

Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue...

Claims, Appeals, and Hearings

Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 5
Quarterly Update to CCI Edits, Version 12.3 8

Coverage/Reimbursement

Medicare Part B Drug Competitive Acquisition Program Additions to Approved CAP Vendor's Drug List Effective October 1, 2006; Information On Price File Updates 9
Changes to the Laboratory National Coverage Determination Edit Software for October 2006 16
Independent Laboratory Billing for the Technical Component of Physician Pathology Services 18
Clarification on Billing Requirements for Percutaneous Transluminal Angioplasty Concurrent with the Placement of an FDA-Approved Carotid Stent 16

HIPAA—The Health Insurance Portability and Accountability Act

MSP Claims—More than One Primary Payer and More Than One Allowed Amount 21
Remittance Advice Remark Code and Claim Adjustment Reason Code Update 21

General Information

National Recovery Contractor for New Medicare Secondary Payer Recovery Claims 23
Modification of National Provider Identifier Editing Requirements in CR 4023 and an Attachment to CR 4320 24
Immunization: Promoting Prevention for a Healthier Life 30
Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens 32

Features

Connecticut and Florida	Medical Review
About the <i>Update!</i> 3	
Claims 5	Connecticut Only
Coverage/Reimbursement .. 9	Medical Review 36
HIPAA and EMC 21	Educational Resources..... 42
General Information 23	Florida Only
Educational Resources 52	Medical Review 44
2006 Part B Materials	Educational Resources..... 56
Order Form 57	

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

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

Routing Suggestions:

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



TABLE OF CONTENTS

Highlights In This Issue.....	1	HIPAA and EMC	
About the Connecticut and Florida Medicare B Update!	3	MSP Claims—More than One Primary Payer and More Than One Allowed Amount	21
Advance Beneficiary Notices (ABNs)	4	Remittance Advice Remark Code and Claim Adjustment Reason Code Update	21
Claims		General Information	
Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500	5	Medicare Secondary Payer	
Revised CMS-1500 Claim Form	6	National Recovery Contractor for New Medicare Secondary Payer Recovery Claims	23
Revised Form CMS-1500—Revised Timeline (08/05)	7	National Provider Identifier	
Quarterly Update to CCI Edits, Version 12.3	8	Modification of NPI Editing Requirements in CR 4023 and an Attachment to CR 4320	24
Coverage/Reimbursement		Stage 2 - Use and Editing of NPI Received in EDI Transactions, via DDE Screens or Paper Claim Forms	26
Ambulatory Surgical Centers		Change in Online Availability of NPI Application/ Update Form (CMS-10114)	30
Enrollment of Manufacturers of Replacement Parts and Supplies for Prosthetic Implant or Implantable DME that is Surgically Inserted at an ASC	9	Preventive Services	
Competitive Acquisition Program		Immunization: Promoting Prevention for a Healthier Life.....	30
Medicare Part B Drug CAP Additions to Approved CAP Vendor's Drug List Effective October 1, 2006; Information On Price File Updates	9	Flu Shot Reminder.....	30
Creation of Automated Tables for Provider Information, Expansion of CAP Fee Schedule File Layout, and Additional Instructions for Claims Received from Railroad Retirement Board Beneficiaries	10	General Information	
Care Plan Oversight		Collection of FFS Payments Made During Periods of Managed Care Enrollment— MANUALIZATION	31
Nonphysician Practitioner Payment for Care Plan Oversight	12	Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens ...	32
Drugs and Biologicals		Laboratory Competitive Bidding Demonstration..	33
October 2006 Quarterly ASP Medicare Part B Drug Pricing File, Effective October 1, 2006, and Revisions to April 2006 and July 2006 Quarterly ASP Medicare Part B Drug Pricing Files	12	Unsolicited/ Voluntary Refunds	35
Durable Medical Equipment		Connecticut Medical Review	
October Quarterly Update for 2006 DMEPOS Fee Schedule	14	Table of Contents	36
Laboratory/Pathology		Advance Notice Statement	36
Changes to the Laboratory NCD Edit Software for October 2006	16	Revisions to LCDs	37
Independent Laboratory Billing for the Technical Component of Physician Pathology Services	18	Additional Information.....	40
Surgery		Connecticut Educational Resources	
Clarification on Billing Requirements for Percutaneous Transluminal Angioplasty Concurrent with the Placement of an FDA-Approved Carotid Stent	19	Upcoming Connecticut Educational Events- Oct 2006	42
		Connecticut Medicare Part B Mail Directory, Phone Numbers, and Websites	43
		Florida Medical Review	
		Table of Contents	44
		Advance Notice Statement	44
		Article Correction	45
		Revisions to LCDs	45
		Additional Information	49
		Florida Medicare Part B Mail Directory, Phone Numbers, and Websites	51
		Educational Resources	
		Medicare Coverage for Preventive Services	52
		Order Form – 2006 Part B Materials	57

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

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

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THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida Medicare B Update!

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

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

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

Who Receives the Update?

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

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

For additional copies, providers may purchase a separate annual subscription in hardcopy or CD-ROM format (see order form on page 66). All issues published since 1997 may be downloaded from the Internet, free of charge.

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

Clear Identification of State-Specific Content

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

Publication Format

The *Update!* is arranged into distinct sections.

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

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

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

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

Advance Beneficiary Notices (ABNs)

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

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

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

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

New Patient Liability Notice

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

There are two ABN forms - the General Use form (CMS-

R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users, following the guidance in CMS Program Memoranda (PM) AB-02-114 and AB-02-168, which may be found on the CMS website at

http://cms.hhs.gov/manuals/pm_trans/AB02114.pdf and http://cms.hhs.gov/manuals/pm_trans/AB02168.pdf.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found on CMS's BNI website at

<http://www.cms.hhs.gov/medicare/bni>.

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

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

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

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

Connecticut

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

OR

Florida

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

CLAIMS

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

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the September 2006 Medicare B Update! pages 5-6.

Note: This article was revised on September 18, 2006, to reflect that change request (CR) 5060 was revised. The transmittal number, CR release date, and the Web address for accessing CR 5060 were revised. All other information remains the same.

Provider Types Affected

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

Key Points

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

January 2, 2007 – March 30, 2007

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

April 2, 2007

The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used.

Note: All rebilling of claims should use the revised Form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12-90).

Background

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

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

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

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

Billing Guidelines

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

Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500, continued**Additional Information****When the NPI is effective and required—May 23, 2007**

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

Legacy identifiers are pre-NPI provider identifiers such as:

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

Additional NPI-Related Information

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

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

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

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

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

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

Please refer to your local carrier or DMERC if you have questions about this issue. To find their toll free phone number, please go to: <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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

MLN Matters Number: MM5060 *Revised*
 Related CR Release Date: September 15, 2006
 Related CR Transmittal #: R1058CP

Related Change Request (CR) #: 5060
 Effective Date: January 1, 2007
 Implementation Date: January 2, 2007

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Revised CMS-1500 Claim Form

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Third Quarter 2006 Medicare B Update! page 140.

Note: This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf> for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR 5060, which is available at <http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf>.

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

CR 4293 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 may 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.

*Revised CMS-1500 Claim Form, continued***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 may 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 carrier regarding this change may 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 *Revised*

Related CR Release Date: March 31, 2006

Related CR Transmittal #: R899CP

Related Change Request (CR) #: 4293

Effective Date: See Note at the beginning of article.

Implementation Date: October 2, 2006

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Revised Form CMS-1500—Revised Timeline (08/05)

This information was previously published in the August 2006 Medicare B Update! page 5. This article is revised to reflect the transmittal change from 1010 to 1058.

The Centers for Medicare and Medicaid Services (CMS) has revised the Form CMS-1500 (12/90) to accommodate the reporting of the National Provider Identifier (NPI) which is scheduled for mandatory implementation on May 23, 2007. The revised Form CMS-1500 is the 08/05 version.

To receive copies of the revised form with the specifications needed for testing purposes, providers may contact TFP Data Systems at JRMagdalen@tfpdata.com.

The new version will be implemented January 2, 2007. Providers will not be mandated to use the revised Form CMS-1500 (08/05) until April 2, 2007.

The following is the Form CMS-1500 (08/05) version implementation timeline (**revised June 30, 2006**):

January 2, 2007: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised Form CMS-1500 (08/05). **NOTE: To circumvent processing delays, providers are encouraged to submit both their NPI and provider identification number (PIN) on the revised Form CMS-1500 (08/05).**

January 2, 2007– March 30, 2007: Providers can use either the current Form CMS-1500 (12/90) version or the revised Form CMS-1500 (08/05) version.

April 2, 2007: The current Form CMS-1500 (12/90) version is discontinued; **only** the revised Form CMS-1500 (08/05) will be accepted.

IMPORTANT: All claims re-billed on or after April 2, 2007 must be submitted on the revised Form CMS-1500 (08/05).

To prevent the return of your paper claims:

DO NOT submit the revised Form CMS-1500 (08/05) prior to January 2, 2007

DO NOT submit your NPI on the current Form CMS-1500 (12/90)

DO NOT submit the current Form CMS-1500 (12/90) on/after April 2, 2007

Additional information is available via a MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf>

Revised Form CMS-1500—Revised Timeline (08/05), continued

For complete details, please see the official instruction issued to your carrier regarding this change at <http://www.cms.hhs.gov/transmittals/downloads/R1058cp.pdf>

Source: Publication 100-04, #1058, Change Request 5060

CMS Office of Information Services (OIS), electronic notification, June 30, 2006

**Quarterly Update to Correct Coding Initiative Edits, Version 12.3,
Effective October 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

Background

This article and related change request (CR) 5258 provide a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of correct coding initiative (CCI) edits will be effective on October 1, 2006. Physicians may view the current CCI edits and the current mutually exclusive code (MEC) edits at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> on the Centers for Medicare & Medicaid Services (CMS) website. The website will be updated with the version 12.3 edits as soon as they are effective.

Key Points

The national CCI developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT)* manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice. The latest package of CCI edits, version 12.3, is effective on October 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.

Implementation

The implementation date for this instruction is October 2, 2006.

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 may be found at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS website.

MLN Matters Number: MM5258

Related Change Request (CR) #: 5258

Related CR Release Date: September 15, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R1056CP

Implementation Date: October 2, 2006

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Flu Shot Reminder

September is the perfect time to start talking with your patients about getting the flu shot. Medicare provides coverage for the flu vaccine and its administration. Please encourage your Medicare patients to take advantage of this vital benefit. And don't forget – health care professionals and their staff benefit from the flu vaccine also. **Protect Yourself. Protect Your Patients. Get Your Flu Shot.**

AMBULATORY SURGICAL CENTERS

Enrollment of Manufacturers of Replacement Parts and Supplies for Prosthetic Implant or Implantable Durable Medical Equipment that is Surgically Inserted at an Ambulatory Surgical Center

This information was previously published in the August 2006 Medicare B Update! page 15.

Effective June 5, 2006, carriers will not enroll manufacturers of implantable or non-implantable prosthetics into the Medicare program. All manufacturers of non-implantable prosthetics and DME and replacement parts and supplies for prosthetic implants and surgically implantable DME are required to enroll in the Medicare program as a supplier with the national supplier clearinghouse (NSC).

All manufacturers currently enrolled in the Medicare program and billing a carrier for orthotic, prosthetic and/or miscellaneous DME will be notified that their enrollment will be terminated within 120 days after being notified by the carrier. This notification will include:

- The option to enroll as a DMEPOS supplier of non-implantable DMEPOS through the NSC within the 120 day time period,
- A prohibition against billing Medicare for any implantable prosthetic or DME,
- NSC contact information,
- A statement that all DMEPOS suppliers must comply with all standards outlined in 42 CFR Section 424.57,
- A statement that DMEPOS suppliers may not bill the Medicare program for any item prior to the issuance of its DMEPOS Medicare supplier billing number and that retroactive billing is not permitted by DMEPOS suppliers in accordance with 42 CFR Section 424.57(b)(2).

Source: CMS Joint Signature Memorandum 06465, dated May 30, 2006

COMPETITIVE ACQUISITION PROGRAM

Medicare Part B Drug Competitive Acquisition Program Additions to Approved CAP Vendor's Drug List Effective October 1, 2006; Information On Price File Updates

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

Provider Types Affected

Physicians participating in the Medicare Part B Drug Competitive Acquisition Program (CAP)

Impact on Providers

This Special Edition article is being provided to inform physicians participating in the CAP program that, effective October 1, 2006; drugs are being added to the CAP drug table.

Background

The list of drugs supplied under the CAP is subject to quarterly updates, and this special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to inform you of additions to the CAP drug list (Per change request [CR] 5079, Business Rules [BRs] 5079.3 and 5079.4. For more details, see the related *MLN Matters* article, MM5079 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf> on the CMS site.)

Effective October 1, 2006, the CAP designated carrier will add the drugs listed in the following table to the CAP drug table, and the following Healthcare Common Procedure Coding System (HCPCS) codes will be available through the CAP

HCPCS Code	Descriptor
J3240	INJECTION, THYROTROPIN ALPHA, 0.9 MG, PROVIDED IN 1.1 MG VIAL (trade name Thyrogen®)
J9160	DENILEUKIN DIFTITOX, 300 MCG (trade name: Ontak®)
J9010	ALEMTUZUMAB, 10 MG (trade name Campath®)

An updated CAP drug list which includes the drugs listed above and updates to the NDC codes available through the CAP will be posted on the approved CAP vendor page of the CMS CAP website

Medicare Part B Drug Competitive Acquisition Program Additions to Approved CAP Vendor's Drug List Effective October 1, 2006; Information On Price File Updates, continued

(http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage) and on the approved CAP vendor's website (<http://www.bioscrip.com/>) on or about September 1, 2006.

Additional Information

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

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: SE0658	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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Competitive Acquisition Program—Creation of Automated Tables for Provider Information, Expansion of CAP Fee Schedule File Layout, and Additional Instructions for Claims Received from Railroad Retirement Board Beneficiaries

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2006 Medicare B Update! pages 18-20.

Note: This article was revised on September 12, 2006, to reflect changes made to CR 5079. The CR release date, transmittal number, and the Web address for accessing CR 5079 were changed. All other information remains the same.

Provider Types Affected

Physicians submitting claims to carriers for services to Medicare beneficiaries under the CAP

Impact on Providers

This article is based on change request (CR) 5079, which provides additional information and instructions for the implementation of the CAP pertaining to CAP drug categories and fee schedule as outlined in CR 4064 (Transmittal 777, dated December 9, 2006).

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 303 (d); <http://www.cms.hhs.gov/MMAUpdate/>) requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. The Social Security Act (Section 1847B(a)(1)(B); http://www.ssa.gov/OP_Home/ssact/title18/1847B.htm) states that for purposes of implementing the CAP:

“The Secretary (of the Department of Health and Human Services) shall establish categories of competitively biddable drugs and biologicals. The Secretary shall phase in the program with respect to those categories beginning in 2006 in such manner as the Secretary determines to be appropriate.”

In addition, the Social Security Act also permits the creation of appropriate geographic regions established by the secretary for contract award purposes.

The Centers for Medicare & Medicaid Services (CMS) will implement the CAP with one category of drugs and one geographic area. However, as the program evolves, additional geographic areas and additional drug categories may be created. Also, approved CAP vendors will be able to request approval for changes to the lists of drugs that they supply under the CAP.

CR 4064 (Transmittal 777, dated December 9, 2006) described requirements for carriers to develop provider files that list physicians who have enrolled with an approved CAP vendor and the category (or categories) of drugs that the CAP vendor will furnish under the CAP.

CMS is issuing CR 5079 to automate the process of updating the list of drugs paid under the CAP. CR 5079 provides additional information and instructions for the implementation of the CAP pertaining to the CAP drug categories and fee schedule as outlined in:

- CR 4064 (Transmittal 777, dated December 9, 2006 at <http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf>); MLN Article MM4064 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>; and
- CR 4309 (Transmittal 866, dated February 6, 2006 (rescinded and replaced with transmittal 866 dated February 17, 2006 at <http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf>); MLN article MM4309 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf>.

CAP—Creation of Automated Tables for Provider Information, Expansion of CAP Fee Schedule File Layout, and Additional Instructions for Claims Received from Railroad Retirement Board Beneficiaries, continued

For the table defined in CR 4064.1.1.2.1, when Medicare carriers receive election forms from providers, the carriers will indicate for each provider:

- Which categories of drugs the provider has chosen to receive; and
- From which approved CAP vendor the provider will receive CAP drugs

CAP Drugs and Drug Categories

Approved CAP vendors will be permitted to request certain changes to the list of drugs that they supply under the CAP. Beginning in July 2006 with changes to be effective October 1, 2006, approved CAP vendors may request that CMS (or its designee) approve the following types of changes:

- **NDC Substitution(s):** Approved CAP vendor may request approval to replace one or more national drug codes (NDCs) in a Healthcare Common Procedure Coding System (HCPCS) code supplied by the approved CAP vendor with one or more other NDCs.
- **NDC Addition(s):** Approved CAP vendor may request that CMS allow it to supply additional NDCs under a HCPCS code that the approved CAP vendor already supplies under the CAP.
- **HCPCS Addition(s):** Approved CAP vendor may request that CMS allow it to supply newly issued HCPCS codes under the CAP.
- **Orphan Drugs:** Approved CAP vendor may request that CMS allow it to supply single indication orphan drugs under the CAP.

As CMS continues to develop the CAP, additional geographical areas and additional drug categories may be created. If additional drug categories are created, certain drugs may appear in more than one drug category.

Changes to the Drug List

Written requests for changes to the approved CAP vendor's drug list must be submitted to CMS and the CAP designated carrier. The requests must include a rationale for the proposed change, and a discussion of the impact on the CAP, including safety, waste, and potential for cost savings. If approved, changes will become effective at the beginning of the following quarter. CMS will post the changes on the CMS website (<http://www.cms.hhs.gov/competitiveacqisforbios/>) and notify the carriers and participating CAP physicians of any changes on a quarterly basis.

Participating CAP physicians will be notified of changes to their approved CAP vendor's CAP drug list on a quarterly basis and at least 30 days before the approved changes are due to take effect. Physicians who participate in the CAP are required to obtain all CAP drugs, including those that have been added or otherwise updated, from the approved CAP vendor unless medical necessity requires the use of a formulation not supplied by the vendor. Please note that approved changes will apply only to the list of drugs

supplied by the approved CAP vendor who submitted the request; therefore, each vendor's drug list may contain different drugs after changes to the initial drug list are approved.

Payment Amount

The payment amount for new HCPCS codes added to an approved CAP drug vendor's drug list will be average sales price (ASP) plus six percent (ASP+ 6 percent).

Addition or substitution of NDC numbers under an existing HCPCS code supplied by an approved CAP vendor will not change the CAP single payment amount for that HCPCS code.

CMS will update the single payment amount based on the approved CAP vendor's reported net acquisition costs for the category of drugs on an annual basis.

Disaster Contingency

Business requirements intended to cover situations where an approved CAP vendor is not able to fill CAP orders or is no longer able to supply drugs under the CAP have also been added. Physicians will be able to revert to the ASP (buy and bill) payment methodology.

Claims for Railroad Retirement Board (RRB) Beneficiaries

As claims for RRB beneficiaries cannot be paid under the CAP, physicians should not order drugs for RRB beneficiaries under the program. However, should this occur, and the claim is sent to the carrier that processes claims for RRB beneficiaries, that carrier will treat the claim as unprocessable. The physician will have to resubmit the claim as a non-CAP claim with the drugs billed as ASP. The vendor will then have to look to the physician for reimbursement of the drugs that were mistakenly ordered under CAP.

Implementation

The implementation date for the instruction is October 2, 2006.

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/R1055CP.pdf> on the CMS website.

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

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

MLN Matters Number: MM5079 *Revised*
 Related Change Request (CR) #: 5079
 Related CR Release Date: September 11, 2006
 Effective Date: October 1, 2006
 Related CR Transmittal #: R1055CP
 Implementation Date: October 2, 2006

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CPO

Nonphysician Practitioner Payment for Care Plan Oversight

The purpose of this instruction is to clarify change request 4374 in regard to the submission of the home health agency (HHA) or hospice numbers on care plan oversight (CPO) claims.

Since there is no HIPAA-compliant way to capture the HHA or hospice provider number on a CPO claim, the Centers for Medicare & Medicaid Services (CMS) has provided approval to waive the requirement.

Until further notice, do not submit a HHA or hospice provider number when billing for CPO services. Submission of the home health or hospice provider number will result in the service being returned unprocessable.

Source: Publication 100-04, Transmittal 999, Change Request 4374

DRUGS AND BIOLOGICALS

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

Provider Types Affected

All Medicare providers who bill Medicare for Part B drugs

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

Change request (CR) 5270, upon which this article is based, provides notice of the updated payment allowance limits effective October 1, 2006, and revisions to the April 2006 and July 2006 quarterly 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 sale 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

CR 5270, upon which this article is based, provides the quarterly ASP Medicare Part B drug pricing file update for October 1, 2006, and also provides revisions to the April 2006 and July 2006 quarterly files. Section 303(c) of the Medicare Modernization Act of 2003 (MMA) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis; and mandated that since January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis be paid based on the ASP methodology. In the same way in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities; specified, covered outpatient drugs; and drugs and biologicals with pass-through status under the outpatient prospective payment system (OPPS) will be paid according to this ASP methodology, which is based on quarterly data submitted to CMS by manufacturers. Note that MMA also requires CMS to update the payment allowance limits quarterly, which CR 5270 does.

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

There are exceptions to this general rule as summarized below.

1. Blood and Blood Products

Blood and blood products furnished in the hospital outpatient department are paid under the OPPS at the amount specified for the ambulatory payment clarification (APC) to which the product is assigned. Conversely, for blood and blood products, not paid on a prospective payment basis (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner used to determine them 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.

October 2006 Quarterly ASP Medicare B Drug Pricing File, Effective October 1, 2006, and Revisions to April and July 2006 Quarterly ASP Medicare B Drug Pricing Files, continued

These payment allowance limits will be updated on a quarterly basis, along with the others.

2. Infusion Drugs

The payment allowance limits for infusion drugs, furnished through a covered item of durable medical equipment, on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. The payment allowance limits were not updated in 2006. The payment allowance limits for infusion drugs (unless compounded), 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) are 95 percent of the first published AWP.

3. Influenza, Pneumococcal and Hepatitis B vaccines

The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. In this latter instance, the vaccine is paid at reasonable cost.

4. Drugs not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File

The payment allowance limits for drugs that are not included in the ASP Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration) are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, Medicare contractors (carriers, including durable medical equipment regional carriers [DMERCs], and fiscal intermediaries, including regional home health intermediaries [RHHIs]) follow the methodology in the Medicare Claims Processing Manual specified 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. And note that for 2006, when the blood clotting factor is not included on the ASP file, the blood clotting furnishing factor of \$0.146 per I.U. is added to the blood clotting factor payment amount. 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.

1. New Drugs

The payment allowance limits for new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B drug pricing file or 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. As mentioned above, for 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for a new blood clotting factor when a new blood clotting factor is not included on the ASP file.

2. Radiopharmaceuticals

The payment allowance limits for radiopharmaceuticals are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio. And your carrier/FI will determine payment limits for radiopharmaceuticals not furnished in the hospital outpatient department based on the methodology in place as of November 2003.

3. Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

CR 5270 clarifies that payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology, as described above. Your carrier or FI will develop the pricing for compounded drugs.

Physicians (or a practitioner described in Section 1842[b][18][C]) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for them to perform the service. Your carrier/FI must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for: 1) The professional service of filling or refilling the implantable pump or reservoir; and 2) For drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if: 1) The medication administered is accepted as a safe and effective treatment of the patient's illness or injury; 2) There is a medical reason that the medication cannot be taken orally; and 3) The nurse's skills are needed to infuse the medication safely and effectively.

Here are some important things you should remember.

- The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.
- Pricing for compounded drugs is performed by your carrier/FI.
- The presence or absence 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 local Medicare contractor processing the claim will make these determinations.
- The October 2006 and revised April 2006 and July 2006 ASP drug pricing files for Medicare Part B drugs will be available via the CMS Data Center (CDC) for your carriers/FIs to download on or after September 19, 2006.
- You can also view the October 2006 and revised April 2006, and July 2006 ASP NOC drug pricing files for Medicare Part B drugs (on or after September 22, 2006) at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#TopOfPage on the CMS website.

October 2006 Quarterly ASP Medicare B Drug Pricing File, Effective October 1, 2006, and Revisions to April and July 2006 Quarterly ASP Medicare B Drug Pricing Files, continued

Note that:

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

Additional Information

You can find the official instructions issued to your carrier/FI/RHHI/DMERC regarding this change by going to CR 5270, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1066CP.pdf> on the CMS website. If you have any questions, please contact your carrier at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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

MLN Matters Number: MM5270

Related Change Request (CR) #: 5270

Related CR Release Date: September 22, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R1066CP

Implementation Date: October 2, 2006

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Flu Shot Reminder

September is the perfect time to start talking with your patients about getting the flu shot. Medicare provides coverage for the flu vaccine and its administration. Please encourage your Medicare patients to take advantage of this vital benefit. And don't forget – health care professionals and their staff benefit from the flu vaccine also. **Protect Yourself. Protect Your Patients. Get Your Flu Shot.**

DURABLE MEDICAL EQUIPMENT

October Quarterly Update for 2006 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) 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 (DME) regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services paid under the DMEPOS fee schedule.

Background

This article and related CR 5255 provide specific information regarding the quarterly update for the October 2006 DMEPOS Fee Schedule.

Key Points Quarterly Update

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

- Implement fee schedule amounts for new codes; and Matters Number: MM5255 Related Change Request Number: 5255
- Revise any fee schedule amounts for existing codes that were calculated in error.

Required Payment

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).

Codes Added to HCPCS

The following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) on October 1, 2006, and are effective for claims with dates of service on or after October 1, 2006:

- HCPCS Code K0738 (portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flow meter, humidifier, cannula or mask, and tubing) This code is to be used for billing and payment for oxygen transfilling equipment used in the beneficiary's home to fill portable gaseous oxygen cylinders.

October Quarterly Update for 2006 DMEPOS Fee Schedule, continued

- HCPCS codes K0800 through K0802, K0806 through K0808, K0812 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891, K0898 and K0899, as appropriate, for related power mobility device claims.

The descriptions for these codes and other codes in this article may be found in CR 5255 at <http://www.cms.hhs.gov/Transmittals/downloads/R1037.pdf> on the CMS website. For power wheelchairs furnished on a rental basis with dates of service prior to October 1, 2006, use codes K0010, K0011, K0012, and K0014 as appropriate. Claims for K0010, K0011, K0012 and K0014 with dates of service on or after October 1, 2006, if the claims are for purchase of initial rental of the item, will be rejected. The fee schedules for HCPCS code E1238 (wheelchair, pediatric size, folding, adjustable, without seating system) are being revised as part of this update to correct errors in calculation and are effective for dates of service on or after January 1, 2006. Fee schedule amounts for codes E2620 and E2621 are being revised to correct fee schedule assignment errors for claims with dates of service on or after January 1, 2006.

The fee schedules for HCPCS code A7043 (vacuum drainage bottle and tubing for use with implanted catheter) are being revised as part of this update to correct calculation errors and will be effective for dates of service on or after January 1, 2006. Previously processed claims for codes E2620, E2621, A7043 and E1238 with dates of service on or after January 1, 2006, will be adjusted if they are resubmitted as adjustments. The fee schedule for HCPCS code L8689 (external recharging system for implanted neurostimulator, replacement only) was revised. FIs and carriers will adjust previously processed claims for code L8689 with dates of service on or after January 1, 2006, if they are resubmitted as adjustments. HCPCS code L8689 should only be used for external systems that recharge implanted batteries (i.e., external recharging of batteries that area inside the patient). Claims for replacements for other types of implanted neurostimulator battery charging systems should be submitted using L8699. The fee schedules for HCPCS code L2232 (addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only) are added to the fee schedule file on October 1, 2006, and are effective for new claims with dates of service on or after January 1, 2005. Codes H0049 (alcohol and/or drug screening) and H0050 (alcohol and/or drug services, brief intervention, per 15 minutes) are being added to the HCPCS on June 30, 2006, and will be available on January 1, 2007, for assignment by insurers in accordance with their programs and policies.

Implementation

The implementation date for the instruction is October 2, 2006.

Additional Information

For complete details, please see the official instruction issued to your Medicare carrier, FI, RHHI, DMERC, or DME/MAC regarding this change. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1037CP.pdf> on the CMS website. If you have questions, please contact your Medicare carrier, DMERC, DME MAC, FI, or RHHI at their toll-free number which may be found at : <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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

MLN Matters Number: MM5255
Related CR Release Date: August 25, 2006
Related CR Transmittal #: R1037CP

Related Change Request (CR) #: 5255
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

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LABORATORY/PATHOLOGY

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

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers and fiscal intermediaries (FIs) for clinical diagnostic laboratory services provided for Medicare beneficiaries

Impact on Providers

This article is based on change request (CR) 5293, which announces the changes that will be included in the October 2006 release of the edit module for clinical diagnostic laboratory services.

Background

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

- | | |
|--|---|
| 1. Culture, Bacterial, Urine | 11. Thyroid Testing |
| 2. Human Immunodeficiency Virus Testing (Prognosis including monitoring) | 12. Lipids |
| 3. Human Immunodeficiency Virus Testing (Diagnosis) | 13. Digoxin Therapeutic Drug Assay |
| 4. Blood Counts | 14. Alpha-fetoprotein |
| 5. Partial Thromboplastin Time | 15. Carcinoembryonic Antigen |
| 6. Prothrombin Time | 16. Human Chorionic Gonadotropin |
| 7. Serum Iron Studies | 17. Tumor Antigen by Immunoassay - CA125 |
| 8. Collagen Crosslinks, Any Method | 18. Tumor Antigen by Immunoassay CA 15-3/CA 27.29 |
| 9. Blood Glucose Testing | 19. Tumor Antigen by Immunoassay CA 19-9 |
| 10. Glycated Hemoglobin/Glycated Protein | 20. Prostate Specific Antigen |
| | 21. Gamma Glutamyl Transferase |
| | 22. Hepatitis Panel/Acute Hepatitis Panel |
| | 23. Fecal Occult Blood |

The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the *Medicare Claims Processing Manual* (Pub.100-4), Chapter 16, section 120.2, <http://www.cms.hhs.gov/manuals/downloads/c1m104c16.pdf>).

CR 5293 informs your Medicare carrier and FI about changes in the laboratory NCD code lists for October 2006, that require updating of the laboratory edit module. These changes become effective for services furnished on or after October 1, 2006.

Changes are being made to the NCD code lists for services furnished on or after October 1, 2006, are as follows:

190.12 - Urine Culture, Bacterial

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Urine Culture, Bacterial (190.12) NCD:

- ICD-9-CM codes 288.00, 288.01, 288.02, 288.03, 288.04, 288.09, 608.20, 608.21, 608.22, 608.23, 608.24, 616.81, 616.89, 780.96, 780.97, 788.64 and 788.65.

The following ICD-9-CM codes are being deleted from the list of ICD-9-CM codes covered by Medicare for the Urine Culture, Bacterial (190.12) NCD:

- ICD-9-CM codes 288.0, 608.2 and 616.8.

190.14 - Human Immunodeficiency Virus (HIV) Testing (Diagnosis)

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (190.14) NCD:

- ICD-9-CM codes 052.2, 053.14, 054.74, 288.00, 288.01, 288.02, 288.03, 288.04, 288.09, 288.4, 288.50, 288.51, 288.59, 288.60, 288.61, 288.62, 288.63, 288.64, 288.65, 288.69, 289.53 and 331.83.

The following ICD-9-CM code is being deleted from the list of ICD-9-CM codes covered by Medicare for the Human Immunodeficiency Virus (HIV) Testing (Diagnosis) (190.14) NCD:

- ICD-9-CM code 288.0.

*Changes to the Laboratory National Coverage Determination Edit Software for October 2006, continued***190.15 - Blood Counts**

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes that do not support medical necessity for the Blood Counts (190.15) NCD:

- ICD-9-CM codes 338.0, 338.11, 338.12, 338.18, 338.19, 338.21, 338.22, 338.28, 338.29, 338.4, 389.15, 389.16, 478.11, 478.19, 521.81, 521.89, 525.60, 525.61, 525.62, 525.63, 525.64, 525.65, 525.66, 525.67, 525.69, 526.61, 526.62, 526.63, 526.69, 608.20, 608.21, 608.22, 608.23, 608.24, 618.84, V26.34, V26.35, V45.86, V72.11 and V72.19.
- ICD-9-CM codes 521.8 and V72.1 are deleted from the list of codes that do not support medical necessity for the Blood Counts (190.15) NCD.

190.16 - Partial Thromboplastin Time (PTT)

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT)(190.16) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 277.30, 277.31, 277.39, 289.81, 649.30, 649.31, 649.32, 649.33, 649.34, 649.50, 649.51, 649.53, 998.12, 995.20, 995.21, 995.27, and 995.29.

The following ICD-9-CM codes are being deleted from the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT)(190.16) NCD:

- ICD-9-CM codes 238.7, 277.3 and 995.2.

190.17 - Prothrombin Time (PT)

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 277.30, 277.31, 277.39, 289.81, 649.30, 649.31, 649.32, 649.33, 649.34, 649.50, 649.51, 649.53, 995.20, 995.21, 995.27, and 995.29.

The following ICD-9-CM codes are being deleted from the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD:

- ICD-9-CM codes 238.7, 277.3 and 995.2.

190.18 - Serum Iron Studies

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, and 238.79.

The following ICD-9-CM code is being deleted from the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD:

- ICD-9-CM code 238.7.

190.20 - Blood Glucose Testing

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Blood Glucose Testing (190.20) NCD:

- ICD-9-CM codes 331.83, 528.00, 528.09, 649.20, 649.21, 649.22, 649.23, 649.24 and 780.32.

The following ICD-9-CM code is being deleted from the list of ICD-9-CM codes covered by Medicare for the Blood Glucose Testing (190.20) NCD:

- ICD-9-CM code 528.0.

190.22 - Thyroid Testing

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD:

- ICD-9-CM codes 331.83, 780.96 and 780.97.

The following ICD-9-CM code is being deleted from the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD

- ICD-9-CM code 793.9.

190.23 - Lipids Testing

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Lipids Testing (190.23) NCD:

- ICD-9-CM codes 277.30, 277.31 and 277.39.

The following ICD-9-CM code is being deleted from the list of ICD-9-CM codes covered by Medicare for the Lipids Testing (190.23) NCD:

- ICD-9-CM code 277.3.

190.24 - Digoxin Therapeutic Drug Assay

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD:

- ICD-9-CM codes 995.20, 995.21, 995.27 and 995.29.

The following ICD-9-CM code is being deleted from the list of ICD-9-CM codes covered by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD:

- ICD-9-CM code 995.2.

190.25 - Alpha-fetoprotein

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Alpha-fetoprotein (190.25) NCD:

- ICD-9-CM codes V86.0, V86.1, 795.89 and 338.3.

190.26 - Carcinoembryonic Antigen

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Carcinoembryonic Antigen (190.26) NCD:

- ICD-9-CM codes 795.81, 795.89 and 338.3.

190.27 - Human Chorionic Gonadotropin

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Human Chorionic Gonadotropin (190.27) NCD:

- ICD-9-CM codes 795.89 and 338.3.

190.28 - Tumor Antigen by Immunoassay CA 125

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Tumor Antigen by Immunoassay CA 125 (190.28) NCD:

- ICD-9-CM codes 795.82, 795.89 and 338.3.

190.29 - Tumor Antigen by Immunoassay CA 15-3/CA27.29

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Tumor Antigen by Immunoassay CA 15-3/CA27.29 (190.29) NCD:

- ICD-9-CM codes 338.3 and 795.89.

*Changes to the Laboratory National Coverage Determination Edit Software for October 2006, continued***190.30 - Tumor Antigen by Immunoassay CA 19.9**

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Tumor Antigen by Immunoassay CA 19.9 (190.30) NCD:

- ICD-9-CM codes 338.3 and 795.89.

190.31 - Prostate Specific Antigen (PSA)

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Prostate Specific Antigen (PSA) (190.31) NCD:

- ICD-9-CM codes 600.00, 600.10, 600.11, 600.21, 788.64 and 788.65.

190.32 - Gamma Glutamyl Transferase (GGT)

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (GGT) (190.32) NCD:

- ICD-9-CM codes 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 277.30, 277.31 and 277.39.

The following ICD-9-CM codes are being deleted from the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (GGT) (190.32) NCD:

- ICD-9-CM codes 238.7 and 277.3.

190.33 - Hepatitis Panel/Acute Hepatitis Panel

The following ICD-9-CM code of 780.32 is being added to the list of ICD-9-CM codes covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

190.34 - Fecal Occult Blood Test (FOBT)

The following ICD-9-CM codes are being added to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (FOBT) (190.34) NCD:

- ICD-9-CM codes 284.2 and 338.3.

The following ICD-9-CM codes are being deleted from the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (FOBT) (190.34) NCD:

- ICD-9-CM code 995.2.

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

List of denied ICD-9-CM codes for all NCDs

The following ICD-9-CM codes are being added to the list of denied ICD-9-CM codes for all NCDs:

- ICD-9-CM codes V18.51, V18.59, V82.71 and V82.79.

ICD-9-CM code V18.5 is deleted from the list of denied ICD-9-CM codes for all NCDs.

Implementation

The implementation date for CR 5293 is October 2, 2006.

Additional Information

To 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/R1050CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS web site.

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).

Flu Shot Reminder

September is the perfect time to start talking with your patients about getting the flu shot. Medicare provides coverage for the flu vaccine and its administration. Please encourage your Medicare patients to take advantage of this vital benefit. And don't forget – health care professionals and their staff benefit from the flu vaccine also. Protect Yourself. Protect Your Patients. Get Your Flu Shot.

MLN Matters Number: MM5293

Related Change Request (CR) #: 5293

Related CR Release Date: September 7, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R1050CP

Implementation Date: October 2, 2006

Independent Laboratory Billing for the Technical Component of Physician Pathology Services

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

Provider Types Affected

Independent laboratories that bill Medicare carriers

Impact of CR5210 on Independent Laboratories

Independent laboratories may not bill for the technical component (TC) of physician pathology services furnished to a patient of a hospital after December 31, 2006.

Background

In CR 5210, the Centers for Medicare & Medicaid Services' (CMS) proposes to implement the 1999 final physician fee schedule regulations (at 42 CFR, section 415.130).

Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology services for hospital inpatients.

Section 732 of the Medicare Modernization Act (MMA) extended, for 2005 and 2006, the provision of section 542 of the Benefits Improvement Act of 2000 (BIPA) that allowed certain independent laboratories to bill under the physician fee schedule for the technical component of physician pathology services furnished to patients of a covered hospital.

Independent Laboratory Billing for the Technical Component of Physician Pathology Services , continued

CR 5210 instructs Medicare carriers to notify all independent laboratories that they may no longer bill for these services after the MMA provision expires on December 31, 2006.

Implementation

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

Additional Information

To review the related article that extended the provision of section 542 of the Benefits Improvement Protection Act of 2000 (BIPA) for services furnished in 2005 and 2006 go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3467.pdf> on the CMS website.

The official instructions, CR 5210, issued to your Medicare carrier regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1046CP.pdf> on the CMS website.

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

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

MLN Matters Number: MM5210

Related Change Request (CR) #: 5210

Related CR Release Date: September 1, 2006

Effective Date: December 1, 2006

Related CR Transmittal #: R1046CP

Implementation Date: December 1, 2006

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SURGERY**Clarification on Billing Requirements for Percutaneous Transluminal Angioplasty Concurrent with the Placement of an FDA-Approved Carotid Stent**

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2006 Medicare B Update! page 36.

Note: This article was revised on August 28, 2006, to reflect changes made to CR 5022, which CMS re-issued on August 25.

The transmittal number, CR release date, and web address for accessing CR 5022 were changed. All other information remains the same.

Provider Types Affected

Providers, physicians, and suppliers that bill Medicare contractors (fiscal intermediaries (FIs) and carriers) for their services

Key Points

- This article is based on CR 5022, which contains instructions (summarized below) that must be implemented to correctly process carotid stenting claims.
- The Centers for Medicare & Medicaid Services (CMS) has additionally updated the carotid artery stenting (CAS) facilities “approved facilities” website link in Publication 100-03, *The National Coverage Determinations Manual*. The list is now available at <http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp> on the CMS website.

Claims that are being billed for category B IDE studies and post-approval studies, per CR 1660 (effective July 1, 2001) and CR 3489 (effective October 12, 2004), respectively, are not subject to the same billing requirements as indicated in CR 3811 (Effective March 17, 2005). The links to CR 1660 and the Medicare Learning Network (MLN) articles relating to CR 3489 and CR 3811 may be found in the *Related Links* section below.

- CMS created a new section in the Medicare Claims Processing Manual specific to carotid stents. Please refer to this new section in the manual attachment to CR 5022, (Publication 100-04, *The Medicare Claims Processing Manual*, Chapter 32, Sections 160.1-160.3) for more information about PTA for implanting the carotid stent. (This includes information on CR 1660, CR 3489 and CR 3811.)

*Clarification on Billing Requirements for PTA Concurrent with the Placement of an FDA-Approved Stent, continued***Background**

Percutaneous transluminal angioplasty (PTA) involves inserting a balloon catheter into a narrow or occluded blood vessel to recanalize and dilate the vessel by inflating the balloon. The objective of PTA is to improve the blood flow through the diseased segment of a vessel so that vessel patency is increased and embolization is decreased. With the development and use of balloon angioplasty for treatment of atherosclerotic and other vascular stenoses, PTA (with and without the placement of a stent) is a widely used technique for dilating lesions of peripheral, renal, and coronary arteries.

Please refer to the manual attachment to CR 5022, Transmittal 53, (Publication 100-03, The Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 20.7) for more information about the nationally covered indications for PTA concurrent with carotid stent placement, and for facilities accepted for services related to CAS with embolic protection. This is available at <http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf> on the CMS website.

Category B IDE Study Claims and Post-approval Study Claims

Effective for dates of service on or after March 17, 2005, the following claims are not subject to the approved facility list. These are CAS claims:

- Billed under a Category B IDE study (identified by a six-digit IDE number preceded by a “G,” i.e., G123456); or a
- Billed under an FDA-approved post-approval study (identified by a six-digit PMA number preceded by a “P,” i.e., P123456)
- Previously denied due to the unintended application of the “approved” facility edit created per CR 3811 that are brought to your FI’s or carrier’s attention will be adjusted (per CR 1660 for Category B IDE Study Claims, and CR 3489 for Post-approval Study Claims).

CAS with Embolic Protection Claims

- Effective for dates of service on or after March 17, 2005, CAS with embolic protection claims will be paid only if they are from facilities listed on the approved list (see <http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp>).

CAS with embolic protection claims from nonapproved facilities will be rejected rather than denied. (CR 3811)

- Effective for dates of service on or after March 17, 2005, CAS with embolic protection claims that contain procedure code 37216 (*transcatheter placement of intravascular stent(s) without distal embolic protection*) will not be paid. CMS has deemed procedure code 37216 a noncovered service for Medicare purposes.

Related Links

CR 1660, Claims Processing Instructions for Clinical Trials on Carotid Stenting With Category B Investigational Device Exemptions (IDEs) may be found at <http://www.cms.hhs.gov/Transmittals/Downloads/AB0174.pdf> on the CMS website.

MM3489, Percutaneous Transluminal Angioplasty (PTA) may be found at the following link <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf> on the CMS website.

MM3811, Expansion of Coverage for Percutaneous Transluminal Angioplasty (PTA) is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf> on the CMS website.

CR 5022 is the official instruction issued to your FI or carrier regarding changes mentioned in this article, MM5022. CR 5022 may be found by going to Transmittal 1042CP at <http://www.cms.hhs.gov/Transmittals/downloads/R1042CP.pdf> for the claims processing instructions and to Transmittal 53NCD for the NCD Manual section, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf> on the CMS website.

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

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

MLN Matters Number: MM5022 *Revised*

Related Change Request (CR) #: 5022

Related CR Release Date: August 25, 2006

Effective Date: March 17, 2005

Related CR Transmittal #: R1042CP and R53NCD

Implementation Date: October 2, 2006

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HIPAA - THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

MSP Claims—More than One Primary Payer and More Than One Allowed Amount

When submitting an MSP claim, Medicare needs to use a primary payer's allowed and paid amounts to calculate the supplemental amount that can be paid by Medicare. In some cases, a beneficiary is covered by more than one other primary payer. Each of those other payers must complete adjudication before Medicare can process those claims. The ASC X12 837 version 40101A1 IG permits reporting of payment information from more than one other payer, but not for reporting of separate allowed amounts at the line or claim level for more than one payer.

As a result of this limitation, when there is more than one primary payer, and the allowed amounts differ, a provider is permitted to submit the claim to Medicare on paper, attaching the remittance advice/explanation of benefits from each of the primary payers.

Unless a provider meets **one** of the exceptions listed below, no other types of MSP claims (e.g. when there is only one primary payer) may be submitted to Medicare on paper. These exceptions are:

- Obligated to accept as payment in full amount (OTAF) claims when there is also more than one primary payer.
- The provider meets the criteria for a "small provider".
- The provider meets one of the temporary exception criteria (e.g. disruption of electricity, communications, etc.).

Source: CMS Internet Only Manual, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 24, Section 90.2, Change Request 5068

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), Medicare carriers, including durable medical equipment regional carriers (DMERCs) and durable medical equipment Medicare administrative contracts (DME MACs).

Provider Action Needed

STOP – Impact to You

The November 2005 through February 2006 updates have been posted for the X12N 835 health care remittance advice remark codes (RARC) and the X12N 835 health care claim adjustment reason codes (CARC).

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has developed a new website located at <http://www.cmsremarkcodes.info/> on the CMS website, to provide information and help navigate the RARC database more easily. A helpful search tool is provided at this site if you need to find a specific category of code. This new website does not replace the Washington Publishing Company (WPC) website, <http://www.wpc-edi.com/codes>, as the official site where the most current RARC list resides. Use the list posted at the WPC website if there are any discrepancies between code text listed either on the new website or in this article, and the code text provided on the WPC website.

GO – What You Need to Do

Please refer to the *Background* section of this article for a summary of the RARC and CARC code text changes.

Background

Among the codes sets mentioned in the Implementation Guide for transaction 835 (Health Care Claim Payment/Advice), the following two code sets must be used to report payment adjustments and related information for transaction 835 and the standard paper remittance advice for Medicare:

- Claim adjustment reason code (CARC); and
- Remittance advice remark code (RARC).

Additionally, for the coordination of benefits (COB) transaction (837), the CARC must be used.

Both of these code sets are updated three times a year, and Medicare issues recurring change requests (CRs) that capture the changes in these code sets that have been approved in the previous four months.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update, continued

Summary of Current Updates (November 1, 2005 – February 28, 2006 Changes)

Remark Code (RARC) Changes

New: The following code table reflects new remark codes:

New Code	Current Narrative
N365	This procedure code is not payable. It is for reporting/information purposes only.
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
N367	The claim information has been forwarded to a Health Savings Account processor for review.
N368	You must appeal the determination of the previously adjudicated claim.
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

Modified: Remark Code **MA02** was modified effective December 29, 2005. Its modified narrative is:

“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.”

This modification is effective January 1, 2006, and was implemented on or before May 17, 2006.

Deactivated: Code **MA03** was deactivated effective October 1, 2006. Remark code MA02 may be used instead.

Reason Code (CARC) Changes

New: The following table reflects new reason codes:

New Code	Current Narrative	New as of:
193	Original payment decision is being maintained. This claim was processed properly the first time.	February 2006
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician.	February 2006
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service	February 2006

Implementation Date

These code changes will be applied by your Medicare carrier/DMERC/FI/RHHI by October 2, 2006.

Additional Information

CR 5212 is the official instruction issued to your Medicare carrier/DMERC/FI/RHHI regarding changes mentioned in this article. CR 5212 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1031CP.pdf> on the CMS website.

For more information on the process used to update these two codes sets, see the *MLN Matters* article, MM44314, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4314.pdf> on the CMS website.

If you have questions please contact your local Medicare carrier/DMERC/FI/RHHI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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

MLN Matters Number: MM5212
 Related Change Request (CR) #: 5212
 Related CR Release Date: August 18, 2006
 Effective Date: October 1, 2006
 Related CR Transmittal #: R1031CP
 Implementation Date: October 2, 2006

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MEDICARE SECONDARY PAYER

National Recovery Contractor for New Medicare Secondary Payer Recovery Claims

The Centers for Medicare & Medicaid Services (CMS) has awarded a contract for a national Medicare Secondary Payer Recovery Contractor (MSPRC) to Chickasaw Nation Industries, Inc. – Administration Services, LLC (CNI). This contract will be implemented **on October 2, 2006**.

Please read the sections immediately below to determine how the change to a national MSPRC will affect you, as some existing MSP recovery claims will remain the responsibility of the claim processing contractors.

What Does Implementation of the MSPRC Mean for You if You Are a Provider, Physician, or Other Supplier?

The recovery of provider, physician or other supplier MSP recovery claims will continue to be the responsibility of the contractor that processed the underlying Medicare claim. Consequently, providers, physicians, and other suppliers should not see any changes in CMS' processes for recovering debts where the provider, physician, or other supplier is overpaid due to receiving a duplicate payment from both an insurer or workers' compensation carrier and Medicare.

What Does Implementation of the MSPRC Mean for You if You Are:

- An employer, insurer, group health plan (GHP), third party administrator, or other plan sponsor subject to the MSP GHP provisions of the Social Security Act;
- A workers' compensation plan/carrier or a liability or no-fault insurer; or
- A beneficiary (or the representative of a beneficiary)?

For all **new** MSP initial recovery demand letters issued **on or after the implementation date for the MSPRC (October 2, 2006)**, you should respond to the entity that issues the recovery demand letter to you. Except for provider, physician, or other supplier MSP recovery claims and a limited number of GHP debts in certain states, this will routinely be the MSPRC.

General Rules

The MSPRC will have responsibility for all **new** MSP recovery demand letters issued on or after the implementation date for the MSPRC (October 2, 2006), as well as all subsequent CMS actions on those recovery claims. Two exceptions to these general rules are:

- Recovery demand letters issued by the MSP recovery audit contractors (RACs) implemented as a demonstration project under the Medicare Modernization Act (MMA) of 2003.

The following three RACs will continue to have responsibility for certain MSP GHP based recovery demands for the respective states:

- Diversified Collection Systems – California
- Public Consulting Group – Florida
- Public Consulting Group – New York
- MSP recovery demand letters issued by the claim processing contractors to providers, physician, and other suppliers.

Note: The responsibility for all pending MSP recovery cases where a recovery demand letter has not yet been issued will, aside from the two exceptions noted in the preceding paragraph, be the responsibility of the MSPRC. (Please note that a letter providing the amount of Medicare's conditional payments in connection with a workers' compensation or liability or no-fault insurance case is not a recovery demand letter.) This responsibility is in line with the MSPRC's responsibility for the issuance of all new MSP recovery demand letters issued on or after October 2, 2006 (again, with the two exceptions noted in the preceding paragraph).

Due to systems issues, the Medicare contractors listed immediately below will continue to have responsibility for all further CMS collection activities with respect to MSP recovery claims where the initial recovery demand letter was issued **prior to the implementation date of the MSPRC (October 2, 2006)**. This includes responsibility for the "Notice of Intent to Refer Debt to the Department of Treasury" letters where a recovery claim is not repaid timely. The RACs will also continue to have this responsibility for all RAC-initiated MSP recovery claims.

- Empire – Syracuse NY or Harrisburg PA
- First Coast Service Options, Inc. (FCSO) – Jacksonville FL
- Mutual of Omaha – Omaha NE
- Palmetto – Augusta GA or Columbia SC or Columbus OH
- Trailblazer – Denison TX

GENERAL INFORMATION

National Recovery Contractor for New Medicare Secondary Payer Recovery Claims, continued

The MSPRC will have responsibility for all further CMS collection actions for MSP recovery demand letters issued **before** the implementation date for the MSPRC (October 2, 2006) **unless** the recovery demand letter was: 1) issued by one of the Medicare contractors listed immediately above; 2) issued by one of the RACs; or 3) issued to a provider, physician, or other supplier.

Once a recovery claim is referred to the Department of the Treasury, the contractor that issued the recovery demand letter and the notice of intent to refer the debt to the Treasury letter will make no further collection attempts. You should direct any further correspondence to the Department of the Treasury (or its contractor if you have received correspondence from an entity working under contract to the Department of the Treasury).

Contact Information for the MSPRC

MSPRC telephone access will **not** be available **before October 2, 2006**. The number for the MSPRC's dedicated call center will be 1-866-MSP-RC20 (1-866-677-7220), available from 8:00 a.m. to 8:00 p.m. Eastern Standard Time, Monday through Friday, with the exception of holidays.

The MSPRC will **not** accept mail **until September 25, 2006**. Mailing information for the MSPRC will be available on CMS' website after September 22, 2006.

The MSPRC is a recovery contractor.

Two Important Points

- The appropriate contact for reporting changes in group health plan (GHP) insurance coverage, or reporting non-GHP claims (workers' compensation, liability insurance (including self-insurance), or no-fault insurance) remains CMS' Coordination of Benefits Contractor (COBC). Initial contact for parties wishing to propose a workers' compensation Medicare set-aside amount also remains with the COBC. See <http://www.cms.hhs.gov/COBGeneralInformation/> for further information about the COBC, including contact information, attorney information, etc. The COBC's toll-free line is 1-800-999-1118 (TTY/TDD 1-800-318-8782 for the hearing and speech impaired).
- The CMS Medicare claims processing contractors continue to be responsible for claims processing for Medicare billing involving Medicare as a secondary payer.

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

NATIONAL PROVIDER IDENTIFIER

Modification of National Provider Identifier Editing Requirements in CR 4023 and an Attachment to CR 4320

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) (or durable medical equipment Medicare administrative contractors (DME MACs) if appropriate)

Provider Action Needed

STOP – Impact to You

This article is based on CR 5229, which corrects certain business requirements from CR 4023 that relate to edits for National Provider Identifiers (NPIs) and provider legacy identifiers when reported on claims, particularly for **referring/ordering or other secondary providers**, effective October 1, 2006 and later. Additionally, CR 5229 revises Attachment 1 to CR 4320.

CAUTION – What You Need to Know

Some of those business requirements erroneously assumed that any provider for whom information is reported in a claim, including a referring/ordering or other secondary provider, would need to be enrolled in Medicare and therefore listed in the Medicare Provider Identifier Crosswalk. This is not always the case. CR 5229 modifies those business requirements.

GO – What You Need to Do

These modifications will enable correct processing of affected claims in October 2006 and later, and will avoid the unnecessary rejection of many claims that involve a referring/ordering or other secondary provider. Please refer to the Background section of this article and to CR 5229 for additional important information regarding these modifications.

Background

The Medicare Learning Network (MLN) articles, MM4023 and MM4320, which are based on CR 4023 and CR 4320 respectively, contain important information about the stages of the NPI implementation process. Some of this information is updated in the current article. The links to these articles are located in the Additional Information section of this article.

Modification of NPI Editing Requirements in CR 4023 and an Attachment to CR 4320, continued

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 online at <https://nppes.cms.hhs.gov>.

During Stage 2 of the NPI implementation process (October 2, 2006 - May 22, 2007), Medicare will utilize a Medicare Provider Identifier Crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions.

Primary and Secondary Providers

Providers, for NPI provider identifier editing purposes, are categorized as either “primary” or “secondary” providers. Primary providers include billing, pay-to, and rendering providers. Primary providers are required to be enrolled in Medicare for the claim to qualify for payment.

Secondary providers are all other providers for which data could be reported on an institutional (837-I) or professional (837-P), free billing software or direct data entry (DDE) claim, or on a revised CMS-1500 or a UB-04 (once those paper claims are accepted by Medicare). Since the UB-92, the currently used CMS-1500, and the HIPAA NCPDP format do not allow reporting of both NPIs and legacy identifiers, information on secondary providers in those claims is not included in the following requirements. Secondary providers may be enrolled, but are not required to be enrolled in Medicare (unless they plan to bill or be paid by Medicare for care rendered to Medicare beneficiaries).

Secondary Provider Claims**Claims Submitted with NPI and Medicare Legacy Identifier:**

During stage 2, claim submitters should submit a provider’s Medicare legacy identifier whenever reporting an NPI for a provider. Failure to report a Medicare legacy number for a provider enrolled in Medicare could result in a delay in processing of the claim. When an NPI and a legacy identifier are reported for a provider, Medicare contractors will apply the same edits to those numbers that would have been applied if that provider was a primary provider. (See MM4023.)

There are two exceptions:

1. A Medicare contractor cannot edit a surrogate unique provider identification number (sometimes called a dummy UPIN, such as OTN000). Despite its name, a surrogate is not actually unique for a specific provider.
2. Only a National Supplier Clearinghouse (NSC) identification number or a UPIN should ever be reported as the legacy numbers on a claim sent to a DMERC/DME MAC. If a carrier provider identification number (PIN) is reported as a legacy identifier with an NPI, DMERCs/DME MACs will edit as if the NPI was the only provider identifier reported for that provider.

Claims Submitted with NPI Only:

The NPI is edited to determine if it meets with the physical requirements of the NPI (10 digits, begins with a 1, 2, 3, or 4, and the check digit in the 10th position is correct), and whether there is a Medicare Provider Identifier Crosswalk entry for that NPI.

If the NPI is located in the crosswalk:

- The taxpayer identification number (TIN) (employer identification number (EIN) or social security number (SSN) and legacy identifier will be sent to the trading partner in addition to the NPI if coordination of benefits (COB) applies.
- However, only the TIN will be forwarded to the COB payer if there is more than one legacy identifier associated with the same NPI in the Medicare Provider Identifier Crosswalk because it may be difficult to know which Medicare legacy identifier applies to that claim.

If the NPI is not located in the Crosswalk:

- No supplemental identifier can be reported to a COB payer.
- However, the claim will not be rejected if the NPI for a referring/ordering provider or another secondary provider cannot be located in the Medicare provider identifier crosswalk, with one exception. Reporting of a Medicare legacy identifier other than a surrogate UPIN signifies a provider is enrolled in Medicare. If a Medicare legacy identifier is reported and cannot be located in the crosswalk, the claim will be rejected, regardless of whether an NPI was reported for that provider.

Claims (including UB-92 or the current CMS-1500 paper claims) submitted with Medicare legacy identifier only

- A Medicare contractor may, but is not required to check a legacy number against the Medicare provider identifier crosswalk.
- As at present, claims will be rejected if any Medicare legacy identifier reported on a claim does not meet the physical requirements (length, if numeric or alphanumeric as applicable) for that type of Medicare provider identifier.

COB and Medigap Trading Partners

Legacy identifiers will not be reported to these trading partners for secondary providers if they are not submitted on the claim sent to Medicare, are surrogate UPINs or if the provider is not enrolled in Medicare. If not enrolled, a legacy identifier or a TIN cannot be sent for a “secondary” provider because Medicare would not have issued a legacy identifier to or collected a TIN from that provider.

GENERAL INFORMATION

Modification of NPI Editing Requirements in CR 4023 and an Attachment to CR 4320, continued

837-I or 837-P version 4010A1 Claims

Attachment 1 to CR 4320 which is being revised as part of CR 5229 addresses (among other issues), the identification of secondary providers for which the 837-I or 837-P version 4010A1 implementation guides only require reporting of an NPI or other identifier “if known.” Unless there is a pre-existing Medicare instruction that mandates the reporting of a specific identifier for those “if known” types of providers, there is no requirement for entry of any identifier for those entities/individuals. If there is no such requirement, claims received that lack an identifier for those types of providers will not be denied.

Note that “secondary” providers such as a referring/ordering physician are not required to be enrolled in Medicare as a condition for payment of the services or supplies they order, furnish, supervise delivery of, etc. for beneficiaries when those services are billed, paid-to or rendered by “primary” providers. For example, Medicare could pay:

- A hospital for services ordered for a patient for inpatient hospital care when the admitting or attending physician is not enrolled in Medicare;
- Hospital surgery costs when the surgeon is not enrolled in Medicare; or
- A hospital when services are purchased from another provider “under arrangements” even if that other provider is not enrolled in Medicare.

Implementation Date

The implementation date for this instruction is October 2, 2006.

Additional Information

CR 4320, issued February 1, 2006, “Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms” is located at <http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf> on the CMS website.

The associated MLN article (with the same title) MM4320, may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf> on the CMS website.

CR 4023, dated November 3, 2005, “Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms” is located at <http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf> on the CMS website. MM4023, the associated MLN article, is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf> on the CMS website.

CR 5229 is the official instruction issued to your Medicare carrier/DMERC (DME MAC if appropriate), FI/RHHI regarding changes mentioned in this article. CR 5229 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R234OTN.pdf> on the CMS website.

If you have questions, please contact your local Medicare carrier/DMERC (DME MAC if appropriate), or FI/RHHI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

MLN Matters Number: MM5229

Related Change Request (CR) #: 5229

Related CR Release Date: August 18, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R234OTN

Implementation Date: October 2, 2006

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Stage 2 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 Third Quarter 2006 Medicare B Update! pages 77-80.

Note: This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf> for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR 5060, which is available at <http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf>.

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.

Stage 2 Requirements for Use and Editing of NPI Numbers Received in EDI Transactions, via DDE Screens or Paper Claim Forms, continued

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/NPPES/Welcome.do>.

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.

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 below:

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 CR 4023)

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.

GENERAL INFORMATION

Stage 2 Requirements for Use and Editing of NPI Numbers Received in EDI Transactions, via DDE Screens or Paper Claim Forms, continued

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.

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 nonrevised 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 SPR Amended Stage 2 Format.

Stage 2 Requirements for Use and Editing of NPI Numbers Received in EDI Transactions, via DDE Screens or Paper Claim Forms, continued**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.

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 MLN Matters article 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," 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.

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

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

MLN Matters Number: MM4023 *Revised*
 Related CR Release Date: November 3, 2005
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 Implementation Date: April 3, 2006

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Change in Online Availability of NPI Application/Update Form (CMS-10114)

National Provider Identifier: Get It. Share It. Use It.

Beginning on September 20, 2006, the PDF version of the NPI Application/Update Form (CMS-10114) will no longer be available for download on the CMS forms website, and there will not be a link to that form from the NPPES page (<https://nppes.cms.hhs.gov/NPPES/Welcome.do>).

Health care providers can still, however, apply for National Provider Identifiers (NPI) in one of these three ways:

1. For the most efficient application processing and the fastest receipt of NPIs, health care providers should consider using the web-based NPI application process. They can log onto the National Plan and Provider Enumeration System (NPPES) and apply on line at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.
2. Health care providers can agree to have an electronic file interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.
3. Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. Health care providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:

Phone: 1-800-465-3203 or TTY 1-800-692-2326

E-mail: customerservice@npienumerator.com

Mail: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

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

Source: CMS Provider Education Resource 200609-06

PREVENTIVE SERVICES

Immunization: Promoting Prevention for a Healthier Life

September 24 – 30 is National Adult Immunization Awareness Week

This annual health observance provides an excellent reminder for you to talk with your Medicare patients about vaccine-preventable diseases and ensure that they are protected against influenza and pneumonia, which together are the fifth leading cause of death among adults 65 and older in the U.S. These vaccines are safe and effective, and there are no out-of-pocket costs for your Medicare patients.

CMS needs your help to ensure that Medicare beneficiaries take full advantage of these preventive benefits. For information about National Adult Immunization Awareness Week, go to <http://www.cdc.gov/nip/events/naiaw/default.htm>.

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

Source: CMS Provider Education Resource 200609-10

Flu Shot Reminder

September is the perfect time to start talking with your patients about getting the flu shot. Medicare provides coverage for the flu vaccine and its administration. Influenza vaccination is a covered Part B benefit.

Note: Influenza vaccine is **NOT** a Part D covered drug.

Please encourage your Medicare patients to take advantage of this vital benefit. And don't forget – health care professionals and their staff benefit from the flu vaccine also. Protect yourself, your patients, and your family and friends. Get your flu shot!

Source: CMS Provider Education Resource 200609-11

GENERAL INFORMATION

Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the August 2006 Medicare B Update! pages 36-37.

Note: This article was revised on August 28, 2006, to reflect revisions made to change request (CR) 5105, which CMS released on August 25, 2006. The transmittal number, CR release date, and web address for accessing CR 5105 have been changed. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers submitting fee-for-service claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services furnished to Medicare beneficiaries enrolled in Medicare Advantage (MA) organizations.

Impact on Providers

This article is based on CR 5105, which was issued to manualize the process that ensures that any duplicate payments for services rendered to Medicare beneficiaries are collected. CR 5105 ensures that any fee-for-service claims that were approved for payment during a period when the beneficiary was enrolled in a managed care organization are submitted to the normal collection process used by the Medicare contractors (carriers/DMERCs/FIs) for overpayments.

Background

The Centers for Medicare & Medicaid Services (CMS) pays for a beneficiary's medical services more than once when a specific set of circumstances occurs. When CMS data systems recognize a beneficiary has enrolled in a MA organization, the MA organization receives capitation payments for the Medicare beneficiary. In some cases, enrollments with retroactive payments are processed.

The result is that Medicare may pay for the services rendered during a specific period twice:

- First, for the specific service that was paid by the fee-for-service Medicare contractor to the provider; and
- Second, by the MA Payment Systems in the monthly capitation rate paid to the MA plan for the beneficiary.

Overview of the MA plan Enrollment Process

When an MA plan enrollment is processed retroactively:

- Fee-for-service claims with dates of service that fall under the managed care plan enrollment period are identified by Medicare's Common Working File (CWF); and
- An Informational Unsolicited Response (IUR) record is created.

In essence, the retroactive enrollment triggers a search for fee-for-service claims that were incorrectly paid for services rendered when the beneficiary was covered by the managed care plan. If such claims are found, the system generates an adjustment and initiation by Medicare systems of overpayment recovery procedures. The current policy/procedures, as outlined in CR 2801 (Transmittal AB-03-101, dated July 18, 2003) and CR 5105, dictates that:

- Claims paid in error (due to enrollment or disenrollment corrections) will be adjusted; and
- Medicare contractors will initiate overpayment recovery procedures.

Note: CR 2801 (Transmittal AB-03-101, dated July 18, 2003) can be found at <http://www.cms.hhs.gov/Transmittals/Downloads/AB03101.pdf> on the CMS website:

Because of the inherent retroactivity in the enrollment process, (e.g., beneficiaries can enroll in plans up to the last day of the month, and the effective date would be the first of the following month), the CWF may receive this information after the enrollment is effective. For this reason, these kinds of adjustments occur routinely.

A variety of the CMS systems issues over the past 18 months have prompted CMS to recently synchronize MA enrollment and disenrollment information for the period September 2003 to April 2006. As a result, providers may have claims that were affected by this synchronization. For details of the impact of this synchronization on providers, please see MLN Matters article, SE0638, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0638.pdf> on the CMS website.

When claims are identified as needing payment recovery, the related remittance advice for the claim adjustment will indicate reason code 24, which states: "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan." Upon receipt, providers are to contact the managed care plan for payment.

- Providers who bill carriers will be alerted by their carrier (via letter or alternate method) of the following:

GENERAL INFORMATION

Collection of FFS Payments Made During Periods of Managed Care Enrollment, continued

- That the beneficiary was in a managed care plan on the date of service;
 - That the provider should bill the managed care plan;
 - What the plan identification number is; and
 - Where to find the plan name and address associated with the plan number on the CMS website.
- For providers who bill FIs, the adjustment will occur automatically and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly.

Note: To associate plan identification numbers with the plan name, go to http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage on the CMS website.

In summary, CMS issued CR 5105 to:

- Ensure that any fee-for-service claims that were approved for payment erroneously are submitted to the normal collection process used by the Medicare contractors (carriers, DMERCs, FIs, and RHHIs) for overpayments; and
- Instruct Medicare contractors to follow the instructions outlined in the Medicare Financial Management Manual (Publication 100-06, Chapter 3, Section 190), which is included as part of CR 5105. Instructions for accessing CR 5105 are in the Additional Information section of this article.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC, intermediary, or RHHI regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R106FM.pdf> on the CMS website.

Also, 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/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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

MLN Matters Number: MM5105 *Revised* Related Change Request (CR) #: 5105
Related CR Release Date: August 25, 2006 Effective Date: October 1, 2003
Related CR Transmittal #: R106FM Implementation Date: June 26, 2006

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

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

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

Provider Types Affected

Physicians, hospitals, including Medicare critical access hospitals, Indian Health Service facilities, and ambulance service providers treating patients eligible for payment of Section 1011 of the Medicare Modernization Act of 2003 (MMA).

Provider Action Needed

STOP – Impact to You

You may be eligible for reimbursement for treating certain individuals under Section 1011 of the MMA. This article help you learn more about this program.

CAUTION – What You Need to Know

As of August 2006, over 15,500 physician and provider enrollment applications have been approved nationwide to participate in the Section 1011 reimbursement process. But, the Centers for Medicare & Medicaid Services (CMS) advises that funds remain available and you may be eligible.

GO – What You Need to Do

CMS scheduled two national outreach conferences to inform providers of their potential eligibility to participate and to provide more details on how this program may help you.

Background

Section 1011 of the MMA provides up to \$250 million per year for federal fiscal years 2005-2008 for payments to eligible providers for emergency services furnished to:

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, continued

- Undocumented aliens
- Aliens who have been paroled into a United States port of entry for the purpose of receiving eligible services
- Mexican citizens permitted to enter the United States on a laser visa, issued in accordance with the requirements of regulations prescribed under the Immigration and Nationality Act.

The covered services are the same as those required by the Emergency Medical Treatment and Labor Act (EMTALA), as well as related hospital inpatient and outpatient services. Providers do not have to be enrolled in the Medicare program to receive Section 1011 eligibility and payments. However, you do have to enroll in the Section 1011 program by submitting an application to TrailBlazer Health Enterprises, LLC, the national contractor for the Section 1011 program.

To provide you with more details about this program, Medicare, through TrailBlazer Health Enterprises, offered two national outreach sessions for the medical community and the general public. These sessions were scheduled for September 2006 and the dates and times were announced and posted to our provider education website <http://www.floridamedicare.com> on August 31, 2006.

Additional Information

Additional information regarding the Section 1011 program may be found on the CMS website at <http://www.cms.hhs.gov/UndocAliens/>.

To enroll as a provider, or to learn more details and updates regarding provider enrollment, medical review, payment request processing, provider education, and customer service assistance related to Section 1011 program visit the TrailBlazer Health Enterprises site on the Web at <http://www.TrailBlazerhealth.com/Section1011>.

You may also reach TrailBlazer Health Enterprises by telephone at 1-866-860-1011.

MLN Matters Number: SE0662
Related CR Release Date: N/A
Effective Date: N/A

Related Change Request (CR) Number: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

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Laboratory Competitive Bidding Demonstration

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

Provider Types Affected

Physicians and all providers who bill Medicare carriers and fiscal intermediaries (FIs) for laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites

Background

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

Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

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

Key Points

This article and change request (CR) 5205 provides instructions for the implementation of a laboratory competitive bidding demonstration. CR 5205 is being implemented in multiple phases. The requirements specified in this article and CR 5205 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

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

Required Bidders

Laboratory firms with \$100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005

GENERAL INFORMATION

Laboratory Competitive Bidding Demonstration, continued

for “demonstration tests” provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration.

These laboratory firms will be referred to as “required bidders.”

Passive Laboratories

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

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

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

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Winners

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

Non-Winners

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

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

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

Demonstration-Covered Laboratory Tests

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

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

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

Demonstration Sites

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

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

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

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

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

Implementation

CR 5205 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

By January 1, 2007, CMS will provide Medicare carriers and fiscal intermediaries (FIs) with a national ZIP code pricing file identifying the ZIP codes included in the first CBA. Also, by the same date, CMS will provide to the carriers/FIs a list of the laboratories eligible to participate in the first CBA demonstration (“winners” and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

Laboratory Competitive Bidding Demonstration, continued

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

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

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

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

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

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

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

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

The demonstration in the first CBA is scheduled to begin on April 1, 2007 and the tentative start date for the demonstration in the second CBA is April 1, 2008.

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

Implementation

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

Additional Information

The official instructions issued to your Medicare carrier/FI regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R49DEMO.pdf> on the CMS website.

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

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

MLN Matters Number: MM5205	Related Change Request (CR) #: 5205
Related CR Release Date: August 1, 2006	Effective Date: January 1, 2007
Related CR Transmittal #: R49DEMO	Implementation Date: January 2, 2007

Disclaimers

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

Unsolicited / Voluntary Refunds

All Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open accounts receivable). Intermediaries generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds. The Centers for Medicare & Medicaid Services reminds providers that:

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Source: CMS Pub 100-6 Transmittal 50, CR 3274

CONNECTICUT MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised local coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier’s medical policies and review guidelines are consistent with accepted standards of medical practice.

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

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It’s very easy to do; go to

<http://www.connecticutmedicare.com>, click on the “eNews” link on the navigational menu and follow the prompts.

More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

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

Medical Review Table of Contents

Advance Notice Statement	36
Revisions to LCDs	
2007 ICD-9-CM Coding Changes	37
Botulinum Toxins	38
J1950: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs—Coding Guideline Revision	39
J9212: Interferon	39
NCSVCS: The List of Medicare Noncovered Services	39
NCSVCS: The List of Medicare Noncovered Services	40
92552: Audiometry	40
97001: Physical Medicine and Rehabilitation	40
Additional Information	
Administration of Certain Biological Response Modifiers	40
Anesthesia Service Overpayments	41
J2354: Octreotide acetate injection removed from Self-administered Drug (SAD) List	41

Advance Notice Statement

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

REVISIONS TO LCDs

2007 ICD-9-CM Coding Changes

The 2007 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2006. Updated diagnosis codes must be used for all services billed on or after October 1, 2006. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued. Connecticut Medicare has reviewed all local coverage determinations (LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2007 ICD-9-CM update. The following table lists the LCDs affected and the specific conditions revised as a result of the 2007 ICD-9-CM update:

LCD Title	2007 Changes
BOTULINUM TOXINS Botulinum Toxins	Change descriptor for diagnosis 333.6 for procedure code J0585 Add diagnosis 333.71 for procedure code J0585
EPO Epoetin alfa	Change descriptor for diagnoses 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, and 404.93 for procedure code J0885 Add diagnoses 995.20 and 995.29 for procedure code J0885 Add diagnoses 238.72, 238.73, 238.74, and 238.75 for procedure code J0585 (Coding Guidelines only) Remove diagnoses 585.4 and 585.5 for procedure code J0886
G0104 Colorectal Cancer Screening	Add diagnosis range V18.51 – V18.59 for procedure codes G0105 and G0120
J1440 G-CSF (Filgrastim, Neupogen®)	Add diagnoses 238.72, 238.73, 238.74, 238.75, 288.00-288.09, 995.20, and 995.29 for procedure codes J1440 and J1441
J1566 Intravenous Immune Globulin	Add diagnosis 288.09 for procedure codes J1566 and J1567
J2505 Pegfilgrastim (Neulasta™)	Add diagnoses 995.20 and 995.29 for procedure code J2505
J2820 Sargramostim (GM-CSF, Leukine®)	Add diagnoses 238.71-238.79, 288.00-288.09, 995.20, and 995.29 for procedure code J2820
J9000 Antineoplastic Drugs	Add diagnosis range 238.71-238.79 for procedure codes J9181, J9182, and J9350
J9209 Mesna (Mesnex®)	Add diagnosis 995.29 for procedure code J9209
NESP Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])	Add diagnoses 995.20 and 995.29 for procedure code J0881 Add diagnoses 238.72, 238.73, 238.74, and 238.75 for procedure code J0881 (Coding Guidelines only) Remove diagnoses 585.4 and 585.5 for procedure code J0882
11055 Routine Foot Care	Add diagnoses 277.30 and 277.39 for procedure codes 11055, 11056, 11057, 11719, 11720, 11721, and G0127
31525 Diagnostic Laryngoscopy	Add diagnoses 288.09 and 519.19 for procedure codes 31525 and 31575
51798 Post-Voiding Residual Ultrasound	Change descriptor for diagnosis 600.01 for procedure code 51798
62263 Epidural	Add diagnosis 053.14 for procedure codes 0027T, 62263, 62264, 62280, 62281, 62282, 62310, 62311, 62318, 62319, 64479, 64480, 64483, and 64484
70544 Magnetic Resonance Angiography (MRA)	Change descriptor for diagnosis ranges 403.00-403.91 and 404.00-404.93 for procedure code 74185 Add diagnosis 171.5 (not new for 2007 ICD-9-CM Update) for procedure code 74185
72192 Computed Tomography of the Pelvis	Change descriptor for diagnoses 995.91 and 995.92 for procedure codes 72192, 72193, and 72194 Add diagnosis range 793.91-793.99 for procedure codes 72192, 72193, and 72194
83735 Serum Magnesium	Add diagnoses 289.53, 429.83, 649.30-649.34, 649.40-649.44, 649.50, 649.51, 649.53, 995.20, 995.23, 995.27, and 995.29 for procedure code 83735
83880 B-Type Natriuretic Peptide (BNP)	Change descriptor for diagnoses 404.01, 404.03, 404.11, 404.13, 404.91, and 404.93 for procedure code 83880
84155 Serum Protein	Add diagnoses 284.01, 284.09, 284.1, and 284.2 for procedure code 84155

LCD Title	2007 Changes
88182 Flow Cytometry and Morphometric Analysis	Add diagnosis range 238.71-238.79 for procedure codes 88184, 88185, 88187, 88188, and 88189 Change diagnosis range 284.0-284.9 to 284.01-284.9 and 288.0-288.9 to 288.00-288.9 for procedure codes 88184, 88185, 88187, 88188, and 88189
88230 Cytogenetic Studies	Add diagnosis range 238.71-238.79 for procedure codes 88230, 88233, 88235, 88237, 88239, 88240, 88241, 88245, 88248, 88249, 88261, 88262, 88263, 88264, 88267, 88269, 88271, 88272, 88273, 88274, 88275, 88280, 88283, 88285, 88289, 88291, 88299, G0265, and G0266
92552 Audiometry	Add diagnosis 995.29 for procedure codes 92552, 92553, and 92557
93000 Electrocardiography	Add diagnoses 277.30 and 277.39 for procedure codes 93000, 93005, and 93010
93701 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance	Change descriptor for diagnoses 403.00-403.01, 403.11, 403.91, 404.00-404.03, 404.11, 404.12, 404.13, 404.91, 404.92, and 404.93 for procedure code 93701 Add diagnoses 429.83 and 518.7 for procedure code 93701
93975 Duplex Scanning	Add diagnoses 288.60 and 608.20 for procedure codes 93975 and 93976
94010 Spirometry	Add diagnoses 519.11 and 519.19 for procedure codes 94010, 94060, 94070, 94240, and 94720

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Botulinum Toxins—LCD Revision

The latest revision for local coverage determination (LCD) botulinum toxins was effective May 8, 2006. Since that time, this LCD has been revised to delete the following statements from the ‘Indications and Limitations of Coverage and/or Medical Necessity’ section of the LCD:

Off-label indications for botulinum toxin type B (myobloc): The use of myobloc may be considered a medically necessary off-label indication for: spasticity caused by stroke or brain injury.

This revision has been implemented as the result of a USPDI revision dated December 5, 2005, reversing their decision to allow treatment of spasticity caused by stroke or brain injury listing under “Acceptance not established”. The USPDI revision further states, “The data describing the treatment of Botulinum toxin type B for upper limb spasticity are limited and inconclusive. In a single, randomized, placebo-controlled trial, BTX-B did not demonstrate a benefit in reducing muscle tone in the elbow, wrist or finger flexors in post-stroke patients. However, improvements in upper limb spasticity were reported in a few small open-labeled trials presented in abstract and/or poster forms”. Therefore, First Coast Service Options, Inc. (FCSO) will no longer allow this indication. In this regard, the ‘Sources of Information and Basis for Decision’ section has been revised accordingly.

In addition, the following ICD-9-CM codes will no longer be allowable for HCPCS code J0587: 342.10–342.12, 344.00–344.09, 344.1, 344.2, 344.30-344.32, 344.40-344.42, 344.5, 438.20-438.22, 438.30-438.32, 438.40-438.42, and 754.1.

This notification serves, as a 45-day notice that the above revisions for HCPCS code J0587 will be **effective for services rendered on or after November 30, 2006**.

Also, in order to indicate a higher degree of specificity when billing for botulinum toxin type A (botox), the following ICD-9-CM codes have been added to the ‘ICD-9 Codes that Support Medical Necessity’ section of the LCD for HCPCS code J0585: 344.5, 438.21, 438.22, 438.31, 438.32, 438.41, and 438.42. These revisions are **effective for services rendered on or after September 18, 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.

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

This coding guideline was last updated on August 7, 2006. Since that time, revisions have been made. First Coast Service Options, Inc. (FCSO) revised the local coverage determination (LCD) for luteinizing hormone-releasing hormone (LHRH) analogs, effective August 7, 2006, which includes language that pertains to the Least Costly Alternative (LCA) policy. Within this LCA policy is a provision that will allow for the “grandfathering” of HCPCS code J3315 (Triptorelin pamoate) for those patients who were receiving and responding well to this drug before the implementation date of this revised LCD. This requires providers to submit documentation per the instructions in the coding guideline attached to the LCD. These instructions state that for those providers wishing to be reimbursed at the higher amount, they can submit documentation that supports the medical necessity of the higher priced drug. Providers must populate block 19 or its electronic equivalent on Form CMS-1500 with the following statement: Documentation of medical necessity available for review. When this field is populated, providers will receive an additional development letter requesting that the documentation be sent in for review. For the grandfathering provision, providers must submit documentation that shows the patient was receiving J3315 and responding well to the drug before August 7, 2006.

FCSO allowed for this grandfathering provision after receiving information during the open comment period that stated it would not be in the best interest of the patient to change drug regimens. It has come to FCSO’s attention that providers may be changing patient’s drug regimens after the notice date of FCSO’s decision to allow the grandfathering for those patients on triptorelin pamoate before August 7, 2006. Providers who changed drug regimens (changing from J1950 or J9217 to J3315) after the notice date of this LCD (June 20, 2006) will not be grandfathered, since this was not the intent of the clause. Providers will be reimbursed at the LCA for J9202.

Effective Date

This revision is effective for services rendered on or after August 7, 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.

J9212: Interferon—LCD Revision

The local coverage determination (LCD) for interferon was last revised on June 26, 2006.

This LCD includes coverage indications for procedure code J9213 (Interferon, alfa-2a). Procedure code J9213 was evaluated for possible addition to the self-administered drug (SAD) list. However, evaluation results revealed that intramuscular injections of this drug might be required for certain medical conditions, which are not appropriate for the SAD list. Therefore, in lieu of placing procedure code J9213 on the SAD list, a separate LCD was developed to define indications and limitations criteria and to provide utilization guidelines for procedure code J9213. Therefore, all information related to procedure code J9213 is being removed from LCD J9212.

Effective Date

This LCD revision is effective for services rendered on or after October 30, 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.

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised on August 7, 2006. Change request 5102, dated May 26, 2006, includes additional Category III codes to be added to the Medicare physician fee schedule database (MPFSDB).

At this time, this LCD is being revised to add the following new category III CPT codes to the “Local Noncoverage Decisions” section of the LCD. These procedure codes have been determined to be investigational/experimental.

- 0159T *Computer aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI (list separately in addition to code for primary procedure)*
- 0160T *herapeutic repetitive transcranial magnetic stimulation treatment planning (Pre-treatment determination of optimal magnetic field strength via titration, treatment location determination and stimulation parameter and protocol programming in the therapeutic use of high power, focal magnetic pulses for the direct, non-invasive modulation of cortical neurons)*
- 0161T *herapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session (treatment session using high power, focal magnetic pulses for the direct, non-invasive modulation of cortical neurons. Clinical evaluation, safety monitoring and treatment parameter review in the therapeutic use of high power, focal magnetic pulses for the direct, non-invasive modulation of cortical neurons)*

Effective Date

This LCD revision is effective for services rendered on or after July 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.

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NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services, was last revised on August 7, 2006. Based on change request (CR) 5037, dated April 28, 2006, the Centers for Medicare & Medicaid Services (CMS) has indicated that contractors shall accept claims containing *CPT* code 90660 on claims when billing for influenza virus vaccine. Therefore, *CPT* code 90660 has been removed from “The List of Medicare Noncovered Services” LCD.

In addition, Medicare will reimburse for FDA-approved indications, for use in patients between the ages of 5–49. Physicians must document in patient records as to why this modality was used over other forms, such as the injectable not available, or patient cannot use for medical reasons. It will not be necessary to submit documentation with the claim, First Coast Service Options, Inc. (FCSO) will request as needed.

Effective Date

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

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92552: Audiometry—LCD Revision

The local coverage determination (LCD) for audiometry was effective August 7, 2006. Since that time, additional clarification was considered necessary regarding limitation #6, under the “Indications and Limitations of Coverage and/or Medical Necessity” and “Documentation Requirements” sections of the LCD. Therefore, this LCD was revised to clarify language in these sections.

Effective Date

This LCD revision is effective for services rendered on or after August 7, 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

This local coverage determination (LCD) was last updated on April 11, 2006. Since that time, the LCD has been revised. Change request 4364, dated February 13, 2006, states that contractors shall require providers to document services in accordance with the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM), Pub 100-2, Chapter 15, Section 220.3 and Pub 100-4, Chapter 5, Section 10.2. The language from these IOM’s appears under the “Documentation Requirements” section of the LCD. Further revision was completed to remove additional references related to weekly documentation requirements found under the heading “Progress Notes”.

Effective Date

This revision is effective for claims processed on or after May 10, 2006 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.connecticutmedicare.com> on or after this effective date.

ADDITIONAL INFORMATION

Administration of Certain Biological Response Modifiers

According to the 2006 edition of the Current Procedural Terminology (CPT) professional edition, *chemotherapy administration codes 96401-96549 apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g, cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers. Any physician can provide these services. Chemotherapy services are typically highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician about these issues.*

Biological response modifiers (BRMs) are agents that modify the relationship between microorganisms and hosts by changing the host’s biological response resulting in a desired therapeutic effect. BRMs are also referred to as immunotherapy or immune therapy. First Coast Service Options, Inc. (FCSO) will allow the use of chemotherapy administration codes for certain BRMs when it is evident that requirements are demonstrated as specified in the *CPT* description for chemotherapy administration codes. It should be documented that the administration of the BRM requires advanced practice, training and

Administration of Certain Biological Response Modifiers, continued

competency of the staff that provide the service; special considerations for preparation, dosage or disposal; and significant patient risk, which requires frequent monitoring.

Currently, FCSO considers the following BRMs for payment using a chemotherapy administration code:

- Monoclonal antibodies
- Tumor necrosis factors
- Interleukins
- Certain fusion proteins

Payment of a chemotherapy administration code will not be allowed when administering the following (**not an all inclusive list**):

- Colony stimulating factors
- Erythroid stimulating agents (EPO, DPA, etc.)
- Leucovorin
- Growth Factors
- Vitamins
- Nesiritide
- Vaccines
- Immunoglobulins, IVIG
- Steroids

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Anesthesia Service Overpayments

The New England Benefit Integrity Support Center (NE-BISC), the Centers for Medicare & Medicaid Services (CMS) Program Safeguard Contractor, has identified overpayments made by carriers for anesthesia services based on a provider-billing anomaly. The Multi-Carrier System (MCS) claim processing system used by First Coast Service Options, Inc. (FCSO) is programmed to convert the total minutes reported in the units field of the [electronic version] CMS-1500 form into 15-minute increments to properly adjudicate payment based on the CMS-prescribed payment methodology. Proper adjudication is dependent upon providers selecting the qualifier “MJ” when billing anesthesia time in minutes. All other services are reported per session or per service with the qualifier value “UN”.

At this time FCSO is asking anesthesia providers to verify their billing procedures relative to this critical detail. Query your billing staff and/or clearing house to ascertain that you are correctly submitting anesthesia minutes on the [electronic version] CMS-1500 form using the “MJ” qualifier. Additionally, we are requesting our anesthesia providers to perform Self-Audits and follow the Voluntary Refund process should you determine an overpayment exists.

Simultaneously, FCSO will implement a corrective action of its own. The data analysis performed by the NE-BISC identified a wide dispersion of units from simple over billing of units to medically unbelievable units of anesthesia services per date of service. An edit will be developed and implemented as a safeguard for medically unbelievable billing errors. Those service units that exceed a medically unbelievable threshold will be denied.

J2354: Octreotide Acetate Injection Removed From Self-administered Drug List (SAD List)

HCPCS code J2354 octreotide acetate injection (Sandostatin®), non-depot form for subcutaneous or intravenous injection 25 mcg, was placed on the self-administered drug (SAD) list for a 45-day notice period beginning July 18, 2006, with an effective date of September 1, 2006.

During the 45-day notice period, it was determined that due to local medical standards of practice the placement of octreotide acetate injection on the SAD list may not be in the best interest for providing access of care to beneficiaries undergoing chemotherapy and experiencing the severe side effects which would require octreotide acetate injection. The administration of octreotide acetate injection for these beneficiaries is for an acute episode of illness and is administered in the physician’s office more than 51 percent of the time or it is administered over a two-week period as a prelude to placing the patient on the once per month administration of the long-acting form of this medication.

Therefore, octreotide acetate injection was removed from the SAD list prior to its implementation date of September 1, 2006.

CONNECTICUT EDUCATIONAL RESOURCES

**Upcoming Connecticut Educational Events
October – December 2006**

Date	Event Description	Event Time	Event Type
October 17	Electronic Data Interchange (EDI) Training – Updates & information on EDI issues, including ASCA, MREP & ERA	8:30 AM – 11:30 AM 1:00 PM – 4:00 PM (2 sessions)	In–Person Seminar (Hartford Marriott Rocky Hill)
October 18	Medicare Executive Circle (MEC) – By invitation only	11:30 AM – 3:30 PM	In–Person Meeting
November 1	Hot Topics Teleconference – Topics based on data analysis and “What’s New” in Medicare as of October 1, 2006	1:00 PM – 2:30 PM	Teleconference
November 15	Ask the Contractor Teleconference (ACT) – Topic to be determined	12:00 PM – 1:00 PM	Teleconference
December 14	Provider Outreach & Education Advisory Group (POE AG) Meeting – For membership information, visit the POE AG page on http://www.connecticutmedicare.com	8:30 AM – 10:30 AM	Teleconference

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

Please Note:

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

Sign up to our eNews electronic mailing list

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

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

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

**CONNECTICUT
MEDICARE PHONE
NUMBERS**

Provider Services

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

Beneficiary Services

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

Electronic Data Interchange (EDI)

**Enrollment
1-203-639-3160, option 1**

PC-ACE® PRO-32

1-203-639-3160, option 2

Marketing and Reject Report Issues

1-203-639-3160, option 4

Format, Testing, and Remittance Issues

1-203-639-3160, option 5

Electronic Funds Transfer Information

1-203-639-3219

Hospital Services

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

Durable Medical Equipment

HealthNow NY
DMERC Medicare Part B
1-800-842-2052

Railroad Retirees

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

Quality of Care

Peer Review Organization
1-800-553-7590

**OTHER HELPFUL
NUMBERS**

**Social Security Administration
1-800-772-1213**

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

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

**Health Insurance Counseling Program
1-800-994-9422**

**Area Agency on Aging
1-800-994-9422**

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

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

**MEDICARE
WEBSITES**

**PROVIDER
Connecticut**

<http://www.connecticutmedicare.com>
**Centers for Medicare & Medicaid
Services**

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

BENEFICIARIES

**Centers for Medicare & Medicaid
Services**

<http://www.medicare.gov>

FLORIDA MEDICAL REVIEW

This section of the *Medicare B Update!* features summaries of new and revised local coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

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

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to

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

More Information

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

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

Medical Review Table of Contents

Advance Notice Statement	44
Article Corrections	
43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy	45
Revisions to LCDs	
2007 ICD-9-CM Coding Changes	45
Botulinum Toxins	47
J1950: Luteinizing Hormone-Releasing Hormone (LHRH) Analog—Coding Guideline Revision	48
J9212: Interferon	48
NCSVCS: The List of Medicare Noncovered Services	48
NCSVCS: The List of Medicare Noncovered Services	49
THERSVCS: Therapy and Rehabilitation Services	49
93965: Non-Invasive Evaluation of Extremity Veins	49
Additional Information	
J2354: Octreotide acetate injection removed from Self-administered Drug List (SAD List)	49
Role of Advanced Registered Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants	50
Administration of Certain Biological Response Modifiers	50

Advance Notice Statement

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

ARTICLE CORRECTIONS

**43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy—
Article Correction**

This information is a correction to an article previously published in the September 2006 Medicare B Update! page 58.

The previously published article revises the local coverage determination (LCD) for diagnostic and therapeutic esophagogastroduodenoscopy by adding ICD-9-CM code V55.1 (Attention to artificial openings, gastrostomy) to the "ICD-9 Codes that Support Medical Necessity" section of the LCD, expanding the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to include follow-up for removal of the PEG, and updating the "Utilization Guidelines" section of the LCD to include verbiage regarding provider qualification requirements when rendering this service.

Correction

The effective date indicated, "for services rendered on or after August 29, 2006". It should have indicated, "claims processed on or after August 29, 2006."

REVISIONS TO LCDs

2007 ICD-9-CM Coding Changes

The 2007 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2006. Updated diagnosis codes must be used for all services billed on or after October 1, 2006. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued. Florida Medicare has reviewed all local coverage determinations (LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2007 ICD-9-CM update. The following table lists the LCDs affected and the specific conditions revised as a result of the 2007 ICD-9-CM update:

LCD Title	2007 Changes
BOTULINUM TOXINS Botulinum Toxins	Change descriptor for diagnosis 333.6 for procedure code J0585 Add diagnosis 333.71 for procedure code J0585
EPO Epoetin alfa	Change descriptor for diagnoses 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, and 404.93 for procedure code J0885 Add diagnoses 995.20 and 995.29 for procedure code J0885 Add diagnoses 238.72, 238.73, 238.74, and 238.75 for procedure code J0585 (Coding Guidelines only) Remove diagnoses 585.4 and 585.5 for procedure code J0886
G0104 Colorectal Cancer Screening	Add diagnosis range V18.51 – V18.59 for procedure codes G0105 and G0120
J0470 Chelation Therapy	Add diagnosis 238.72 for procedure code J0895
J0637 Caspofungin acetate (Cancidas®)	Add diagnosis range 288.00-288.09 for procedure code J0637
J0640 Leucovorin (Wellcovorin®)	Add diagnoses 995.20 and 995.29 for procedure code J0640
J0800 Corticotropin	Add diagnosis range 284.01-284.09 for procedure code J0800
J1440 G-CSF (Filgrastim, Neupogen®)	Add diagnoses 238.72, 238.73, 238.74, 238.75, 288.00-288.09, 995.20, and 995.29 for procedure codes J1440 and J1441
J1566 Intravenous Immune Globulin	Add diagnosis 288.09 for procedure codes J1566 and J1567
J2505 Pegfilgrastim (Neulasta™)	Add diagnoses 995.20 and 995.29 for procedure code J2505
J2820 Sargramostim (GM-CSF, Leukine®)	Add diagnoses 238.71-238.79, 288.00-288.09, 995.20, and 995.29 for procedure code J2820
J3420 Vitamin B12 Injections	Add diagnosis 995.29 for procedure code J3420
J9000 Antineoplastic Drugs	Add diagnosis range 238.71-238.79 for procedure codes J9181, J9182, and J9350
NESP Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])	Add diagnoses 995.20 and 995.29 for procedure code J0881 Add diagnoses 238.72, 238.73, 238.74, and 238.75 for procedure code J0881 (Coding Guidelines only) Remove diagnoses 585.4 and 585.5 for procedure code J0882

LCD Title	2007 Changes
PULMDIAGSVCS Pulmonary Diagnostic Services	Add diagnosis range 519.11-519.19 for procedure codes 93720, 93721, 93722, 94010, 94060, 94070, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725, and 94750
11055 Routine Foot Care	Add diagnoses 277.30 and 277.39 for procedure codes 11055, 11056, 11057, 11719, 11720, 11721, and G0127
31231 Diagnostic Nasal Endoscopy	Add diagnosis 784.99 for procedure codes 31231, 31233, 31235, and 92511
31525 Diagnostic Laryngoscopy	Add diagnoses 288.09 and 519.19 for procedure codes 31525 and 31575
43235 Diagnostic and Therapeutic Esophagogastroduodenoscopy	Add diagnoses 538, 784.91-784.99, and V18.51-V18.59 for procedure codes 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, and 43258
44388 Diagnostic Colonoscopy	Add diagnosis range V18.51-V18.59 for procedure codes 44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, and 45392
51798 Post-Voiding Residual Ultrasound	Change descriptor for diagnosis 600.01 for procedure code 51798
62310 Epidural	Add diagnoses 053.14, 333.71, 333.72, 333.79, 338.21, 338.29, 338.3, and 338.4 for procedure codes 62310, 62311, 62318, 62319, 64479, 64480, 64483, and 64484
64561 Sacral Neuromodulation	Add diagnoses 788.64 and 788.65 for procedure codes 64561 and 64581
69220 Mastoidectomy Cavity Debridement	Change descriptor for diagnoses 389.11, 389.12, and 389.18 for procedure codes 69220 and 69222 Add diagnoses 389.15 and 389.16 for procedure codes 69220 and 69222
70540 Magnetic Resonance Imaging of the Orbit, Face, and Neck	Add diagnosis ranges 379.60-379.63 and 478.11-478.19 for procedure codes 70540, 70542, and 70543
70544 Magnetic Resonance Angiography (MRA)	Change descriptor for diagnosis ranges 403.00-403.91 and 404.00-404.93 for procedure code 74185 Add diagnosis 171.5 (not new for 2007 ICD-9-CM Update) for procedure code 74185
70551 Magnetic Resonance Imaging of the Brain	Change descriptor for diagnosis range 345.00-345.91 for procedure codes 70551, 70552, and 70553 Add diagnoses 054.74 and 768.7 for procedure codes 70551, 70552, and 70553
72141 Magnetic Resonance Imaging of the Spine	Add diagnoses 793.91-793.99 for procedure codes 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, and 72158
73218 Magnetic Resonance Imaging of Upper Extremity	Add diagnoses 238.71-238.79, 729.71, and 958.91 for procedure codes 73218, 73219, 73220, 73221, 73222, and 73223
76510 B-Scan	Add diagnoses 277.30 and 277.39 for procedure codes 76510, 76512, and 76513
78460 Myocardial Perfusion Imaging	Add diagnoses 995.20 and 995.29 for procedure codes 78460, 78461, 78464, 78465, 78478, and 78480
82310 Total Calcium	Add diagnoses 519.11 and 519.19 for procedure code 82310
83735 Magnesium	Add diagnosis 995.29 for procedure code 83735
83880 B-Type Natriuretic Peptide (BNP)	Change descriptor for diagnoses 404.01, 404.03, 404.11, 404.13, 404.91, and 404.93 for procedure code 83880
84100 Serum Phosphorus	Change descriptor for diagnoses 403.01, 403.11, 404.02, 404.03, 404.12, and 404.13 for procedure code 84100

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2007 ICD-9-CM Coding Changes, continued

LCD Title	2007 Changes
86706 Hepatitis B Surface Antibody and Surface Antigen	Change descriptor for diagnoses 403.01, 403.11, 404.02, 404.03, 404.12, and 404.13 for procedure codes 86706 and 87340
93000 Electrocardiography	Add diagnoses 277.30 and 277.39 for procedure codes 93000, 93005, and 93010
93303 Transthoracic Echocardiogram	Change descriptor for diagnosis range 404.00-404.93 for procedure codes 93307 and 93308 Add diagnoses 277.30, 277.39, 770.88, 995.20, and 995.29 for procedure codes 93307 and 93308
93350 Stress Echocardiography	Add diagnoses 995.20 and 995.29 for procedure code 93350
93701 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance	Change descriptor for diagnoses 403.00-403.01, 403.11, 403.91, 404.00-404.03, 404.11, 404.12, 404.13, 404.91, 404.92, and 404.93 for procedure code 93701 Add diagnoses 429.83 and 518.7 for procedure code 93701
93975 Duplex Scanning	Add diagnoses 288.60 and 608.20 for procedure codes 93975 and 93976
94760 Noninvasive Ear or Pulse Oximetry for Oxygen Saturation	Change descriptor for diagnoses 404.01, 404.03, 404.11, 404.13, 404.91, and 404.93 for procedure codes 94760, 94761, and 94762
95900 Nerve Conduction Studies	Add diagnoses 729.71 and 729.72 for procedure codes 95900, 95903, and 95904

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Botulinum Toxins—LCD Revision

The latest revision for local coverage determination (LCD) botulinum toxins was effective May 8, 2006. Since that time, this LCD has been revised to delete the following statements from the ‘Indications and Limitations of Coverage and/or Medical Necessity’ section of the LCD:

Off-label indications for botulinum toxin type B (Myobloc): The use of myobloc may be considered a medically necessary off-label indication for: spasticity caused by stroke or brain injury.

This revision has been implemented as the result of a USPDI revision dated December 5, 2005, reversing their decision to allow treatment of spasticity caused by stroke or brain injury listing under “Acceptance not established”. The USPDI revision further states, “The data describing the treatment of Botulinum toxin type B for upper limb spasticity are limited and inconclusive. In a single, randomized, placebo-controlled trial, BTX-B did not demonstrate a benefit in reducing muscle tone in the elbow, wrist or finger flexors in post-stroke patients. However, improvements in upper limb spasticity were reported in a few small open-labeled trials presented in abstract and/or poster forms”. Therefore, First Coast Service Options, Inc. (FCSO) will no longer allow this indication. In this regard, the ‘Sources of Information and Basis for Decision’ section has been revised accordingly.

In addition, the following ICD-9-CM codes will no longer be allowable for HCPCS code J0587: 342.10–342.12, 344.00–344.09, 344.1, 344.2, 344.30-344.32, 344.40-344.42, 344.5, 438.20-438.22, 438.30-438.32, 438.40-438.42, and 754.1.

This notification serves, as a 45-day notice that the above revisions for HCPCS code J0587 will be **effective for services rendered on or after November 30, 2006**.

Also, in order to indicate a higher degree of specificity when billing for botulinum toxin type A (botox), the following ICD-9-CM codes have been added to the ‘ICD-9 Codes that Support Medical Necessity’ section of the LCD for HCPCS code J0585: 344.5, 438.21, 438.22, 438.31, 438.32, 438.41, and 438.42. These revisions are **effective for services rendered on or after September 18, 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.

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

This coding guideline was last updated on August 7, 2006. Since that time, revisions have been made. First Coast Service Options, Inc. (FCSO) revised the local coverage determination (LCD) for luteinizing hormone-releasing hormone (LHRH) analogs, effective August 7, 2006, which includes language that pertains to the Least Costly Alternative (LCA) policy. Within this LCA policy is a provision that will allow for the ‘grandfathering’ of HCPCS code J3315 (triptorelin pamoate) for those patients who were receiving and responding well to this drug before the implementation date of this revised LCD. This requires providers to submit documentation per the instructions in the coding guideline attached to the LCD. These instructions state that for those providers wishing to be reimbursed at the higher amount, they can submit documentation that supports the medical necessity of the higher priced drug. Providers must populate Block 19 or its electronic equivalent on CMS form 1500 with the following statement: **Documentation of medical necessity available for review.** When this field is populated, providers will receive an additional development letter requesting that the documentation be sent in for review. For the grandfathering provision, providers must submit documentation that shows the patient was receiving J3315 and responding well to the drug before August 7, 2006.

FCSO allowed for this grandfathering provision after receiving information during the open comment period that stated it would not be in the best interest of the patient to change drug regimens. It has come to FCSO’s attention that providers may be changing patient’s drug regimens after the notice date of FCSO’s decision to allow the grandfathering for those patients on triptorelin pamoate before August 7, 2006. Providers who changed drug regimens (changing from J1950 or J9217 to J3315) after the notice date of this LCD (June 20, 2006) will not be grandfathered, since this was not the intent of the clause. Providers will be reimbursed at the LCA for J9202.

Effective Date

This revision is effective for services rendered on or after August 7, 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

The local coverage determination (LCD) for interferon was last revised on June 26, 2006. This LCD includes coverage indications for procedure code J9213 (Interferon, alfa-2a). Procedure code J9213 was evaluated for possible addition to the self-administered drug (SAD) list. However, evaluation results revealed that intramuscular injections of this drug might be required for certain medical conditions, which are not appropriate for the SAD list. Therefore, in lieu of placing procedure code J9213 on the SAD list, a separate LCD was developed to define indications and limitations criteria and to provide utilization guidelines for procedure code J9213. Therefore, all information related to procedure code J9213 is being removed from LCD J9212.

Effective Date

This LCD revision is effective for services rendered on or after October 30, 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.

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised on August 7, 2006. Change request 5102, dated May 26, 2006, includes additional category III codes to be added to the Medicare physician fee schedule database (MPFSDB).

At this time, this LCD is being revised to add the following new category III CPT codes to the “Local Noncoverage Decisions” section of the LCD. These procedure codes have been determined to be investigational/experimental.

- 0159T *Computer aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI (list separately in addition to code for primary procedure)*
- 0160T *Therapeutic repetitive transcranial magnetic stimulation treatment planning (Pre-treatment determination of optimal magnetic field strength via titration, treatment location determination and stimulation parameter and protocol programming in the therapeutic use of high power, focal magnetic pulses for the direct, non-invasive modulation of cortical neurons)*
- 0161T *Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session (treatment session using high power, focal magnetic pulses for the direct, non-invasive modulation of cortical neurons. Clinical evaluation, safety monitoring and treatment parameter review in the therapeutic use of high power, focal magnetic pulses for the direct, non-invasive modulation of cortical neurons)*

Effective Date

This LCD revision is effective for services rendered on or after July 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.

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NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services, was last revised on August 7, 2006. Based on change request (CR) 5037 dated April 28, 2006, the Centers for Medicare & Medicaid Services (CMS) has indicated that contractors shall accept claims containing *CPT* code 90660 on claims when billing for influenza virus vaccine. Therefore, *CPT* code 90660 has been removed from “The List of Medicare Noncovered Services” LCD.

In addition, Medicare will reimburse for FDA-approved indications, for use in patients between the ages of 5–49. Physicians must document in patient records as to why this modality was used over other forms, such as the injectable not available, or patient cannot use for medical reasons. It will not be necessary to submit documentation with the claim, First Coast Service Options, Inc. (FCSO) will request as needed.

Effective Date

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

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THERSVCS: Therapy and Rehabilitation Services—LCD Revision

This local coverage determination (LCD) was last updated on April 11, 2006. Since that time, the LCD has been revised. Change request 4364, dated February 13, 2006, states that contractors shall require providers to document services in accordance with the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM), Pub 100-2, Chapter 15, Section 220.3 and Pub 100-4, Chapter 5, Section 10.2. The language from these IOM’s appears under the “Documentation Requirements” section of the LCD. Further revision was completed to remove additional references related to weekly documentation requirements found under the heading “Progress Notes”.

Effective Date

This revision is effective for claims processed on or after May 10, 2006 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.

93965: Non-Invasive Evaluation of Extremity Veins—LCD Revision

This local coverage determination (LCD) was last updated on April 11, 2006. Since that time, the LCD has been revised. The ICD-9-CM codes that support medical necessity were revised to include ICD-9-CM code 451.2 (phlebitis and thrombophlebitis of lower extremities, unspecified) as medically necessary.

Effective Date

This revision is effective for services rendered on or after September 18, 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

J2354: Octreotide acetate injection removed from Self-administered Drug List (SAD List)

HCPSC code J2354 octreotide acetate injection (Sandostatin®), non-depot form for subcutaneous or intravenous injection 25 mcg, was placed on the self-administered drug (SAD) list for a 45-day notice period beginning July 18, 2006, with an effective date of September 1, 2006.

During the 45-day notice period, it was determined that due to local medical standards of practice the placement of octreotide acetate injection on the SAD list may not be in the best interest for providing access of care to beneficiaries undergoing chemotherapy and experiencing the severe side effects which would require octreotide acetate injection. The administration of octreotide acetate injection for these beneficiaries is for an acute episode of illness and is administered in the physician’s office more than 51 percent of the time or it is administered over a two week period as a prelude to placing the patient on the once per month administration of the long-acting form of this medication.

Therefore, octreotide acetate injection was removed from the SAD list prior to its implementation date of September 1, 2006.

Role of Advanced Registered Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants

The Centers for Medicare & Medicaid Services (CMS) expanded the role of advanced registered nurse practitioners (ARNP), clinical nurse specialists (CNS), and physician assistants (PA) in accordance to changes proscribed by the Balanced Budget Act of 1997. In the final rule published in the Federal Register on November 2, 1998 (42 CFR Part 405), instructions were issued that outlined this expansion of role performance, as well as requirements for education, billing CMS for program services, and licensure and certification requirements.

States regulate licensing of professionals through their respective licensing boards and boards of professional regulation. In the final rule, CMS deferred to each state in determining whether a professional met the state licensing requirements as ARNPs, CNS', and PAs, because CMS is a federal program and most professional licensing is administered at the state level and varies from state to state. In other words, if a professional meets the state guidelines for licensing and obtains the appropriate state license as one of the professionals listed above, then CMS will allow that person to participate in and bill the program, as long as licensing requirements are maintained in good standing.

survey of billing data revealed that the Florida Medicare contractor, First Coast Service Options, Inc. (FCSO), had erroneously paid claims filed by professionals lacking the appropriate state licensure required to bill the program. Only ARNPs, PAs, certified registered nurse anesthetists (CRNA), and certified nurse midwives are recognized at the advanced level of practice required to bill the Florida Medicare program. This means any nurse in Florida who wishes to bill the Medicare program must hold one of these professional nursing designations. Certain nurses may have a more advanced level of education and training than at the baccalaureate level,

Florida is one of several states that do not recognize CNSs as advanced practice nurses. Nurses, who are certified as a CNS in other states, or even in Florida, must apply to the state board of professional regulation for licensing as an ARNP and obtain the license by meeting state-determined education, training, and credentialing requirements. Once a license as an ARNP has been obtained, and all certification and training requirements outlined in the federal register have been satisfied, an advanced practice nurse may apply for a Medicare provider identification number, or national provider identifier, when appropriate.

Until such time as Florida adjusts its standards of advance practice to recognize CNS', when it is discovered that a CNS may have been paid in error, a request for a refund to the contractor may be undertaken.

Administration of Certain Biological Response Modifiers

According to the 2006 edition of the Current Procedural Terminology (CPT) professional edition, *chemotherapy administration codes 96401-96549 apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g, cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers. Any physician can provide these services. Chemotherapy services are typically highly complex and require direct physician supervision for any or all purposes of patient assessment, provision of consent, safety oversight and intra-service supervision of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician about these issues.*

Biological response modifiers (BRMs) are agents that modify the relationship between microorganisms and hosts by changing the host's biological response resulting in a desired therapeutic effect. BRMs are also referred to as immunotherapy or immune therapy. First Coast Service Options, Inc. (FCSO) will allow the use of chemotherapy administration codes for certain BRMs when it is evident that requirements are demonstrated as specified in the CPT description for chemotherapy administration codes. It should be documented that the administration of the BRM requires advanced practice, training and competency of the staff that provide the service; special considerations for preparation, dosage or disposal; and significant patient risk, which requires frequent monitoring.

Currently, FCSO considers the following BRMs for payment using a chemotherapy administration code:

- Monoclonal antibodies
- Tumor necrosis factors
- Interleukins
- Certain fusion proteins

Payment of a chemotherapy administration code will not be allowed when administering the following (**not an all inclusive list**):

- Colony stimulating factors
- Erythroid stimulating agents (EPO, DPA, etc.)
- Leucovorin
- Growth Factors
- Vitamins
- Nesiritide
- Vaccines
- Immunoglobulins, IVIG
- Steroids

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**FLORIDA MEDICARE
PART B MAIL
DIRECTORY**

CLAIMS SUBMISSIONS

Routine Paper Claims

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

Participating Providers

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

Chiropractic Claims

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

Ambulance Claims

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

Medicare Secondary Payer

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

ESRD Claims

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

COMMUNICATIONS

Redetermination Requests

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

Fair Hearing Requests

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

Administrative Law Judge Hearing

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

Status/General Inquiries

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

Overpayments

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

**DURABLE MEDICAL EQUIPMENT
(DME)**

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
DMERC Operations
P. O. Box 100141
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries

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

**MEDICARE PART B ADDITIONAL
DEVELOPMENT**

Within 40 days of initial request:

Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request:

**Submit the charge(s) in question,
including information requested, as
you would a new claim, to:**

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

MISCELLANEOUS

**Provider Participation and Group
Membership Issues; Written Requests for
UPINs, Profiles & Fee Schedules:**

Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:

Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider Education:

**For Educational Purposes and Review
of Customary/Prevailing Charges or
Fee Schedule:**

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

For Education Event Registration:

Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting Charge Issues:

For Processing Errors:

Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:

Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

**Medicare Claims for Railroad
Retirees:**

MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and Abuse

First Coast Service Options, Inc.
P. O. Box 45087
Jacksonville, FL 32232-5087

**FLORIDA
MEDICARE
PHONE NUMBERS**

BENEFICIARY

Toll-Free:

1-800-MEDICARE

Hearing Impaired:

1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

PROVIDERS

Toll-Free

Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992

For Education Event Registration (not

toll-free):
1-904-791-8103

EMC

Format Issues & Testing:

1-904-354-5977 option 4

Start-Up & Front-End Edits/Rejects:

1-904-791-8767 option 1

Electronic Funds Transfer

1-904-791-8016

Electronic Remittance Advice, Electronic

Claim Status, & Electronic Eligibility:

1-904-791-6895

PC-ACE Support:

1-904-355-0313

Marketing:

1-904-791-8767 option 1

New Installations:

(new electronic senders; change of address
or phone number for senders):
1-904-791-8608

Help Desk:

(Confirmation/Transmission):
1-904-905-8880 option 1

OCR

Printer Specifications/Test Claims:

1-904-791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare

1-866-270-4909

MEDICARE PART A

Toll-Free:

1-866-270-4909

Medicare Websites

PROVIDERS

Florida Medicare Contractor

www.floridamedicare.com

Centers for Medicare & Medicaid
Services

www.cms.hhs.gov

BENEFICIARIES

Centers for Medicare & Medicaid
Services

www.medicare.gov

EDUCATIONAL RESOURCES

2006 - 2007 Influenza Season Resources For Health Care Professionals

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 (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare carriers/Medicare Administrative Contractors (MAC) or fiscal intermediaries (FI) for flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider Action Needed

- Keep this special edition MLN Matters article and refer to it throughout the 2006 - 2007 flu season.
- Talk with your patients about the flu virus and their risks for complications of the disease and encourage them to get the flu shot. (*Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.*)
- Stay abreast of the latest influenza information and inform your patients.
- Order appropriate provider resources for yourself and your staff.
- Have appropriate literature on hand about influenza that can be handed out to your patients during the flu season.
- Don't forget to immunize yourself and your staff – Protect yourself, protect your patients, and protect your family and friends. Get Your Flu Shot.

Introduction

On average, 36,000 people in the United States die each year from influenza and complications arising from influenza. Greater than 90 percent of deaths occur in persons 65 years of age and older. Individuals with chronic medical conditions such as diabetes and heart disease are particularly at risk of influenza infection, as are people in nursing, convalescent, or other institutional settings.

Historically, the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that Medicare beneficiaries are informed about this vaccine-preventable disease and get their flu shot this flu season. In addition, unvaccinated health care workers can spread influenza to patients, family, and friends. CMS encourages you and your staff to get vaccinated. Protect your patients, protect your family and friends, and protect yourself.

CMS has developed a variety of educational resources, listed in the next section, to ensure that Medicare FFS health care professionals have the information they need to bill Medicare correctly for the Medicare-covered vaccines and help promote increased awareness and utilization of the flu vaccine among beneficiaries, providers, and their staff.

Products

The following products have been developed by CMS to be used by the Medicare FFS health care community and are not intended for distribution to Medicare beneficiaries.

- **MLN Matters Articles**
 - MM4240 ~ Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf>
 - MM5037 ~ Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf>
- **MLN Flu Related Products for Health Care Professionals**
 - Quick Reference Information: Medicare Immunization Billing ~ This two-sided chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the flu, pneumococcal, and hepatitis B vaccines and their administration. This product is currently available as a download. http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf
 - An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals. This educational video program provides health care professionals with an overview of Medicare-covered preventive services. The program includes a section on Medicare's coverage of flu, pneumococcal, and hepatitis B vaccines. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered through the MLN Product Ordering Web page. http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5
 - The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals ~ This comprehensive guide to Medicare-covered preventive services and screenings is intended to give Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement to help them file claims effectively, while also giving providers information that will enable them to encourage utilization of these benefits as appropriate. Pages 97 – 104 cover the flu vaccine. Pages 117 – 119 include a discussion of mass immunizers and Roster billing. Available in print or as a download. http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

2006 - 2007 Influenza Season Resources For Health Care Professionals, continued

- Medicare Preventive Services Adult Immunizations Brochure ~ This two-sided tri-fold brochure gives an overview of the coverage information for flu, pneumococcal, and hepatitis B. Available in print or as a download.
http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization_06-08-05.pdf
- Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course ~ This course was updated August 2006 and has been approved for .1 IACET* CEU for successful completion. This WBT contains four modules that include information about Medicare's coverage of flu, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. This course can be accessed through the MLN Product Ordering Web page.
http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1
- Quick Reference Information: Medicare Preventive Services ~ This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals 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. This chart includes flu, pneumococcal, and hepatitis B. Available in print or as a download.
http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- Medicare Preventive Services Bookmark ~ This bookmark lists the preventive services and screenings covered by Medicare (including flu) and serves as a handy reminder to health care professionals about the many preventive benefits covered by Medicare. Available in print or as a download.
<http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcsbkmrk.pdf>
- 2006 - 2007 Influenza (Flu) Season Educational Products and Resources PDF Document ~ This online PDF document includes links to flu-related educational products developed by CMS for provider use and links to other resources where clinicians may find useful information and tools for the 2006 - 2007 flu season. The resource document will be updated as new flu information becomes available. The 2006 - 2007 Influenza (Flu) Season Educational Products and Resources online document can be accessed by going to the Downloads section of the MLN Preventive Services Educational Products Web page, located at
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS site.
- **Other CMS Resources**
 - CMS Adult Immunizations Web Page <http://www.cms.hhs.gov/AdultImmunizations/>
 - 2006 Administration Fees for Flu and Pneumococcal (PPV)
<http://www.cms.hhs.gov/AdultImmunizations/Downloads/0506vaccreimburs033006.pdf>
 - CMS Frequently Asked Questions
http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEdhi
- **Other Resources**
The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2006 flu season.
 - Advisory Committee on Immunization Practices <http://www.cdc.gov/nip/acip>
 - American Lung Association's Influenza (Flu) Center <http://www.lungusa.org/> ~ This site provides a flu clinic locator <http://www.flucliniclocator.org/>. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
 - Centers for Disease Control and Prevention <http://www.cdc.gov/flu>
 - Immunization Action Coalition <http://www.immunize.org/>
 - Immunization: Promoting Prevention for a Healthier Life <http://www.nfid.org/pdf/publications/naiaw06.pdf>
 - Medicare Quality Improvement Community <http://www.medqic.org/>
 - National Alliance for Hispanic Health <http://www.hispanichealth.org/>
 - National Foundation For Infectious Diseases <http://nfid.org/influenza>
 - National Immunization Program <http://www.cdc.gov/nip>
 - National Network for Immunization Information <http://www.immunizationinfo.org/>
 - National Vaccine Program <http://www.hhs.gov/nvpo>
 - Office of Disease Prevention and Promotion <http://odphp.osophs.dhhs.gov>
 - Partnership for Prevention <http://prevent.org>
 - World Health Organization <http://www.who.int/csr/disease/influenza/en/>

*The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington, DC 20006. The authors of the video program and web-based training course have no conflicts of interest to disclose. The video program and web-based training course was developed without any commercial support

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September is Prostate Cancer Awareness Month!

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting awareness of prostate cancer and the prostate cancer screening benefit covered by Medicare.

Prostate cancer is the second most common type of cancer and the second leading cause of cancer-related deaths among men in the US. According to the American Cancer Society, approximately 234,460 new cases and 27,350 deaths are expected in 2006. All men are potentially at risk; however, the incident of prostate cancer rises dramatically with increasing age. The risk of prostate cancer is significantly higher among African American men, and men who have a family history of the disease are also at increased risk.

Medicare began providing coverage of prostate cancer screening tests/procedures for the early detection of prostate cancer January 1, 2000. Medicare provides coverage of a digital rectal examination (DRE) and a prostate specific antigen (PSA) blood test once every 12 months for all men with Medicare over the age of 50 for the early detection of prostate cancer.

PSA and DRE screening can detect prostate cancer in its early stages. However, while the U.S. Preventive Services Task Force (USPSTF) found good evidence that PSA screening can detect early-stage prostate cancer, it has mixed and inconclusive evidence that early detection improves health outcomes. The USPSTF notes that screening is associated with potential harms and concludes that evidence is insufficient to determine whether the benefits outweigh the possible harms for a screened population. Consequently, the USPSTF recommends that clinicians discuss the potential benefits and possible harms of prostate cancer screening with their patients before performing screening procedures. (For more information on potential benefits and possible harms associated with prostate cancer screening, please refer to “USPSTF Screening for Prostate Cancer” <http://www.ahcpr.gov/clinic/uspstf/uspSprca.htm> on the Internet.)

You Can Help Your Patients Make An Informed Decision

You can help your Medicare patients make an informed decision about prostate cancer screening by:

- Providing your patients with current information to help them understand the nature of prostate cancer and their risks factors for developing the disease; and,
- Talking with your patients about the types of prostate cancer screenings covered by Medicare and the potential benefits and possible risks of the screenings.

Prostate Cancer Awareness Month is the perfect time to promote discussion about prostate cancer and the screening benefit covered by Medicare. As a trusted source of health care information, your recommendation can help your patients make an informed decision about prostate cancer screening. It could potentially save their lives.

For More Information

- For more information about Medicare’s prostate cancer screening benefit, visit the CMS website: www.cms.hhs.gov/ProstateCancerScreening/
- CMS has also developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.
- The MLN Preventive Services Educational Products Web Page—provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS website.
- The CMS website provides information for each preventive service covered by Medicare. Click on www.cms.hhs.gov, select “Medicare”, and scroll down to “Prevention”.
- For products to share with your Medicare patients, visit www.medicare.gov on the Web.
- For more information about prostate cancer and Prostate Cancer Awareness Month, visit the following websites:
 - Centers for Disease Control and Prevention www.cdc.gov/cancer/prostate
 - National Cancer Institute www.cancer.gov/
 - National Prostate Cancer Coalition www.fightprostatecancer.org

Thank you for joining with CMS to promote awareness of prostate cancer and the screening benefit covered by Medicare.

Source: CMS Learning Resource, Message 200609-03

An Overview of Medicare Preventive Services Video

The *Medicare Learning Network* is pleased to announce the availability of the latest provider education resource on Medicare’s coverage of preventive benefits, *An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* video program.

This educational video program provides an overview of preventive services covered by Medicare including the newest preventive services that became effective January 2005 as a result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This program provides information on risk factors associated with various preventable diseases and highlights the importance of prevention, detection, and early treatment of disease. The information presented in this program is useful for physicians, providers, suppliers, and other health care professionals involved in providing preventive services to Medicare beneficiaries. The program runs approximately 75 minutes in length.

The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington, DC 20006.

An Overview of Medicare Preventive Services Video, continued

CMS has awarded for this educational video program 0.1 of CEUs (continued education units) to participants who successfully complete this program. This program is appropriate for use by a single individual or may be shown to a large group. Credit expires July 4, 2009. The authors of this program have no conflicts of interest to disclose. This course was developed without the use of any commercial support.

The video program may be accessed at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.

Flu Season Resources for Health Care Professionals

The *Medicare Learning Network* has developed the *2006 – 2007 Influenza (Flu) Season Educational Products and Resources* online PDF document. This online document includes links to flu-related educational products developed by CMS for provider use and links to other resources where clinicians may find useful information and tools for the 2006 – 2007 flu season. The resource document will be updated as new flu information becomes available.

The **2006 – 2007 Influenza (Flu) Season Educational Products and Resources** online document may be accessed by going to the Downloads section of the MLN Preventive Services Educational Products Web page, located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage.

Source: CMS Provider Education Resource 200609-08

Introducing the Provider Outreach and Education Advisory Group

Effective October 1, 2006, the name of the Provider Communication Advisory Group (PCOM AG) will be officially changed and referred to as the Provider Outreach and Education Advisory Group (POE AG).

The primary function of the Provider Outreach and Education Advisory Groups remains the same. These groups of providers/suppliers assist the Medicare contractors with ideas and recommendations in the creation and implementation of provider education strategies and efforts. Providers interested in participating in a POE AG may access the provider education website <http://www.connecticutmedicare.com> or <http://www.floridamedicare.com>. From the home page, click on the POE AG section on the left navigational bar. The POE AG page contains important information, including a membership request form and an overview of this initiative. Providers lacking Internet access and interested in becoming a POE AG member may leave a message on the provider education registration hot line:

Connecticut 1-203-634-5527

Florida 1-904-791-8103.

We look forward to hearing from you.

2006 Hurricane Season—Are You Prepared?

Hurricane preparedness is paramount this time of the year. Whether we face an active hurricane season, like last year, or a below-normal season, the vital message for Medicare customers is to be prepared!

First Coast Service Options, Inc. (FCSO) Disaster Preparedness Task Force has been invoked to proactively assist providers.

How Can Providers Communicate with FCSO During and After an Emergency?

1. Visit our website <http://www.floridamedicare.com> for announcements.
2. Subscribe to the appropriate *general* eNews list and receive automatic notices about urgent or other critical information. By signing up, you will receive periodic messages advising you of updates to the website <http://www.floridamedicare.com>.
3. Access the Interactive Voice Response (IVR) unit by calling the Medicare Customer Service Contact Center: (Part A) 1-877-602-8816 or (Part B) 1-866-454-9007.

The IVR is available 24/7! Sunday thru Saturday from 6:00 a.m. to 6:00 p.m. Eastern and Central standard times. You may obtain claims specific, eligibility, or Medicare payment information. Only general information is available from 6:00 p.m. to 6:00 a.m. Eastern and Central standard times.

The Disaster Preparedness Task Force will continue to work with CMS and other federal agencies to address your concerns, *and explain any unique procedures to process and pay claims for providers impacted by a disaster.*

More To Come...Stay Tuned!

Additional information will be posted to <http://www.floridamedicare.com> as it becomes available.

Other Related Sources:

DHHS (Department of Health & Human Services) Disasters & Emergencies: <http://www.hhs.gov/emergency/>

FEMA (Federal Emergency Management Agency): <http://www.fema.gov/>

Florida Division of Emergency Management: <http://www.floridadisaster.org/>

National Mail Service Updates: <http://www.usps.com/communications/news/serviceupdates.htm>

NOAA National Hurricane Center: <http://www.nhc.noaa.gov/>

FLORIDA EDUCATIONAL RESOURCES

**Upcoming Provider Outreach and Education Events
October – December 2006**

Date	Event Description	Event Time	Event Type
October 24	Provider Outreach & Education Advisory Group (POE AG) Meeting – For membership information, visit the POE AG page on http://www.floridamedicare.com	11:30 AM – 1:00 PM	Teleconference
November 7	Hot Topics Teleconference – Topics based on inquiry and unprocessable claims data analysis	11:30 AM – 12:30 PM	Teleconference
November 16	Ask the Contractor Teleconference – Topic to be determined	11:30 AM – 1:00 PM	Teleconference
December 7	Educational Webcast – Appeals and Overpayments	12:00 PM – 1:00 PM	Webcast*

More events will be planned soon for this quarter. Keep checking our website, <http://www.floridamedicare.com>, for details and newly scheduled events!

*Webcasting is our newest training approach, combining the best of in-person events and teleconferences into one venue! Webcasts may include online presentations, website demonstrations, handouts and interactive quizzes. Experience the interactivity of training online with the convenience of listening to the speaker via teleconference!

Please Note:

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

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.

ORDER FORM

ORDER FORM — 2007 PART B MATERIALS

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

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

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

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