please refer to the *Additional Information* section of this article for remark and reason code changes approved between July 1, 2005, to October 30, 2005, and in September, 2005, respectively. By April 3, 2006, all applicable code text changes and new codes should be in use and the deactivated codes terminated.

GO – What You Need to Do

The above codes are updated three times a year. Be sure your staff is aware of these changes in order to ensure correct interpretation of the electronic or paper remittance advice notices sent by Medicare.

Background

Two code sets—the claim adjustment reason code set and the remittance advice remark code set—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination of benefits transactions.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers. Additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities. This list is updated three times a year, and posted at *http://wpc-edi.com/codes*.

The RARC database has expanded rapidly in the last couple of years. CMS has developed a new Web site to help navigate the database more easily. A tool is provided to help search if you are looking for a specific category of code. You can also find at this site some other information that is available from the WPC website. The new website address is: *http://www.cmsremarkcodes.info/*.

Note: This website is not replacing the WPC website as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC website.

Implementation

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

Additional Information

The following list summarizes changes made from July 1, 2005, through October 30, 2005:

Remittance Advice Remark Code Changes

Code	Status	Current Narrative	Comment
N357	New	Time frame requirements between this service procedure/ supply and a related service procedure/supply have not been met	Medicare Initiated
N358	New	This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.	Not Medicare Initiated
N359	New	Missing/incomplete/invalid height.	Not Medicare Initiated
N360	New	Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.	Not Medicare Initiated
N361	New	Charges are adjusted based on multiple diagnostic imaging procedure rules.	Not Medicare Initiated
N362	New	The number of Days or Units of Service exceeds our acceptable maximum.	Not Medicare Initiated
N363	New	Alert: in the near future we are implementing new policies/procedures that would affect this determination.	Not Medicare Initiated

Remittance Advice Remark Code and Claim Adjustment Reason Code Update, continued

Code	Status	Current Narrative	Comment
N364	New	According to our agreement, you must waive the deductible and/or coinsurance amounts.	Medicare Initiated
M16	Modified	Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	Modified effective 11/18/05
MA02	Modified	If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.	Modified effective 12/29/05 (1)
MA03	Modified	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time.	Modified effective 11/18/05 (2)
N9	Modified	Adjustment represents the estimated amount a previous payer may pay.	Modified effective 11/18/05
N34	Modified	Incorrect claim form/format for this service.	Modified effective 11/18/05
N207	Modified	Missing/incomplete/invalid weight.	Modified effective 11/18/05
N355	Modified	The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at anytime within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days.	Modified effective 11/18/05

Remittance Advice Remark Code and Claim Adjustment Reason Code Update, continued

Code	Status	Current Narrative	Comment
M78	Deactivated	Missing/incomplete/invalid HCPCS modifier.	Deactivated effective 5/18/06, consider using reason code 4.

Claim Adjustment Reason Code Changes

Code	Status	Current Narrative	Comment
190	New	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	New as of 10/05
191	New	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier.	New as of 10/05
192(3)	New	Non standard adjustment code from paper remittance advice.	New as of 10/05
182	Modified	Payment adjusted because the procedure modifier was invalid on the date of service.	Modified 8/8/05
B18	Modified	Payment adjusted because this procedure code and modifier were invalid on the date of service.	Modified 8/8/05
52	Retired	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	Inactive as of 2/1/06
B17	Retired	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	Inactive as of 2/1/06

1 This modification is effective January 1, 2006, and has been communicated in a separate instruction (CR 4326).
2 Medicare will not use MA03 effective from January 1, 2006, and that has been communicated in CR4326.
3 This new code was created at the request of Medicare because:

- Providers who do not qualify for Administrative Simplification Compliance Act (ASCA) exemption must submit claims electronically;
- If Medicare is secondary, and the primary payer has sent a paper RA with proprietary code(s), the provider could not send a compliant electronic claim unless a crosswalk between the payer proprietary codes and the standard CARC is available.

In CR 4123, Medicare contractors were instructed to complete entry of 192 as a valid code, and accept claims containing this code for adjudication. CMS encourages providers to utilize this code, and submit COB claims electronically.

Reason Codes 1 and 2

In September, CMS requested two new codes to be used in lieu of current reason codes 1 ("Deductible") and 2 ("Coinsurance Amount") when a provider is not allowed to collect any deductible and/or any coinsurance.

Section 630 of the Medicare Modernization Act (MMA) permits Indian Health Service (IHS) facilities to directly bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Federal government agencies do not permit providers to collect coinsurance or deductible payments from IHS patients.

The committee did not approve the CMS request for new codes, but suggested that reason codes 1 and 2 should be used with Group Code CO (Contractual Obligation) instead of PR (Patient Responsibility). Currently, in most situations Group Code PR is used with reason codes 1 and 2. Medicare contractors must use Group code CO under this special situation with codes 1 and 2. (See related CR 3845 and the Medlearn Matters article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3845.pdf* on the CMS website.)

The official instructions (CR4314) issued to your Medicare carrier, intermediary, DMERC, or RHHI regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R859CP.pdf* on the CMS website.

If you have questions, please contact your Medicare carrier, DMERC, FI, or RHHI at their toll-free number which may be found at *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4314
Related CR Release Date: February 17, 2006
Related CR Transmittal #: R859CP
Related Change Request (CR) #: 4314
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Understanding the Remittance Advice – Updated Guide

Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers has been updated and is now available online through the Medicare Learning Network's publication page located at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*, on the CMS website.

This comprehensive publication provides practical information on the types, uses, components of and standardized codes sets used on the RA as well as how to read the standard paper remittance advice and the electronic remittance advice using PC-Print software (for institutional providers who receive RAs from fiscal intermediaries or regional home health intermediaries) and Medicare Remit Easy Print (MREP) software (for professional providers who receive RAs from carriers or DMERCs). It also includes a number of helpful resources including field indexes (for institutional RAs and professional RAs), an acronym list, and a glossary.

In addition to the online version of *"The RA Guide"*, it will also be available in print and on CD ROM later this spring. CMS will announce the availability of these products as they become accessible.

Source: Provider Education Resources Listserv, Message #200603-15

Competitive Acquisition Program

CMS has announced approved drug vendor information for the Competitive Acquisition Program (CAP.) View the CMS Web page dedicated to providing all the latest CAP news for health care providers at *http://www.cms.hhs.gov/CompetitiveAcquisforBios* on the Web.

This page is your source for news on CAP including how to participate in the CAP program. Bookmark this page as new information and resources will continue to be posted.

Note: CMS issued a reminder of this benefit via the Contractor Provider Education Resources Listserv on April 21, 2006, posted to our provider education website on April 24, 2006.

Source: CMS Joint Signature Memorandum (JSM) 06413, dated April 21, 2006
Provider Education Resources Listserv, Message 200604-13

Instructions for Provider Notification Regarding Streamlined Drug Coverage Materials for Health Care Professionals, a New Fact Sheet and Script for Recent Audio Conference

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

Provider Types Affected

Providers, physicians, and suppliers and their staff who prescribe medications for Medicare patients

Key Points

The Centers for Medicare & Medicaid Services (CMS) has developed three new products as part of the Medicare Prescription Drug Coverage (Part D) campaign for health care professionals:

Consolidated List of Links

A consolidated list of links to resources for prescribers is located at *http://www.cms.hhs.gov/center/provider.asp* on the CMS website.

At this Web page, offices can get access to direct telephone numbers to a Medicare drug plan's coverage determination staff, as well as to obtain model forms that will help speed this process.

Educational information for Fee-For-Service (FFS) providers is always available through our Medicare Learning Network drug coverage page at *http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp* on the CMS website.

Transition Policy Fact Sheet

A new fact sheet regarding the new transition policy, as well as the exceptions and appeals process for Medicare Prescription Drug Coverage, is available for use in prescriber offices. This resource fact sheet provides ready links to tools that will streamline the prescribing process under the new coverage.

CMS continues to work with groups representing physicians, pharmacists, patients, and Part D plans to simplify and standardize the information that physicians need to provide to plans.

The fact sheet is at *http://www.cms.hhs.gov/MedlearnProducts/downloads/Part_D_Resource_Factsheet.pdf* on the CMS website.

An Important Message for Providers Regarding Medicare Part D from CMS Administrator Dr. Mark McClellan

Dr. McClellan's message to providers describes the steps CMS is taking to implement the new Medicare prescription drug coverage. Dr. McClellan also discusses helpful resources for providers. Streaming video of this message is available at *http://media.cms.hhs.gov/cms/McClellanPartDProvider.wmv* on the CMS website.

Instructions for Provider Notification Regarding Streamlined Drug Coverage Materials, continued

Phone Conference Training Session

A PowerPoint presentation and audio replay of a recent phone conference training session is available, entitled "Working with Plan Formularies: Transition Supplies, Prior Authorization, Quantity Limits, Step Therapy, and Exceptions."

This training session is geared towards guiding office staff through the exceptions process. These materials are located at *http://media.cms.hhs.gov/cms/partner03022006.wma* on the CMS website.

Other Special Edition Articles

Other special edition articles regarding the prescription drug program include, but are not limited to, the following:

- SE0618 – "2006 Standard Medicare Prescription Drug Coverage: Understanding Costs to Beneficiaries," available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0618.pdf* on the CMS website.
- SE0603 – "Medicare Prescription Drug Coverage: Essential Information and Resources for Prescribing Health Care Professionals – The Eleventh in the Medlearn Matters Series on the New Prescription Drug Plans," available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0603.pdf* on the CMS website.
- SE0557 – "Clarification on Part D and Fee-for-Service (FFS) Providers," available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0557.pdf* on the CMS website.
- SE0502 – "The Facts for Providers Regarding the Medicare Prescription Drug Program," available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0502.pdf* on the CMS website.

Medlearn Matters Number: SE0619	Related Change Request (CR) #: N/A
Related CR Release Date: N/A	Effective Date: March 3, 2006
Related CR Transmittal #: N/A	Implementation Date: N/A

An Important Message for Providers Regarding Medicare Part D

Prescribers are vital to the well being of their patients. The Centers for Medicare & Medicaid Services (CMS) is doing everything we can to streamline the new Part D coverage to make it easier for you to help your patients, while not infringing on the scarce clinical time you have with them.

The following link will take you to a video that we hope explains what we are doing during the transition to help prescribers and their office staffs smooth the process of prior authorizations, exceptions and appeals. Go to our provider center at *http://www.cms.hhs.gov/center/provider.asp* (go to Part D tools) and select the video. There are a number of other useful lists that we have assembled there to help ease the process of helping your patients with their new drug coverage.

CMS has a dedicated email for prescriber's questions at *PRIT@cms.hhs.gov*, as well as a standing teleconference every Tuesday at 2PM by calling 1-800-619-2457 Passcode: RBDML

Source: Source: Provider Education Resources Listserv, Message 200603-10

Streamlined Drug Coverage Materials for Health Care Professionals

NEW! Visit *http://www.cms.hhs.gov/center/provider.asp* and scroll down to "Part D Tools for Health Care Professionals" for a comprehensive list of links to agency-wide resources for providers on Medicare prescription coverage. These resources can help providers and office staff access direct phone numbers to a Medicare drug plan's coverage determination staff, as well as obtain model forms that will help speed the process.

Additionally, a new fact sheet, as well as other educational products for the Medicare fee-for-service community, is now available on the CMS website at *http://www.cms.hhs.gov/MLNProducts/23_drugcoverage.asp*.

Source: CMS Joint Signature Memorandum 06312, March 3, 2006

Assignment of Physicians, Providers, and Suppliers to the Medicare Administrative Contractors

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

Provider Types Affected

Providers, physicians and suppliers who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers, including durable medical equipment regional carriers (DMERCs)) for their services.

Key Points

The Centers for Medicare & Medicaid Services (CMS) is implementing significant changes to the Medicare fee-for-service program's administrative structure. This Medicare Contracting Reform (MCR) will:

- Integrate and simplify the administration of Medicare Parts A and B with primary A/B Medicare Administrative Contractors (MACs) which will process both Part A and Part B claims for the fee-for-service benefit;
- Make contracting dynamic, competitive and performance-based, resulting in more accurate claims payments and greater consistency in payment decisions; and

- Centralize information, creating a platform for advances in the delivery of comprehensive care.

Under MCR, there will be 23 MACs with no national MAC. These new MACs will include:

- Fifteen primary A/B MACs to serve the majority of all types of providers for Part A and Part B;
- Four specialty MACs to serve home health and hospice providers; and
- Four specialty MACs to serve durable medical equipment (DME) suppliers.

MACs will serve as the primary point of contact for provider enrollment, Medicare coverage and billing requirements training for providers, and the receipt, processing and payment of Medicare fee-for-service claims for Medicare providers' respective jurisdictions.

Medicare providers will be assigned to the local designated MAC based on their geographic location to the MAC, which has jurisdiction for that benefit category and location.

Note: Please be aware that in the event that your current FI does not win the contract to serve the area where you are located, you will be required to be reassigned to the MAC that has won the jurisdiction for your area.

The new MAC jurisdictions will be more similar to each other in size than the existing fiscal intermediary (FI) and carrier jurisdictions. The workload allocation and the number of fee-for-service beneficiaries and providers in each MAC jurisdiction will be reasonably balanced. The jurisdictions of the eight specialty MACs will overlay the boundaries of the fifteen primary A/B MAC jurisdictions.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173) allows the CMS to take appropriate steps to transition from agreements under Section 1816 of the Social Security Act to contracts with Medicare Administrative Contractors (MACs) under section 1874A. The changes to Medicare's administration are designed to increase the efficiency of Medicare's claims processing and related functions. They will benefit Medicare providers and Medicare's enrollee population.

Additional Information

During the initial implementation phase (2005-2011) of the Medicare fee-for-service administrative contracting reform, CMS intends to issue Requests for Proposals (RFPs) to compete and award contracts for 23 MACs (four DME and four Home Health/Hospice MACs, and 15 primary A/B MACs).

The transition to the MAC administrative structure will be implemented through a series of acquisition cycles (9-12 months from solicitation to award). The subsequent workload transition to the new MAC system is projected to take 6-13 months after contract award.

Medicare's MAC Jurisdictions

Specialty MAC Jurisdictions (DME and Home Health/Hospice)

Jurisdiction	States Included	RFP Issuance	Award Date
A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont	**DME** March 2005 **Home Health/ Hospice** Sept. 2007	**DME** Jan. 2006 **Home Health/Hospice** Sept. 2008
B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin		
C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia		
D	Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming		

Assignment of Physicians, Providers, and Suppliers to the Medicare Administrative Contractors, continued

Primary A/B MAC Jurisdictions

Jurisdiction	States Included	RFP Issuance	Award Date
1	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands	Sept. 2006	Sept. 2007
2	Alaska, Idaho, Oregon, and Washington	Sept. 2006	Sept. 2007
3	Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming	Sept. 2005	June 2006
4	Colorado, New Mexico, Oklahoma, and Texas	Sept. 2006	Sept. 2007
5	Iowa, Kansas, Missouri, and Nebraska	Sept. 2006	Sept. 2007
6	Illinois, Minnesota, and Wisconsin	Sept. 2007	Sept. 2008
7	Arkansas, Louisiana, and Mississippi	Sept. 2006	Sept. 2007
8	Indiana and Michigan	Sept. 2007	Sept. 2008
9	Florida, Puerto Rico, and U.S. Virgin Islands	Sept. 2007	Sept. 2008
10	Alabama, Georgia, and Tennessee	Sept. 2007	Sept. 2008
11	North Carolina, South Carolina, Virginia and West Virginia	Sept. 2007	Sept. 2008
12	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania	Sept. 2006	Sept. 2007
13	Connecticut and New York	Sept. 2006	Sept. 2007
14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	Sept. 2007	Sept. 2008
15	Kentucky and Ohio	Sept. 2007	Sept. 2008

For additional information about the MCR process, please refer to *http://www.cms.hhs.gov/MedicareContractingReform/* on the CMS website.

CR 4002, transmittal 670, *Realignment of States and Medicare Claims Processing Workload from DMERC Regions A, B, C and D to the DME MAC Jurisdictions A, B, C, and D* discusses phase 1 of the MAC acquisition and transition schedule. It can be found at *http://www.cms.hhs.gov/transmittals/downloads/R670CP.pdf* on the CMS website.

MLN Matters Number: SE0624 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

The Centers for Medicare & Medicaid Services Recovery Audit Contractor Initiative

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

Provider Types Affected

Physicians, providers, and suppliers, especially in California, Florida, and New York

Provider Action Needed

Based on comments received during provider open door forums and community meetings, CMS has amended the payment methodology for the Recovery Audit Contractors (RAC) to include payment for the identification of Medicare underpayments.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Section 306, directs the Secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in: 1) identifying underpayments and overpayments; and 2) recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

Update

The RACs are paid on a contingency basis; that is, the RACs receive a portion of what they identify and collect. Beginning with underpayments identified on or after March 1, 2006, the RACs will receive an equivalent percentage for all underpayment and overpayment identifications.

The RACs will use the same methodologies of automated and complex reviews to identify potential Medicare underpayments.

The Centers for Medicare & Medicaid Services Recovery Audit Contractor Initiative, continued

Important Things Providers Need to Know About the Underpayment Identification Portion of the Recovery Audit Contractor Demonstration

- The RAC may request a medical record for an underpayment determination. However, the medical record request letter will not indicate if the medical record is being requested for overpayment or underpayment review. When responding to a medical record request from the RAC, the provider may attach its own opinion regarding an underpayment. However, the findings from the RAC may differ from that of the provider.
- Upon identification of a potential underpayment, the RAC will forward the claim and all supporting documentation to the appropriate Medicare fiscal intermediary, carrier or durable medical equipment regional carrier (DMERC) for their review. An underpayment identification will not be final unless the fiscal intermediary, carrier or DMERC agrees with the identification. The RAC or the fiscal intermediary, carrier or DMERC will NOT ask the provider to correct and resubmit the claim. Under the RAC demonstration, the RAC contractors have no authority to make refunds. Therefore, once the underpayment has been validated by the appropriate fiscal intermediary, carrier or DMERC, the RAC will send the provider written notice of the underpayment determination. This notice will include claim and beneficiary details.
- The RACs do not have the authority to review unsolicited cases from providers where underpayment is thought to have occurred. Outside of the RAC program if a provider feels they have received an underpayment they may resubmit a corrected claim if the timely filing limit has not yet passed.
- The provider does not have any official appeals rights in relation to an underpayment determination. The provider may utilize the RAC rebuttal process and discuss the underpayment determination with the RAC. If the provider disagrees with the RAC that an underpayment exists, the RAC will defer to the billing provider's judgment.

Definition of an Underpayment

For purposes of the RAC demonstration, a Medicare underpayment is defined as those lines or payment groups (APC, RUG) on a claim that were billed at a low level of payment but should have been billed at a higher level of payment. The RAC will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group.

If changes to the diagnosis, procedure or order of diagnoses would change a line or payment group on the claim from a low level of payment to a higher level of payment (and the medical record supports such a change), an underpayment exists. Service lines or payment groups that a provider failed to include on a claim are **not** considered underpayments for the purposes of this demonstration.

Note: CMS has excluded the review of physician evaluation and management codes relevant to the level of an office visit or the medical necessity of the level of office visit from the RAC demonstration. This includes the review of overpayments and underpayments.

Examples of an Underpayment

The following **are** considered underpayments:

- The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided. (This provider type is paid based on a fee schedule that pays more for 30 minutes of therapy than for 15 minutes of therapy.)
- The provider billed for a particular service and the amount the provider was paid was lower than the amount on the CMS physician fee schedule.
- A diagnosis/condition was left off the MDS but appears in the medical record. Had this diagnosis or condition been listed on the MDS, a higher payment group would have been the result.
- The physician submitted a claim for a surgical procedure using a code for a simpler procedure when in fact the procedure was a more complex one such as in the case of skin repair which can be billed at a simple, intermediate, or complex level depending upon size and complexity.

The following are **not** considered underpayments:

- The medical record indicates that the provider performed additional services such as an EKG, but did not bill for the service.
- The provider billed for 15 minutes of therapy when the medical record clearly indicates 30 minutes of therapy was provided; however, the additional minutes do not affect the grouper or the pricer. (This provider type is paid based on a prospective payment system that does not pay more for this much additional therapy.)
- The medical record indicates that the provider implanted a particular device for which a device APC exists (and is separately payable over and above the service APC), but the provider did not bill for the device APC.

Questions concerning the recovery audit contractor demonstration may be directed to a special email address CMS has established specifically for the demonstration: *cmsrecoveryauditdemo@cms.hhs.gov*.

Additional Information

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

Find out more about the Medicare Prescription Drug and Modernization Act of 2003 (MMA) at *http://www.cms.hhs.gov/MMAUpdate/* on the CMS website.

The Centers for Medicare & Medicaid Services Recovery Audit Contractor Initiative, continued

MLN Matters Number: SE0617 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

Centers for Medicare & Medicaid Services Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

CMS has issued the following "MLN Matters... Information for Medicare Providers" article.
This information was previously published in the HCPCS 2006 January Special Medicare B Update! page 98.

Note: This article was revised on March 17, 2006, to show the data collection period will continue through April 2006.

Provider Types Affected

Sample of 25,000 Medicare providers served by 42 Medicare fee-for-service (FFS) contractors, including fiscal intermediaries (FIs), carriers, durable medical equipment regional carriers (DMERCs), and rural home health intermediaries (RHHIs)

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) would like to provide a channel for you to voice your opinions about the services you receive from your FFS contractors. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to gather quantifiable data on provider satisfaction with the performance of FFS contractors. The MCPSS is one of the tools CMS will use to measure provider satisfaction levels, a requirement of the Medicare Modernization Act (MMA). Specifically, the survey will enable CMS to gauge provider satisfaction with key services performed by the 42 contractors that process and pay the more than $280 billion in Medicare claims each year.

Those Medicare contractors will use the results to improve service. CMS will use the results to improve its oversight of and increase the efficiency of the administration of the Medicare program.

CAUTION – What You Need to Know

The first national implementation of the MCPSS will begin January 3, 2006. If you have been selected, you will receive a notification packet in the mail with background information about the survey, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet website. The letter will also include a phone number that you can call to request a paper copy of the survey instrument to submit your responses by mail or fax, if you prefer to do so.

GO – What You Need to Do

Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the time to complete and submit your survey responses as soon as possible. The data collection period will continue through April 2006.

Background

The 2006 survey will query approximately 25,000 randomly selected providers – those physicians, healthcare practitioners, and facilities that serve Medicare beneficiaries across the country – on the seven key areas of the provider-contractor interface:

- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

It contains a total of 76 questions and takes approximately 21 minutes to complete. The target date to respond is approximately three weeks after receipt of the notification packet. CMS will analyze the data and release a summary report in July that will be made available on the Internet. Contractors will also receive an individual report on their performance in June. The MCPSS will be conducted on an annual basis.

CMS has awarded a contract to Westat, a survey research firm, to administer the MCPSS.

Additional Information

For questions or additional information about the MCPSS, please visit *http://www.cms.hhs.gov/MCPSS/* on the CMS website.

Medlearn Matters Number: SE0602 *Revised* Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: January 3, 2006
Related CR Transmittal #: N/A Implementation Date: January 3, 2006

Physician Voluntary Reporting Program Using Quality G-Codes and CPT Category II Codes

CMS has issued the following "MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. MLN Matters article MM4183 was previously published in the Second Quarter 2006 Medicare B Update! pages 75-81.

Note: This article was revised on March 30, 2006, to show that the implementation date is April 3, 2006, as shown in CR5036. Several Physician Voluntary Reporting Program (PVRP) performance measure CPT codes in CR 4183 have been modified as a result of additional input received by CMS from medical specialty societies. In addition, CPT Category II codes are now available for certain measures. The changes are reflected in CR 5036 and, if you are viewing a color print of this article, are highlighted yellow. This article contains the same information as MLN Matters article MM4183 with the following additions:

- The code changes and the addition of Category II CPT codes in the attachments.
- An "Introduction" section that helps physicians understand who can report and the benefits of registering their intent to participate in the program.
- Announcement of a website address that contains additional information on the PVRP. This Web address is *http://www.cms.hhs.gov/PVRP*. Also, in the "Additional Information" section of this article is a note about some helpful worksheets that will be placed on this site in the near future.

Provider Types Affected

Physicians

Introduction

In January of 2006, the Centers for Medicare and Medicaid Services (CMS) launched the PVRP with a core starter set of 16 measures. Collection of data on the 16 measures is currently underway.

Physicians can report on the PVRP measures regardless of whether or not they register their intent to participate. However, CMS is strongly encouraging physicians to register their intent to participate in the PVRP through the secured link *http://www.qualitynet.org*. By registering their intent to participate, physicians will be able to receive confidential feedback on their reporting rate and performance rate for each measure they report on. Registering the intent to participate is the first step to receiving the confidential feedback report. In June, CMS will begin contacting those who register their intent to participate to walk them through finishing the confidential registration process. By registering the intent to participate now, physicians not only have the ultimate benefit of receiving feedback reports on the PVRP measures, but will also have CMS assistance in completing the full registration for the feedback reports.

Registration of intent to participate does not obligate a physician to participate. CMS understands that unpredictable events may occur that would ultimately prevent one from actually participating. Also, as stated earlier, physicians can submit data on the PVRP measures without registering their intent to participate.

CMS encourages physicians to register their intent to participate by April 1, 2006. The first physician feedback reports will be available in December 2006.

Reports will be based on second quarter data, collected from claims data with dates of service between April 1 and June 30. Although registration of intent to participate will be welcomed after April 1, CMS encourages physicians to register their intent by April 1 so that comprehensive feedback reports reflect as much data collected in the second quarter as possible. Again, physicians can continue to submit data on PVRP measures whether they register their intent or not.

Provider Action Needed

This article provides information about the CMS PVRP. It will assist physicians in understanding this new voluntary reporting program and the use of G-codes or newly added CPT II codes to report data about the quality of care provided to Medicare beneficiaries.

Background

As part of its overall quality improvement efforts, CMS launched the PVRP in January 2006. This new program builds on Medicare's comprehensive efforts to substantially improve the health and function of our beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered.

Under the voluntary reporting program, physicians who choose to participate will help capture data about the quality of care provided to Medicare beneficiaries, in order to identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care. Voluntary reporting of quality data through the PVRP began in January 2006.

National Consensus Measures and Indicators

CMS has begun the process of developing a comprehensive set of national consensus measures and indicators that will allow physicians to more efficiently report quality information on the health services provided to Medicare beneficiaries.

CMS identified 36 evidence-based clinically valid measures that have been part of the guidelines endorsed by physicians and medical specialty societies. The 36 measures are the result of extensive input and feedback from physicians and other quality care experts.

However, after announcing the PVRP on October 28, 2005, suggestions were made by several physician organizations to identify a starter set in order to lessen the potential reporting burden for physicians and better align the PVRP with other quality measurement activities affecting physicians.

PVRP Using Quality G-Codes and CPT Category II Codes,continued

CMS decided to adopt the suggestion of a smaller core starter set of PVRP measures. The core set consists of 16 measures, which will significantly reduce the number of measures applicable to any individual physician practice specialty.

Despite the reduction to a core starter set of 16 measures, the PVRP maintains the same scope of coverage for physician specialties. Additional measures to cover a broader set of specialties will be developed in the future.

CMS has selected measures based on the work of the National Quality Forum (NQF) and the Ambulatory Care Quality Alliance (AQA).

Confidential feedback reports available to physicians will be limited to the 16 core starter set. The confidential feedback reports will provide physicians with information about their performance and reporting rates for measures associated with submitted data. The feedback reports are intended to assist physicians in improving their data accuracy and reporting rate. The first feedback report will be available December 2006 and will reflect data submitted during the second quarter (April 1 – June 30).

Data Collection Through the Administrative Claims System

The usual source of the clinical data for quality measures is retrospective chart abstraction, but data collection through chart abstraction can be quite burdensome. In addition, while electronic health records (EHRs) may greatly facilitate clinical data reporting in the future, most physicians currently are not using an EHR.

Therefore, to avoid the necessity for chart abstraction, CMS is beginning the process of collecting quality information on services provided to the Medicare population by using the administrative claims system.

Use of G-Codes and CPT II Codes

Specifically, CMS has defined a set of HCPCS codes to report data for the calculation of the quality measures. These new codes will supplement the usual claims data with clinical data that can be used to measure the quality of services rendered to beneficiaries.

Each measure has a defined numerator (the appropriate G-code or CPT II code) and a denominator (specifically defined according to the appropriate services or condition). The reporting rate is calculated as a percentage for each of the 16 measures.

You can use G-codes or CPT II codes when all of the following circumstances are met:

- The G-code or CPT II code reported on the claim relates to a covered diagnosis, covered treatment(s), or covered preventive service(s) that are applicable to the beneficiary.
- The basis for the G-code or CPT II code is documented in the beneficiary medical record.

Note: Submit either a G-code or a CPT II code, but never both.

Important Points: PVRP Reporting on Medicare Claims G-codes or CPT II codes:

- Are submitted on the Medicare claim form generated after a covered service has been performed.
- Should be reported with a submitted charge of zero ($0.00).
- Are not specialty-specific. However, it is anticipated that the reporting of certain G-codes or CPT II codes will be predominated by physicians in certain specialties.

Additional Information

The specific quality measures related to the G-codes or CPT II codes in this initial program launch are reflected in the table at the end of this article.

You can find more information about the PVRP and quality G-Codes and CPT II codes in CR 5036. CR 5036 is available at *http://www.cms.hhs.gov/Transmittals/downloads/R43DEMO.pdf* on the CMS website. CR 4183 is also available at *http://www.cms.hhs.gov/Transmittals/downloads/R35DEMO.pdf* on the CMS website.

Additional information about the program is available at *http://www.cms.hhs.gov/PVRP* on the CMS website. You may want to visit this site periodically for updates. CMS will soon post the one-page worksheets developed specifically for certain specialties to assist in reporting relevant information to the PVRP.

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

Physician Voluntary Reporting Program
G-Codes and CPT II Codes and Descriptions for Clinical Measures
Effective April 1, 2006

Aspirin at arrival for acute myocardial infarction

- **G8006**: Acute myocardial infarction: patient documented to have received aspirin at arrival
- **G8007**: Acute myocardial infarction: patient not documented to have received aspirin at arrival
- **G8008**: Clinician documented that acute myocardial infarction patient was not an eligible candidate to receive aspirin at arrival measure

Beta blocker at time of arrival for acute myocardial infarction

- **G8009**: Acute myocardial infarction: patient documented to have received beta-blocker at arrival OR *CPT* Cat II code *4006F:* Beta-blocker therapy prescribed
- **G8010**: Acute myocardial infarction: patient not documented to have received beta-blocker at arrival
- **G8011**: Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure OR CPT Cat II code 4006F WITH modifier 1P, 2P, or 3P: Beta-blocker therapy prescribed with exclusion

PVRP Using Quality G-Codes and CPT Category II Codes,continued

Hemoglobin A1c control in patient with Type I orType II diabetes mellitus

- **G8015**: Diabetic patient with most recent hemoglobin A1c level (within the last 12 months) documented as greater than 9% OR *CPT* Cat II code 3046F: Most recent hemoglobin A1c level > 9.0%
- **G8016**: Diabetic patient with most recent hemoglobin A1c level (within the last 12 months) documented as less than or equal to 9% OR *CPT* Cat II code *3047F*: Most recent hemoglobin A1c level = 9.0%
- **G8017**: Clinician documented that diabetic patient was not an eligible candidate for hemoglobin A1c measure OR CPT Cat II code 3046F WITH modifier 1P, 2P, or 3P: Most recent hemoglobin A1c level > 9.0% with exclusion
- **G8018**: Clinician has not provided care for the diabetic patient for the required time for hemoglobin A1c measure (12 months)

Low-density lipoprotein control in patient with Type I orType II diabetes mellitus

- **G8020**: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as less than 100 mg/dl OR *CPT* Cat II code *3048F*: Most recent LDL-C < 100 mg/dL
- **G8019**: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as greater than or equal to 100 mg/dl OR *CPT* Cat II code *3049F*: Most recent LDL-C 100-129 mg/dL OR CPT Cat II code 3050F: Most recent LDL-C > 130 mg/dL
- **G8021**: Clinician documented that diabetic patient was not eligible candidate for low-density lipoprotein measure OR *CPT* Cat II code *3048F* WITH modifier 1P, 2P, or 3P: Most recent LDL-C < 100 mg/dL with exclusion
- **G8022**: Clinician has not provided care for the diabetic patient for the required time for low-density lipoprotein measure (12 months)

High blood pressure control in patient with Type I or Type II diabetes mellitus

- **G8024**: Diabetic patient with most recent blood pressure (within the last 12 months) documented less than 140 systolic and less than 80 diastolic OR *CPT* Cat II code **3076F**: Most recent systolic blood pressure <140 mm Hg AND *CPT* Cat II code *3078F*: Most recent diastolic blood pressure < 80 mm Hg
- **G8023**: Diabetic patient with most recent blood pressure (within the last 12 months) documented as equal to or greater than 140 systolic or equal to or greater than 80 mmHg diastolic OR *CPT* Cat II code *3077F*: Most recent systolic blood pressure > 140 mm Hg AND *CPT* Cat II code *3079F*: Most recent diastolic blood pressure 80-89 mm Hg OR *CPT* Cat II code *3077F*: Most recent systolic blood pressure > 140 mm Hg AND *CPT* Cat II code *3080F*: Most recent diastolic blood pressure > 90 mm Hg
- **G8025**: Clinician documented that the diabetic patient was not an eligible candidate for blood pressure measure OR *CPT* Cat II code *3076F* WITH modifier 1P, 2P, or 3P: Most recent systolic blood pressure < 140 mm Hg with exclusion AND *CPT* Cat II code *3078F* WITH modifier 1P, 2P, or 3P: Most recent diastolic blood pressure < 80 mm Hg with exclusion
- **G8026**: Clinician has not provided care for the diabetic patient for the required time for blood pressure measure (within the last 12 months)

Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction

- **G8027**: Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy OR *CPT* Cat II code *4009F*: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed
- **G8028**: Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy
- **G8029**: Clinician documented that heart failure patient was not an eligible candidate for either angiotensinconverting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy measure OR *CPT* Cat II code *4009F* WITH modifier 1P, 2P, or 3P: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed with exclusion

Beta-blocker therapy for patient with prior myocardial infarction

- **G8033**: Prior myocardial infarction - coronary artery disease patient documented to be on beta-blocker therapy OR *CPT* Cat II code *4006F*: Beta-blocker therapy prescribed
- **G8034**: Prior myocardial infarction - coronary artery disease patient not documented to be on beta –blocker therapy
- **G8035**: Clinician documented that prior myocardial infarction - coronary artery disease patient was not an eligible candidate for beta - blocker therapy measure or the patient had no prior myocardial infarction OR *CPT* Cat II code *4006F* WITH modifier 1P, 2P, or 3P: Beta-blocker therapy prescribed with exclusion

Assessment of elderly patients for falls

- **G8055**: Patient documented for the assessment for falls within last 12 months
- **G8054**: Patient not documented for the assessment for falls within last 12 months
- **G8056**: Clinician documented that patient was not an eligible candidate for the falls assessment measure within the last 12 months

Dialysis dose in end stage renal disease patient

- **G8075**: End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2)
- **G8076**: End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2)
- **G8077**: Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure

PVRP Using Quality G-Codes and CPT Category II Codes,continued

Hematocrit level in end stage renal disease patient

- **G8078**: End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11)
- **G8079**: End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11)
- **G8080**: Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure

Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis

- **G8081**: End-stage renal disease patient requiring hemodialysis vascular access documented to have received autogenous AV fistula
- **G8082**: End-stage renal disease patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula
- **G8085**: End-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula

Antidepressant medication

- **G8126**: Patient documented as being treated with antidepressant medication during the entire 12 week during acute phase for patient diagnosed with new episode of major depression acute treatment phase
- **G8127**: Patient not documented as being treated with antidepressant medication during the entire 12 weeks acute treatment phase
- **G8128**: Patient was not treated with antidepressant medication or was not an eligible candidate for completion of the entire 12 week acute treatment phase

Antibiotic prophylaxis in surgical patient

- **G8152**: Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin and fluoroquinolone)
- **G8153**: Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin and fluoroquinolone)
- **G8154**: Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin and fluoroquinolone) measure

Thromboembolism prophylaxis in surgical patient

- **G8155**: Patient with documented receipt of thromboemoblism prophylaxis
- **G8156**: Patient without documented receipt of thromboemoblism prophylaxis
- **G8157**: Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure

Use of internal mammary artery in coronary artery bypass graft surgery

- **G8158**: Patient documented to have received coronary artery bypass graft with use of internal mammary artery
- **G8159**: Patient documented to have received coronary artery bypass graft without use of internal mammary artery
- **G8160**: Clinician documented that patient was not an eligible candidate for coronary artery bypass graft with use of internal mammary artery measure

Pre-operative beta blocker for patient with isolated coronary artery bypass graft

- **G8161**: Patient with isolated coronary artery bypass graft documented to have received pre-operative beta-blockade OR *CPT* Cat II code *4006F*: Beta-blocker therapy prescribed
- **G8162**: Patient with isolated coronary artery bypass graft not documented to have received pre-operative beta-blockade
- **G8163**: Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for pre-operative beta-blockade measure OR CPT Cat II code *4006F* WITH modifier 1P, 2P, or 3P: Beta-blocker therapy prescribed with exclusion

MLN Matters Number: MM5036 *Revised* Related Change Request (CR) #: 5036 and 4183
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2006 Oncology Demonstration Project

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

Provider Types Affected

Hematologists and oncologists who bill Medicare for the care of cancer patients

Provider Action Needed

This article provides information on the oncology demonstration project for 2006.

Additional information and guidance is available in *Medlearn Matters* article SE0588, which is available at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0588.pdf* on the Centers for Medicare & Medicaid Services' (CMS) website.

Background

The Social Security Act Amendments of 1967 (Pub. L. 90-248, Sections 402(a) (1) (B) and 402(b)), give the Secretary of Health and Human Services the authority to develop and implement experiments and demonstration projects to:

- Provide incentives for economy, while
- Maintaining or improving quality in health services delivery.

In this context, CR4219, upon which this article is based, announces the implementation of the Medicare oncology demonstration project for 2006. This one-year demonstration project's purpose is to identify and assess, in office-based oncology practices, certain oncology services that positively affect outcomes in the Medicare population.

This 2006 oncology demonstration project replaces the 2005 chemotherapy demonstration project, and substantially changes the reporting emphasis. In the 2006 project, your reporting will no longer be specific to chemotherapy administration services, but, instead, will be associated with physician evaluation and management (E & M) visits for established patients with cancer.

The project builds on the use of G-codes (temporary national codes for items or services requiring uniform national coding between one year's update and the next) to gather more specific information about patients with particular types of cancer (noted below), including information about the primary focus of the visit and the spectrum of care that you provide.

It will emphasize practice guidelines as the source for standards of care, permitting CMS to monitor and encourage quality care to cancer patients, and to identify and promote best cancer care practices that should lead to improved patient outcomes.

This purpose is facilitated by the elimination of some G-codes and the adoption of new ones. Calendar year 2005 G-codes (G0921 to G0932), specific to the assessment of patient symptoms, have been eliminated, effective December 31, 2005.

G-Codes Address Three Reporting Categories

To facilitate the collection of the oncology demonstration information, CMS has established 81 new G-codes that address three reporting categories:

1) The primary focus of the evaluation and management visit;

2) Whether current management adheres to clinical guidelines; and

3) The current disease state.

Capturing these variables will form the building blocks of efficiency-oriented demonstrations in the future. You can find these new G-codes in the table at the end of this article.

Diagnostic Categories

Office-based hematologists and oncologists can participate in this demonstration, for services they furnish in 2006, when they provide an evaluation & management (E & M) service of level 2, 3, 4, or 5 to an established patient (American Medical Association's Current Procedural Terminology (CPT) codes 99212, 99213, 99214 and 99215) with a primary diagnosis of cancer belonging to one of the following 13 major diagnostic categories:

1.) Head and neck cancer (140.0 –149.9, 161.0-161.9)
2.) Esophageal cancer (150.0-150.9)
3.) Gastric cancer (151.0-151.9)
4.) Colon cancer (153.0-153.9)
5.) Rectal cancer (154.0, 154.1)
6.) Pancreatic cancer (157.0, 157.1, 157.2, 157.3, 157.8, 157.9)
7.) Lung cancer (both non-small cell and small cell) (162.2-162.9)
8.) Female breast cancer (invasive) (174.0-174.9)
9.) Ovarian cancer (183.0)
10.) Prostate cancer (185)
11.) Non-Hodgkin's lymphoma (202.00-202.08, 202.80-202.98)
12.) Multiple myeloma (203.00, 203.01)
13.) Chronic myelogenous leukemia (205.10, 205.11)

To Qualify for the Payment

To qualify for the payment associated with this demonstration payment, you must submit one G-code from each of the three categories mentioned above when you bill for an E & M of level 2, 3, 4, or 5 for established patients. Practices reporting data on all three categories will qualify for an additional oncology demonstration payment of $23 in addition to the E & M visit.

Important Details

The following are some important details that you should be aware of:

Participation is Voluntary

Participation in this demonstration is voluntary and the physician participates by filing a claim for services (i.e., a level 2, 3, 4, or 5 established office visit with three separate G codes, one from each category) with the Medicare carrier.

Qualifying Specialties

The physician specialties that qualify for this 2006 oncology demonstration are hematology (specialty code 82), medical oncology (specialty 90), and hematology/oncology (specialty 83).

Mid-level practitioners, such as nurse practitioners or others who may bill independently for Medicare services, are not eligible to participate in the demonstration. Medicare carriers will deny claims for the 2006 oncology demonstration submitted by other than a qualifying specialty. Such claims will be denied with remittance advice code N95 and claim adjustment reason code 185.

Other Cancer Types Not Included

E & M services that you furnish for patients with cancer types as the principal diagnosis, other than these mentioned in this CR, will not be included in the demonstration. If you report

2006 Oncology Demonstration Project, continued

claims with these demonstration G codes that are not related to the 13 specific cancer types, those G codes will be denied.

Applies to Beneficiaries Not Enrolled in Medicare Advantage Plan

The project applies only to Medicare beneficiaries who are not enrolled in a Medicare Advantage plan, and is effective only for services provided on or after January 1, 2006, and before January 1, 2007. Medicare carriers will return/reject, as not able to process, oncology demonstration G-codes that are billed for dates of service not within CY 2006, using Remittance Advice reason code B18 and remark code N56 and Medicare Summary Notice (MSN) message 16.13.

Chemotherapy

While chemotherapy may be provided to the patient on the same day as the E & M visit, it is only the latter that is linked to the demonstration project. In this instance, therefore, you should attach modifier 25 to the E & M service. This denotes that you have performed a significant, separately identifiable evaluation and management service on the same day of a procedure (the chemotherapy administration service). Further, you should appropriately document the patient's record to support the level of the E & M service billed.

Billing Codes

You must bill a code from each of the three categories mentioned above. If you bill one or more (but not one from all three categories) of the demonstration codes on a single claim, carriers will return/reject the claim as not able to process and use Remittance Advice reason code 16 and remark code MA 130.

Conversely, if you bill more than one G-code from the same category for the same date of service on the same claim (for instance, you submit a claim for more than two G-codes from the category of "primary focus of the visit"), carriers will also reject the claim as not able to process, and use remittance advice reason code 125 and remittance advice remark code MA130.

Note: Some Medicare carriers may choose to manually split the claim and only return the not-able-to-process portion (i.e., the portion related to submitting data for the oncology demonstration). However, CMS will not require carriers to do this.

Claims Must Be Assigned

Your claims must be assigned. If a participating provider submits a non-assigned claim for the oncology demonstration G codes, carriers will process the claim as assigned and generate Remittance Advice remark code MA09.

If a nonparticipating provider submits a non-assigned claim for the G-codes and related E & M service, carriers will process the claim for coverage and payment of those services that do not require assignment (e.g., the evaluation and management service) and deny the G-codes using Remittance Advice reason code 111, remark code N149, and MSN message 16.6.

Resubmitting G-Codes

Providers may resubmit oncology demonstration G-codes that were denied for not accepting assignment and, in such instances, the G-codes will be approved if the related E & M codes were approved. However, if there is no approved E & M code for the same service date and place of service as the G-codes on the claim or in the history, carriers will deny the G-codes using Remittance Advice reason code 107 and MSM code 16.26.

Place of Service

The place of service reported for codes must be "office" (place of service code 11). If the place of service reported is other than "office," carriers will return/reject the claim as not able to process, using Remittance Advice reason code 5 and MSN code 16.2.

Payment Allowances

Carriers will establish the following payment allowances for the demonstration codes and determine payment based on the lesser of 80% of the actual charge or on the allowance by code:

1. G9050 to G9055 - $7.67
2. G9056 to G9062 - $7.67
3. G9063 to G9130 - $7.66

These amounts apply in all localities, and the usual Part B coinsurance and deductible apply.

SNF Consolidated Billing

During the demonstration, the oncology G-codes will bypass SNF consolidated billing for beneficiaries in a Part A stay.

Additional Information

The new 2006 oncology G codes and their descriptors can be viewed beginning on the next page of this article.

In addition, a special edition *Medlearn Matters* article is available to provide additional coding guidance. That article is available at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0588.pdf* on the CMS website.

To view the actual instruction, CR4219, issued to your carrier, visit *http://www.cms.hhs.gov/Transmittals/downloads/R42DEMO.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/apps/contacts/* on the CMS website.

Oncology Demonstration Project G-codes (in Numerical Order by Code)

Primary focus of the visit

G9050 ONCOLOGY; PRIMARY FOCUS OF VISIT; WORK-UP, EVALUATION, OR STAGING AT THE TIME OF CANCER DIAGNOSIS OR RECURRENCE (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)

G9051 ONCOLOGY; PRIMARY FOCUS OF VISIT; TREATMENT DECISION-MAKING AFTER DISEASE IS STAGED OR RESTAGED, DISCUSSION OF TREATMENT OPTIONS, SUPERVISING/COORDINATING ACTIVE CANCER DIRECTED THERAPY OR MANAGING CONSEQUENCES OF CANCER DIRECTED THERAPY

G9052 ONCOLOGY; PRIMARY FOCUS OF VISIT; SURVEILLANCE FOR DISEASE RECURRENCE FOR PATIENT WHO HAS COMPLETED DEFINITIVE CANCER-DIRECTED THERAPY AND CURRENTLY LACKS EVIDENCE OF RECURRENT DISEASE; CANCER DIRECTED THERAPY MIGHT BE CONSIDERED IN THE FUTURE

G9053 ONCOLOGY; PRIMARY FOCUS OF VISIT; EXPECTANT MANAGEMENT OF PATIENT WITH EVIDENCE OF CANCER FOR WHOM NO CANCER DIRECTED THERAPY IS BEING ADMINISTERED OR ARRANGED AT PRESENT; CANCER DIRECTED THERAPY MIGHT BE CONSIDERED IN THE FUTURE

2006 Oncology Demonstration Project, continued

G9054 ONCOLOGY; PRIMARY FOCUS OF VISIT; SUPERVISING, COORDINATING OR MANAGING CARE OF PATIENT WITH TERMINAL CANCER OR FOR WHOM OTHER MEDICAL ILLNESS PREVENTS FURTHER CANCER TREATMENT; INCLUDES SYMPTOM MANAGEMENT, END-OF-LIFE CARE PLANNING, MANAGEMENT OF PALLIATIVE THERAPIES

G9055 ONCOLOGY; PRIMARY FOCUS OF VISIT; OTHER, UNSPECIFIED SERVICE NOT OTHERWISE LISTED

Guideline Adherence Codes

G9056 ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT ADHERES TO GUIDELINES

G9057 ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT DIFFERS FROM GUIDELINES AS A RESULT OF PATIENT ENROLLMENT IN AN INSTITUTIONAL REVIEW BOARD APPROVED CLINICAL TRIAL

G9058 ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT DIFFERS FROM GUIDELINES BECAUSE THE TREATING PHYSICIAN DISAGREES WITH GUIDELINE RECOMMENDATIONS

G9059 ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT DIFFERS FROM GUIDELINES BECAUSE THE PATIENT, AFTER BEING OFFERED TREATMENT CONSISTENT WITH GUIDELINES, HAS OPTED FOR ALTERNATIVE TREATMENT OR MANAGEMENT, INCLUDING NO TREATMENT

G9060 ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT DIFFERS FROM GUIDELINES FOR REASON(S) ASSOCIATED WITH PATIENT COMORBID ILLNESS OR PERFORMANCE STATUS NOT FACTORED INTO GUIDELINES

G9061 ONCOLOGY; PRACTICE GUIDELINES; PATIENT'S CONDITION NOT ADDRESSED BY AVAILABLE GUIDELINES

G9062 ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT DIFFERS FROM GUIDELINES FOR OTHER REASON(S) NOT LISTED

Lung cancer, Non-small cell, small cell lung cancer (162.2-162.9)

G9063 ONCOLOGY; DISEASE STATUS; LIMITED TO NON-SMALL CELL LUNG CANCER; EXTENT OF DISEASE INITIALLY ESTABLISHED AS STAGE I (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9064 ONCOLOGY; DISEASE STATUS; LIMITED TO NON-SMALL CELL LUNG CANCER; EXTENT OF DISEASE INITIALLY ESTABLISHED AS STAGE II (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9065 ONCOLOGY; DISEASE STATUS; LIMITED TO NON-SMALL CELL LUNG CANCER; EXTENT OF DISEASE INITIALLY ESTABLISHED AS STAGE III A (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9066 ONCOLOGY; DISEASE STATUS; LIMITED TO NON-SMALL CELL LUNG CANCER; STAGE III B- IV AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE

G9067 ONCOLOGY; DISEASE STATUS; LIMITED TO NON-SMALL CELL LUNG CANCER; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT YET DETERMINED, OR NOT LISTED

G9068 ONCOLOGY; DISEASE STATUS; LIMITED TO SMALL CELL AND COMBINED SMALL CELL/NON-SMALL CELL; EXTENT OF DISEASE INITIALLY ESTABLISHED AS LIMITED WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9069 ONCOLOGY; DISEASE STATUS; SMALL CELL LUNG CANCER, LIMITED TO SMALL CELL AND COMBINED SMALL CELL/NON-SMALL CELL; EXTENSIVE STAGE AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE

G9070 ONCOLOGY; DISEASE STATUS; SMALL CELL LUNG CANCER, LIMITED TO SMALL CELL AND COMBINED SMALL CELL/NON-SMALL; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, PRE-SURGICAL, OR NOT LISTED

Female breast cancer (174.0-174.9)

G9071 ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE I OR STAGE IIA-IIB; OR T3, N1, M0; AND ER AND/OR PR POSITIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9072 ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE I, OR STAGE IIA-IIB; OR T3, N1, M0; AND ER AND PR NEGATIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9073 ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE IIIA-IIIB; AND NOT T3, N1, M0; AND ER AND/OR PR POSITIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9074 ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE IIIA-IIIB; AND NOT T3, N1, M0; AND ER AND PR NEGATIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9075 ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE

2006 Oncology Demonstration Project, continued

G9076 ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, PRE-SURGICAL OR NOT LISTED

Prostate cancer (185)

G9077 ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; T1-T2C AND GLEASON 2-7 AND PSA < OR EQUAL TO 20 AT DIAGNOSIS WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9078 ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; T2 *OR T3A+* GLEASON 8-10 OR PSA > 20 AT DIAGNOSIS WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9079 ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; T3B-T4, ANY N; ANY T, N1 AT DIAGNOSIS WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9080 ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; AFTER INITIAL TREATMENT WITH RISING PSA OR FAILURE OF PSA DECLINE

G9081 ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; NON-CASTRATE, INCOMPLETELY CASTRATE; CLINICAL METASTASES OR M1 AT DIAGNOSIS

G9082 ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; CASTRATE; CLINICAL METASTASES OR M1 AT DIAGNOSIS

G9083 ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION OR NOT LISTED

Colon cancer (153.0-153.9)

G9084 ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-3, N0, M0 WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9085 ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T4, N0, M0 WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9086 ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-4, N1-2, M0 WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9087 ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE WITH CURRENT CLINICAL, RADIOLOGIC, OR BIOCHEMICAL EVIDENCE OF DISEASE

G9088 ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE WITHOUT CURRENT CLINICAL, RADIOLOGIC, OR BIOCHEMICAL EVIDENCE OF DISEASE

G9089 ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, NOT YET DETERMINED, UNDER EVALUATION, PRE-SURGICAL, OR NOT LISTED

Rectal cancer (154.0, 154.1)

G9090 ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-2, N0, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9091 ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T3, N0, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9092 ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-3, N1-2, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE OR METASTASES

G9093 ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T4, ANY N, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9094 ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMAAS PREDOMINANT CELL TYPE; M1AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE

G9095 ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, NOT YET DETERMINED, UNDER EVALUATION, PRE-SURGICAL, OR NOT LISTED

2006 Oncology Demonstration Project, continued

Esophageal cancer (150.0-150.9)

G9096 ONCOLOGY; DISEASE STATUS; ESOPHAGEAL CANCER, LIMITED TO ADENOCARCINOMA OR SQUAMOUS CELL CARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-T3, N0-N1 OR NX (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9097 ONCOLOGY; DISEASE STATUS; ESOPHAGEAL CANCER, LIMITED TO ADENOCARCINOMA OR SQUAMOUS CELL CARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T4, ANY N, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9098 ONCOLOGY; DISEASE STATUS; ESOPHAGEAL CANCER, LIMITED TO ADENOCARCINOMA OR SQUAMOUS CELL CARCINOMA AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE

G9099 ONCOLOGY; DISEASE STATUS; ESOPHAGEAL CANCER, LIMITED TO ADENOCARCINOMA OR SQUAMOUS CELL CARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, NOT YET DETERMINED, UNDER EVALUATION, PRE-SURGICAL, OR NOT LISTED

Gastric cancer (151.0-151.9)

G9100 ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; POST R0 RESECTION (WITH OR WITHOUT NEOADJUVANT THERAPY) WITH NO EVIDENCE OF DISEASE RECURRENCE, PROGRESSION, OR METASTASES

G9101 ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; POST R1 OR R2 RESECTION (WITH OR WITHOUT NEOADJUVANT THERAPY) WITH NO EVIDENCE OF DISEASE PROGRESSION, OR METASTASES

G9102 ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; CLINICAL OR PATHOLOGIC M0, UNRESECTABLE WITH NO EVIDENCE OF DISEASE PROGRESSION, OR METASTASES

G9103 ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; CLINICAL OR PATHOLOGIC M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE

G9104 ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT YET DETERMINED, PRESURGICAL, OR NOT LISTED

Pancreatic cancer (157.0-157.3, 157.8, 157.9)

G9105 ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; POST R0 RESECTION WITHOUT EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9106 ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA; POST R1 OR R2 RESECTION WITH NO EVIDENCE OF DISEASE PROGRESSION, OR METASTASES

G9107 ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA; UNRESECTABLE AT DIAGNOSIS, M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE

G9108 ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT YET DETERMINED, PRE-SURGICAL, OR NOT LISTED

Head and neck cancer (140.0-149.9, 161.0-161.9)

G9109 ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-T2 AND N0, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9110 ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T3-4 AND/OR N1-3, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

G9111 ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE

G9112 ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, NOT YET DETERMINED, PRE-SURGICAL, OR NOT LISTED

Ovarian cancer (183.0)

G9113 ONCOLOGY; DISEASE STATUS; OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER; PATHOLOGIC STAGE IA-B (GRADE 1) WITHOUT EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)

G9114 ONCOLOGY; DISEASE STATUS; OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER; PATHOLOGIC STAGE IA-B (GRADE 2-3); OR STAGE IC (ALL GRADES); OR STAGE II; WITHOUT EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

2006 Oncology Demonstration Project, continued

G9115 ONCOLOGY; DISEASE STATUS; OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER; PATHOLOGIC STAGE III-IV; WITHOUT EVIDENCE OF PROGRESSION, RECURRENCE

G9116 ONCOLOGY; DISEASE STATUS; OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER; EVIDENCE OF DISEASE PROGRESSION, OR RECURRENCE, AND/OR PLATINUM RESISTANCE

G9117 ONCOLOGY; DISEASE STATUS; OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, INCOMPLETE SURGICAL STAGING, PRE-SURGICAL STAGING, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)

Non-Hodgkin's lymphoma (202.00-202.08, 202.80-202.98)

G9118 ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; STAGE I, II AT DIAGNOSIS, NOT RELAPSED, NOT REFRACTORY

G9119 ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; STAGE III, IV NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE –APPROVED DEMONSTRATION PROJECT)

G9120 ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, TRANSFORMED FROM FOLLICULAR LYMPHOMA TO DIFFUSE LARGE B-CELL LYMPHOMA

G9121 ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; RELAPSED/ REFRACTORY

G9122 ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NONRESPONSE TO THERAPY, OR NOT LISTED

Chronic Myelogenous leukemia (205.10, 205.11)

G9123 ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; CHRONIC PHASE NOT IN HEMATOLOGIC, CYTOGENETIC, OR MOLECULAR REMISSION

G9124 ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND /OR BCR-ABL POSITIVE; ACCELERATED PHASE NOT IN HEMATOLOGIC CYTOGENETIC, OR MOLECULAR REMISSION

G9125 ONCOLOGY; DISEASE STATUS; CHRONIC MYLOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIACHROMOSOME POSITIVE AND /OR BCR-ABL POSITIVE; *BLAST PHASE NOT†* IN HEMATOLOGIC, CYTOGENETIC, OR MOLECULAR REMISSION

G9126 ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND /OR BCR-ABL POSITIVE; IN HEMATOLOGIC, CYTOGENETIC, OR MOLECULAR REMISSION

G9127 ONCOLOGY; DISEASE STATUS; CHRONIC MEYLOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND /OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT

Multiple Myeloma (203.00, 203.01)

G9128 ONCOLOGY; DISEASE STATUS; LIMITED TO MULTIPLE MYELOMA, SYSTEMIC DISEASE; SMOLDERING, STAGE I

G9129 ONCOLOGY; DISEASE STATUS; LIMITED TO MULTIPLE MYELOMA, SYSTEMIC DISEASE; STAGE II OR HIGHER

G9130 ONCOLOGY; DISEASE STATUS; LIMITED TO MULTIPLE MYELOMA, SYSTEMIC DISEASE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, OR NOT LISTED

†Italicized text reflects impending change to long descriptor to be implemented in January 2006. The coding physician should assume the long descriptor includes this change.

Medlearn Matters Number: MM4219
Related Change Request (CR) #: N/A
Related CR Release Date: March 10, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R36DEMO
Implementation Date: January 17, 2006

2006 Oncology Demonstration Project - Reminder

To qualify for the payment associated with this demonstration payment, you must submit one G-code from each of the three categories mentioned above when you bill for an E & M of level 2, 3, 4, or 5 for established patients. In addition, the G-codes and the E & M must be billed on the same claim. If billed on separate claims, the service will be denied.

Source: Publication 100-19, Transmittal 42, Change Request 4219

March is National Kidney Month

As you know, chronic kidney disease (CKD) is a growing problem in the United States. CKD can lead to cardiovascular disease, among other serious health conditions, and left unchecked can eventually lead to kidney failure. Over 400,000 Americans suffer from kidney failure (end stage renal disease, or ESRD) and require either kidney dialysis or transplantation to live. Additionally, 8 to 20 million Americans have reduced kidney function, due primarily to diabetes and hypertension, which can lead to kidney failure. ESRD is Medicare's only disease-specific program that entitles people of all ages to Medicare coverage on the basis of their diagnosis. Your patients may be at risk for chronic kidney disease if they:

- Have Diabetes
- Have High Blood Pressure
- Have a Family History of Chronic Kidney Disease
- Are 60 Years of Age or Older
- Are from the following ethnic groups (African American, Hispanic, Asian or Pacific Islander)

The Medicare Program provides coverage of kidney dialysis and kidney transplant services for eligible Medicare patients. Your Medicare patients may also be eligible for coverage of cardiovascular disease and diabetes screenings, diseases that may increase the risk of kidney damage.

What can you do?

Prevention is possible! Talk with your patients about their risk for kidney disease and encourage them to take advantage of the appropriate Medicare benefits, such as cardiovascular disease and diabetes screenings and medical nutrition therapy services. Early treatment can slow progression of kidney disease and reduce cardiovascular risk.

Resources

To learn more about Medicare's coverage of and payment for kidney related services, please refer to the following publications, developed by the Medicare Learning Network (MLN) for health care professionals:

- Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services *www.cms.hhs.gov/MedlearnProducts/downloads/Book_Kidney_Dialysis-Final.pdf* (Available in print or download)
- Fistula First Breakthrough Initiative *http://www.cms.hhs.gov/MedlearnProducts/downloads/FistulaFirstbroch.pdf* (Available in download only)
- End Stage Renal Disease Composite Payment Rate System *http://www.cms.hhs.gov/MedlearnProducts/downloads/ESRDCompRatePaymentSys.pdf* (Available in download only)
- The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals *http://www.cms.hhs.gov/MedlearnProducts/downloads/PSGUID.pdf* (Available in print or download)

Print products may be ordered, free of charge, from the MLN Product Ordering page located at *http://www.cms.hhs.gov/medlearn* on the CMS website. These products are also available to view on line as a download and may be reprinted or redistributed as needed.

Other Helpful Education Resources

- National Kidney Disease Education Program *http://www.nkdep.nih.gov/* to learn more about kidney disease and how you can help your patients.

For more information about National Kidney Month visit *http://www.kidney.org/* on the Web.

Source: Provider Education Resources Listserv, Message 200603-07

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *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.

Revisions to Instructions for Contractors Other Than the RNHCI Specialty Contractor Regarding Claims for Beneficiaries with RNHCI Elections

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

Provider Types Affected

Physicians, providers, and suppliers who may treat Medicare patients who have elected Religious Nonmedical Health Care Institutions (RNHCI) care and bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) for those services.

Provider Action Needed

STOP – Impact to You

This change request (1) replaces the current process that develops claims via telephone inquiry for beneficiaries with RNHCI elections with a letter using "yes" or "no" questions; (2) places into the *Medicare Claims Processing Manual* RNHCI claims processing instructions; (3) restructures much of the existing RNHCI manual material to be more complete and accessible; (4) defines the RNHCI; and (5) lists the qualifying criteria for RNHCI benefits.

CAUTION – What You Need to Know

Note the business requirements in this CR that apply to your billing area.

GO – What You Need to Do

For providers other than RNHCIs, use the letter issued by your contractor that asks questions key to determining excepted versus nonexcepted care. For RNHCIs, incorporate the new claims submission instructions into your billing procedures.

Background

The transmittal publishes enhancements to Medicare manuals to more clearly explain the RNHCI benefit. The majority of these manual changes do not create any new business requirements. However, the transmittal revises instructions from Program Memorandum (PM) AB-03-145.

That PM changed the development process for claims for beneficiaries with RNHCI elections from a review of medical records to a telephone contact process.

The intent of PM AB-03-145 was to simplify the development process. Since the issuance of PM AB-03-145, a number of Medicare contractors (i.e., carriers and fiscal intermediaries) other than the RNHCI specialty contractor have expressed sufficient concerns about the telephone contact process to cause the Centers for Medicare & Medicaid Services (CMS) to revise that process.

Non-specialty contractors with high volumes of RNHCI-related claims rejects reported difficulty contacting providers. In addition, they reported beneficiaries were not willing or able to supply the necessary information to enable the contractor to determine whether the care was excepted or non-excepted care under RNHCI benefit policies.

These contractors also expressed concerns about the lack of written documentation from the provider in the telephone-based process. To address these concerns without reverting to a review of medical records, CMS has developed the requirements listed below that will be incorporated into the letter issued to providers.

Briefly, if you bill Medicare for services provided to a patient who has elected RNHCI coverage, the following requirements of CR4218 will apply.

Requirements of CR4218

Development Letters for Providers Other than RNHCIs

Upon receipt of a claim rejected by Medicare systems due to an RNHCI election on file for that Medicare beneficiary, contractors must issue a development letter designed to determine whether care was excepted or nonexcepted.

Contractors must issue RNHCI development letters that ask questions about the following:

- Whether the beneficiary paid for the services out of pocket in lieu of requesting payment from Medicare;
- Whether the beneficiary was unable to make his/her beliefs and wishes known before receiving the services that have been billed; and
- Whether, for a vaccination service, the vaccination performed was required by a government jurisdiction.

The letters will phrase questions in RNHCI to be answered with a Yes or No response. The wording and format of this letter will be based on the experience of your contractor in effectively communicating with their community of providers.

Determinations Based on Development Letter

- Contractors will make determinations of excepted or non-excepted care based on provider responses to development letters.
- Contractors will make determinations within 30 days of receipt of the provider's response.
- Contractors will make determinations of excepted care when a provider responds 'Yes' to any of the questions in the letter.
- Contractors will make determinations of non-excepted care when a provider responds 'No' to all of the questions in the letter.
- Contractors will make an excepted/non-excepted determination based on the evidence presented by the claim itself if the provider does not reply in a timely manner to the development letter.
- For claims for which no timely response was received, contractors will make a determination of non-excepted care if the claim contains durable medical equipment or prosthetic/orthotic devices.

Instructions for Contractors Other Than the RNHCI Specialty Contractor, continued

- For claims for which no timely response was received, contractor staff with a clinical background will use the diagnoses and procedures reported on the claim to make their best determination whether the services were excepted or non-excepted care.
- For claims for which no timely response was received, contractors will make determinations of excepted or non-excepted care within 30 days of the end of the timely response period.

For RNHCI Providers

CR 4218 provides complete instructions for completion of claims to Medicare. RNHCIs should review the instructions in CR 4218 and ensure their current billing processes are consistent with these instructions. The "Related Instructions" section of this article provides information on accessing the transmittals that comprise CR 4218.

Implementation

The implementation date for the instruction is May 11, 2006.

Related Instructions

For a beneficiary to receive benefits under section 1821 of the Social Security Act (the Act) and payment under the Medicare program upon admission to a RNHCI and prior to the RNHCI billing for services, the beneficiary must make a written election.

The document detailing the process for a beneficiary to elect RNHCI care or to terminate that election is attached to transmittal R45BP of CR 4218. CR 4218 may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R45BP.pdf* on the CMS website.

The ten qualifying provisions that must be met for a provider to be defined as an RNHCI, as contained in Section 1861 (ss) (1) of the Act for RNHCIs, are defined in transmittal R35GI of CR 4218. The transmittal may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R35GI.pdf* on the CMS website.

Chapter 3 of the *Medicare Claims Processing Manual*, Inpatient Hospital Billing, was also completely revised and is contained in transmittal R851CP of CR 4218.

Transmittal R851CP is available at *http://www.cms.hhs.gov/Transmittals/downloads/R851CP.pdf* on the CMS website.

Additional Information

The official instructions issued to the RNHCI intermediary regarding this change can be found in three parts, i.e., the transmittals parts as shown in the Web addresses provided above.

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

MLN Matters Number: MM4218 — Related Change Request (CR) #: 4218
Related CR Release Date: February 10, 2006 — Effective Date: May 11, 2006
Related CR Transmittal #: R35GI, R45BP, and R851CP — Implementation Date: May 11, 2006

Extension of Transitional Drug Coverage

A new fact sheet, describing the recent extension of transitional drug coverage to 90 days, can be found at *http://www.medicare.gov/Publications/Pubs/pdf/11193.pdf* on the Web.

On February 1, 2006 HHS Secretary Mike Leavitt announced that plans would be extending the 30-day transitional drug coverage period, extending it from the 30-day period to an additional sixty more days. That means that the plans are providing a full ninety days of drug coverage (through March 31, 2006).

Source: Provider Education Resources Listserv, Message 200602-05

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *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.

Announcing a New Name for Medicare's Provider Education Articles—MLN Matters

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

The Medicare Learning Network is pleased to announce a new name for our very popular provider education articles. To more closely associate these articles with the Medicare Learning Network, i.e., the official educational information source for Medicare Fee-for-Service (FFS) providers, the articles previously known as "Medlearn Matters" articles will now be known as *"MLN Matters"* articles (the MLN standing for "Medicare Learning Network").

You will also notice a new logo at the top of the articles indicating the name change. The Centers for Medicare & Medicaid Services (CMS) knows that you have come to rely on these articles to help you more easily understand new or changed Medicare policy and to help you gain quick access to accurate Medicare program information.

The articles can now be accessed from *http://www.cms.hhs.gov/MLNMattersArticles* on the CMS website. If you have previously bookmarked the "Medlearn Matters" page, please update your bookmark to the new URL.

We hope that you will continue to utilize these articles that are always prepared with the affected provider audience in mind.

In conjunction with the above referenced change, the urls for the Medicare Learning Network (MLN) web pages have also been changed. You can reach our MLN web pages from the cms.hhs.gov main page - just click on "Outreach and Education." The full URLs to access the various MLN sections on the CMS website are:

MLN General Information – *http://www.cms.hhs.gov/MLNGenInfo*
MLN Products – *http://www.cms.hhs.gov/MLNProducts*

Additional Information

Also, note that if you know the specific number of an article you are after, such as SE0620, you can go directly to the specific URL for an article by using the format below. For example, the website for SE0620 is *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0620.pdf*.

For any other article, just substitute its number for the SE0620 in this URL to go directly to the PDF version of the article on the CMS website.

Note: CMS issued a reminder of this change via the Contractor Provider Education Resources Listserv on: April 10, 2006, posted to our provider education website on April 17, 2006.

Source: CMS Special Edition Article SE0620
Provider Education Resources Listserv, Message 200604-05

MLN Matters Number: SE0620	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 PRESCRIPTION DRUG COVERAGE

Provider Part D Fact Sheet

The Centers for Medicare & Medicaid Services has assembled a fact sheet for use in prescriber's offices regarding the new transition policy, as well as the exceptions and appeals process for the Medicare Prescription Drug Benefit. This resource fact sheet is designed to provide ready-links to tools that will streamline the prescribing process under the new benefit. We continue to work with groups representing physicians, pharmacists, patients and Part D plans to simplify and standardize the information that physicians need to provide to plans.

The URL for the physician fact sheet is:
http://www.cms.hhs.gov/MedlearnProducts/downloads/Part_D_Resource_Factsheet.pdf.

We have consolidated most of the resources for prescribers into the provider website at *www.cms.hhs.gov/center/provider.asp* where offices can get access to direct phone numbers to the plan's coverage determination people, as well as copies of model forms that will help speed the process. Of course, information is always available through our Medicare Learning Network at *www.cms.hhs.gov/medlearn/drugcoverage.asp*.

We are hopeful that you will share this fact sheet with your members and feature it in your electronic and print outlets so that as many prescriber's offices know about the processes and tools we have designed to make it easier for them and their patients.

Source: Provider Education Resources Listserv, Message 200602-07

Medicare Prescription Drug Coverage, continued

Medicare Prescription Drug Coverage: Essential Information and Resources for Prescribing Health Care Professionals – The Eleventh in the MLN Matters Series on the New Prescription Drug Plans

CMS has issued the following "MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Second Quarter 2005 Medicare B Update! pages 54-55.

Note: This article was revised to contain Web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

All health care professionals who prescribe prescription medications for Medicare beneficiaries

Impact on Providers

The new Medicare prescription drug coverage began on January 1, 2006. Already, pharmacists have filled millions of prescriptions for people with Medicare. During this important transition period to the new prescription drug coverage, the Centers for Medicare & Medicaid Services (CMS) understands that there is much that prescribing health care professionals need to know about this new coverage in order to help their Medicare patients.

Essential Information for Prescribing Health Care Professionals

CMS has compiled a list of information, resources, and tools that will allow health care professionals and their support staff to help their Medicare patients during this transition period.

Finding Formulary Information

CMS has a formulary finder that provides direct access to all plan websites at *http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp* on the Web. In addition, we have worked with Epocrates to provide free software, which makes the formulary selection process very simple. You can load this program into your PDA or run the software on a desktop. This tool is available at *http://www.epocrates.com/* on the Web.

Coverage Determination

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, an enrollee can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

CMS does not have the authority to mandate a standard exception process for each Medicare drug plan or MA-PD; however, the Agency is working to simplify the exceptions process. Like typical commercial payers, health care professionals may occasionally need to help a patient file a prior authorization for a medication or appeal a medication's tier. CMS is working with medical specialty societies to address these issues.

A form has been created by a coalition of medical societies and advocacy groups that can be faxed to your office by a pharmacist when he or she is given a prescription that is either not on the formulary or on a higher tier.

This form streamlines communication between the pharmacist and the physician and reduces the need for time consuming telephone calls to the doctor's office.

The form is located at *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartDPharmacyFaxForm.pdf* on the CMS website, as well as at several medical society websites.

Expedited Review Process

There is an expedited review process that CMS has outlined to ensure that drug plans can move an appeal quickly, i.e., within a 24-hour turnaround time, to provide medicines to patients with an immediate need. Beyond this expedited review process, the standard appeals process to challenge a plan's coverage determination has five levels:

- Redetermination by the plan;
- Reconsideration by a Medicare drug coverage qualified independent contractor (QIC);
- An Administrative Law Judge (ALJ) hearing;
- Review by the Medicare Appeals Council; and
- Review by federal district court.

Visit *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp* for a list of plan contacts you can use to query your patient's plan should you need to pursue an appeal or require clarification on an issue.

Part B Drugs vs. Drugs Covered under Medicare Prescription Drug Coverage (Part D)

A previous MLN Matters article explains the difference between drugs covered under Part B versus those covered under Part D.

This article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0570.pdf* on the CMS website.

Medicare Prescription Drug Coverage, continued

Additionally, a chart explaining specific drugs can be found at *http://www.cms.hhs.gov/pharmacy/downloads/partsbdcoverageissues.pdf* on the CMS website.

Verifying Beneficiary Enrollment in a Medicare Drug Plan

Office staff can use the Medicare Prescription Drug Plan Finder, located at *http://www.medicare.gov*, to verify a beneficiary's enrollment in a Medicare drug plan. By entering all information provided on a beneficiary's Medicare card, the Plan Finder will identify the plan in which the beneficiary is enrolled.

Pharmacists have access to a new computer tool called "E1" that provides real time enrollment and eligibility information. This tool provides both eligibility and billing information at the point of sale and is constantly updated by CMS.

Obtaining Prior Authorizations

A prior authorization can only be obtained by calling the drug plan directly. 1-800-MEDICARE cannot process a prior authorization.

Ensuring Coverage for a Dual Eligible Beneficiary Who Needs to be Enrolled in a Plan

CMS has ensured that people with Medicare and full Medicaid benefits (full dual) will have drug coverage by enabling customer service representatives at 1-800-MEDICARE to enroll these beneficiaries in WellPoint, a national plan.

If these beneficiaries have **immediate prescription needs**, they should visit their local pharmacies. The pharmacist can enroll them in WellPoint at the pharmacy.

To find out more about what happens with Medicare prescription drug coverage in certain situations, visit *http://www.cms.hhs.gov/Pharmacy/Downloads/whatif.pdf* on the CMS website.

Providing a 90-day Supply of Transitional Prescription Medication

CMS has instructed all Medicare-approved plans to extend the original 30-day transitional coverage period by an additional 60 days. This means that a Part D beneficiary will be able to get a 90-day supply of all of his or her medications when they enroll in Part D, even if some of the medications are not on formulary. This 90 day period will give the patient's doctor and pharmacist time to adjust the patient's drug regimen, or request exceptions to the plan's formulary, so that the next refill of medications will be consistent with the plan's coverage rules. Beneficiaries who enroll after March 31st will get a 30-day transitional fill so that they have time to adjust their medication regimen to the plan formulary.

Important Contact Information to Report Problems with Medicare Prescription Drug Coverage

Health Care Professionals: E-mail *prit@cms.hhs.gov* with problems and issues encountered. Please take advantage of CMS' regular conference call at 2PM EST every Tuesday. This call gives health care professionals an opportunity to ask questions of CMS staff. Call 1-800-619-2457; Passcode: RBDML.

Pharmacists: Call 1-866-835-7595, a CMS dedicated line designed to help answer questions regarding billing and beneficiary enrollment information.

Additional Information

Health care professionals can visit *http://www.cms.hhs.gov/MLNProducts/23_DrugCoverage.asp#TopOfPage* on the CMS website. The redesigned Web page contains all the latest information on Medicare prescription drug coverage.

MLN Matters Number: SE0603 *Revised*	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

2006 Standard Medicare Prescription Drug Coverage: Understanding Costs to Beneficiaries- The Twelfth in the MLN Matters Series on Drug Plans

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

Provider Types Affected

Physicians, providers, and suppliers, and their staff who provide service to people with Medicare

Important Points to Remember

Key points to remember about the new Medicare prescription drug coverage include the following:

- Beneficiaries can join a Medicare Prescription Drug Plan that covers prescription drugs only and keep their Original Medicare coverage. Or, they can join a Medicare Advantage Plan or other Medicare Health Plan that covers doctor and hospital care as well as prescriptions.
- Medicare prescription drug coverage is NOT automatic - people must join a plan to get coverage
- Your patients have an initial opportunity to join a Medicare drug plan now through May 15, 2006.
- Most people will have to pay a higher premium that includes a penalty if they wait to join a Medicare drug plan until after May 15, 2006, unless they have other coverage that, on average, is at least as good as Medicare prescription drug coverage.

Medicare Prescription Drug Coverage, continued

This penalty consists of an additional 1% of the base premium for every month the person went without coverage, and is levied as long as the person is enrolled in a Medicare drug plan.

- People who do not join a Medicare drug plan by May 15, 2006, may also have to wait until November 15, 2006 for their next opportunity to join.

If your Medicare patients ask you questions about the new coverage, you can refer them to *http://www.medicare.gov* and 1-800-MEDICARE for additional information and assistance.

General Information

One of the issues that may be most important for your patients involves what Medicare prescription drug coverage means to them in terms of cost. This article focuses on the out-of-pocket expenses that your patients will incur under this new program and highlights the costs covered by a standard plan.

Actual costs of the specific Medicare Prescription Drug Plans and the Medicare Advantage Plans or other Medicare Health Plans in each area are available in the "Medicare & You 2006" handbook and at *http://www.medicare.gov* on the Web.

Costs Covered by a Standard Plan

Costs for your patients who join a Medicare drug plan will vary depending on their financial situation and which Medicare drug plan they join. All Medicare drug plans will offer at least the standard level of coverage described below.

Medicare drug plans may design their plans differently as long as what their plan offers is, on average, at least as good as the standard coverage. Some plans may offer more coverage for higher premiums.

Patient costs under standard Medicare drug coverage as defined by the MMA for 2006 will include the following:

- A monthly premium (average of $32 in 2006);
- A $250 deductible;
- Person pays, on average, 25% of allowable drug expenses up to a coverage limit of $2,250 (plan pays the other 75%);
- After $2,250 in covered drug costs, person pays 100% of covered drug costs until $3,600 limit in true out-of-pocket spending is reached;
- About 5% coinsurance for covered drug costs after $3,600 out-of-pocket limit is reached.

Individuals with standard coverage will pay the full cost of their prescriptions for drug spending between $2,250 and up to their true out-of-pocket limit of $3,600.

However, plan enrollees will still be able to obtain their plan's discounted price for prescription drugs in this coverage gap.

Alternate Coverage

Plans are able to offer alternative coverage structures. For example, a plan can offer a deductible lower than $250, or use tiered copayments rather than coinsurance – provided that the alternative coverage structure meets certain tests of actuarial equivalence.

Also, plans may offer additional drug coverage that supplements the standard coverage. Medicare payments to plans do not subsidize such supplemental coverage.

Costs for Patients With Medicare and Full Medicaid Benefits

Under Part D, starting in 2006, Medicare will provide primary drug coverage for individuals who are dually eligible for Medicare and Medicaid. Dually eligible individuals who earn incomes up to 100% of the federal poverty level will have Medicare prescription drug coverage with no deductibles, no premiums, nominal co pays, and no coverage gap.

Beneficiaries who do not qualify for Medicaid, but whose incomes are below 150 percent of poverty and who meet an asset test, will qualify for extra help paying for Medicare prescription drug coverage. Beneficiaries who qualify for extra help can join a Medicare drug plan with full or partial coverage for premiums and cost sharing and no coverage gap.

Specific Information on Out-of-Pocket Expenses

Medicare Drug Plan Premiums

Medicare drug plan monthly premiums vary, depending on the plan; however:

- All regions of the country have multiple plan options with premiums significantly below $30.
- There will be at least one prescription drug plan with a premium below $20 per month in every region of the country except Alaska.
- The average monthly beneficiary premium is $32.20, about $384 per year.

True Out-Of-Pocket Costs

The cost to beneficiaries with Medicare for Medicare prescription drug coverage over and above the monthly premium is often referred to as "true out-of-pocket expenses" or TrOOP.

The TrOOP represents the amount a beneficiary must spend on Part D covered drugs until catastrophic coverage begins. That catastrophic coverage begins when the beneficiary's out-of-pocket expenses reach $3,600 in a year.

In addition to paying the base premium for their plan, Medicare beneficiaries will also pay TrOOP costs including the following:

- A deductible amount ($250) and coinsurance (25% of covered drug costs during the plan payment + coinsurance stage);
- All costs during the coverage gap stage; and
- Five percent of covered drug costs during the catastrophic coverage stage.

Medicare Prescription Drug Coverage, continued

These additional TrOOP expenses are explained as follows:

Deductible (From $0 to $250: A net value of $250)

Under standard coverage, plan enrollees pay a $250 deductible each calendar year out of their own pockets for Part D covered drugs.

Plan Payments + Coinsurance (From $251 to $2250)

Once the annual ($250) deductible is met, standard coverage pays for 75% of the next $2,000 (or up to $1,500) for covered (allowable) drugs and biologicals. The remaining 25% (a maximum of $500) of the cost is covered by the beneficiary via coinsurance/copayments.

Coverage Gap (From $2,251 to $3,600 TROOP limit)

Once covered drug costs have reached the plan payment + coinsurance +deductible limit of $2,250, the plan does not pay again until the plan enrollee has reached the $3,600 limit in out-of-pocket spending. The beneficiary pays all covered drug costs incurred in this "gap." The total out of pocket cost (not including premiums) to this point (deductible + plan payments + coinsurance + coverage gap) is $3,600 for coverage through the full "gap" (see TrOOP discussion below.)

Catastrophic Coverage (Costs over $3,600 TROOP limit)

Once the individual's true out-of-pocket spending reaches $3,600, costs for necessary covered drugs are covered as follows:

- Reinsurance – 80% of covered drug-related costs are covered by Medicare;
- Plan payments – 15% of covered drug-related costs are covered by the drug plan;
- Coinsurance – 5% of covered drug-related costs are covered by the individual.

What Counts Toward True Out-of-Pocket (TrOOP) Costs?

Beneficiaries must adhere to their plan's formulary, prior authorization, and formulary exceptions processes in order for their out-of-pocket spending to count toward the $3,600 limit.

The following types of spending count toward the $3,600 threshold:

- The beneficiary's own out-of-pocket spending;
- Spending by a family member or official charity, on behalf of the beneficiary;
- Supplemental drug coverage provided through qualifying state pharmacy assistance programs (SPAP) or Medicare's extra help; and
- Under the Centers for Medicare & Medicaid Services' (CMS') demonstration authority, supplemental drug coverage paid for with MA rebate dollars.

In summary, the amount that a beneficiary must spend on part D-covered drugs until catastrophic coverage is reached, based on the 2006 standard coverage, is as follows:

$250 deductible
+ $500 plan enrollee coinsurance during initial coverage
+ $2,850 coverage gap
= $3,600 (plus the monthly premium, which averages $384/year)

Once this cost has been reached for covered drugs, catastrophic coverage begins.

Related Links

HHS Secretary Mike Leavitt recently released a two-month progress report on Medicare Prescription Drug Coverage that takes a hard look at what is working and what needs to improve. To view the report, visit: *http://www.hhs.gov/medicare2final.pdf* on the Web.

For more information about *Medicare Prescription Drug Coverage for Providers*, visit *http://www.cms.hhs.gov/MLNProducts/23_DrugCoverage.asp#TopOfPage* on the CMS website.

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Related CR Release Date: N/A Effective Date: N/A
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PREVENTIVE SERVICES

Medicare Provides Coverage for Many Preventive Services and Screenings

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

Provider Types Affected

All Medicare fee-for-service physicians, providers, suppliers, and other health care professionals who provide and bill for preventive services and screenings provided to Medicare beneficiaries.

Provider Action Needed

This article serves as a reminder that we need your help to ensure that Medicare beneficiaries receive the preventive services they need. Become familiar with the preventive services and screenings covered by Medicare. Help the Centers for Medicare & Medicaid Services (CMS) spread the news about the many preventive services and screenings covered by Medicare.

Talk with your Medicare patients about preventive services and screenings and encourage use of those services, where appropriate. Order and use the educational products developed by CMS to educate your staff about these benefits. The information found in these products will also help you communicate with your patients about Medicare preventive benefits.

Introduction

Medicare provides coverage for many diseases that are preventable through immunization or amendable through early detection, treatment, and lifestyle changes. This special edition MLN Matters article informs health care professionals about the preventive services and screenings covered by Medicare and highlights the educational and informational products developed by CMS for health care professionals to promote awareness and increase appropriate utilization of these services.

Medicare provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):

- Adult Immunizations
  - Influenza (flu)
  - Pneumococcal polysaccharide vaccine (PPV)
  - Hepatitis B virus (HBV)
- Bone Mass Measurements
- Cancer Screenings
  - Breast (mammography)
  - Cervical & vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- Cardiovascular Disease Screening
- Diabetes Screening
  - Self-Management Training
  - Medical Nutrition Therapy
  - Supplies
- Glaucoma Screening
- Initial preventive physical exam (IPPE) ("Welcome to Medicare" Physical Exam)
- Smoking and Tobacco-Use Cessation Counseling Services

CMS needs your help to get the word out about the many preventive services and screenings covered by Medicare. Each of these benefits presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing certain diseases.

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about preventive services and screenings. As a trusted source, your recommendation is the most important factor in increasing the use of appropriate preventive services.

Talk to your Medicare patients about the benefits of preventive medicine, detecting disease earlier when outcomes are best, reducing infectious disease, and improving the quality of their lives.

Educational Products and Informational Resources for Health Care Professionals

CMS has developed a variety of educational products to:

- Help increase your awareness of Medicare's coverage of disease prevention and early detection
- Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible
- Give you resources to help you effectively file claims.

Print products may be ordered, free of charge, from the Medicare Learning Network (MLN). All print products are available to download and view on line and may be reprinted or redistributed as needed. Some print products are only available as a download and will be notated as such.

Product Ordering Instructions

To order a product, free of charge, access this link: *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

You may click on the title of the publications below to view them online.

Brochures

The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals – This series of tri-fold brochures provides an overview of Medicare's coverage for preventive services and screenings including the new benefits: diabetes and cardiovascular disease screenings and the initial preventive physical examination (IPPE). (See *Expanded Benefits* brochure.)

- Adult Immunizations [PDF 279KB]
- Bone Mass Measurements [PDF 269KB]
- Cancer Screenings [PDF 295KB]
- Expanded Benefits [PDF 255KB]
- Glaucoma Screening [PDF 242KB]
- Smoking and Tobacco-Use Cessation Counseling Services [PDF, 562KB] (available in download only at this time)

Guides

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals [PDF 2MB] – This guide provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing and reimbursement. (May 2005. See the errata sheet for corrections identified since May 2005 printing.)

Determining a Medicare Beneficiary's Eligibility for Medicare Preventive Services [PDF 304KB] – This guide provides information on interpreting the Medicare beneficiary preventive services "next eligible date" data and is intended to supplement the educational materials already available for the HIQA, HIQH, HUQA, ELGA, ELGB and ELGH eligibility inquiry screens used to access common working file (CWF) records. (September 2005; Available in download only)

Medicare Preventive Services CD ROM

Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals – This CD ROM contains The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals; six brochures: 1) Expanded Benefits, 2) Glaucoma Screenings, 3) Cancer Screenings, 4) Bone Mass Measurements, 5) Adult Immunizations, and 6) Smoking and Tobacco-Use Cessation Counseling Services; and a Quick Reference Information: Medicare Preventive Services chart.

These resources are useful for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals that bill Medicare for preventive services. *(*See errata sheets for corrections identified since May 2005 printing of these products. See product ordering instructions above.)

Quick Reference Information Chart

Quick Reference Information: Medicare Preventive Services [PDF 74KB] – This two-sided laminated chart gives a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. (May 2005. See errata sheet for corrections identified since May 2005 printing.)

Video Programs

Flu Billing Made Easy – This video explains the process of billing for flu and pneumonia vaccinations. (January 2004) (English and Spanish) Ordering and other relevant information can be found at the following Web pages:

- ***Flu Billing Made Easier – Order (English and Spanish video)***
- ***Flu Billing Made Easier – Video Transcript [PDF 91KB]***
- ***Flu Billing Made Easier – Video Errata [PDF 13KB]***
- ***Flu Billing Made Easier Recommended Dial-Up***
- ***Flu Billing Made Easier Recommended DSL/Cable***
- ***Flu Billing Made Easier Recommended T1/DS3***

Web-Based Training Courses

Web-Based Training Modules (WBTs) – Three Web-based training courses covering coding, billing, overage and reimbursement for Medicare preventive services and screenings. (To access these WBT courses, go to the MLN Products Web page at *http://www.cms.hhs.gov/MLNProducts/*, scroll to the bottom of the page to "Links Inside CMS" and click on Web-based training modules.

Web Page

MLN Preventive Services Web Page – This Medicare Learning Network (MLN) Web page, for Medicare fee-for-services health care professionals, provides links to all of the provider/supplier specific preventive services educational and informational products mentioned in this article.

Other Useful Provider Resources

Other useful provider resources include the following:

Prevention Toolkit – This online toolkit contains resources that you may find useful when talking to your patients about Medicare preventive benefits.

Immunizations Toolkit – This online toolkit contains printable resources that nursing home providers can use to help improve the influenza and pneumococcal immunization rates among their residents, staff, and volunteers.

CMS Prevention Web Pages

CMS has created individual web pages for each of the preventive services and screenings covered by Medicare. For additional information visit *http://www.cms.hhs.gov/home/medicare.asp* and scroll down to the Prevention section.

Medicare Learning Network (MLN)

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's Web page on the CMS website at *http://www.cms.hhs.gov/MLNGenInfo*.

We encourage you to order and use these provider-specific products to:

- Increase your awareness of preventive services covered by Medicare
- Equip you to talk with your patients about Medicare-covered preventive services and encourage utilization of these potentially life saving benefits
- Help you file preventive services claims more effectively.

Note: These products have been developed for you, the health care professional.

Provider-specific products are not meant for distribution to Medicare beneficiaries. See below for where to obtain beneficiary specific information.

Preventive Benefit Information for Medicare Beneficiaries

Medicare beneficiaries may obtain information about Medicare preventive benefits by going to *http://www.medicare.gov/* and clicking on "Preventive Services."

They may also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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GENERAL EDUCATION

Cultural Competency: A National Health Concern

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

Provider Types Affected

This article is for informational purposes only and does not affect Medicare billing processes.

Background

The increasing diversity of the racial, ethnic, and linguistic composition of the U.S. challenges providers as they strive to deliver health care services. Cultural and language differences between patients and providers may generate miscommunication of critical health care information, a lack of compliance with prescribed treatment or medication, or other factors that negatively influence clinical situations and health outcomes. The existence of racial and ethnic disparities in health has been well documented by organizations such as the Institute of Medicine and the Agency for Healthcare Research and Quality.

Cultural competency, or the ability of health care providers to work effectively with colleagues and patients in cross-cultural situations, is a vital component of professional competence. Culturally competent practice can offer a variety of benefits to health care providers and their organizations, including:

- Improved patient care and satisfaction
- Decreased malpractice risk
- Enhanced operational efficiency
- Increased compliance with State and Federal regulations
- Reduction in health disparities

Highlights of the Centers for Medicare & Medicaid Services' (CMS) Activities to Address Health Disparities

To ensure that providers are prepared for the challenges they face to deliver the right care to every person every time, CMS's Quality Improvement Organizations (QIOs) are working with healthcare providers to become more effective and culturally aware of how they provide care to diverse populations. As part of a national initiative, QIOs are recruiting health providers to participate in a FREE online (web-based) program *A Family Physician's Practical Guide to Culturally Competent Care* to ensure that Medicare providers are prepared to effectively serve the increasingly diverse patient population. QIOs have adopted the Guide as the "Program of Choice" for health care provider cultural competency education. The Guide is an innovative educational product designed to equip health care providers with the cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities.

A Family Physician's Practical Guide to Culturally Competent Care is anchored in the three themes of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) and serves a key initiative in helping the Department of Health and Human Services' Office of Minority Health to achieve its mission of "improving the health of racial and ethnic minority populations' through the development of effective health policies and programs that help to eliminate disparities in health care."*A Family Physician's Practical Guide to Culturally Competent Care* is a case study based curriculum, featuring video vignettes and a diverse group of providers and clinic staff at a fictional practice setting that reinforce learning points throughout the modules. Participants can also share their reactions to the case studies in an online bulletin-board feature. This program was designed with the busy health care provider in mind, offering "anytime, anywhere" continuing education credit in an engaging and innovative format.

This curriculum is available to all health care providers at *http://www.thinkculturalhealth.org*. The program is accredited for Continuing Medical Education (CME) credits for physicians and Continuing Education Units (CEUs) for nurses and pharmacists.

Please visit *http://www.thinkculturalhealth.org* to access the free accredited continuing education program, *A Family Physician's Practical Guide to Culturally Competent Care*, and to view updates about the nursing program.

Additional Information

To access the free program, *A Family Physician's Practical Guide to Culturally Competent Care*, please visit *http://www.thinkculturalhealth.org*.

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care are available at *http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15*.

For more information about the QIO cultural competency initiative, please visit *http://www.qsource.org/uqiosc/*.

Additional information about the Office of Minority Health is available at *http://www.omhrc.gov/*.

MLN Matters Number: SE0621 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

Evaluation & Management Services Guide

The electronic version of the Evaluation & Management Services Guide, which provides evaluation and management services information regarding medical record documentation; International Classification of Diseases, 9th Revision, Clinical Modification and American Medical Association Current Procedural Terminology Codes; and key elements of service is now available from the Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf* on the CMS website.

Source: Provider Education Resources Listserv, Message 200604-09 & 200604-10

New Vascular Training Module

The training module titled "Creating AV Fistulas in All Eligible Hemodialysis Patients" is now available free of charge from the Medicare Learning Network located at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website. Scroll down and select "MLN Product Ordering Page" to request the training module.

Primary Affected Providers: Vascular access surgeons, interventional radiologists/nephrologists, nephrologists, physicians, and hospital health care professionals.

Source: Provider Education Resources Listserv, Message 200604-09

Revised Health Insurance Claim Form CMS-1500

Effective October 1, 2006 the Centers for Medicare & Medicaid Services (CMS) is revising the Form CMS-1500 (12-90) to accommodate the reporting of the national provider identifier (NPI) which is scheduled for implementation in May 2007

To receive copies of the revised Form CMS-1500 (08-05) with the specifications needed for testing purposes, contact TFP Data Systems at *JRMagdaleno@tfpdata.com*.

Although the new version will be effective October 1, 2006, providers will not be mandated to use the revised form until February 1, 2007.

The following is the Form CMS-1500 implementation timeline:

- **October 1, 2006**: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised Form CMS-1500 (08/05).
- **October 1, 2006 – January 31, 2007**: Providers can use either the current Form CMS-1500 (12/90) version or the revised Form CMS-1500 (08/05) version.
- **February 1, 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. 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).

IMPORTANT: **All claims re-billed on/after February 1, 2007 should be on the revised Form CMS-1500 (08/05), even though earlier submissions may have been on the current Form CMS-1500 (12/90). Claims submitted on/after February 1, 2007 utilizing the Form CMS-1500 (12/90) version will be returned unprocessable.**

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

Additional information is available via Medlearn Matters article MM4293 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf*

Source: Publication 100-04, Transmittal 899, Change Request 4293

New eLearning Course Now Available!

First Coast Service Options, Inc. (FCSO) is pleased to announce the posting of one new online course titled "The Appeals Process." The goal of this course is to provide you with information regarding the 2006 Medicare Appeals Process.

In order to give you a complete picture of the appeals process, this course will include an overview of the electronic claims filing process, unprocessable claims, and explain the differences in denied, partially paid, and paid claims. You will learn the different levels of the appeals process along with the specific guidelines for appealing a claim denial at each level.

This is just one of the many online courses that are available 24 hours a day, 7 days a week, at no charge, through our provider education website. Click "Education" on the top navigation menu and "eLearning" on the left navigation menu. Courses currently available include:

- Ambulance Services
- Beneficiary Name and Medicare Number Mismatch
- Chiropractic Services
- Comprehensive Error Rate Testing (CERT)
- Introduction to Global Surgery
- Medical Documentation Requests
- Modifier 24
- Modifier 25
- Modifier 58
- Modifier 78
- Modifier 79
- Part B Duplicate Claims
- Progressive Corrective Action (PCA)
- Split Care
- Unprocessable Claims

Be sure to regularly check our provider education website for upcoming online courses on Medicare secondary payer and evaluation and management (E/M) services.

CMS Electronic Mailing Lists (listservs)

The Division of Provider Information Planning and Development (DPIPD) within the Centers for Medicare & Medicaid Services (CMS) has developed a mailing list fact sheet informing providers about the advantage of receiving Medicare updates through the listservs.

CMS electronic mailing lists (listservs) can help you with your business! For more details, download the fact sheet from the following URL: *http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf.*

Source: CMS Joint Signature Memorandum 06403, April 20, 2006

GENERAL MEDICAL REVIEW

Articles in this section apply to both Florida and Connecticut.

Angiojet Thrombolytic Therapy: 37799 or 93799

Background

First Coast Service Options, Inc. (FCSO) has seen an increased billing of Angiojet Thrombolytic Therapy. The purpose of this article is to describe the service and outline coverage. This therapy can be performed on peripheral or coronary vessels. Angiojet Thrombolytic Therapy has not been FDA-approved for use in the carotid vessels.

Description of Service

The AngioJet shoots jets of high-speed saline solution through tiny openings in the tip of a surgical instrument called a catheter. Plaque and clots then dissolve into small pieces that are vacuumed back through the catheter. Unlike earlier technology, the AngioJet removes the clot entirely, eliminating the possibility that tiny pieces could move downstream and cause additional complications. Because Angiojet destroys blood clots (also known as thrombi), the Angiojet System is classified as a type of *thrombolytic therapy*. It is important for the beneficiary to be thoroughly educated about the benefits and risks of this modality.

Regulatory Information

At this point and time, there is no National Coverage Determination (NCD) about this service, and FCSO has not published a local coverage determination (LCD).

Billing and Coding

When billing a peripheral AngioJet procedure, CPT code *37799* (unlisted procedure, vascular surgery) must be used. When AngioJet is applied in the coronary arteries, the applicable CPT code is *93799* (unlisted cardiovascular service or procedure). The description "AngioJet" should be noted in Item 19 of the CMS-1500 claim form or the free form line of electronic claims.

Documentation

Providers should not submit any medical record documentation with the claim. FCSO may request this by means of an additional documentation request (ADR) letter, as appropriate.

Billing and Coding of 26040 and 20550

It has come to the attention of First Coast Service Options, Inc. (FCSO) that providers may not be billing *CPT* code *26040* correctly.

CPT code *26040* **Fasciotomy, palmar (eg, Dupuytren's contracture); percutaneous** and *CPT 26045*, **open partial**, have a clear descriptor referring to palmar fasciotomy. There is no reference to one or multiple tendon releases and there is one palmar fascia per hand. The fascia covers the tendons of the palm of the hand. Therefore the code should be billed once per hand.

CPT 4 coding is based on Level I and II procedure coding terminology. If a bilateral procedure is performed, then the *CPT* code *26040* or *26045* should be billed with modifier RT, LT, or 50. *CPT* code *26040* or *26045* cannot be billed more than once per hand and the use of certain modifiers would be inappropriate, i.e., F1, F2, etc.

When *CPT* code *20550* Injection(s); tendon sheath, or ligament, aponeurosis) is billed in addition to *CPT* code *26040* or *26045*, it must be a separate service. *CPT* code *20550* Injection(s); tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia") has editing related to CCI (and is considered a column 2 Code to *26040* or *26045* – a component of *CPT* code *26040* or *26045*). Documentation must support the appropriate use of a modifier 59 to bypass CCI edits. The documentation should be available to FCSO upon request.

There is no local coverage determination (LCD) for *CPT* code *26040* or *26045*, but FCSO does have an LCD for *CPT* code *20550* that further defines medical necessity, which is the focus of a LCD.

Billing Compounded Drugs, Service Date on/after March 20, 2006

This article addresses and provides clarification for the billing and reimbursement of compounded drugs. There continues to be a pattern of inconsistent billing and handling of these type claims resulting in an increase in appeals and hearings.

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 number, the specific HCPCS Level II "J" codes may not be used. Instead, providers should use J3490 (unclassified drug) as appropriate for reimbursement of the drug (s).

The use of compounded medications has been especially prevalent in the filling of implantable infusion pumps, (*CPT* 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 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 non-physician 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 non-physician 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.

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 March 20, 2006, the following guidelines should be followed:

EMC/Paper Claims

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

- Name(s) and dose (s) of drug(s) administered into the implantable pump
- Volume of refill in ml
- Pump reservoir size (ml)
- Exact invoice price for that individual patient

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

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. (FCSO) will request specific documentation by means of an additional documentation request (ADR) letter. This will slow down processing and payment.

Billing Compounded Drugs, Service Date prior to March 20, 2006

This article addresses and provides clarification for the billing and reimbursement of compounded drugs. There has been inconsistent billing and handling of these type claims causing an increase in appeals and hearings

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

The use of compounded medications has been especially prevalent in the filling of implantable infusion pumps *CPT* code *96530*. Whether a single agent or a combination of agents is used, the compounded medication must be billed under HCPCS code J3490 even though the compound was similar to a specific HCPCS code (e.g., J2275 for preservative free morphine). Of course, providers who document and use the true "off-the –shelf" product from their office supply may continue to use the specific HCPCS code. The powdered form of these medications should also be mixed / compounded by the pharmacist for the physician.

Effective for services rendered prior to March 20, 2006, the following guidelines should be followed when submitting your claims:

EMC claims

Name and strength of drug administered via the implantable pump should be reported in the electronic equivalent field for block 19 of the CMS 1500 claim form or the comment screen.

- The name and phone number of the pharmacy, if applicable.
- The number (1) should always be entered in the quantity billed (QB) field.
- The supplier invoice must be available upon request and the total number of "cc" instilled in the pump and what drugs were provided.

If any of the above information is omitted from an electronic claim, the claim will be developed for the requesting the supplier's invoice and the total number of "cc" instilled in the pump and what drugs were provided.

Paper claims

The term "compounded prescription, invoice attached" must be indicated in block 19 of the CMS-1500 claim form and a copy of the invoice from the pharmacy or supplier.
The invoice should include the following information:

- The name, NDC#, quantity, and strength of each drug in the mixture
- The suppliers invoice
- Documentation of the total number of "cc" instilled in the pump and what drugs were provided

The claim will develop for the invoice if one is not received with the claim.

In either case, the invoice cost may include a reasonable compounding fee and state tax if applicable. **Medicare will reimburse the lower of the invoice cost or 95 per cent of AWP of all components in the mixture.**

- Claims for infusion drugs furnished through implanted DME, with dates of service on or after January 1, 2004, shall be identified using the "KD" modifier.

Cardiac Computed Tomography and Computed Tomography Coronary Angiography 0144T-0151T—Emerging Technology

Background information for Category III Codes

Emerging technologies that do not have specific HCPCS/CPT codes are submitted to the contractor for review with **unlisted codes**. In 2002 the CPT Editorial Panel established Category III CPT codes as temporary codes used to collect data for certain emerging technology, services, and procedures. Prior to the implementation of Category III codes, there has been no way to collect data for these services and procedures since unlisted codes lack specific descriptors. Category III codes are different from typical CPT codes in that they are for services that may have limited use by health care professionals, may not have complete FDA approval, and the service/procedure may not have proven clinical efficacy in the peer-reviewed literature. Category III codes are also different from typical CPT codes because they are 5-digit alphanumeric codes as opposed to 5-digit numeric codes. If a **category III code** is available, this code **must** be reported instead of a category I unlisted code. Per CPT, the inclusion of a service or procedure in the category III code section neither implies nor endorses clinical efficacy, safety or the applicability to clinical practice.

Category III CPT Codes for Cardiac Computed Tomography (CCT) and Cardiac Computed Tomographic Angiography (CCTA) are effective January 1, 2006. The use of Category III CPT Codes is mandatory.

CCTA using multislice (multidetector) scanner

There have been significant developments in the field of Cardiac Computed Tomography with new applications for conventional scanners, emergence of helical (spiral) and electron beam technologies, and multislice (multidetector) CT utilizing 16, 32, 64, and more slice acquisition. —In regard to coronary artery disease, there currently are not clinical algorithms that are strictly followed that define the current variety of atherosclerosis imaging modalities and associated test. The issue is not just the sensitivity, specificity, PPV, and NPV of an emerging technology in the diagnosis of coronary artery disease, but the use of the imaging modality in serial monitoring, subsequent medical management, or risk-reducing strategies.

Consideration for coverage of this modality for coronary artery assessment is limited to devices that process thin, high resolution slices (1 mm or less). The multidetector scanner must have at least 32 slices per second capability.

Calcium scoring

Cardiac computed tomography (electron-beam or multislice [multidector] CT) used to demonstrate the presence of coronary calcification in patients with atherosclerotic heart disease is not a Medicare covered service. Currently the value of this test appears to be that of 'screening' for the presence of atherosclerosis. Medicare does not cover screening services in the absence of signs or symptoms unless Congress adds a specific benefit.

Coding in 2006

Effective January 1, 2006, category III codes *0144T, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T,* and *0151T* must be reported instead of procedure code *76497* (unlisted CT procedure). The use of category III CPT codes is mandatory to report cardiac CT and coronary CTA.

- ***0144T*** *Computed tomography, heart, without contrast material, including image post processing and quantitative evaluation of coronary calcium*

  ***0144T* is noncovered as investigational effective 01/01/2006 and is included in The List of Noncovered Services local coverage determination (LCD).**

  (Do not report *0144T* in conjunction with *0145T-0151T*)

Cardiac Computed Tomography and Computed Tomography Coronary Angiography, continued

- ***0145T*** *Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology*

(For cardiac structure and morphology in congenital heart disease, use *0150T*)

- ***0146T*** *Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium.*
- ***0147T*** *Computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium*

(Do not report *0147T* in conjunction with *0144T*)

- ***0148T*** *cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium*
- ***0149T*** *cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium*

(Do not report *0149T* in conjunction with *0144T*)

- ***0150T*** *cardiac structure and morphology in congenital heart disease*
- ***+0151T*** *Computed tomography, heart, without contrast material followed by contrast material (s) and further sections, including cardiac gating and 3D image post processing; function evaluation (left and right ventricular function, ejection fraction and segmental wall motion)*

(Use *0151T* in conjunction with *0145T-0150T*)

Coding Guidelines

The following codes should not be billed to describe CCT and CCTA or billed in addition to category III codes. If a separately identifiable service is performed on the same day of service, documentation has to support this as well as the medical necessity.

71275	Ct angiography, chest
71250	Ct thorax w/o dye
71260	Ct thorax w/ dye
71270	Ct thorax w/o & w/ dye

The following codes should never be billed for CCT or CCTA.

76376 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomogrpahic modality; not requiring image post processing on an independent workstation*

76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomogrpahic modality; requiring image post processing on an independent workstation*

The guidelines of the Correct Coding Initiative (CCI) are applicable as implemented by CMS.

The administration of contrast material is included in the category III codes.

Billing for these Services

Providers should submit claims EMC as usual. If CT scanner is hospital based (in or outpatient) the hospital should bill the fiscal intermediary (FI) and not the carrier. Prior to the April Update to the 2006 Medicare Physician Fee Schedule Database, (CR 4399), dated March 29, 2006, Category III codes *0144T-0151T*, did not allow billing of the professional and technical component modifiers on the line item; and providers were instructed to bill the carrier with the appropriate Category III code and note in block 19; 26 or PC, TC, or global as appropriate. Since that time, professional and technical components have been established for Category III codes *0144T-0151T* and should be billed with the procedure codes, effective January 01, 2006. The global and technical (TC) components are payable in the following places of service: office (11) and independent clinic (49). The professional component (26) is payable in the following places of service: office (11), inpatient hospital (21), outpatient hospital (22), emergency room - hospital (23), ambulatory surgical center (24) and independent clinic (49). Of course all state and federal anti-kickback and self-referral regulations are applicable to free standing facilities billing the carrier.

Coverage Issues

It is expected that CCT or CTCA be used in necessary decision-making and not merely to add a new layer of testing. The services could be evaluated either prepayment (request for medical records prior to payment) or post payment (request for records in the future after adjudication). Records must support the medical necessity of the service.

Since these codes describe emerging technologies and FCSO currently does not have an LCD, it is recommended that patients receive an advance beneficiary notice (ABN) of the possibility of noncoverage and the **modifier GA** be appended to the codes on a claim. The beneficiary may be liable in this situation.

Cardiac Computed Tomography and Computed Tomography Coronary Angiography, continued

0144T, quantitative calcium score is noncovered as noted and will result in a denial. If other CAT III codes used for CCT or CCTA are clearly performed for screening (i.e., in the absence of signs, symptoms or disease), the **modifier GY** may be applicable. It is the intention of the Centers for Medicare & Medicaid Services (CMS) to allow providers to use the **modifier GY** to bill for items or services that are statutorily non-covered or not a Medicare benefit. The **modifier GY** triggers a denial.

The **modifier GZ** (no ABN given) may be applicable if the provider recognizes that medical necessity may not be met but does not want to hold the beneficiary liable for a not medically necessary service.

For further details about CMS' Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.hhs.gov/BNI/*.

Coverage of less than 500 cc of D5W

It has come to the attention of First Coast Service Options, Inc. (FCSO) that providers are billing less than 500cc of D5W using unlisted procedure code J3490. This is considered incorrect billing. If less than 500 cc of D5W is provided to a patient, it is always bundled in the other services billed on the same day by the same physician and is not billed separately.

Intravitreal Bevacizumab (Avastin®) for Neovascular Age-Related Macular Degeneration

Bevacizumab, FDA-approved for intravenous use in combination with intravenous 5-fluorouracil-based chemotherapy, is indicated for first-line treatment of patients with metastatic carcinoma of the colon or rectum. The United States Pharmacopeia (USP) supports one unlabeled indication: advanced/metastatic non-squamous non-small cell lung cancer.

Early observations indicate that bevacizumab may be useful in the treatment of age-related macular degeneration (AMD). Ophthalmologists have been using intravitreal bevacizumab increasingly in the treatment of wet AMD. Even though the intravitreal administration looks promising and may be cost effective, there are still a number of concerns, specifically about safety. Currently, publications in peer-reviewed literature are not sufficient to support a positive coverage statement by means of a local coverage determination (LCD).

Until appropriately designed and powered studies are published and evaluated, bevacizumab for the treatment of age-related macular degeneration (AMD) will be considered on an individual case-by-case basis.

HCPCS code J9035 (Injection, bevacizumab, 10 mg) does not apply to the intravitreal administration, as a pharmacist has processed the agent. Providers billing for intravitreal bevacizumab should use CPT code *67028* for the intravitreal injection and HCPCS code J3490 (unclassified drugs) for the bevacizumab. Please enter "Intravitreal bevacizumab" in Item 19 of CMS 1500 Form or its electronic equivalent. The applicable ICD-9 code is 362.52 (exudative senile macular degeneration of retina). Documentation in the medical record must support the following:

- The diagnosis of neovascular (wet) macular degeneration has been firmly established (fluorescein angiogram).
- The patient does not have any contraindications to bevacizumab.
- The patient has been thoroughly educated about the benefits and risks of this therapy and that it is being used "off-label."
- Actual dose administered in milligrams.

When billing Medicare, the intravitreal injection and the drug injected should be billed on the same claim. Remember to use the appropriate modifiers when performing the service on both eyes.

Providers should not submit this information with the claim. First Coast Service Options, Inc. (FCSO) may request it separately with an additional documentation request (ADR) letter.

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 HCPCS codes. If and when a denial should be received, providers may collect from the beneficiary based on the fee schedule. For further details about CMS' Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*.

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Modifier 50 – Bilateral Procedures

First Coast Service Options, Inc. (FCSO) Provider Contact Center has been receiving numerous inquiries regarding the usage of modifier 50. The purpose of this article is to provide clarification on how modifier 50 should be billed.

Bilateral surgery is defined as a procedure performed on both sides of the body at the same operative session or on the same day. This definition does not include procedures that are bilateral in nature or include the terms "bilateral" or "unilateral/bilateral" in their descriptors.

When submitting claims for bilateral surgery, use modifier 50 with the procedure code. Claims for bilateral surgical procedures should be billed on a single claim detail line with the appropriate procedure code and modifier 50.

When billing for claims that are bilateral in nature, whether the services are performed unilaterally or bilaterally, providers should bill the surgical procedure code as a single claim detail line item without the modifier 50.

To determine if a procedure can be billed with the modifier 50 as a bilateral procedure, providers may access the on-line Medicare Physician Fee Schedule Database (MPFSDB) at *http://www.cms.hhs.gov/apps/pfslookup/*.

Vagal Nerve Stimulation for Intractable Depression

Effective July 15, 2005, the Food and Drug Administration (FDA) has given post-marketing approval for the use of vagal nerve stimulation (VNS) for intractable or refractory depression in patients 18 years of age or older who have not had an adequate response to four or more "adequate" antidepressant treatments.

There are several CMS national coverage determinations (NCDs) about nerve stimulation procedures; one is related to vagal nerve stimulation for seizure disorders (160.18 – Vagus Nerve Stimulation for Treatment of Seizures, *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf*); another is related to implantation of neurostimulators for pain control. At this time, there are no NCDs referencing the use of vagal nerve stimulation for the treatment of depression or other psychiatric disorders.

Currently, publications in peer-reviewed literature, position statements by technology assessment organizations, and the communication released by the manufacturer are not sufficient to issue a positive coverage statement by way of a local coverage determination (LCD) based on Medicare's medical reasonableness and necessity criteria. There have been no closely controlled clinical trials conducted to date or studies focusing on comparison with other treatments generally available.

Until appropriately designed and powered studies are published and evaluated, claims for vagal nerve stimulation for depression will be evaluated individually on a case-by-case basis. 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/HCPCS codes. For further details about CMS' Beneficiary Notice Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*.

Please note that services that lead up to or are associated with non-covered services are not covered as well. The beneficiary should be thoroughly educated about the benefits and risks of this modality.

Billing and Coding

Providers billing for this procedure should use the following CPT codes, as applicable:

61885 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61888 Revision or removal of cranial neurostimulator pulse generator or receiver
64573 Incision for implantation of neurostimulator electrodes; cranial nerve
64585 Revision or removal of peripheral neurostimulator electrodes
95970 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
95974 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour
95975 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

As there is no specific code for "intractable" or "refractory" depression, the following ICD-9-CM code should be used:

311 Depressive disorder, not elsewhere specified

Providers should not submit any medical record documentation with the claim. First Coast Service Options will request this by means of an additional documentation request (ADR) letter. The required information will include details about the pharmacotherapy and non-pharmacologic interventions (psychotherapy, ECT, etc.) over the past 18 months, documentation of a second opinion of a psychiatrist who is not involved in the care of the beneficiary, the patient's compliance, response to treatment, and other factors, as necessary.

Vertebral Fracture Assessment - CPT Code 76077

Background

First Coast Service Options, Inc. (FCSO) currently has a local coverage determination (LCD) for Bone Mineral Density Studies. This LCD is based on 42 CFR, Section 410.31 and the CMS Manual System. Therefore, vertebral fracture assessment (VFA) (CPT code *76077*) is outside the scope of this LCD, and this LCD does not apply to it. It is the intent of this article to inform providers about FCSO's approach to this service.

Description of the Service

Lateral spine dual energy x-ray absorptiometry (DXA) (CPT code *76077)*, or vertebral fracture assessment, is a relatively recently developed technique for imaging vertebral fractures that are not clinically evident. It assists in the diagnosis of prevalent vertebral fractures using less radiation than the anterior-posterior technique. If it is accurate in identifying vertebral fractures, when combined with bone mineral density measurement, it potentially could offer a method for more accurately determining risk of future fracture. Such risk assessment may help determine whether a patient is an appropriate candidate for pharmacologic treatment.

Regulatory Information

Medicare coverage of bone density measurements is defined in 42 CFR, Section 410.31 as reflected in First Coast Service Option's LCDs on this subject matter . There are five qualifying criteria:

- A patient with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture.
- A patient being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.
- A patient with known primary hyperparathyroidism.
- A patient receiving (or expecting to receive) glucocorticoid (steroid) therapy greater than 3 months, on the equivalent dose of 30 mg cortisone or 7.5 mg prednisone or greater per day.
- A woman who has been determined by the physician or a qualified non-physician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.

A local contractor does not have discretion of decision or authority to expand or contract this list.

According to 42 CFR, Section 410.31, "Bone mass measurement…is performed for the purpose of identifying bone mass, detecting bone loss, or determining bone quality" and does not include a provision for diagnosing a fracture. Therefore, vertebral fracture assessment is outside the scope of Medicare's bone mass measurement benefit, as defined by the law. It is a separate modality.

Contractor's (FCSO) Observations

It is the standard of practice to identify and evaluate vertebral fractures with traditional radiological techniques. However, screening for detection of vertebral fractures is generally not performed. As a result, diagnosis occurs either incidentally or as a result of symptoms. Traditional radiological evaluations for signs and symptoms have not been considered as a screening test. Importantly, screening for vertebral fractures is not a Medicare covered benefit. Therefore, VFA performed for screening for vertebral fractures is never covered.

Current literature has not demonstrated that treatment decisions based on VFA, along with bone mineral density measurements, have resulted in better patient outcomes than treatment based solely on bone mineral density and clinical risk factors. There is a lack of clinical trial evidence showing that patients with vertebral fractures on DXA but with bone mineral density levels above treatment thresholds benefit from pharmacologic treatment. There have not been an adequate number of closely controlled clinical trials conducted to date or studies focusing on comparison with other modalities generally available, and currently publications in peer-reviewed literature, as well as position statements by technology assessment organizations are not sufficient to issue a positive coverage statement by way of a local coverage determination (LCD).

Because in situations when there is no National Coverage Determination (NCD) or LCD, services are evaluated individually based on Medicare's general medical reasonableness and necessity criteria, claims for VFA will be given individual consideration on a case-by-case basis until appropriately designed and powered studies are published and evaluated.

Providers should not interpret the process of individual consideration as synonymous with coverage and payment by Medicare. This means only that the claims will be reviewed against the background of the presently available evidence and specific patient circumstances.

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 CPT code. For further details about CMS' Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*. Please note that services that lead up to or are associated with non-covered services are not covered as well.

Billing and Coding

The applicable CPT code is *76077* - Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment

Documentation

Providers should not submit any medical record documentation with the claim. FCSO will request this by means of an additional documentation request (ADR) letter. The required information will include details for the current episode of care about symptoms, signs, and findings suggestive of the presence of a vertebral fracture, other diagnostic modalities utilized, and the rationale for choosing VFA. Like any diagnostic test, the VFA must be specifically ordered by the treating physician, for which there must be documentation in the medical record.

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 Department
PO Box 2078
Jacksonville, FL 32231-0048

Phone: 1-866-419-9455

Medical Review Table of Contents

Advance Notice Statement

Advance beneficiary notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

CORRECTIONS

APBI: Accelerated Partial Breast Irradiation – Correction to Article

An article was published in the 1st Quarter 2005 *Medicare B Update!* (page 87) that addressed coverage guidelines for APBI. Since that time, it has been determined that the indications in the article did not match the local coverage determination (LCD) indications. A correction has been made to the indication that the size of the lesion should be "less than or equal to 3 cm.". The original article stated the lesion should be "greater than or equal to 3 cm." All other information remains the same.

Survival after breast-conservation therapy (BCT) is equivalent to survival after mastectomy for patients diagnosed with tumors categorized as stage I or II. The standard of care for local management is breast-conserving surgery to excise the tumor with adequate margins (lumpectomy), followed by whole-breast external-beam radiation therapy (WB-EBRT).

Accelerated Partial Breast Irradiation (APBI) differs from WB-EBRT in two ways. First, the radiation targets only a segment surrounding the tumor rather than the entire breast. Second, since the duration of treatment is 4 to 5 days rather than 5 to 6 weeks, radiation is delivered in fewer fractions at larger doses per fraction. APBI comprises several techniques, including interstitial brachytherapy via catheters, the MammoSite radiation treatment system, accelerated external beam radiotherapy, and intra-operative radiotherapy delivery.

When compared with whole breast irradiation, APBI offers the potential advantages of convenience and decreases radiation dose to healthy breast tissue. However, published studies are limited in patient size and follow-up period. Given access to care issues, an LCD has been developed to define the indications and limitations of coverage, establish a procedure to diagnosis relationship, and clarify the appropriate use of APBI after breast-conserving surgery for early stage breast cancer. In addition, a coding guideline has also been developed to assist in billing this type of service.

APBI after breast-conserving surgery is considered medically necessary for patients with early stage breast cancer when all of the following criteria are met:

Age: ≥50 years old
Diagnosis: Invasive ductal carcinoma or ductal carcinoma in situ
Size: Less than or equal to 3 cm.
Margin status: Negative – at least 2mm in all directions
Nodal status: Negative axillary lymph node dissection or sentinel lymph node evaluation

This LCD is effective for services rendered on or after January 1, 2005. The full-text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

REVISIONS TO LCDS

J1950: Leuprolide Acetate – Revised Coding Guideline

The coding guideline attachment for this local coverage determination (LCD) was effective on April 11, 2005. Since that time this coding guideline has been revised.

First Coast Service Options, Inc. (FCSO) implements the least costly alternative (LCA) policy for Leuprolide Acetate. Medical literature indicates there is no demonstrable difference in clinical efficacy between J9217 leuprolide acetate (for depot suspension) and J9202 goserelin acetate implant (Zoladex) in the treatment of malignant neoplasm of the prostate (ICD-9-CM code 185) and malignant neoplasm of female breast (ICD-9-CM codes 174.0-174.9). If there are medical indications that require the use of J9217 instead of J9202, Medicare will consider payment at the higher rate if documentation to support the medical necessity of the use of the more costly agent accompany the claim.

The coding guideline attachment of this LCD has been revised to include instructions for those providers who submit electronic claims and want to provide documentation to support reimbursment at the higher rate (J9217). These instructions state that those providers who bill electronically, and have documentation that supports reimbursement of the more costly agent, can populate field 19 or the electronic equivelent with the following statement: Supporting documentation available for J9217**.** By doing this, providers will receive a development letter with instructions to submit the claim for review. Providers are not mandated or required to populate block 19 or its electronic equivalent for claim development. FCSO recommends that providers who wish to have claims reviewed for reimbursment for the use of the more costly agent, implement these instructions for those claims.

These revisions will be effective for claims processed on or after January 24, 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.

Revisions to LCDs, continued

J2430: Pamidronate (Aredia®, APD) – LCD Revision

This local coverage determination (LCD) for Pamidronate was last updated on October 11, 2005. Since that time, this LCD has been revised to update the verbiage and dosages under the "Indications and Limitations of Coverage and/or Medical Necessity" section to correspond with the FDA indications and recommended dosages.

Under the "ICD-9 Codes that Support Medical Necessity" section, the dual diagnosis requirement for osteolytic lesions of multiple myeloma (code range 203.00 – 203.01) was removed because the involvement of bone and/or bone marrow may be part of this disease process. In addition, the "Sources of Information and Basis for Decision" section was updated.

This revision is effective for services rendered on or after April 10, 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.

J2505: Pegfilgrastim (Neulasta™) – LCD Revision

This local coverage determination (LCD) for Pegfilgrastim was last updated on October 1, 2005. Based on current literature, this LCD has since been revised to include an additional indication and ICD-9-CM code regarding prophylactic use of Neulasta.

The following statement was added under the "Indications and Limitations of Coverage and/or Medical Necessity" section:

- Prophylactic use of Neulasta in patients undergoing chemotherapy reduces the risk of febrile neutropenia and infections. Prophylactic therapy can be considered for patients receiving myelosuppressive chemotherapy if the risk of febrile neutropenia is 20% or greater.

Under List II of the "ICD-9 Codes that Support Medical Necessity" section, the following diagnosis code was added:

- V07.8 – Other specified prophylactic measure

Coverage of Pegfilgrastim requires the billing of dual diagnoses. Under the "ICD-9 Codes that Support Medical Necessity" section, the appropriate primary diagnosis code under List I, which represents a non-myeloid malignancy, and the appropriate secondary diagnosis code under List II, which represents an encounter for myelosuppressive chemotherapy, must be billed.

In addition to the above, the "Sources of Information and Basis for Decision" section was updated.

This revision is effective for services rendered on or after March 13, 2006. The full-text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

J9000: Antineoplastic Drugs – LCD Revision

This local coverage determination (LCD) for Antineoplastic Drugs was last updated on October 1, 2005. Since that time, based on FDA approved indications and/or off-label indications published in the USP DI, the following revisions have been made to the HCPCS codes listed below under the "Indications and Limitations of Coverage and/or Medical Necessity" section:

- J9000 – Doxorubicin HCl (Ewing's sarcoma was moved from the off-labeled section to FDA approved indications)
- J9015 – Aldesleukin (under off-labeled indications, "acute" was added to chronic myelogenous leukemia)
- J9170 – Docetaxel (FDA approved and off-labeled indications were corrected)
- J9181 & J9182 – Etoposide (Ovarian germ cell tumor was indicated for ovarian carcinoma and Myelodysplastic syndromes (MDS) was added to off-labeled indications)
- J9200 – Floxuridine (Carcinoma of the ovary and kidney not responsive to other antimotabolites was added to the off-labeled indications)
- J9201 – Gemcitabine (FDA indication of Gemzar in combination with Paclitaxel for first line treatment of patients with metastatic breast cancer after failure of prior anthracycline-containing adjuvant chemotherapy, unless contraindicated was added. Off-labeled indications of epithelial for ovarian carcinoma was indicated, and ovarian germ cell tumor was added)
- J9263 – Oxaliplatin (FDA approved indication stating "Oxaliplatin is indicated in combination with 5-FU/LV or capecitabine for first line treatment of nonresectable advanced or metastatic colon or rectal carcinoma" was added)
- J9265 – Paclitaxel (FDA approved indication stating "Adjuvant treatment of node-positive breast cancer when administered sequentially to standard Doxorubicin-containing combination chemotherapy" was added. In addition, under off-labeled indications, "First line therapy for treatment of metastatic breast cancer" was added)
- J9300 – Gemtuzumab (under FDA approved indications, "other" was added to cytotoxic chemotherapy for treatment of patients with CD33 positive acute myeloid leukemia in first relapse who are 60 years of age or older and who are not considered candidates for cytotoxic chemotherapy)

In addition to the above, under the "ICD-9 Codes that Support Medical Necessity" section, the following HCPCS codes have additional diagnoses added:

- J9015 – Aldesleukin (added diagnosis code range 205.00 – 205.01 – acute myeloid leukemia)
- J9160 – Denileukin (added diagnosis code range 202.80 – 202.88 – Other lymphomas)
- J9181 & J9182 – Etoposide (added diagnosis code 238.7 – Other lymphatic and hematopoietic tissue)

The "Sources of Information and Basis for Decision" sections as well as the "Coding Guidelines" section were also updated.

This revision is effective for services rendered on or after March 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.

Revisions to LCDs, continued

J9212: Interferon – LCD Revision

This local coverage determination (LCD) for Interferon was last updated on January 18, 2005. Since that time, this LCD has been revised to include ICD-9-CM code 184.4 (malignant neoplasm of vulva, unspecified) for HCPCS codes J9213 and J9214. This code will be used for malignant melanoma of the vulva for this LCD.

In addition, the "Sources of Information and Basis for Decision" section was updated.

This revision is effective for services rendered on or after March 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.

17304: Mohs Micrographic Surgery (MMS) – LCD Revision

The local coverage determination (LCD) for Mohs Micrographic Surgery (MMS) (*17304*) was effective on January 1, 2006. Since that time, it has been determined that additional ICD-9-CM codes 173.5, 173.6, 173.7, and 232.0-232.8 would give providers more specific diagnosis codes to bill for the MMS procedures; therefore, these codes have been added to the LCD.

This revision is effective for services rendered on or after April 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.

62263: Epidural – LCD Revision

The local coverage determination (LCD) was last updated on October 1, 2004. Since that time, the LCD has been revised to include additional ICD-9-CM codes.

ICD-9-CM codes 781.0 (abnormal involuntary movements) and 728.85 (spasm of muscle) were added to the "ICD-9 that support Medical Necessity" section of the LCD. These diagnosis codes should only be used with procedure codes *62310, 62311, 62318* and *62319*.

This revision was effective for services rendered on or after February 13, 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.

97001: Physical Medicine and Rehabilitation – LCD Revision

The local coverage determination (LCD) for physical medicine and rehabilitation – 97001 was previously revised on January 1, 2006. Since that time, the following changes have been made to the LCD:

Per CMS Transmittal 805, Change Request 4226, "Annual Update to the Therapy Code List," the documentation requirements were updated for unlisted procedures and the coding guideline section was updated to clarify codes that are always considered therapy services. These revisions are effective for **services rendered on or after January 1, 2006**.

Per Change Request 4364, "Therapy Caps Exception Process," the following changes have been made to the LCD: Added national language to the Indications and Limitations section of the LCD to clarify the therapy cap exception process. The documentation requirements, treatment encounter notes, and progress report/notes sections of the LCD have been updated to include instruction for the therapy cap exception process. The coding guidelines section has been updated to clarify the use of the KX, GO, GN, and GP modifiers, as well as, clarification of the use of the Notice of Exclusion from Medicare Benefits (NEMB) and advance beneficiary notice (ABN) forms. These revisions are effective for **services rendered on or after January 1, 2006.**

Per BESS data, procedure code *97001* was identified as being billed inappropriately. Therefore, a recommendation was made by our Statistical Medical Data Department to clarify the use of the evaluation (*97001*) and re-evaluation (*97002*) codes. A revision was done to the "Specific Procedure and Modality Guidelines for Physical and/or Occupational Therapy" section of the LCD to clarify the difference in an evaluation versus a re-evaluation. This revision is effective for **claims processed on or after April 11, 2006**.

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

ADDITIONAL INFORMATION ON LCDS

Hemophilia Clotting Factors—Billing and Coding

An article addressing the inconsistent billing and handling of hemophilia clotting factors was published in the First Quarter 2006 *Medicare Part B Update!* The article contained information that would ensure that providers would receive correct payment.

Since that time, HCPCS changes have occurred that require additional instructions for providers to ensure that they continue to receive correct payment for services rendered.

The applicable HCPCS codes are:

J7188 Injection, Von Willebrand factor complex, human, IU **(effective 01/01/2006)**
J7189 Factor VIIa (antihemophilic Factor, recombinant), per 1 mcg (**effective 01/01/2006)**
J7190 Factor VIII (antihemophilic factor, human) per IU
J7191 Factor VIII (antihemophilic factor [porcine]), per IU
J7192 Factor VIII (antihemophilic factor, recombinant) per IU
J7193 Factor IX (antihemophilic factor, purified, non-recombinant) per IU
J7194 Factor IX complex, per IU
J7195 Factor IX (antihemophilic factor, recombinant) per IU
J7198 Anti-inhibitor, per IU
Q0187 Factor VIIa (coagulation factor, recombinant) per 1.2 mg (**for services rendered prior to 01/01/2006)**
Q2022 Von Willebrand factor complex, human, per IU (**for services rendered prior to 01/01/2006**)

To ensure that providers continue to receive correct payment for these services, the following guidelines must be followed:

The claims for HCPCS codes J7188 (for services rendered **on or after** 01/01/2006), J7190-J7198, and Q2022 (for services rendered **prior to** 01/01/2006) must include the following information for EMC or paper claims:

- **EMC**: Number of international units provided/supplied in the electronic equivalent field of Item 19 of CMS 1500 Form or the comment screen. In the electronic equivalent of the Days/Unit field (Item 24G), the number of units must be one (1).
- **PAPER CLAIMS**: Number of international units provided/supplied in Item 19 of CMS 1500 Form. In the Days/Unit field (Item 24G), the number of units must be one (1).

It is very important that special notice be given to HCPCS codes Q0187 and J7189. Even though HCPCS code J7189 replaces Q0187 for services rendered on or after January 1, 2006, it must be noted that the unit of measurement for the two codes is different. Therefore, the billing of each of these codes is different

Q0187 dosage is 1.2 milligrams (mg)
J7189 dosage is 1 microgram (mcg)

The paper or EMC claims for HCPCS code Q0187 must include the following information:

- The number of supplied units should be placed in the Days/Unit field (Item 24G) or its electronic equivalent. For example, if 4.8 mg was supplied, the number of units billed must be "4", because one unit billed corresponds to 1.2 mg.
- No entry is required in Item 19 of CMS 1500 Form or its electronic equivalent when billing for HCPCS code Q0187.

The EMC or paper claims for HCPCS code J7189 must include the following information:

- The number of units billed in the Days/Unit field (Item 24G) or its electronic equivalent should be a "1". The field would not be adequate for placing the actual number of micrograms administered. Therefore, an entry is required in Item 19 of CMS 1500 Form or its electronic equivalent when billing for HCPCS code J7189. The entry should accurately reflect the total amount provided/supplied in micrograms.

When billing for hemophilia clotting factors, providers should not be submitting additional documentation with the claim. If necessary, First Coast Service Options, Inc. (FCSO) will request this information by means of an additional documentation request (ADR). The response to such a request must include the following information to support the medical necessity and reasonableness of the services:

- A letter/attestation of medical necessity from the treating physician. This must include the statement that he/she is the treating provider, the patient's diagnosis, and the patient's usual or anticipated dose requirement over time. If a patient requires unusually high doses of a particular clotting factor, the reason for this must be documented in this letter (such as a high antibody titer, extraordinary frequent bleeding episodes, etc.); and
- From the treating physician, the dosage prescribed for the claim in question. This information must be indicated in the above letter, in a separate statement, or in a current prescription; and
- Supplier invoice.

Local Anesthetic Agents Used for Anesthesia or Therapeutic Injection

First Coast Service Options, Inc. (FCSO) has observed irregular billing related to local anesthetic agents. Local anesthetic agents can be used for anesthesia or therapeutic injections. Examples of local anesthetic agents, include but are not limited to: Lidocaine, Xylocaine, Articaine, Bupivicaine, Chloroprocaine, Levobupivicaine, Mepivacaine, Procaine, Marcaine, and Tetracaine.

For this article all brand/generic names of "caine drugs" are considered local anesthetic agents. In most instances Medicare does not allow separate reimbursement for the "caine drugs"

Providers usually bill these agents with an unlisted procedure code J3490. Remember that J2001 is used only for the intravenous administration of Xylocaine/ Lidocaine.

The cost of local anesthetic agents is included in the practice expense of procedures whether used as local anesthetic or part of a therapeutic injection and are not separately payable.

Wireless Capsule Endoscopy of the Esophagus

The wireless capsule of the esophagus is a wireless diagnostic video capsule specifically designed for the visualization of the esophagus. The wireless capsule endoscopy of the esophagus is based on the same clinically proven technology as the wireless capsule endoscopy of the small bowel.

Wireless capsule endoscopy of the *small bowel* received approval from the FDA on August 1, 2001, through a 510(k) approval process. The FDA clearance provided for the capsule's use "along with" -not as a replacement for other endoscopic and radiologic evaluations of the small bowel. In July of 2003 a supplemental 510 (k) pre-market notification was cleared and the labeled indications were modified by removing the "adjunctive use" qualification. The diagnostic system associated with wireless capsule endoscopy was intended for visualization of the small bowel mucosa. However, in November 2004 the FDA approved the diagnostic system for use with wireless capsule endoscopy for visualization of the *esophageal* mucosa.

First Coast Service Options, Inc. (FCSO) currently has a local coverage determination (LCD) for wireless capsule endoscopy. This LCD provides coverage guidelines for the use of *wireless capsule endoscopy of the small bowel* only. The full text of this LCD may be viewed at *http://www.connecticutmedicare.com*

To date, there have not been an adequate number of closely controlled clinical trials conducted or studies focusing on a comparison between wireless capsule endoscopy of the esophagus and other diagnostic modalities such as conventional endoscopy. Current publications in peer-reviewed literature, position statements by technology assessment organizations, and the communication released by the manufacturer are not sufficient to issue a positive coverage statement by way of a LCD.

Currently, there is no National Coverage Determination (NCD) for *wireless capsule endoscopy of the esophagus*, and FCSO has not published a LCD. When there is no NCD or LCD, services are evaluated individually based on Medicare's general medical reasonableness and necessity criteria. Claims for wireless capsule endoscopy of the esophagus will be given individual consideration on a case-by-case basis until appropriately designed and powered studies are published and evaluated. Providers should not interpret the process of individual consideration as synonymous with coverage and payment by Medicare. This means claims will be reviewed against the background of the presently available evidence and specific patient circumstances.

Anytime 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 code. For further details about CMS' Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*. Please note that services that lead up to, or are associated with, non-covered services are not covered as well.

Effective for claims processed on or after April 20, 2006 for services rendered on or after March 23, 2006 providers should use *CPT* code *91110* with modifier 52 when submitting a claim for *wireless capsule endoscopy of the esophagus.*

Providers should not submit any medical record documentation with the claim. FCSO will request this by means of an additional documentation request (ADR) letter. The required information will be included in the ADR letter.

76514: Ocular Corneal Pachymetry—Coding Guideline Development

This local coverage determination (LCD) was last revised October 24, 2005. Since that time coding guidelines defining acceptable places of service (POS) for performing *CPT* code *76514* (Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral [determination of corneal thickness]) have been developed.
Ocular corneal pachymetry may be performed in the following POS:

21: inpatient hospital	22: outpatient hospital
11: office	32: nursing facility
31: skilled nursing facility	81: independent laboratory
24: ambulatory surgical center	23: emergency room - hospital

This coding guidleine development is effective for claims processed on or after April 11, 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.

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

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

1-904-791-8465

Medical Review Table of Contents

Advance Notice Statement

Advance beneficiary notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

CORRECTIONS

APBI: Accelerated Partial Breast Irradiation – Correction to Article

An article was published in the 1st Quarter 2005 *Medicare B Update!* (page 87) that addressed coverage guidelines for APBI. Since that time, it has been determined that the indications in the article did not match the local coverage determination (LCD) indications. A correction has been made to the indication that the size of the lesion should be "less than or equal to 3 cm.". The original article stated the lesion should be "greater than or equal to 3 cm." All other information remains the same.

Survival after breast-conservation therapy (BCT) is equivalent to survival after mastectomy for patients diagnosed with tumors categorized as stage I or II. The standard of care for local management is breast-conserving surgery to excise the tumor with adequate margins (lumpectomy), followed by whole-breast external-beam radiation therapy (WB-EBRT).

Accelerated Partial Breast Irradiation (APBI) differs from WB-EBRT in two ways. First, the radiation targets only a segment surrounding the tumor rather than the entire breast. Second, since the duration of treatment is 4 to 5 days rather than 5 to 6 weeks, radiation is delivered in fewer fractions at larger doses per fraction. APBI comprises several techniques, including interstitial brachytherapy via catheters, the MammoSite radiation treatment system, accelerated external beam radiotherapy, and intra-operative radiotherapy delivery.

When compared with whole breast irradiation, APBI offers the potential advantages of convenience and decreases radiation dose to healthy breast tissue. However, published studies are limited in patient size and follow-up period. Given access to care issues, an LCD has been developed to define the indications and limitations of coverage, establish a procedure to diagnosis relationship, and clarify the appropriate use of APBI after breast-conserving surgery for early stage breast cancer. In addition, a coding guideline has also been developed to assist in billing this type of service.

APBI after breast-conserving surgery is considered medically necessary for patients with early stage breast cancer when all of the following criteria are met:

Age: ≥50 years old
Diagnosis: Invasive ductal carcinoma or ductal carcinoma in situ
Size: Less than or equal to 3 cm.
Margin status: Negative – at least 2mm in all directions
Nodal status: Negative axillary lymph node dissection or sentinel lymph node evaluation

This LCD is effective for services rendered on or after January 1, 2005. The full-text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

Stereotactic Radiosurgery and Stereotactic Radiotherapy – Correction to Article

An article was published in the 1st Quarter 2006 *Medicare B Update!* (pages 112-113) that addressed coding/billing guidelines. Since that time, new 2006 CPT/HCPCS codes have been published. This article updates those added/deleted codes. All other information remains the same.

Stereotactic radiosurgery is a form of external beam radiation that delivers a high-dose during a single session to shrink or destroy lesions while leaving tissue surrounding the lesion unaffected. Initially restricted to intracranial lesions, advances in technology have extended interventions to other parts of the body for lesions inaccessible or unsuitable for open surgery. The stereotactic techniques have incorporated single session high-dose, hyper fractionation (currently defined as 2-5 high dose sessions), and conventional fractionation collectively referred to as stereotactic radiotherapy (SRT). Stereotactic radiotherapy relies on reproducible spatial correlation of the target of interest and the radiation source; using computer generated three-dimensional simulations. This can be accomplished with several methodologies including specially designed external frames, implanted fiducial markers or imaging techniques. Currently FCSO does not have a local medical policy addressing stereotactic radiotherapy. Specifically, body radiation therapy (therapy outside the CNS) is considered an emerging technology as indicated by the assignment of a Category III Code in 2005. Review of current literature and discussion with Radiation Oncologists suggest that there is no consensus on the optimal technology (planning and Rx delivery) for given indications. Currently there are satisfactory coding and billing guidelines for hospitals to submit claims to the FI for stereotactic radiotherapy treatment planning and delivery. Free standing facilities that bill the carrier should use this article as a guide to coding and billing the carrier when applicable given there are no active HCPCS codes with pricing in the Medicare Fee Schedule for claims administration of stereotactic radiotherapy treatment planning and delivery. Claims to the carrier will continue to be developed for documentation and evaluated for coverage and payment on individual consideration. The documentation must show what was done. Also it must support that the intervention was medical necessary and reasonable for the condition as well as superior to conventional radiation therapy or IMRT given the risk and benefit to the beneficiary.

This coding article addresses:

- Physician *treatment management* services: Stereotactic radiation therapy & radiosurgery is an emerging technology and involves a process of care directed by radiation oncologist, in some cases neurosurgeons, and other allied health care professionals.

- Stereotactic radiation therapy & radiosurgery *treatment planning* and *delivery* given with either Co 60 gamma rays or with mega voltage photons from a linear accelerator for claims submitted to the carrier from a free standing facility. The goal of these treatments is great accuracy and precision in the delivery of dose to the planned target.

The conduct of a course of radiation therapy includes an episode of care with steps of consultation, clinical treatment planning, establishment of treatment parameters, and treatment delivery and management. All of the coding encompassed in an episode of care is not addressed in this article. However, it is expected that professional and technical components billed to Medicare on behalf of a beneficiary are medically necessary and reasonable with no duplication of services within the episode of care unless the medical necessity of the repeated or duplicated services is clearly documented. If multiple providers are involved in the patient's episode of care, clinical treatment planning, establishment of treatment parameters, and treatment delivery and management should be appropriately coordinated.

Coding of CPT/HCPCS Codes

SRT Treatment Management:

61793 Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions.

- Reported for work attributed to neurosurgeon or surgeon
- Same physician cannot report *77427-77432*

77432 Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session):

- Generally reflects the work by the radiation oncologist

0083T Stereotactic body radiation therapy, treatment management, per day

- SRT per day management of non cerebral lesions
- Do not report *0083T* in conjunction with *77427-77432, 61793*

Free Standing Facilities billing technical work to the Carrier

SRT Treatment Planning:

77295-TC Therapeutic radiology simulation-aided field setting; three-dimensional, per course of treatment; ***OR*** one of the following, as appropriate:

LINAC based

77261-77370 Linear accelerator based stereotactic radiosurgery plan, including dose volume histograms for target critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment

Cobalt 60-based

77261-77370 Multi-source photon stereotactic radiosurgery (cobalt-60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment

SRT Treatment Delivery:

0082T Stereotactic body radiation therapy, treatment delivery, one or more treatment areas, per day

Use G codes as outlined below, if appropriate, unless more than five sessions, then use *0082T* (per day) as noted.

The work should reflect the following descriptors currently used in the hospital setting:

LINAC based

- Image-guided robotic LINAC treatment

G0339 Image guided robotic linear accelerator base stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment
G0340 Image guided robotic linear accelerator base stereotactic radiosurgery, delivery including collimator changes in custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment

- Non-robotic LINAC treatment

G0173 Stereotactic radiosurgery, complete course of therapy in one session
G0251 Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment

Cobalt 60-based

G0243 Multi-source photon stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions

REVISIONS TO LCDS

J0640: Leucovorin (Wellcovorin®) – LCD Revision

This local coverage determination (LCD) for Leucovorin was last updated on September 29, 2003. Since that time, the LCD has been edited for FDA and off-label indications. The following ICD-9-CM code has been added under the "ICD-9 Codes that Support Medical Necessity" section:

- 186.9 – Malignant neoplasm of other and unspecified testis

In addition, under the "Indications and Limitations of Coverage and/or Medical Necessity" section, "Malignant neoplasm of testis" was added. References were updated under the "Sources of Information and Basis for Decision" section.

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

J1745: Infliximab (Remicade®) – LCD Revision

The local coverage determination (LCD) was last updated on August 23, 2005. Since that time, the Indications and Limitations section and the ICD-9-CM section of the LCD has been revised.

For services rendered on or after February 13, 2006:

Under indications and limitations, bullet #2 was revised to include coverage for rectovaginal fistulas and to maintain fistula closure for fistulizing Crohn's disease. Bullet #3 was revised to read active arthritis in patients with psoriatic arthritis. Bullet #4 was revised to remove the requirement that the patient must have had an inadequate response to methotrexate. A fifth bullet was added that allows coverage for the following: To reduce signs and symptoms, achieve clinical remission and mucosal healing, and eliminate corticosteroid use in patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy. The following ICD-9-CM codes were added to the list of "ICD-9 codes that support medical necessity" section, related to the above revisions: 556.0, 556.1, 556.2, 556.3, 556.5, 556.6, 556.8, 556.9 and 714.2.

For services rendered on or after March 21, 2006:

Bullet #5 was revised to read that patients can receive the infusion at 0, 2, and 6 weeks and every 8 weeks thereafter.

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®, APD) – LCD Revision

This local coverage determination (LCD) for Pamidronate was last updated on October 11, 2005. Since that time, this LCD has been revised to update the verbiage and dosages under the "Indications and Limitations of Coverage and/or Medical Necessity" section to correspond with the FDA indications and recommended dosages.

Under the "ICD-9 Codes that Support Medical Necessity" section, the dual diagnosis requirement for osteolytic lesions of multiple myeloma (code range 203.00 – 203.01) was removed because the involvement of bone and/or bone marrow may be part of this disease process. In addition, the "Sources of Information and Basis for Decision" section was updated.

This revision is effective for services rendered on or after April 10, 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.

J2505: Pegfilgrastim (Neulasta™) – LCD Revision

This local coverage determination (LCD) for Pegfilgrastim was last updated on October 1, 2005. Based on current literature, this LCD has since been revised to include an additional indication and ICD-9-CM code regarding prophylactic use of Neulasta.

The following statement was added under the "Indications and Limitations of Coverage and/or Medical Necessity" section:

- Prophylactic use of Neulasta in patients undergoing chemotherapy reduces the risk of febrile neutropenia and infections. Prophylactic therapy can be considered for patients receiving myelosuppressive chemotherapy if the risk of febrile neutropenia is 20% or greater.

Under List II of the "ICD-9 Codes that Support Medical Necessity" section, the following diagnosis code was added:

- V07.8 – Other specified prophylactic measure

Coverage of Pegfilgrastim requires the billing of dual diagnoses. Under the "ICD-9 Codes that Support Medical Necessity" section, the appropriate primary diagnosis code under List I, which represents a non-myeloid malignancy, and the appropriate secondary diagnosis code under List II, which represents an encounter for myelosuppressive chemotherapy, must be billed.

In addition to the above, the "Sources of Information and Basis for Decision" section was updated.

This revision is effective for services rendered on or after March 13, 2006. The full-text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J9000: Antineoplastic Drugs – LCD Revision

This local coverage determination (LCD) for Antineoplastic Drugs was last updated on October 1, 2005. Since that time, based on FDA approved indications and/or off-label indications published in the USP DI, the following revisions have been made to the HCPCS codes listed below under the "Indications and Limitations of Coverage and/or Medical Necessity" section:

- J9000 – Doxorubicin HCl (Ewing's sarcoma was moved from the off-labeled section to FDA approved indications)
- J9015 – Aldesleukin (under off-labeled indications, "acute" was added to chronic myelogenous leukemia)
- J9170 – Docetaxel (FDA-approved and off-labeled indications were corrected)
- J9181 & J9182 – Etoposide (Ovarian germ cell tumor was indicated for ovarian carcinoma and Myelodysplastic syndromes (MDS) was added to off-labeled indications)
- J9200 – Floxuridine (Carcinoma of the ovary and kidney not responsive to other antimotabolites was added to the off-labeled indications)
- J9201 – Gemcitabine (FDA indication of Gemzar in combination with Paclitaxel for first line treatment of patients with metastatic breast cancer after failure of prior anthracycline-containing adjuvant chemotherapy, unless contraindicated was added. Off-labeled indications of epithelial for ovarian carcinoma was indicated, and ovarian germ cell tumor was added)
- J9263 – Oxaliplatin (FDA-approved indication stating "Oxaliplatin is indicated in combination with 5-FU/LV or capecitabine for first line treatment of nonresectable advanced or metastatic colon or rectal carcinoma" was added)
- J9265 – Paclitaxel (FDA approved indication stating "Adjuvant treatment of node-positive breast cancer when administered sequentially to standard Doxorubicin-containing combination chemotherapy" was added. In addition, under off-labeled indications, "First line therapy for treatment of metastatic breast cancer" was added)
- J9300 – Gemtuzumab (under FDA approved indications, "other" was added to cytotoxic chemotherapy for treatment of patients with CD33 positive acute myeloid leukemia in first relapse who are 60 years of age or older and who are not considered candidates for cytotoxic chemotherapy)

In addition to the above, under the "ICD-9 Codes that Support Medical Necessity" section, the following HCPCS codes had additional diagnoses added:

- J9015 – Aldesleukin (added diagnosis code range 205.00 – 205.01 – acute myeloid leukemia)
- J9160 – Denileukin (added diagnosis code range 202.80 – 202.88 – Other lymphomas)
- J9181 & J9182 – Etoposide (added diagnosis code 238.7 – Other lymphatic and hematopoietic tissue)

The "Sources of Information and Basis for Decision" section as well as the "Coding Guidelines" section was also updated.

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

J9212: Interferon – LCD Revision

This local coverage determination (LCD) for Interferon was last updated on January 18, 2005. Since that time, this LCD has been revised to include ICD-9-CM code 184.4 (malignant neoplasm of vulva, unspecified) for HCPCS codes J9213 and J9214. This code will be used for malignant melanoma of the vulva for this LCD.

In addition, the "Sources of Information and Basis for Decision" section was updated.

This revision is effective for services rendered on or after March 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.

OOS: Outpatient Observation Services – LCD Revision

The local coverage determination (LCD) for Observation Services was last updated on January 1, 2006. Since that time, the LCD has been revised to include updated language pertaining to the ending time for observation care in the "Indications and Limitations of Coverage and/or medical necessity", and Documentation Requirements" sections of the LCD.

This revision was based on CMS Change Request 3632, dated January 6, 2005 and was effective for services rendered on or after January 1, 2005. The full-text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

THERSVCS: Therapy and Rehabilitation Services – LCD Revision

The local coverage determination (LCD) for therapy and rehabilitation services – THERSVCS was previously revised on January 1, 2006. Since that time, the following changes have been made to the LCD:

Per CMS Transmittal 805, Change Request 4226, "Annual Update to the Therapy Code List," the documentation requirements were updated for unlisted procedures and the coding guideline section was updated to clarify codes that are always considered therapy services. These revisions are effective for **services rendered on or after January 1, 2006**.

Per Change Request 4364, "Therapy Caps Exception Process," the following changes have been made to the LCD: Added national language to the "Indications and Limitations" section of the LCD to clarify the therapy cap exception process. The documentation requirements, treatment encounter notes, and progress report/notes sections of the LCD have been updated to include instruction for the therapy cap exception process. The coding guidelines section has been updated to clarify the use of the KX, GO, GN, and GP modifiers, as well as, clarification of the use of the Notice of Exclusion from Medicare Benefits

THERSVCS: Therapy and Rehabilitation Services , continued

(NEMB) and advance beneficiary notice (ABN) forms. These revisions are effective for **services rendered on or after January 1, 2006**.

Per BESS data, procedure code *97001* was identified as being billed inappropriately. Therefore, a recommendation was made by our Statistical Medical Data Department to clarify the use of the evaluation (*97001*) and re-evaluation (*97002*) codes. A revision was done to the "Specific Procedure and Modality Guidelines for Physical and/or Occupational Therapy" section of the LCD to clarify the difference in an evaluation versus a re-evaluation. This revision is effective for **claims processed on or after April 11, 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.

11000: Debridement Services—LCD Revision

The local coverage determination (LCD) for debridement services (*11000*) was previously revised on January 1, 2005. Since that time, it has been determined that the ICD-9-CM code ranges 946.20-946.29, 946.30-946.39, and 946.40-946.49 were added to the LCD as fifth digit specificity in error. These ICD-9-CM code ranges have been corrected to 946.2, 946.3, and 946.4, respectively, for *CPT* codes *97597* and *97598* only. This revision is effective for claims processed on or after March 27, 2006 for services rendered on or after January 1, 2005.

The following change has been made to the coding guidelines section of the LCD based on change request 4226 – Annual Update to the Therapy Code List: Clarifying therapy modifier usage with *CPT* codes *97597, 97598,* and *97602*. This revision is effective for services rendered on or after January 1, 2006.

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

17304: Mohs Micrographic Surgery (MMS)—LCD Revision

The local coverage determination (LCD) for Mohs Micrographic Surgery (MMS) (*17304*) was previously revised on January 1, 2006. Since that time, it has been determined that additional ICD-9-CM codes 173.5, 173.6, 173.7, and 232.0-232.8 would provide more specific diagnosis codes to bill for the MMS procedures; therefore, these codes have been added to the LCD.

This revision is effective for services rendered on or after April 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.

32491: Lung Volume Reduction Surgery—LCD Revision

The local coverage determination (LCD) for lung volume reduction surgery (LVRS) (*32491*) was effective on September 30, 2004. Since that time, the LCD has been updated per CMS Transmittal 768, Change Request 4149, updating the protocol for determining approved facilities for LVRS and removing language regarding the National Emphysema Treatment Trial (NETT) protocol. In addition, the coding guideline section was updated to include national non-covered indications.

This revision is effective for claims processed on or after March 2, 2006 for services rendered on or after November 17, 2005. The full-text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

43644: Surgical Management of Morbid Obesity—LCD Revision

This local coverage determination (LCD) was last revised January 1, 2006. Since that time, CMS issued change request 4399, transmittal 889, dated March 17, 2006 which noncovers *CPT* code *43842* (Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty) for services rendered on or after February 21, 2006. The LCD has been revised to reflect this change.

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

93025: Microvolt T-wave Alternans—LCD Revision

The local coverage determination was last updated on November 8, 2005. Since that time, there has been a national coverage determination for the evaluation of patients at risk of sudden cardiac death, only when the spectral analysis method is used. (National Coverage Determinations Manual, Chapter 1, Section 20.30).

Based on Change Request 4351, dated March 24, 2006, this LCD has been revised. Language has been added to the "Indications and Limitations" and "Documentation Requirements" sections of the LCD. Prior to March 21, 2006, Microvolt T-wave Alterans was covered based on contractor discretion.

This revision is effective for services rendered on or after March 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.

93303: Transthoracic Echocardiography – LCD Revision

The local coverage determination was last updated on October 1, 2005. Since that time, the "ICD-9 Codes that Support Medical Necessity" section has been revised.

ICD-9-CM codes V42.1 (Heart replaced by transplant), V42.2 (Heart valve replaced by transplant), and V43.3 (Heart valve replaced by other means) have been added to the "ICD-9 Codes that support Medical Necessity" section of the LCD for *CPT* codes *93307* and *93308*. These ICD-9-CM codes are secondary diagnosis codes and should not be billed as the primary diagnosis.

This revision is effective for services rendered on or after May 12, 2006. The full-text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

ADDITIONAL INFORMATION ON LCDS

93042: Rhythm ECG, one to three leads; interpretation and report only

A review of utilization data of *CPT* code *93042* (Rhythm ECG, one to three leads; interpretation and report only) has revealed that providers are billing interpretation of EKG rhythm strips obtained from telemetry or cardiac monitoring equipment within hospitals or other facilities.

Electrocardiography (ECG) is the graphic tracing of the variations in electrical potential caused by the excitation of the heart muscle as detected at the body surface by electrodes placed on the patient's limbs and chest. The monitoring electrodes detect the electrical activity of the heart from a variety of spatial perspectives. The rhythm ECG lead system is composed of two electrodes that are placed at varying sites on the chest. It provides information regarding rate, rhythm, and the conduction system.

The ECG tracing is appropriately billed when performed as a stand-alone test, on a dedicated machine specifically for the purpose of the diagnosis of an arrhythmia or during its treatment.

Interpretation and/or performance of a rhythm strip performed as a separate service from continuous cardiac or telemetry monitoring with the result being an official interpretation and written report would be considered for Medicare reimbursement. The appropriate rhythm strip *CPT* codes (*93040-93042*) should be used and the documentation should support the medical necessity.

Interpretation of a rhythm strip from a cardiac monitoring equipment in settings including but not limited to inpatient hospital, emergency room and ambulance is not separately allowable. It is included as part of the medical decision portion of a physician's evaluation and management (E/M) services. Simply signing the report printed out by the ECG monitoring equipment is not acceptable documentation for billing and interpretation of a rhythm strip.

76514: Ocular Corneal Pachymetry—Coding Guideline Development

This local coverage determination (LCD) was last revised October 24, 2005. Since that time, coding guidelines defining acceptable places of service (POS) for performing *CPT* code *76514* (Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral [determination of corneal thickness]) have been developed.

Ocular corneal pachymetry may be performed in the following POS:

21: inpatient hospital	22: outpatient hospital
11: office	32: nursing facility
31: skilled nursing facility	81: independent laboratory
24: ambulatory surgical center	23: emergency room - hospital

This coding guideline development is effective for claims processed on or after April 11, 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.

Hemophilia Clotting Factors-Billing and Coding

An article addressing the inconsistent billing and handling of hemophilia clotting factors was published in the First Quarter 2006 *Medicare Part B Update!* The article contained information that would ensure that providers would receive correct payment.

Since that time, HCPCS changes have occurred that require additional instructions for providers to ensure that they continue to receive correct payment for services rendered.

The applicable HCPCS codes are:

J7188 Injection, Von Willebrand factor complex, human, IU **(effective 01/01/2006)**

J7189 Factor VIIa (antihemophilic Factor, recombinant), per 1 mcg (**effective 01/01/2006)**

J7190 Factor VIII (antihemophilic factor, human) per IU

J7191 Factor VIII (antihemophilic factor [porcine]), per IU

J7192 Factor VIII (antihemophilic factor, recombinant) per IU

J7193 Factor IX (antihemophilic factor, purified, non-recombinant) per IU

J7194 Factor IX complex, per IU

J7195 Factor IX (antihemophilic factor, recombinant) per IU

J7198 Anti-inhibitor, per IU

Q0187 Factor VIIa (coagulation factor, recombinant) per 1.2 mg (**for services rendered prior to 01/01/2006)**

Q2022 Von Willebrand factor complex, human, per IU (**for services rendered prior to 01/01/2006**)

Florida local coverage determination (LCD) J7188 regulates Medicare coverage of hemophilia clotting factors locally. It can be accessed at *http://www.floridamedicare.com.* Select the Part B section and click on the "final" link located under Medical Coverage/Local on the navigational menu.

To ensure that providers continue to receive correct payment for these services, the following guidelines must be followed:

The claims for HCPCS codes J7188 (for services rendered **on or after** 01/01/2006), J7190-J7198, and Q2022 (for services rendered **prior to** 01/01/2006) must include the following information for EMC or paper claims:

- **EMC**: Number of international units provided/supplied in the electronic equivalent field of Item 19 of CMS 1500 form or the comment screen. In the electronic equivalent of the Days/Unit field (Item 24G), the number of units must be one (1).
- **PAPER CLAIMS**: Number of international units provided/supplied in Item 19 of CMS 1500 form. In the Days/Unit field (Item 24G), the number of units must be one (1).

It is very important that special notice be given to HCPCS codes Q0187 and J7189. Even though HCPCS code J7189 replaces Q0187 for services rendered on or after January 1, 2006, it must be noted that the unit of measurement for the two codes is different. Therefore, the billing of each of these codes is different

Q0187 dosage is 1.2 milligrams (mg)
J7189 dosage is 1 microgram (mcg)

The paper or EMC claims for HCPCS code Q0187 must include the following information:

- The number of supplied units should be placed in the Days/Unit field (Item 24G) or its electronic equivalent. For example, if 4.8 mg was supplied, the number of units billed must be "4", because one unit billed corresponds to 1.2 mg.
- No entry is required in Item 19 of CMS 1500 form or its electronic equivalent when billing for HCPCS code Q0187.

The EMC or paper claims for HCPCS code J7189 must include the following information:

- The number of units billed in the Days/Unit field (Item 24G) or its electronic equivalent should be a "1". The field would not be adequate for placing the actual number of micrograms administered. Therefore, an entry is required in Item 19 of CMS 1500 form or its electronic equivalent when billing for HCPCS code J7189. The entry should accurately reflect the total amount provided/supplied in micrograms.

When billing for hemophilia clotting factors, providers should not be submitting additional documentation with the claim. If necessary, First Coast Service Options, Inc. (FCSO) will request this information by means of an additional documentation request (ADR). The response to such a request must include the following information to support the medical necessity and reasonableness of the services:

- A letter/attestation of medical necessity from the treating physician. This must include the statement that he/she is the treating provider, the patient's diagnosis, and the patient's usual or anticipated dose requirement over time. If a patient requires unusually high doses of a particular clotting factor, the reason for this must be documented in this letter (such as a high antibody titer, extraordinary frequent bleeding episodes, etc.); and
- From the treating physician, the dosage prescribed for the claim in question. This information must be indicated in the above letter, in a separate statement, or in a current prescription; and
- Supplier invoice.

Local Anesthetic Agents Used for Anesthesia or Therapeutic Injection

First Coast Service Options, Inc. (FCSO) has observed irregular billing related to local anesthetic agents. Local anesthetic agents can be used for anesthesia or therapeutic injections. Examples of local anesthetic agents, include but are not limited to: lidocaine, xylocaine, articaine, bupivicaine, chloroprocaine, levobupivicaine, mepivacaine, procaine, marcaine, and tetracaine.

For this article all brand/generic names of "caine drugs" are considered local anesthetic agents. In most instances Medicare does not allow separate reimbursement for the "caine drugs"

Providers usually bill these agents with an unlisted procedure code J3490. Remember, J2001 is used only for the intravenous administration of xylocaine/lidocaine.

The cost of local anesthetic agents is included in the practice expense of procedures whether used as local anesthetic or part of a therapeutic injection and are not separately payable.

Wireless Capsule Endoscopy of the Esophagus

The wireless capsule of the esophagus is a wireless diagnostic video capsule specifically designed for the visualization of the esophagus. The wireless capsule endoscopy of the esophagus is based on the same clinically proven technology as the wireless capsule endoscopy of the small bowel.

Wireless capsule endoscopy of the *small bowel* received approval from the Federal Drug Administration (FDA) on August 1, 2001, through a 510(k) approval process. The FDA clearance provided for the capsule's use "along with" -not as a replacement for other endoscopic and radiologic evaluations of the small bowel. In July 2003 a supplemental 510 (k) premarket notification was cleared and removing the "adjunctive use" qualification modified the labeled indications. The diagnostic system associated with wireless capsule endoscopy was intended for visualization of the small bowel mucosa. However, in November 2004 the FDA approved the diagnostic system for use with wireless capsule endoscopy for visualization of the *esophageal* mucosa.

First Coast Service Options, Inc. (FCSO) currently has a local coverage determination (LCD) for wireless capsule endoscopy. This LCD provides coverage guidelines for the use of *wireless capsule endoscopy of the small bowel* only. The full text of this LCD may be viewed at *http://www.floridamedicare.com*.

To date, there have not been an adequate number of closely controlled clinical trials conducted or studies focusing on a comparison between wireless capsule endoscopy of the esophagus and other diagnostic modalities such as conventional endoscopy. Current publications in peer-reviewed literature, position statements by technology assessment organizations, and the communication released by the manufacturer are not sufficient to issue a positive coverage statement by way of a LCD.

Currently, there is no National Coverage Determination (NCD) for *wireless capsule endoscopy of the esophagus,* and FCSO has not published a LCD. When there is no NCD or LCD, services are evaluated individually based on Medicare's general medical reasonableness and necessity criteria. Claims for wireless capsule endoscopy of the esophagus will be given individual consideration on a case-by-case basis until appropriately designed and powered studies are published and evaluated. Providers should not interpret the process of individual consideration as synonymous with coverage and payment by Medicare. This means only that the claims will be reviewed against the background of the presently available evidence and specific patient circumstances.

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 CPT code. For further details about CMS' Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*. Please note that services that lead up to, or are associated with, non-covered services are not covered as well.

Effective for claims processed on or after April 20, 2006 for services rendered on or after March 23, 2006, providers should use *CPT* code *91110* with modifier 52 when submitting a claim for wireless capsule endoscopy of the esophagus.

Providers should not submit any medical record documentation with the claim. FCSO will request this by means of an additional documentation request (ADR) letter. The required information will be included in the ADR letter.

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

FLORIDA MEDICARE PART B MAIL DIRECTORY

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

Redetermination Requests
Medicare Part B Claims Review
P. O. Box 2360
Jacksonville, FL 32231-0018

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

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

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

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

DURABLE MEDICAL EQUIPMENT (DME)

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

ELECTRONIC MEDIA CLAIMS (EMC)

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

MEDICARE PART B ADDITIONAL DEVELOPMENT

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

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

MISCELLANEOUS

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

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

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Medicare Communication and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For Seminar Registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare Claims for Railroad Retirees:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and Abuse
First Coast Service Options, Inc.
P. O. Box 45087
Jacksonville, FL 32232-5087

FLORIDA MEDICARE PHONE NUMBERS

BENEFICIARY

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

PROVIDERS

Toll-Free
Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992

For Seminar Registration Only (*not* toll-free)**:**
1-904-791-8103

EMC

Format Issues & Testing:
1-904-354-5977 option 4
Start-Up & Front-End Edits/Rejects:
1-904-791-8767 option 1
Electronic Funds Transfer
1-904-791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
PC-ACE Support:
1-904-355-0313
Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
Help Desk:
(Confirmation/Transmission):
1-904-905-8880 option 1

OCR

Printer Specifications/Test Claims:
1-904-791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
1-866-270-4909

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

Reader Survey—*Medicare B Update!*

We want readers of this publication to find it to be a helpful tool that is easy to use and understand. This survey is your opportunity to suggest ways we can better meet your needs. After the survey closes, we will publish the results on our websites and work to implement suggested enhancements as appropriate. Thank you for taking the time to complete this survey!

Please complete the questions below and return your reply to us by July 31, 2006.

Please Indicate Your Location: ❑ **Connecticut** ❑ **Florida**

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On a scale of 5 to 1, with 5 being very satisfied and 1 being very dissatisfied, how satisfied are you with the publication overall? Please ***circle*** the number that best applies.

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Medicare Communication and Education
P.O. Box 2078
Jacksonville, FL 32231-0048

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❒	**2006 Fee Schedule –** The revised Medicare Part B Physician and Non-Physician Practitioner Fee Schedule, effective for services rendered January 1, 2006, through December 31, 2006, is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Providers who do not have Internet access may purchase a hardcopy or CD-ROM. The Fee Schedule contains calendar year 2006 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	Hardcopy: $5.00 (CT) $10.00 (FL) CD-ROM: $6.00 (Specify CT or FL)

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