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

Highlights In This Issue…

Features

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

Routing Suggestions:

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

_____

TABLE OF CONTENTS

Medicare B Update!

Vol. 4, No. 6
September 2006

Publications Staff
Terri Drury
Kimberly McCarron
Millie C. Pérez

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

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

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

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 Medicare Communication and Education Provider 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** (wavier of liability statement on file).

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

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

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

OR

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

CLAIMS

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

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

Provider Types Affected

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

Key Points

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

January 2, 2007 – March 30, 2007

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

April 2, 2007

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

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

Background

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

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

In a related change request (CR) 4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report 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 (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 Information

When the NPI Number 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 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 Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS–1500, continued

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/R1010CP.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	Related Change Request (CR) #: 5060
Related CR Release Date: July 28, 2006	Effective Date: January 1, 2007
Related CR Transmittal #: R1010CP	Implementation Date: January 2, 2007

2007 Annual Update for the Health Professional Shortage Area Bonus Payments

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

Provider Types Affected

Physicians and providers submitting claims to Medicare carriers and fiscal intermediaries (FIs) for services provided in a health professional shortage area (HPSA)

Impact on Providers

This article is based on change request (CR) 5237, which alerts affected physicians, providers, carriers, and FIs that the new HPSA bonus payment information for 2007 will soon be available.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Section 413[b]) mandated an annual update to the automated HPSA bonus payment files, and the Centers for Medicare & Medicaid Services (CMS) creates these new automated HPSA bonus payment files annually.

CR 5237 instructs carriers and FIs to use the new HPSA bonus payment file for the automated bonus payment for claims with dates of service on or after January 1, 2007, through December 31, 2007.

In addition, CMS is notifying affected physicians/providers that it will post the new HPSA information to the CMS website on or about October 1, 2006.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier or FI regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1021CP.pdf* on the CMS website.

If you have any questions, please contact your carrier/FI 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: MM5237	Related Change Request (CR) #: 5237
Related CR Release Date: August 4, 2006	Effective Date: January 1, 2007
Related CR Transmittal #: R1021CP	Implementation Date: January 2, 2007

Health Professional Shortage Area Listing

The following are counties (all census tracts) designated as geographic health professional shortage areas (HPSAs) and therefore eligible for the bonus payment for primary care for Connecticut, as of July 5, 2006.

Connecticut—Primary Care

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

The following are counties (all census tracts) designated as geographic health professional shortage areas (HPSAs) and therefore eligible for the bonus payment for primary care and mental health for Florida, as of July 5, 2006.

Florida—Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Clay/Keystone Heights		Rural
Collier/Imokalee/Everglades		Rural
Columbia (effective March 3, 2006)		Rural
Dixie		Rural
Escambia/Atmore (AL/FL)	0038.00, 0039.00, 0040.00	Rural
Gadsden		Urban
Glades		Rural
Hamilton		Rural
Hardee		Rural
Hendry (revised March 3, 2006)		Rural
Jefferson (effective March 3, 2006)		Rural
Lafayette		Rural
Liberty		Rural
Madison		Rural
Martin/Indiantown		Rural
Okeechobee (effective March 3, 2006)		Rural
Palm Beach (effective July 5, 2006)	0080.01, 0080.02, 0081.01, 0081.02, 0082.01, 0082.02, 0082.03, 0083.01, 0083.02	Rural
Sumter		Rural
Suwannee		Rural
Wakulla		Rural

Sign up to our *eNews* electronic mailing list

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

Health Professional Shortage Area Listing (continued)

Florida—Mental Health

County	Type
Bradford	Rural
Calhoun (effective March 3, 2006)	Rural
Columbia	Rural
Dixie	Rural
Franklin (effective July 5, 2006)	Rural
Gilchrist	Rural
Gulf (effective March 3, 2006)	Rural
Hamilton	Rural
Hillsborough. Ruskin CCD/Wimauma-Lithia CCD (effective November 3, 2005)	Urban
Holmes	Rural
Indian River/Fellsmere (effective July 5, 2006)	Rural
Lafayette	Rural
Lake (effective July 5, 2006)	Rural
Liberty (effective July 5, 2006)	Rural
Jefferson (effective July 5, 2006)	Rural
Lafayette	Rural
Lake (effective July 5, 2006)	Rural
Liberty (effective July 5, 2006)	Rural
Jefferson (effective July 5, 2006)	Rural
Madison (effective July 5, 2006)	Rural
Martin/Indiantown (effective September 27, 2005)	Rural
Monroe/Upper Keys (revised July 5, 2006)	Rural
Okeechobee (effective March 3, 2006 – July 5, 2006)	Rural
Putnam	Rural
St Johns	Urban
Suwannee	Rural
Union	Rural
Walton	Rural
Washington	Rural

Source: CMS Atlanta Regional Office Memorandum, July 31, 2006
CMS Boston Regional Office Memorandum, August 10, 2006

Sign up to our *eNews* electronic mailing list

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

COMPETITIVE ACQUISITION PROGRAM

Transitional Use of Medicare Part B Drug Competitive Acquisition Program Resupply Option and the J2 Modifier

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

Provider Types Affected

Physicians participating in the competitive acquisition Program (CAP) who have submitted claims to Medicare carriers for services related to the emergency administration of Part B drugs to Medicare beneficiaries in their office.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) discovered that during CAP implementation, certain situations arose where participating CAP physicians may have 1) administered drugs to Medicare beneficiaries from their office stock in situations that may not have met the required criteria, and 2) sought a replacement drug product through the use of the 'J2' restocking modifier.

CAUTION – What You Need to Know

Until September 30, 2006, CAP participating physicians who submitted claims for CAP drugs under the average sale price (ASP) (buy and bill) system may request that these claims be reopened and reprocessed as a CAP claim if the claims are submitted with the appropriate CAP information and the J2 modifier.

GO – What You Need to Do

See the *Background* and *Additional Information* sections of this for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) established the CAP to offer physicians who administer Part B drugs to Medicare beneficiaries in their offices the option of obtaining many of these drugs under the CAP starting on January 1, 2006. Additional background information on the CAP maybe found at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/* on the CMS website.

Physicians are required to obtain all drugs on the CAP drug list from an approved CAP vendor. However, in certain circumstances the physician may administer a drug from his/her office stock using the "J2" restocking modifier if (in the physician's clinical judgment) the conditions stated in business requirement (BR) 4064.5 are met (To view full details of CR 4064, see its related MLN Matters article, MM4064, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf*.)

CMS discovered that during CAP implementation, certain situations arose where participating CAP physicians may have 1) administered drugs to Medicare beneficiaries from their office stock in situations that may not have met the criteria listed in BR 4064.5, and 2) sought a replacement drug product through the use of the "J2" restocking modifier.

Many of these situations 1) arose during the CAP physicians' transition from the ASP (buy and bill) system to the CAP, and 2) were related to delays and other procedural issues encountered during the physician election process.

Prior to September 30, 2006

During the next several weeks, CMS advises CAP participating physicians who have had ASP claims for CAP drugs denied that they may request that their claims be reopened and reprocessed as a CAP claim if the claims are submitted with the appropriate CAP information and the "J2" modifier.

After September 30, 2006

CMS expects the CAP resupply option to be used only in situations that meet the criteria described in BR 4064.5.

Additional Information

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: SE0657	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

CONSOLIDATED BILLING

Correction to Skilled Nursing Facility Consolidated Billing Coding File

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

Provider Types Affected

Physicians and providers billing Medicare carriers for skilled nursing facility (SNF) services to Medicare beneficiaries

What You Need to Know

Because claims for the procedure codes listed below have been processing incorrectly, carriers will begin to reopen and reprocess affected claims, when brought to their attention.

Background

CMS has become aware that claims for the procedure codes listed below, have not been processing correctly. In order to ensure that you receive payment for these procedure codes, CR 5103, from which this article is taken, instructs Medicare carriers to reopen and reprocess these claims, when brought to the their attention.

The information shown below, displays the procedure codes (and applicable claim dates of service) subject to the overriding of the SNF consolidated billing edit. When brought to their attention, carriers will use the SNF consolidated billing override code to bypass the edits and adjust claims (claims with the dates of service as shown, and processed prior to July 3, 2006) to pay appropriately for these procedure codes.

Procedure Codes Subject Reopening and Reprocessing (processed prior to July 3, 2006)

Date of Service on or after April 1, 2001
54150, 90471-90472, 92977, 93790

Date of Service on or after January 1, 2002
0019T

Date of Service on or after January 1, 2003
90871, 90918-90921, 92617

Date of Service on or after January 1, 2005
G0345, J9395, L6697-L6698, L7181, *36818, 44137, 90467-90468*

Date of Service on or after March 22, 2005
G0375-G0376

Date of Service on or after October 25, 2005
G0372

Additional Information

You can find more information about the correction to the skilled nursing facility (SNF) consolidated billing (CB) coding file by going to CR 5103, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1032CP.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*

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: MM5103
Related Change Request (CR) #: 5103
Related CR Release Date: August 18, 2006
Effective Date: April 1, 2001
Related CR Transmittal #: R1032CP
Implementation Date: September 18, 2006

PRESCRIPTION DRUG SERVICES

Medicare Part B Versus Part D Drug Coverage Determinations

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

Provider Types Affected

Physicians, pharmacists, providers, health care professionals, suppliers, and their staff

Impact on Providers

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist physicians, providers, other prescribers, and pharmacists to understand the CMS' recommended approach to simplifying and expediting the coverage determination process for Medicare Part B versus Part D. Affected physicians, pharmacists, providers, and their staff may also wish to review *MLN Matters* article number SE0570, which provides a good summary of Medicare's drug coverage under Parts A, B, and D of Medicare. That article is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0570.pdf* on the CMS website.

Background

Part B — Medical Insurance

Medicare Part B covers drugs that are:

- Not usually self-administered; and
- Furnished and administered as part of a physician service.

Medicare Part B covers other selected drugs, such as the following:

- Drugs requiring administration via a piece of covered durable medical equipment (DME), such as a nebulizer or infusion pump in the home (because the law specifies "in the home" this coverage is generally not available in nursing facilities);
- Immunosuppressive drugs for people who had a Medicare covered transplant;
- Hemophilia clotting factors;
- Antigens;
- Intravenous immune globulin provided in the home;
- Certain oral anti-cancer and oral anti-emetic drugs;
- Erythropoietin for people with end stage renal disease (ESRD);
- Certain vaccines (influenza, pneumococcal, and [for intermediate- to high-risk individuals] hepatitis B); and
- Parenteral nutrition for people with a permanent dysfunction of their digestive tract.

Regional differences in Part B drug coverage policies can occur in the absence of a national coverage decision. For more information on local coverage determinations, go to *http://www.cms.hhs.gov/coverage* on the CMS website.

Part D — Prescription Drug Insurance

Part D-covered drugs are defined as:

- Drugs available only by prescription, approved by the FDA, and used for a medically accepted indication which are not covered under part B (or Part A)

Certain drugs or classes of drugs (or their medical uses) are excluded by law from Part D coverage. These exclusions include the following:

- Benzodiazepines;
- Barbiturates;
- Drugs for anorexia, weight loss, or weight gain;
- Drugs used to promote fertility;
- Drugs used for cosmetic purposes or for hair growth;
- Drugs used for symptomatic relief of cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparation products;
- Non-prescription drugs; and
- Drugs for which the manufacturer seeks to require as a condition of purchase that associated tests and monitoring services be purchased exclusively from the manufacturer or its designee.
- Drugs for the treatment of sexual or erectile dysfunction (beginning in 2007 for Medicare Part D beneficiaries)

For more detailed information about Part B drugs and Part D coverage, please refer MLN Matters article SE0570 or to the detailed report at *http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/BvsDCoverage_07.27.05.pdf* on the CMS website. This report provides excellent detail on the overall issue of Part B and Part D drugs.

Medicare Part B versus Part D Drug Coverage Determinations, continued

Recommended Process to Expedite Part B versus Part D Coverage Determinations

Plans may rely on physician information included with the prescription, such as diagnosis information (e.g., to determine if the prescription is related to a Medicare covered transplant) or location of administration (e.g., to determine if the prescription is being dispensed for a beneficiary in a nursing home) to the same extent they rely on similar information acquired through documentation from physicians on prior authorization forms. Assuming the indication on the script is sufficient to make the coverage determination, there is no need in such cases to require additional information to be obtained from the physician.

To the extent that the plan requires their contracted pharmacies to report the information provided on the prescription to assist in the determination of Part B versus Part D coverage, the plan may rely on the pharmacist's report of appropriate information to make the coverage determination under Part D. For example, for cases in which prednisone is prescribed for a condition other than immunosuppression secondary to a Medicare-covered transplant, and this is indicated on the prescription, a plan may authorize the pharmacy to dispense the drug under Part D without seeking further information from the prescribing physician.

PDPs are prohibited from paying for drugs that are covered under Part B. Certain drugs such as prednisone are covered under Part B when they are used to prevent organ rejection for a patient who has had a Medicare-covered transplant. When a plan gets a prescription for prednisone, they must have a process by which they can verify that the prednisone is being used for a disease that would not trigger Part B coverage. Initially the plans instituted cumbersome prior authorizations procedures which required that the prescriber fill out a prior authorization form and send the form to the plan. In order to simplify the process CMS has instructed the plans that if a prescription is written for a B/D drug and the prescription has written on it the words "Part D" and a part D diagnosis such as "contact dermatitis" the prescription should be filled.

CMS is not requiring physicians to fill out prescriptions in the manner described below; instead, it is suggested as a way to save time and bypass what may be a burdensome process of completing a prior authorization form and faxing it back.

For example, prednisone used for immunosuppression following Medicare covered transplants or methotrexate used for cancer would be Part B drugs for these diagnoses, but they would be Part D drugs if they were used to treat rheumatoid arthritis.

Using the CMS guidance outlined above, if prednisone is prescribed for rheumatoid arthritis:

- The diagnosis is "rheumatoid arthritis;"
- The statement of status is "for Part D."

The information recommended by CMS for inclusion on the written prescription for prednisone prescribed for rheumatoid arthritis is "rheumatoid arthritis" for Part D.

Note: This clarification should not be construed to indicate that a Part D plan may not impose prior authorization or other procedures to ensure appropriate coverage under the Medicare drug benefit.

The Part D plan is ultimately responsible for making the Part D coverage determination. However, CMS believes that the Part D plan will have met appropriate due diligence standards without further contacting a physician if:

- Necessary and sufficient information is provided on the prescription; and
- The contracted pharmacy is able to communicate this information to the plan in order to make the coverage determination. CMS is preparing additional guidance to assist plans, pharmacies, and physicians in operationalizing these Part B versus Part D coverage determinations.

This special edition information does not supersede any existing guidance concerning documentation for Part B prescriptions.

Additional Information

For more detailed information on Part B versus Part D coverage, see the following CMS websites:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0570.pdf
http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/DueDiligenceQA_03.24.06.pdf
http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf

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

MLN Matters Number: SE0652
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

PREVENTIVE SERVICES

Medicare Provides Coverage for Diabetes-screening tests for Eligible Medicare Beneficiaries—Reminder

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, providers, suppliers, and other health care professionals who provide referrals for and/or file claims for Medicare-covered diabetes-screening tests

Provider Action Needed

This article serves as a reminder that Medicare provides coverage of diabetes-screening tests for eligible Medicare beneficiaries. We need your help in ensuring that Medicare beneficiaries are assessed for and informed about their risks factors for diabetes or prediabetes, and that those who are eligible take full advantage of the Medicare diabetes screening benefit.

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) expanded preventive services covered by Medicare to include diabetes-screening tests, effective for services provided on or after January 1, 2005, for beneficiaries at risk for diabetes or those diagnosed with prediabetes.

The information in this special edition *MLN Matters* article reminds health care professionals about the coverage, eligibility, frequency, and coding guidelines for diabetes-screening tests so that you can talk with your Medicare patients about this preventive benefit and file claims properly for the screening service.

Tests Included

Coverage includes the following diabetes-screening tests:

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

Note: Other diabetes screening blood tests for which the Centers for Medicare & Medicaid Services (CMS) has not specifically indicated national coverage continue to be noncovered.

Eligibility

Medicare beneficiaries who have any of the following risk factors for diabetes are eligible for this screening benefit:

- Hypertension
- Dyslipidemia
- Obesity (a body mass index equal to or greater than 30 kg/m2), or
- Previous identification of elevated impaired fasting glucose or glucose tolerance.

OR

Medicare beneficiaries who have a risk factor consisting of at least two of the following characteristics are eligible for this screening benefit:

- Overweight (a body mass index > 25, but < 30 kg/m2)
- A family history of diabetes
- Age 65 years or older
- A history of gestational diabetes mellitus, or delivering a baby weighing > nine pounds.

Note: No coverage is permitted under the MMA benefit for beneficiaries previously diagnosed with diabetes since these individuals do not require screening.

Frequency

- Beneficiaries diagnosed with prediabetes:
  - Medicare provides coverage for two diabetes-screening tests per year (once every six months) for beneficiaries diagnosed with pre-diabetes.
- Beneficiaries not previously diagnosed with pre-diabetes:
  - Medicare provides coverage for one screening per year for beneficiaries who were previously tested who were not diagnosed with prediabetes, or who have never been tested.

Note: A physician or qualified nonphysician practitioner must provide the Medicare beneficiary with a referral for the diabetes-screening test (s).

Medicare Provides Coverage for Diabetes-screening tests for Eligible Medicare Beneficiaries—Reminder

Claim Filing Information

The following *CPT (Current Procedural Terminology)* codes, diagnosis code, and modifier **must** be used when filing claims for diabetes-screening tests:

***CPT* Codes**	**Code Descriptors**
82947	*Glucose; quantitative, blood (except reagent strip)*
82950	*Glucose; post glucose dose (includes glucose)*
82951	*Glucose; tolerance test (GTT), three specimens (includes glucose)*

Diagnosis Code V77.1

To indicate that the purpose of the test(s) is for diabetes screening for a beneficiary that *does not* meet the *definition of prediabetes, screening diagnosis code V77.1 is required in the header diagnosis section of the claim.

To indicate that the purpose of the test (s) is for diabetes screening for a beneficiary that meets the *definition of prediabetes, screening diagnosis code V77.1 is required in the header diagnosis section of the claim **and** modifier "TS" (follow-up service) is to be reported on the line item.

***Definitions**

Diabetes: Diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on two different occasions; a two-hour post-glucose challenge > 200 mg/dL on two different occasions; or a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

Prediabetes: Abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to 125 mg/dL, or a two-hour post-glucose challenge of 140 to 199 mg/dL. The term "prediabetes" includes impaired fasting glucose and impaired glucose tolerance.

Payment for Diabetes-screening Tests

Medicare will pay for diabetes-screening tests under the Medicare clinical laboratory fee schedule. Medicare beneficiaries can receive the diabetes-screening test at no cost to them. There is no coinsurance, co-payment, or deductible for this benefit.

For More Information

For more information about Medicare's diabetes screening benefit, visit the CMS diabetes screening Web page on the CMS website at *http://www.cms.hhs.gov/DiabetesScreening/*.

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

- The MLN Preventive Services Educational Products Web page provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- The CMS website provides information for each preventive service covered by Medicare. Visit *http://www.cms.hhs.gov*, select "Medicare," and scroll down to "Prevention."

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

Medicare beneficiaries may obtain information about Medicare preventive benefits at *http://www.medicare.gov* and then click on "Preventive Services."

Medicare beneficiaries may also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

MLN Matters Number: SE0660
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Non–Application of Deductible for Colorectal Cancer Screening Tests

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

Provider Types Affected

Physicians and providers who provide colorectal cancer screening services to Medicare beneficiaries

Impact on Providers

Effective January 1, 2007, Medicare will waive the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS codes listed in the following chart. While the deductible will be waived, and will not apply for colorectal cancer screening test services furnished on or after January 1, 2007, the Medicare Part B coinsurance still applies for these screening tests.

HCPCS Screening Code	Code Description
G0104	Colorectal cancer screening: Flexible sigmoidoscopy
G0105	Colorectal cancer screening: Colonoscopy on individual at high risk;
G0121	Colorectal cancer screening: Colonoscopy on individual not meeting criteria for high risk
G0106	Colorectal cancer screening: Barium enema as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening: Barium enema as an alternative to G0105, screening colonoscopy

Currently (prior to January 1, 2007, for colorectal cancer screening test services furnished before January 1, 2007), **the annual Medicare Part B deductible AND coinsurance apply to the above codes**.

Please note that the annual Medicare Part B deductible and coinsurance **do not apply** for the following tests**:**

- **G0107** (colon cancer screening; fecal occult blood tests (FOBT), 1-3 simultaneous determinations); and
- **G0328** (colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations).

Background

This policy is directed by Section 5113 of the Deficit Reduction Act (DRA) of 2005.

It amends Section 1833(b) of the Social Security Act (SSA) by eliminating the requirement of the annual Part B deductible for colorectal cancer screening tests furnished on or after January 1, 2007.

Additional Information

SE0613 "Colorectal Cancer: Preventable, Treatable, and Beatable: Medicare Coverage and Billing for Colorectal Cancer Screening" contains pertinent information. It may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0613.pdf* on the Centers for Medicare & Medicaid Services (CMS) website. This special edition also includes links to other resources related to colorectal cancer screening and Medicare-covered preventive services.

The manual attachment to CR 5127 (*Medicare Claims Processing Manual*, Chapter 18, "Preventive and Screening Services", Section 60.1 "Colorectal Cancer Screening; Payment") contains additional information about colorectal cancer screening. CR 5127 is the official instruction issued to your Medicare carrier or fiscal intermediary (FI) regarding changes mentioned in this article. CR 5127 may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1004CP.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: MM5127
Related Change Request (CR) #: 5127
Related CR Release Date: July 21, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1004CP
Implementation Date: January 2, 2007

RADIOLOGY

Update of Radiopharmaceutical Imaging Agents Healthcare Common Procedure Coding System Codes Applicable to Positron Emission Tomography Scan Services for Carriers

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

Provider Types Affected

Physicians and non-physician practitioners who bill Medicare carriers for positron emission tomograghy (PET) scan services provided to Medicare beneficiaries.

Background

This article is based on CR 5054, which updates Publication 100-04, *The Medicare Claims Processing Manual*, Chapter 13, Section 60.3.2 (Tracer Codes Required for PET Scans) to include two new HCPCS codes for radiopharmaceutical diagnosis imaging agents (tracers) applicable to PET scan services.

A prior change request (CR), CR 4270, Transmittal 822, released on February 1, 2006, addressed manual updates for Medicare fiscal intermediaries (FIs), but did not update the manual for carriers.

Key Points

Effective for claims dates of service on or after January 1, 2006:

- **A9555** (Rubidium Rb-82, diagnostic, per study dose, Up to 60 millicuries) replaces Q3000; and
- **A9552** (Fluorodeozyglucose F-18 FDG, diagnostic, per study dose, upt to 45 millicuries) replaces C1775.

Effective for dates of service on or after January 1, 2006:

- HCPCS codes Q3000 and C1775 are deleted.
- A9555 is a tracer code applicable to CPT *78491* and *78492*.

Additional Information

Note: For claims with dates of service prior to January 1, 2006, OPPS hospitals report C1775 and other providers billing fiscal intermediaries report A4641 for supply of radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F1.

For claims with dates of service January 1, 2006, and later, providers billing fiscal intermediaries report **A9552** for radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F18 in place of C1775 and A4641.

The Medicare Learning Network (MLN) article addressing the updated codes for FIs, MM4270, "Update of Radiopharmaceutical Imaging Agents Healthcare

Common Procedure Coding System (HCPCS) Codes Applicable to Positron Emission Tomography (PET) Scan Services," may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4270.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

CR 5054, the official instruction issued to your carrier regarding changes mentioned in this article, may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R923CP.pdf* on the CMS website.

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

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

MLN Matters Number: MM5054
Related Change Request (CR) #: 5054
Related CR Release Date: April 28, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R923CP
Implementation Date: August 1, 2006

RADIOLOGY

Clarification Regarding Effective Dates for Carrier Claim Adjustments: Denied Replacement Defibrillator Claims Lacking a QR Modifier

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

Provider Types Affected

Providers who bill carriers for automatic implantable cardiac defibrillator (ICD) services rendered to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

If you have a claim for a replacement ICD that was denied solely because it lacked a QR modifier, you may request an adjustment for that claim for any date of service for which the replacement ICD was otherwise covered.

CAUTION – What You Need to Know

CR 5104 clarifies CR 4273 to establish that your carrier will consider any payable date of service when you seek an adjustment of a replacement ICD claim previously denied solely because it did not contain a QR modifier.

GO – What You Need to Do

Make sure that your billing staff are aware that they can seek an adjustment for your replacement ICD claim denied due to lack of the QR modifier for any date of service for which the claim would otherwise have been payable.

Background

CR 3604 (transmittal 497), effective January 27, 2005, gave CMS carriers instructions on how to process ICD claims for services provided under expanded coverage for new indications. One of these instructions was the requirement that the patient be enrolled in a data collection system.

Such patient enrollment is noted on the claim by the QR modifier, which identifies services being covered under a clinical study, and is required as a condition for payment on claims for ICD services rendered as:

- Part of the new indications (effective on January 27, 2005); or
- For any other ICD services rendered as a primary prevention of cardiac arrest (i.e., no history of induced or spontaneous arrhythmias).

To identify these instances, CMS systems maintainers created an edit to check the diagnosis code on the claim. If the diagnosis code was not a secondary prevention diagnosis code, then the QR modifier was required in order to cover the services.

Carriers turned on this edit, effective April 1, 2005. In order to ensure that the QR modifier was being applied to the extent possible to claims for ICD services rendered for the primary prevention of cardiac arrest, carriers were instructed to turn on the original edit such that claims with dates of service prior to April 1, 2005, would also be checked for this modifier as appropriate.

Note: When any of the secondary prevention diagnosis codes appear on an ICD claim, the QR modifier is not required. However, you can append the QR modifier for secondary prevention diagnoses when it is appropriate, i.e., when the data is submitted to a data collection registry.

After publication of CR 3604 , CMS became aware of additional possible diagnoses which show neither primary nor secondary prevention of cardiac arrest, for example when the ICD is replaced, due to ICD recall or device complication (such as the end of battery-life).

Since claims such as these should not be denied because they lack a QR modifier, on January 27, 2006, CMS issued CR 4273 (Transmittal 819). CR 4273 added two new ICD-9-CM diagnosis codes to the list of those that do not require a QR modifier and which do not, by themselves, represent a condition where primary or secondary prevention can be ascertained:

- **996.04**, Mechanical complication of cardiac device, implant, and graft, due to automatic implantable cardiac defibrillator; and
- **V53.32**, Fitting and adjustment of other device, automatic implantable cardiac defibrillator.

To ensure that replacement ICD claims are not erroneously denied for a lack of QR modifier, the new edit accompanying CR 4273 affects claims with dates of service on and after April 1, 2005. However, because the original carrier edit considered all dates of services as it checked for a QR modifier, including dates prior to April 1, 2005, it is possible that there will be replacement ICD claims erroneously denied with dates of service prior to April 1, 2005.

For this reason, when this issue is brought to their attention, Medicare carriers are to consider for possible adjustment all payable dates of service for replacement ICD claims when these claims have been denied solely for the lack of a QR modifier.

CR 5104, from which this article is taken, makes this clarification and instructs carriers to inform you that you may have had claims for replacement ICDs erroneously denied for lack of a QR modifier and requiring such an adjustment.

Clarification Regarding Effective Dates for Carrier Claim Adjustments: Denied Replacement Defibrillator Claims Lacking a QR Modifier, continued

Be aware, however, that the carriers do not have to search their files to retroactively pay claims, nor does this instruction apply to claims submitted to fiscal intermediaries (FIs), who implemented the original and revised edits according to dates of service.

Additional Information

You can find more information about the effective dates for carrier claim adjustments for replacement ICD claims denied because they lacked a QR modifier by going to CR 5104, which is available at *http://www.cms.hhs.gov/Transmittals/downloads/R971CP.pdf* on the CMS website.

Additionally, more information about ICD claims may be found in MLN Matters articles MM3604 and MM4273, which you can find at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3604.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4273.pdf*, respectively.

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: MM5104 Related Change Request (CR) #: 5104
Related CR Release Date: June 2, 2006 Effective Date: April 1, 2005
Related CR Transmittal #: R971CP Implementation Date: September 5, 2006

THERAPY SERVICES

Outpatient Therapy—Additional Deficit Reduction Act Mandated Service Edits

Note: CMS has rescinded transmittal 1016 and replaced it with transmittal 1019 to correct typographical errors in the business requirement section addressed to contractors. This replacement does not affect the instructions provided in the CMS Internet-only-manual Pub 100-04, *Medicare Claim Processing*, and the information in section 20.2 – Reporting of Service Unit with HCPCS remains the same.

The Centers for Medicare & Medicaid Services (CMS) has issued instructions that provide additional limitations on outpatient therapy services, consistent with the provisions of the Deficit Reduction Act of 2005 Section 5107 requires limitations on outpatient therapy services, for the purpose of identifying and eliminating improper payments.

Certain services are limited to certain numbers of units per day for physical therapy, occupational therapy and speech-language pathology, separately to control inappropriate billing. CMS Internet-only-manual Pub 100-04, Medicare Claim Processing, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services, Section 20.2, Reporting of Service Units with HCPCS has been revised to incorporate these instructions and proper billing examples.

20.2 – Reporting of Service Units with HCPCS

A. General

Effective with claims submitted on or after April 1, 1998, providers billing on Form CMS-1450 were required to report the number of units for outpatient rehabilitation services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. This was already in effect for billing on the Form CMS-1500, and CORFs were required to report their full range of CORF services on the Form CMS-1450. These unit-reporting requirements continue with the standards required for electronically submitting health care claims under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) – the currently adopted version of the ASC X12 837 transaction standards and implementation guides. The Administrative Simplification Compliance Act mandates that claims be sent to Medicare electronically unless certain exceptions are met.

B. Timed and Untimed Codes

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day).

Example: A beneficiary received a speech-language pathology evaluation represented by HCPCS "untimed" code 92506. Regardless of the number of minutes spent providing this service only one unit of service is appropriately billed on the same day.

Outpatient Therapy—Additional Deficit Reduction Act Mandated Service Edits, continued

Providers billing to FIs and RHHIs should report value code 50, 51, or 52, the total number of physical therapy, occupational therapy, or speech–language pathology visits provided from start of care through the billing period. This item is visits, not service units. Value codes do not apply to claims sent to carriers.

Several *CPT* codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any single calendar day** using *CPT* codes and the appropriate number of 15-minute units of service.

Example: A beneficiary received occupational therapy (HCPCS "timed" code*97530* which is defined in 15-minute units) for a total of 60 minutes. The provider would then report revenue code 043x and 4 units.

C. Counting Minutes for Timed Codes in 15 Minute Units

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed *CPT* code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

Units	Number of Minutes
1 unit:	= 8 minutes through 22 minutes
2 units:	= 23 minutes through 37 minutes
3 units:	= 38 minutes through 52 minutes
4 units:	= 53 minutes through 67 minutes
5 units:	= 68 minutes through 82 minutes
6 units:	= 83 minutes through 97 minutes
7 units:	= 98 minutes through 112 minutes
8 units:	= 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes.

When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of units billed.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes.

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

If more than one 15 minute timed *CPT* code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day.

Pub. 100-02, chapter 15, section 230.3B Treatment Notes indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented. These examples indicate how to count the appropriate number of units for the total therapy minutes provided.

Example 1

24 minutes of neuromuscular reeducation, *CPT* code *97112*
23 minutes of therapeutic exercise, *CPT* code *97110*
Total timed code treatment time was 47 minutes.

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes.

Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of *CPT* code *97110*, assigning more timed units to the service that took the most time.

Example 2

20 minutes of neuromuscular reeducation (*97112*)
20 minutes therapeutic exercise (*97110*)
40 Total timed code minutes.

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Outpatient Therapy—Additional Deficit Reduction Act Mandated Service Edits, continued

Example 3

33 minutes of therapeutic exercise (*97110*)
7 minutes of manual therapy (*97140*)
40 Total timed minutes.

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of *CPT* code *97110* and 1 unit of *CPT* code *97140*. Count the first 30 minutes of *97110* as two full units. Compare the remaining time for *97110* (33-30 = 3 minutes) to the time spent on *97140* (7 minutes) and bill the larger, which is *97140*.

Example 4

18 minutes of therapeutic exercise (*97110*)
13 minutes of manual therapy (*97140*)
10 minutes of gait training (*97116*)
8 minutes of ultrasound (*97035*)
49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of *97110, 97116,* and *97140*. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Example 5

7 minutes of neuromuscular reeducation (*97112*)
7 minutes therapeutic exercise (*97110*)
7 minutes manual therapy (*97140*)
21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See definition in Pub 100-02/15, sec. 220) shall select one appropriate *CPT* code (*97112, 97110, 97140*) to bill since each unit was performed for the same amount of time and only one unit is allowed.

Note: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The total minutes of active treatment counted for all 15 minute timed codes includes all direct treatment time for the timed codes. Total treatment minutes – including minutes spent providing services represented by untimed codes – are also documented. For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 230.3: Documentation, Treatment Notes.

D. Specific Limits for HCPCS

The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day. When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary (according to 1862(a)(1)(A)). Denied claims may be appealed and an ABN is appropriate to notify the beneficiary of liability.

This chart does not include all of the codes identified as therapy codes; refer to section 20 of this chapter for further detail on these and other therapy codes. For example, therapy codes called "always therapy" must always be accompanied by therapy modifiers identifying the type of therapy plan of care under which the service is provided.

Use the chart in the following manner:

- The codes that are allowed one unit for "Allowed Units" in the chart below may be billed no more than once per provider, per discipline, per date of service, per patient.
- The codes allowed 0 (zero) units in the column for "Allowed Units", may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP).
- When physicians/NPPs bill "always therapy" codes they must follow the policies of the type of therapy they are providing e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed units on the chart below for PT, OT or SLP depending on the plan. A physician/NPP shall not bill an "always therapy" code unless the service is provided under a therapy plan of care. Therefore, NA stands for "Not Applicable" in the chart on the following page.
- When a "sometimes therapy" code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart below per patient, per provider/supplier, per day.

Outpatient Therapy—Additional Deficit Reduction Act Mandated Service Edits, continued

HCPCS	Code Description and Claim Line Outlier/Edit Details	Timed or Untimed	PT Allowed units	OT Allowed units	SLP Allowed units	Physician/NPP NOT under Therapy POC
92506	*Speech/hearing evaluation*	Untimed	0	0	1	NA
92597	*Oral speech device eval*	Untimed	0	1	1	NA
92607	*Ex for speech device rx, 1hr*	Timed	0	1	1	NA
92611	*Motion fluroscopy/swallow*	Untimed	0	1	1	1
92612	*Endoscope swallow test (fees)*	Untimed	0	1	1	1
92614	*Laryngoscopic sensory test*	Untimed	0	1	1	1
92616	*Fees w/laryngeal sense test*	Untimed	0	1	1	1
95833	*Limb muscle testing, manual*	Untimed	1	1	0	1
95834	*Limb muscle testing, manual*	Untimed	1	1	0	1
96110	*Developmental test, lim*	Untimed	1	1	1	1
96111	*Developmental test, extend*	Untimed	1	1	1	1
97001	*PT evaluation*	Untimed	1	0	0	NA
97002	*PT re-evaluation*	Untimed	1	0	0	NA
97003	*OT evaluation*	Untimed	0	1	0	NA
97004	*OT re-evaluation*	Untimed	0	1	0	NA

Source: CMS Pub. 100-04, Transmittal 1019, CR 5253

Incorrect Denials for Therapy Claims Billed with the KX Modifier

Therapy claims submitted with the KX modifier are incorrectly denying with the following message: **PR-119-Benefit maximum for this time period has been reached.** We are working to resolve the issue as quickly as possible..

No Action Required by Providers

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

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

We apologize for any inconvenience this may have caused

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.

HIPAA - The Health Insurance Portability and Accountability Act

End of Contingency for Electronic Remittance Advice—ACTION

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

Provider Types Affected

Providers and physicians who bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and carriers, including durable medical equipment regional carriers (DMERCs)

Background

The purpose of this special edition article is to clarify for providers the information issued by the Centers for Medicare & Medicaid Services (CMS) regarding the date to end the contingency plan for electronic remittance advice (ERAs).

Key Points

Effective October 1, 2006, Medicare will only generate Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice – transaction 835 version 004010A1 – to all electronic remittance advice receivers. In addition, CMS issued instructions in change request (CR) 5047 that required a one-time hold of Medicare payments for the period of September 22, 2006, to September 30, 2006, for claims that would have been paid during the last 9 business days of fiscal year 2006. (See the *MLN Matters* article on CR 5047 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf* on the CMS website.)

CMS has further instructed that on or after October 1, 2006:

- Any ERA for claims that would be held per CR5047 or for any other reason shall be created in the HIPAA compliant format.
- Any duplicate remittance advice per provider request shall be created in the HIPAA compliant, if electronic, or paper format.

Current figures indicate that 99 percent of all ERA receivers (providers and other entities that receive the ERA on behalf of providers) are receiving a HIPAA compliant ERA format and they are unaffected by the end of the contingency plan. The remaining **one percent of legacy ERA receivers need to transition to a HIPAA compliant ERA format** between now and October 1, 2006. The following are the **options available** to you as a legacy ERA receiver:

- Start receiving HIPAA compliant ERAs beginning on October 1, 2006.
- Request to switch to standard paper remittance (SPR) advice.
- If you are already receiving an SPR, and do not want to receive the HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier to stop sending any ERA.
- If providers are not currently receiving SPR, and do not wish to switch to HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier that you would like to start receiving SPR and not receive any ERA.

There are tools available to providers to view and print the remittance advice information using free Medicare software (PC Print for institutional providers and Medicare Remit Easy Print [MREP] for professional providers and suppliers).

These free software packages are 835 version 004010A1 compatible and will not work with any legacy ERA. Both software packages have important advantages over the SPR. Both packages can also be used to generate a hard copy remittance to be sent for secondary/tertiary billing, and for accounts receivable reconciliation. See the additional information section of this article for MREP details.

Additional Information

To learn about more MREP benefits, download the brochure available at *http://www.cms.hhs.gov/MLNProducts/downloads/remit_easy_print.pdf* on the CMS website. Or, you may view Special Edition MLN Matters article SE0611 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf* or a related MLN Matters article (MM4376) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4376.pdf* on the CMS website.

For more information about the MREP software and how to receive the HIPAA 835, please contact your FI, RHHI, carrier/DMERC. Medicare Part B Electronic Data Interchange (EDI) helpline phone numbers are available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartBEDIHelpline.pdf* on the CMS website. Those billing for Part A services may find the appropriate toll free number at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartAEDIHelpline.pdf* on the CMS website.

MLN Matters Number:SE0656 Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Source: CMS Special Edition MLN Matters Article SE0656
CMS JSM/TDL-06599, 07-26-06

Update to the Healthcare Provider Taxonomy Codes Version 5.1

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 28-29.

Note: This article was revised to contain Web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 4072, which includes details regarding the Healthcare Provider Taxonomy Code (HPTC) version 5.1 update.

CAUTION – What You Need to Know

CR 4072 advises your carrier and/or DMERC to obtain the (HPTC) list version 5.1 and use it to update their internal HPTC tables to process your claim(s) correctly.

GO – What You Need to Do

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

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that submitted data, which is part of a named code set, be valid data from that code set. Claims with invalid data are noncompliant.

Because health care provider taxonomy is a named code set in the American National Standards Institute (ANSI) X12N 837 Professional Implementation Guide, Medicare carriers, including DMERCs, must validate the inbound taxonomy codes against their internal HPTC tables.

The HPTC is an external nonmedical data code set designed for use in classifying healthcare providers in an electronic environment according to provider type, or practitioner specialty. HPTCs are scheduled to be updated twice per year (April and October).

The updated code list that is available from the Washington Publishing Company is available in two forms at *http://www.wpc-edi.com/codes/taxonomy*:

- Free Adobe PDF download; and
- An electronic representation of the list, available for purchase, which will facilitate the automatic loading of the code set.

CR 4072 advises your carrier and/or DMERC to use the most cost effective means to obtain the version 5.1 HPTC list and update their HPTC tables as necessary.

Implementation

The implementation date for the instruction is October 30, 2005.

Additional Information

To summarize the changes in version 5.1, the following taxonomy codes are added:

- 170300000X
- 171000000X
- 1710I1002X
- 1710I1003X

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change at *http://www.cms.hhs.gov/transmittals/downloads/R694CP.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).

Related Change Request (CR) #: 4072 *Revised*
Related CR Release Date: September 30, 2005
Effective Date: October 30, 2005
MLN Matters Number: MM4072
Related CR Transmittal #: 694
Implementation Date: October 30, 2005

Problem with 270/271 Health Care Eligibility Inquiry and Response Transactions

Between Monday, July 24, and Thursday, July 27, 2006, the CMS 270/271 health care eligibility inquiry and response transaction used by providers to obtain beneficiary eligibility information was returning "Patient Not Found" response for beneficiaries that are actually entitled to Medicare.

This problem had to do with a large number of beneficiaries that had been inadvertently deleted from the data extract used by the 270/271 transaction. This problem did not impact the provider IVRs, it only impacted the CMS 270/271 eligibility inquiry and response transaction.

If you received a "Patient Not Found" response after inputting the correct beneficiary information for the 270/271 transaction, the Centers for Medicare & Medicaid Services apologizes for this problem and informs you that the problem was correct on July 27, 2006.

Approximately two million 270/271 transactions are processed each week and it is unclear how many transactions returned bad data.

Source: CMS Provider Education Resource 200608-01

GENERAL INFORMATION

Role of a Medicare Fiscal Intermediary Versus a Medicare Carrier

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that runs the Medicare program and ensures that the Medicare beneficiaries are able to get high quality health care. CMS contracts with private companies to administer the primary parts of the program: the hospital insurance – commonly known as Medicare Part A, and the medical insurance – commonly known as Medicare Part B.

A **contractor** having an agreement with CMS to administer Medicare Part A is designated as a **fiscal intermediary** (FI) and a **contractor** administering Medicare Part B is known as a **carrier**.

Role of a Medicare Fiscal Intermediary

Any organization and institution that provides health care services to Medicare beneficiaries can bill their designated **FI** for institutional benefits. Providers billing institutional medical services to **FIs** are:

- Hospital (acute and critical care)
- Skilled nursing facilities (SNFs)
- End-stage renal disease facilities (stand-alone clinics and hospital-based renal dialysis units)
- Rural health clinics
- Hospice centers
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Outpatient rehabilitation facilities (ORFs)
- Community mental health centers (CMHCs)
- Home health agencies (HHAs).

All requests for payment submitted to a **FI** must be billed on the uniform institutional claim form CMS-1450 or its electronic equivalent format.

For electronic claim submission, Part A claims must follow the billing guidelines established by ANSI 837 as specified in the *ANSI 4010A1x096 Institutional Implementation Guide.*

Role of a Medicare Carrier

Any medical professional individual or organization that provides health care services to Medicare beneficiaries can bill their designated **carrier** for medical benefits. Providers billing medical services to Medicare **carrier** are:

- Physicians and nonphysician practitioners (individual and group centers)
- Ambulatory surgical centers (ASCs)
- Ambulance services centers
- Anesthesiologist centers
- Clinical laboratory centers
- Durable medical equipment suppliers
- Prosthetic and orthotic providers
- Pharmacy centers

Medicare Part B coverage helps pay for medically necessary physicians' services, nonphysician practitioners' services and a variety of other medical services such as:

- Medical and surgical services, including anesthesia
- Diagnostic tests and procedures which are part of a normal course of treatment
- Radiology and pathology services
- Screening mammographies and pelvis examinations
- Colorectal cancer screenings
- Drugs and biological substances that cannot be self-administered
- Medical supplies
- Physical/occupational therapy and speech therapy services
- Ambulance transportation
- Hepatitis B, pneumococcal and influenza vaccines
- Durable medical equipment.

All requests for payment submitted to a Medicare **carrier** must be billed on the uniform professional claim form CMS-1500 or its electronic equivalent format.

For electronic claim submission, Part B claims must follow the billing guidelines established by ANSI 837 as specified in the *ANSI 4010A1x098 Professional Implementation Guide.*

For additional information contact First Coast Service Options, Inc. Medicare Part B Customer Service Center toll-free number at 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

Source: CMS Joint Signature Memorandum 06604, August 3, 2006

Sign up to our *eNews* electronic mailing list

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

CMS Awards the First of 15 Medicare Administrative Contractors To Process Part A and Part B Medicare Claims

The Centers for Medicare & Medicaid Services (CMS) has announced the award of the first of 15 contracts for the combined handling in six states of both Part A and Part B Medicare claims.

The winning contractor is Noridian Administrative Services, LLC, (NAS), headquartered in Fargo, N.D.

As the new Part A/Part B Medicare administrative contractor (A/B MAC), NAS will serve as the first point-of-contact for processing and paying fee-for-service claims from hospitals and other institutional providers, physicians, and other practitioners in Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming.

"The contract award is a major step to improved Medicare service for beneficiaries and providers, and significant cost savings from greater efficiency in managing the original fee-for-service Medicare program," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "Noridian Administrative Services was selected through a full and open performance-based competition to administer the program as effectively and efficiently as possible."

The A/B MAC contract, which has a value of $28.9 million for the first year of performance, is the first of 15 to be awarded by 2011 to fulfill requirements of the contracting reform provisions of the Medicare Modernization Act of 2003. NAS will immediately begin implementation activities and will assume full responsibilities for the claims processing work in its six-state jurisdiction no later than March 2007.

For more information, see: *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1919*.

Source: CMS Provider Education Resource 200607-17

Planned Release of a Request for Information Concerning the Next Medicare Administrative Contractor Procurements

The Centers for Medicare & Medicaid Services (CMS) announced on July 31, 2006, the awarding of the first of 15 contracts for the combined administration of Part A and Part B claim activities in a multi-state jurisdiction. That first Medicare administrative contractor (MAC) award was for the six-state jurisdiction of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming (Jurisdiction 3).

CMS has 14 more Part A/Part B MAC contracts to acquire through the competitive process. These procurements will be conducted in two cycles. Cycle one of the A/B MAC acquisitions will be for seven jurisdictions, accounting for approximately 45 percent of the Part A/Part B fee-for-service claim workload. CMS will conduct these seven competitions in two rounds.

The first round of competitions under cycle one will cover three jurisdictions:

- Jurisdiction 4 (J4) – Colorado, Oklahoma, New Mexico, and Texas
- J5 – Iowa, Kansas, Missouri, and Nebraska
- J12 – Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania

The request for proposal for this first round of competitions under cycle one will include mandatory options for the following specialty activities:

- Indian health services for J4
- Veterans Affairs Medicare equivalent remittance advice for J4
- Centralized billing for mass immunizers and for J4
- Rural community hospitals, which will also be required for J4 and J5.

On Wednesday, August 9, 2006 CMS published on the Federal Business Opportunities website (*http://www.FedBizOpps.gov*) a request for information (RFI) containing the planned SOW (scope of work) for the second round of competitions under cycle one. Public comments will be due on Thursday, August 31. CMS encourages everyone to review the RFI and provide comments or questions.

You will find guidance on how/where to submit comments and questions about the RFI on that same FedBizOpps site.

The second round of competitions under cycle one will include the remaining jurisdictions:

- J1 – American Samoa, California, Guam, Hawaii, Nevada and Northern Mariana Islands
- J2 – Alaska, Idaho, Oregon and Washington
- J7 – Arkansas, Louisiana and Mississippi
- J13 – Connecticut and New York

The RFP for this second round of competition will include the following mandatory options:

- Competitive acquisition program (CAP) for Part B Drugs
- Rural community hospital for J1, and J2

To learn more about the transition to the A/B MAC environment, please visit the Medicare Contracting Reform website at: *http://www.cms.hhs.gov/MedicareContractingReform/*.

Third-party Websites. *This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

Source: CMS Provider Education Resource 200608-03

New Site for Medicare Provider Service Toll Free Numbers

Provider Types Affected

All Medicare physicians, providers, and suppliers

Impact on Providers

This article is mainly for informational purposes and discusses a new and more convenient Web address and site that houses toll-free numbers that physicians, providers, and suppliers can use to contact their Medicare contractor (carriers, including durable medical equipment (DME) regional carriers and DME Medicare administrative contractors (DME MACs), and fiscal intermediaries, including regional home health intermediaries (RHHIs).

Background

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce to all Medicare physicians, providers, and suppliers a new and improved website for accessing Medicare Contractor Provider Call Center toll-free number information.

The new site is located at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

This change is a result of replacing the previous "Provider Call Center Toll-Free Numbers Directory" (with map) document with an Excel® file that contains all of the information previously available plus many improvements.

The original document proved difficult to update and download while keeping the functionality of the map intact. The new Excel smaller file size allows for a significantly faster download, and the improved functionality, provided by the pull down menus, makes more targeted contact information available while filtering the displays appearing on the screen.

Additionally, a "Coverage Area" column has been added to the original four columns of information (i.e., State Served, Call Center, Program, and Toll-Free Number) and each column has a menu allowing users to filter the information displayed on the screen. Selecting the menus to "ALL" resets the spreadsheet to display all available information.

Many of the existing MLN Matters articles contain links to the previous map document, which was *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf* on the CMS website. As you can see, the new address is almost identical, except for the last three characters, "*pdf*," which are now "*zip*."

Please be aware that articles already housed on the MLN Matters pages will not be updated with the new link, except where such articles are revised in the future for other reasons. However, those providers who have been using the map document directory should already know where to find it within the CMS website and should, therefore, be able to locate the new document.

The directory is also prominent on all MLN pages and should be easy to find. In fact, now might be a good time to bookmark the new address or add it to your "Favorites" list:

http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.

The new spreadsheet directory will be updated approximately once every three months—more often if necessary.

As previously mentioned, you can access the new file from all major MLN Web pages, including the main section pages at:

http://www.cms.hhs.gov/MLNGenInfo/ *http://www.cms.hhs.gov/MLNProducts/*
http://www.cms.hhs.gov/MLNMattersArticles/
http://www.cms.hhs.gov/MLNEdWebGuide/

The new file can be downloaded directly from:

http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

CMS hopes you find this new site to be useful and we invite your comments and feedback on this and other Medicare Learning Network Web-based products. You can provide such feedback by going to *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/site_fdbck.php* on the CMS website.

MLN Matters Number: SE0655
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

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.

Health Care Quality Leaders Join Forces

AQA and HQA Collaborate to Expedite National Quality Strategy

Two key health care quality alliances, the AQA alliance and the Hospital Quality Alliance (HQA), have formed a new national Quality Alliance Steering Committee to better coordinate the promotion of quality measurement, transparency and improvement in care.

Through the joint efforts of the AQA – an alliance of 135 physician organizations, consumers, employers and health plan representatives that makes available quality information about physician care – and the HQA – a coalition of hospitals, nurses, physician organizations, accrediting agencies, government, consumers and business that shares quality information about key aspects of hospital care – Americans will have helpful information on health care available through the Internet.

The new steering committee will work closely with the Centers for Medicare & Medicaid Services (CMS) and Agency for Healthcare Research and Quality (AHRQ), which are key members of both the AQA and HQA.

As a first step, this new steering committee will coordinate and expand several ongoing pilot projects that are designed to combine public and private information to measure and report on performance in a way that is fully transparent and meaningful to all stakeholders.

In March 2006, the AQA alliance announced six pilot projects charged with the responsibility of identifying, collecting and reporting data on the quality of physician performance across care settings. The joint steering committee will explore options for expanding these pilots to include hospital and cost-of-care measures. The committee also will develop a strategy to expand the number of pilots.

The HQA has been providing meaningful and useful information on the quality of heart attack, heart failure and pneumonia care to patients in more than 4,000 of the nation's hospitals since April 2005. In September 2005, the HQA expanded its Web site to include information on prevention of surgical wound infections, and has plans to add many additional aspects of care over the next couple of years.

"This collaborative effort is an important step toward the critical goals of enabling consumers to make more informed health care decisions and supporting improvements in the quality and cost of health care in the United States," said Dr. Mark McClellan, administrator of the Centers for Medicare & Medicaid Services.

A key responsibility of the steering committee will be to consider how best to expand the scope, speed and adoption of the work of AQA and HQA.

"This new steering committee will help coordinate efforts across a broad spectrum of crosscutting issues as the two organizations continue working toward a more uniform approach to measuring and reporting hospital and physician performance nationwide," said Dr. Carolyn Clancy, AHRQ director.

The new joint steering committee comprises physicians, hospitals, consumers, and employers and includes Janet Corrigan, National Quality Forum; Robert Dickler, Association of American Medical Colleges; Karen Ignagni, America's Health Insurance Plans; Chip Kahn, Federation of American Hospitals; Peter Lee, Pacific Business Group on Health; Debra Ness, National Partnership for Women & Families; Nancy Nielsen, American Medical Association; Margaret O'Kane, National Committee for Quality Assurance; Jeff Rich, Society of Thoracic Surgeons; Gerry Shea, AFL- CIO; John Tooker, American College of Physicians; and Rich Umbdenstock, American Hospital Association.

About the AQA Alliance

The AQA alliance is a broad-based national coalition of more than 135 organizations that seeks to improve health care quality through a process in which key stakeholders agree on a strategy for measuring, reporting, and improving performance at the physician level. These 135 organizations represent physicians, consumers, employers, government, health insurance plans, and accrediting and quality organizations. For further information, visit *http://www.aqaalliance.org*.

About the Hospital Quality Alliance

The Hospital Quality Alliance (HQA) is a public-private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care. The goal of the voluntary program is to collect and report data on a robust set of standardized and easy-tounderstand hospital quality measures. The hospital quality information is available on the Web at *http://www.hospitalcompare.hhs.gov/*.

Source: CMS Provider Education Resource 200607-13

Deficit Reduction Act of 2005–Nine-day Payment Hold

This message is a reminder for all providers and physicians who bill Medicare contractors for their services. A brief hold will be placed on Medicare payments for all claims during the last nine days of the 2006 federal fiscal year (September 22 through September 30, 2006).

These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or individual by reason of this one-time hold on payments.

All claims held during this time will be paid on October 2, 2006.

This policy only applies to claims subject to payment. It does not apply to full denials, no-pay claims, and other nonclaim payments such as periodic interim payments, home health requests for anticipated payments, and cost report settlements.

Please note that payments will not be staggered and no advance payments will be allowed during this nine-day hold.

For more information, please view the MLN Matters article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf*.

Source: CMS Joint Signature Memorandum 06549, July 12, 2006

National Provider Identifier Roundtable

NPI: Get It. Share It. Use It

The Centers for Medicare & Medicaid Services (CMS) will host a national NPI roundtable; open to all health care professionals:

Date: Tuesday, September 26, 2006
Time: 2:00-3:30PM ET
Deadline for Questions: Friday, September 8, 2006

Conference Phone Number: 1-877-203-0044
Pass Code: 4795739

CMS will address common questions related to Medicare's guidance on subparts. While CMS will only address questions from a Medicare perspective, this information may be helpful to all providers. Questions received after the deadline date will not be considered.

Where to Send Questions
Medicare providers who bill a Fiscal Intermediary:
NPIQuestionsfromFIBillers@cms.hhs.gov
Medicare providers who bill a Carrier:
NPIQuestionsfromCarrierBillers@cms.hhs.gov
Medicare providers who bill a durable medical equipment regional carrier (DMERC):
NPIQuestionsfromDMERCBillers@cms.hhs.gov.

Think You Don't Need an NPI? Think Again.
Even those providers who do not bill for services may need to disclose their NPIs to those providers who do (e.g., physicians who order lab tests or refer patients for diagnostic testing must be identified on the lab's or testing facility's claims).

Even if you plan to retire in April, but know that some of your claims will not be submitted until after the May 23, 2007 compliance date, you still need an NPI. Without the NPI, those claims may be adversely affected, with payment delayed or possibly even denied.

Reminder to Supply Legacy Identifiers on NPI Application
CMS continues to urge providers to include legacy identifiers on their NPI applications.

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

New NPI Slogans and Partnership with WEDI
Recently, CMS and the Workgroup for Electronic Data Interchange (WEDI) agreed to common NPI slogans for use in outreach campaigns. These slogans appear at the beginning and end of this listserv message, and will continue to appear on our messages and products. A recent WEDI press release, found at *http://www.wedi.org/npioi/public/articles/dis_viewArticle.cfm?ID=537*, discusses the slogans and partnership in more detail.

Special Information for Medicare Providers

Designation of Subparts
CMS reminds Medicare providers to visit Medicare's Subparts Expectation Paper (located at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf* on the CMS NPI Web page) for more suggestions on how to determine their subparts. Remember, no health plan, not even Medicare, can instruct a provider on how to enumerate subparts. This is a business decision that the organization provider must make considering its unique business operations.

Medicare Provider Enrollment and NPIs
CMS requires that providers and suppliers obtain their NPIs prior to enrolling in Medicare or updating their Medicare enrollment information. Providers and suppliers must enter their NPIs on the CMS-855 Medicare provider enrollment applications and submit a copy of their NPI notifications with each CMS-855 application that they submit.

Required Use of NPI on Medicare Paper Claim Forms
Medicare will require the NPI on its paper claim forms. To learn more visit a recent MLN Matters article on this topic at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm4023.pdf* on the CMS website.

Medicare DME Suppliers and NPIs
CMS issued a special communication regarding DME suppliers and the NPI which can be viewed at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/npi_dme_comm.pdf* on the CMS website.

Medicare to Require Taxonomy Codes on Institutional Claims
Effective January 1, 2007, institutional Medicare providers (e.g., hospitals, HHAs, SNFs) who submit claims for their primary facility and its subparts must report a taxonomy code on all claims submitted to their fiscal intermediary. To learn more, visit a recent MLN Matters article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5243.pdf* on the CMS website.

Use of NPI on Medicare Claims on October 1st
Beginning October 1, 2006 Medicare can accept claims that only have an NPI on them, however, to facilitate further testing, Medicare strongly encourages its providers to submit both legacy identifiers and their NPI on claims.

As always, more information and education on the NPI can be found at the CMS NPI page *http://www.cms.hhs.gov/apps/npi/* on the CMS website. Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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

Source: CMS Learning Resource, Message 200608-10

Important! National Provider Identifiers are Free!

NPI: Get It. Share It. Use It.

As the industry transitions to National Provider Identifier (NPI) compliance, remember that there is no charge to get an NPI. Providers may apply online for their NPI, free of charge, by visiting *https://nppes.cms.hhs.gov* or by calling 1-800-465-3203 to request a paper application. The CMS NPI page, located at *http://www.cms.hhs.gov/NationalProvIdentStand/*, is the only source for official CMS education and information on the NPI initiative; all products located on this site are free of charge. CMS continues to urge providers to include legacy identifiers on their NPI applications, not only for Medicare but also for all payers. If reporting a Medicaid number, include the associated State name. If providers have already applied for their NPI, CMS asks them to go back into the NPPES and update their information with their legacy identifiers. This information is critical for payers in the development of crosswalks to aid in the transition to the NPI.

REMINDER: The National Plan and Provider Enumeration System (NPPES) will be down for scheduled maintenance on August 2nd and 3rd, and will return to operation on August 4th **after** 8:00 a.m., Eastern Time.

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

Source: Provider Education Resources Listserv, Message 200607-15

Important Guidance Regarding National Provider Identifier Usage in Medicare Claims

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

Provider Types Affected

Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries

Provider Action Needed

STOP – Impact to You

You must report your national provider identifier (NPI) correctly on all electronic data interchange (EDI) transactions that you submit, as well as on paper claims you send to Medicare and telephone interactive voice response (IVR) queries **by no later than May 23, 2007, or your transactions will be rejected.**

CAUTION – What You Need to Know

Carriers have reported errors on claims (see Background, below) that will impact your payment when you begin to submit NPIs. Although not mandated until May 23, 2007, providers are currently allowed to submit NPIs in Medicare transactions other than paper claims. NPI will be accepted on the revised paper claim CMS-1500 (0805) and UB-04 forms early in 2007.

GO – What You Need to Do

Make sure that your billing staffs are using your NPI correctly when they submit your claims for services provided to Medicare beneficiaries or submit electronic beneficiary or claim status queries to Medicare.

Background

All HIPAA covered health care providers who would either bill Medicare; render care to Medicare beneficiaries; order durable medical equipment, supplies, or services for beneficiaries; refer beneficiaries for other health care services; act as an attending physician when a beneficiary is hospitalized; prescribe covered retail prescription drugs for beneficiaries; operate on beneficiaries; or could otherwise be identified on a claim submitted to Medicare for payment **must** obtain an NPI. This applies whether providers are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, managed care organizations, suppliers of durable medical equipment, pharmacies, etc.) **must** obtain an NPI for use to identify themselves in HIPAA standard transactions.

Although the NPI requirement applies by law to covered entities such as health care providers, health care clearinghouses, and health plans in the U.S. when exchanging electronic transactions for which a national standard has been adopted under HIPAA, HIPAA permits healthcare plans to elect to require reporting of NPIs in paper claims and for non-HIPAA transaction purposes.

Medicare will also require NPIs for identification of all providers listed on the UB-04 institutional paper claim form and of physicians and suppliers listed on the revised CMS-1500 (08-05) professional paper claim form by May 23, 2007.

Medicare will reject paper claims received after May 22, 2007, that do not identify each provider, physician or supplier listed on a paper or electronic claim with an NPI. Medicare will also begin to require an NPI in interactive voice response (IVR) queries effective May 23, 2007.

Retail pharmacies are required to use the NCPDP format adopted as a HIPAA standard for submission of prescription drug claims to Medicare. Since that format permits entry of only one provider identifier each for a pharmacy and the physician who prescribed the medication, retail pharmacies that use the NCPDP HIPAA format can use either their National Supplier Clearinghouse (NSC) number or their NPI to identify themselves, and either the unique provider identification number (UPIN) or the NPI to identify the prescribing physician prior to May 23, 2007.

May 23, 2007 and later, only an NPI may be reported for identification of pharmacies and prescribing physicians. NCPDP claims received by Medicare after May 22, 2007 that lack an NPI for either the pharmacy or the prescribing physician will be rejected.

Important Guidance Regarding National Provider Identifier Usage in Medicare Claims, continued

This being said, Medicare carriers and fiscal intermediaries (FIs) have reported receiving X12 837-P (professional) and X12-837–I (institutional) claims containing errors that will result in claim rejection, and/or processing delays, if they continue to occur once NPI reporting begins.

Some of the errors seen by Medicare carriers include the following:

Incorrect information in the 2010A/A Billing Provider Loop in X12 837-P Claims

Prior to May 23, 2007, carriers will reject claims when the NPI in a loop does not belong to the owner of the PIN or UPIN that should also be reported in REF02 of the same loop, or if the name and address of the provider in that loop do not correlate with either the NPI, PIN or UPIN in the same loop. The same edits will also be applied to NPIs when received on paper claims prior to May 23, 2007.

Carriers have also detected claims where the rendering physician's or supplier's NPI is reported in the 2010A/A NM1 segment when the claim was submitted by a group to which the physician belongs or the home office of a chain to which a supplier belongs. The 2010A/A loop of an 837-P claim must contain the identifier that applies to the groups/chains (NPI entity 2) that submitted the claims. This rule also applies to identification of the billing provider on a paper claim. Information concerning a billing agent or a healthcare clearinghouse may never be reported in the billing provider loop for a Medicare claim.

To prevent this error, you must report the rendering physician's or supplier's NPI in the NM109 data element in the rendering provider claim level loop (2310B), unless multiple services were furnished by different members of the group/chain.

If multiple rendering providers were involved, the information for each must be reported in the service level 2420A loop along with the service(s) each of them rendered.

To facilitate claim processing prior to May 23, 2007, you should also report the rendering provider(s) PIN(s) as the REF02 data element with 1C in REF01 in that same rendering provider loop (2310B for the claim or 2420A for individual services, as applicable).

Reporting of the Pay-to Address in the Billing Provider (2010A/A) Loop

Once NPI reporting begins, carriers will reject claims when the pay-to-address, if different than the actual practice location address, is in the 2010A/A (billing provider) loop, rather than in the 2010A/B (pay-to-provider) loop.

When groups or organizations submit claims, and the billing and the pay-to providers are different individuals or entities, the pay-to information must always be reported in the 2010A/B loop and the billing provider information in the 2010A/A loop.

Reporting of the Name and Address of a Billing Provider in the 2010A/A Loop of an X12 837-I (Institutional) Electronic Claim

FIs will reject claims in which the billing provider and the rendering provider are different entities, and you report the billing provider's name and address in the 2010A/A loop of an X12 837-I (institutional) electronic claim, and the OSCAR number of the rendering provider in that same loop.

If the home office of a chain has obtained one NPI for all facilities it owns, or one of a chain's facilities bills for all (or other) facilities owned by that chain, or a hospital bills for its special units, the home office, hospital or other facility submitting those claims is considered a form of billing agent for Medicare purposes.

In this instance, you must identify the specific provider, for whom the claim is being submitted, as the billing provider for that claim. If a provider that furnished the care had a separate OSCAR (online survey certification and reporting) system number than the entity submitting its claims, the provider that furnished the care must be identified in the billing provider loop. You must also report the name of the facility for whom the claim is being submitted, that facility's address, and should report applicable NPI (when obtained prior to May 23, 2007), as well as the Medicare OSCAR number assigned to that provider in the 2010A/A (billing provider) loop of the claim.

If the home office, hospital or other entity that prepared the claim is to be sent payment for the claim, you must report the name and address, and should report the NPI if issued, and the applicable OSCAR number associated with that entity in the 2010A/B (pay-to-provider) loop prior to May 23, 2007.

However, you should note that Medicare will not issue payment to a third party for a provider solely as result of completion of the 2010A/B loop of an electronic claim.

The facility that furnished the care, or the established owner of that facility, must have indicated on their CMS-855 provider enrollment form filed when that facility enrolled in Medicare (or via a subsequent CMS-855 used to update enrollment information) that payments for that facility are to be issued to that home office, hospital, other facility or an alternate third party.

For those providers still permitted to submit any paper claims under the restrictions imposed by the Administrative Simplification Compliance Act, Medicare plans to begin accepting paper claims on the revised CMS-1500 (08-05 version) beginning January 2, 2007 (allowing you to report a provider's NPI as well as the applicable PIN or UPIN); and on the revised UB-04 (CMS-1450) form beginning March 1, 2007 (allowing you to report a provider's NPI as well as the applicable OSCAR or UPIN). Medicare carriers plan to reject "old" CMS-1500 forms received after March 31, 2007, and FIs plan to reject UB-92 forms received after April 30, 2007.

Note: Medicare does not accept NPIs on the "old" versions of the CMS-1500 or UB-92 forms. There are no fields on those forms designed for NPI reporting.

Important Guidance Regarding National Provider Identifier Usage in Medicare Claims, continued

CMS highly recommends that for electronic or paper Medicare claims that you submit during the transition period to full NPI implementation on May 23, 2007, you include both the NPI and the Medicare legacy identifier of each provider for whom you report information.

- When you report an NPI on a claim sent to a carrier for a referring, ordering, purchased service or supervising physician, or for a provider listed in the service facility locator loop, use a UPIN as the Medicare legacy identifier.

Furthermore, if any of those physicians are not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007, you should report OTH000 as the UPIN.

- When you report an NPI on a claim sent to an FI for an attending, operating or other physician, or in the service facility locator loop (when those loops apply), you should also report the provider's UPIN. And as above, you may report OTH000 as the surrogate UPIN if any of those providers is not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007.
- Finally, when you report an NPI for a billing, pay-to, or rendering provider identified on a claim sent to a carrier, you should also report the valid Medicare PIN that applies to that physician or supplier. Additionally, you should always report an OSCAR number for each billing, pay-to, or possibly a service facility locator loop provider identified on a claim sent to an FI, as well as the NPI if issued to each of those providers, prior to May 23, 2007.

Remember that failure to report information as described here may result in delayed processing or rejection of your claims. You may find more information about NPI by going to the NPI page on the CMS website at *http://www.cms.hhs.gov/apps/npi/01_overview.asp*.

In addition, if you have any questions on the NPI, you may call your carrier or FI 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: SE0659 Related Change Request (CR) Number: N/A
Related CR Release Date: N/A Related CR Transmittal Number: N/A
Effective Date: N/A Implementation Date: N/A

Additional Information Regarding National Provider Identifier as Contained in CR 4320

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

Impact on Providers

This article is based on change request CR 5217, which instructs your Medicare carrier/DMERC/DME MAC, or FI/RHHI to provide specific national provider identifiers (NPIs) for those providers identified in electronic claims, such as a billing, pay-to, rendering or other provider, that have already obtained NPIs.

Prior to May 23, 2007, providers should report the Medicare legacy identifiers of those providers enrolled to submit claims to Medicare, as well as their NPI.

Note: Pending Medicare implementation of the UB-04 and the revised CMS-1500, providers are not to report NPIs on the current paper claim forms.

If not already available, the following information will be posted on your local Medicare contractor's website, or included in provider newsletters from your local Medicare contractor:

- Adjustments to edits to be applied when an NPI is included in an electronic data interchange (EDI) transaction.
- Actions that can be taken by claim and 276 submitters to avoid rejection of their transactions as result of these edits, and information about how to correct and resubmit a transaction if the transactions are rejected as result of these edits.

Additional Information Regarding National Provider Identifier as Contained in CR 4320, continued

Additional Information

CR 4320, "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" may be located on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf*.

MM4320, the similarly titled Medicare Learning Network (MLN) article associated with CR 4320, is found on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf*.

CR 5217 is the official instruction issued to your Medicare carrier/DMERC/DME MAC/FI/RHHI regarding changes mentioned in this article. CR5217 may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R235OTN.pdf*.

If you have questions, please contact your local Medicare carrier/DMERC/DME MAC/FI/RHHI 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: MM5217	Related Change Request (CR) Number: 5217
Related CR Release Date: August 18, 2006	Related CR Transmittal Number: R235OTN
Effective Date: January 1, 2006	Implementation Date: November 20, 2006

Do You Have Your National Provider Identifier Number Yet?

If so, that's great! If not, remember there are three ways that you can obtain your National Provider Identifier number (NPI): Complete the **online application** at the NPPES website at *https://NPPES.cms.hhs.gov*, download the **paper application** form at *http://www.cms.hhs.gov/forms* (CMS-10114), or call the NPI Enumerator at 1-800-465-3203 and request a paper application. In addition, you may also authorize an employer or other approved organization that has obtained the permission of the provider, to obtain the NPI for you through bulk enumeration, known as **Electronic File Interchange** (EFI).

Regardless of how you obtain your NPI, it is important that you **retain the notification documentation that NPPES sends to you that contains your NPI**. You will need to share this notification with other health care partners, when enrolling in Medicare for the first time, or making changes to your current Medicare provider file.

NPI Timeline

Electronic claim submitters only

January 3, 2006 – October 1, 2006	NPI optional and Medicare numbers required
October 2, 2006 – May 22, 2007	NPI and Medicare number
May 23, 2007 – Forward	NPI only

Small health plans have until May 23, 2008

Important Note!

Paper claim submitters

Submission of the NPI on paper claims will not be applicable until the new CMS-1500 form (08/05) and the CMS-1450 (UB-04) is implemented.

EDI Information

For specific electronic claim guidelines for NPI submission, visit the EDI section of the website at:

Florida: *www.floridamedicare.com*
Connecticut: *www.connecticutmedicare.com*

Beginning January 3, 2006, through October 1, 2006, electronic Medicare claims can be submitted with the NPI number along with the existing Medicare number. If the NPI is submitted alone, the claims will reject as unprocessable.

Beginning October 2, 2006, through May 22, 2007, CMS systems (including those used by the fiscal intermediaries and carriers) will accept the NPI with or without an existing Medicare number on claims. If there is an issue with the provider's NPI, the claim may not be paid. Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare number in addition to the NPI.

Beginning May 23, 2007, CMS systems will only accept the NPI. Small health plans have until May 23, 2008, to begin using the National Provider Identifier.

For more information, go to *http://www.cms.hhs.gov/NationalProvIdentStand/*.

Source: Publication 100-20, Transmittal 190, Change Request 4023

Suppression of Standard Paper Remittance (SPR) Advice for Electronic Remittance Receivers

If you are a provider who received payment on or after June 1, 2006 and did not receive a standard paper remittance, this article is for you.

Effective June 1, 2006, the SPR is no longer available to providers and suppliers who have also been receiving an electronic remittance advice (ERA) for 45 days or more. The change applies to all SPRs, including no-pay remits, and is effective whether the ERA is received directly or through a billing agent, clearinghouse, or other entity representing a provider or supplier.

To assist those providers who receive electronic remittance but still needing paper remittance copies to submit to supplemental insurance, the Centers for Medicare & Medicaid Services (CMS) developed a free tool–Medicare Remit Easy Print (MREP) software–that allows providers and suppliers to read and print paper remittance advice (RA) from the HIPAA compliant Health Care Claim Payment/Advice (835) ERA file. Providers may obtain further information on the MREP software at:

Connecticut: *http://www.connecticutmedicare.com/edi_getstarted_edepl.asp*
Florida: *http://www.floridamedicare.com/edi_getstarted_edepl.asp#TopOfPage*.

Providers may also contact their existing software vendor to determine if a remittance print feature is available.

Note: Providers who are not receiving ERA will continue to receive SPR.

If you are a provider who expected a standard paper remittance (SPR) and did not receive one, call our EDI Department at either (203) 639-3160 (CT) or (904) 354-5977 (FL).

The EDI Department will help you understand why you did not receive a paper remittance, and will explain the steps you should take to obtain a copy of your remittance notice. Those steps may include contacting your vendor, using the free MREP software, or setting you up to receive paper remittance only.

Sources: IOM - Pub 100-04, Chapter 24, Section 40.1.
MLN Matters MM4376 & MLN Matters SE0627

Clinical Laboratory Improvement Amendments Brochure

The updated Clinical Laboratory Improvement Amendments (CLIA) brochure which has been available in a downloadable format is now available in print format on the *Medicare Learning Network's* (MLN). A print version of the brochure is available for ordering on the MLN Publications page at *http://www.cms.hhs.gov/MLNProducts/* and access the MLN Products Ordering page.

The brochure includes an overview of CLIA, why it is important, how test methods are categorized, enrollment information, as well as information regarding the five types of laboratory certificates.

Source: CMS Provider Education Resource 200608-07

Disaster Response Plan Announcement for Individuals with Kidney Failure

The Centers for Medicare & Medicaid Services (CMS) today announced that CMS and other federal agencies have joined with organizations and health care providers in the kidney community to form the Kidney Community Emergency Response Coalition and to develop a nationwide disaster response plan.

"The Kidney Community Emergency Response Coalition is an excellent example of effective collaboration," said CMS Deputy Administrator Leslie Norwalk. "This is a model of how we can work together to ensure that health care needs of individuals with kidney disease are met, even in a time of a disaster."

The Coalition will ensure that national resources are in place to assist state and local response efforts in meeting the life saving medical needs of individuals with kidney failure in the event of a disaster.

Kidney failure (end-stage renal disease, or ESRD) is a life threatening condition. As of March 2006, there were nearly half a million individuals with ESRD in the United States. Individuals with ESRD require medications to prevent rejection of a kidney transplant if they have received one, or regular repeated dialysis treatments to clean the blood supply, as frequent as three to four times a week, if they have not. Going without dialysis for even a short time can result in severe illness or even death for an individual with ESRD.

Dialysis is dependent on the availability of electricity, gas, supplies, and water – commodities that, without proper planning, are difficult to access in the event of a disaster. One dialysis treatment alone requires a minimum of 100 gallons of pressurized, clean water.

"Other health care provider groups, in preparing for disasters, can learn a great deal from the kidney community, Barry Straube, M.D., CMS Chief Medical Officer and a nephrologist. "This effort will help save lives by making sure critical needs such as supplies, medications and services are available."

The kidney community understands the continued need for improved processes. Toward this end, representatives from over 50 health care organizations across 25 states and the District of Columbia participated in a national summit hosted by CMS in January to review lessens learned in recent disasters, and use these lessons to plan for the future. The Kidney Community Emergency Response Coalition was formed, at the summit, with the National Kidney Foundation serving as the administrative coordination lead for Coalition activities.

Disaster Response Plan Announcement for Individuals with Kidney Failure, continued

The Coalition is comprised of partners representing kidney patient and professional organizations; practitioners such as nurses, technicians, dieticians, social workers, surgeons and physicians; independent dialysis and transplant facilities; large dialysis organizations; hospitals; medical equipment suppliers; ESRD Networks; state representatives; the Renal Leadership Council (RLC); as well as the CMS and other federal agencies such as the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NHI).

Phase I of the Coalition work has been completed with the development and initial dissemination of tools and resources and a national kidney community response plan to help patients, facilities, emergency responders, and coalition members plan for, and respond to, emergencies and disasters.

CMS will assume the administrative coordination lead as the Coalition moves into Phase II. Coalition activities will focus on making individuals with ESRD and the state and local response workers aware of the tools and materials available, as well as testing and refining the national kidney community response plan. ESRD networks, healthcare practitioners, dialysis facilities, industry, and patient representatives will play a critical role as the Coalition moves into Phase II, and in the event of a disaster, will be at the forefront of implementation of the response plan.

CMS has a number of additional activities including education campaigns, and contractual (e.g., ESRD networks) and regulatory (e.g., proposed ESRD Conditions for Coverage) changes underway to supplement the work of the Coalition, as well as activities to ensure all Medicare beneficiaries have access to health care services in the event of a disaster, including the possibility of a flu pandemic.

For more information and links to CMS disaster planning activities and resources, please visit *http://www.cms.hhs.gov/Emergency/*.

The National Kidney Foundation is host of a clearinghouse of Coalition activities that may be accessed at *http://www.kidney.org/help*.

Source: CMS Provider Education Resource 200607-14

Disclosure Desk Reference for Provider Contact Centers

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

Provider Types Affected

All physicians, providers, and suppliers billing Medicare

Provider Action Needed

STOP – Impact to You

When you call or write a Medicare fee-for-service provider contact center (PCC) to request beneficiary protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, will authenticate your identity prior to disclosure.

CAUTION – What You Need to Know

CR 5089 revises *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3, Section 30, and Chapter 6, Section 80, to update the guidance to PCCs for authenticating providers who call or write to request beneficiary protected health information, and to clarify the information they may disclose after authentication.

GO – What You Need to Do

Be prepared to supply the required authentication information when contacting a PCC to request protected health information.

Background

In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare PCCs must first authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

CR 5089, from which this article is taken, completely revises Section 30 in Chapter 3 and Section 80 in Chapter 6 of the *Medicare Contractor Beneficiary and Provide Communications Manual* (Publication 100-9). It updates the PCC Disclosure Desk Reference, the main purpose of which is to protect the privacy of Medicare beneficiaries by ensuring that protected health information is disclosed to providers only when appropriate, to include:

- Guidance for authenticating providers who call or write to request beneficiary protected health information; and
- Clarification of the information that may be disclosed after authentication of writers and callers.

Please note that while new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements.

Below is the authentication guidance that the PCCs will be using:

Telephone Inquiries

Provider Authentication

CSR Telephone Inquiries – Through May 22, 2007, customer service representatives (CSR) will authenticate providers using provider number and provider name.

Disclosure Desk Reference for Provider Contact Centers, continued

Interactive Voice Response (IVR) Telephone Inquiries - Through May 22, 2007, IVRs will authenticate providers using only the provider number.

Note: See "Final Note" below to learn more about provider authentication after May 22, 2007.

Written Inquiries

Provider Authentication

Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider number and provider name.

Note: See "Final Note" below to learn more about provider authentication after May 22, 2007.

At this point, there are some specific details about provider authentication in written inquiries of which you should be aware.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider's official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider's name and address are included in the letterhead and clearly establish the provider's identity.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered as written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you.

Rather, they will send you the requested information by regular mail, or respond to these requests by telephone. In either of these response methods, or if they elect to send you an automated e-mail reply (containing no beneficiary-specific information), they will remind you that such information cannot be disclosed electronically via email or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

And lastly, inquiries received without letterhead, including hardcopy, fax, e-mail, pre-formatted inquiry forms, or inquiries written on remittance advice (RAs) or Medicare summary notices (MSNs), will be authenticated the same as written inquiries,(explained above) using provider name and the provider number.

Insufficient or Inaccurate Requests

You should also understand that for any protected health information request in which the PCC determines that the authentication elements are insufficient or inaccurate, you will have to provide complete and accurate input before the information would be released to you.

Such requests that are submitted in written form and those on pre-formatted inquiry forms, will be returned in their entirety by regular mail, with a note stating that the requested information will be supplied upon submission of all authentication elements, and identifying which elements are missing or do not match the Medicare record.

Alternatively, if you sent the request by e-mail (containing no protected health information), the PCC may return it by e-mail, or may elect to respond by telephone to obtain the rest of the authentication elements.

Beneficiary Authentication

Regardless of the type of telephone inquiry (CSR or IVR) or written inquiry, PCCs will authenticate four beneficiary data elements before disclosing any beneficiary information:

1) Last name;

2) First name or initial;

3) Health Insurance Claim Number; and

4) Either date of birth (eligibility, next eligible date, certificate of medical necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) [pre-claim]) **or** date of service (claim status, CMN/DIF [post-claim]).

Please refer to the disclosure charts attached to CR 5089 for specific guidance related to these data elements as well as details on the beneficiary information that will be made available in response to authenticated inquiries. CR 5089 is available at *http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf* on the CMS website.

Special Instances

Below are three special instances that you should know about.

Overlapping Claims

Overlapping claims (multiple claims with the same or similar dates of service or billing period) occur when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect. Sometimes this happens when the provider is seeking to avoid have a claim be rejected, for example:

- When some end stage renal disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated, thus allowing the facility to code the claim appropriately and bill around the inpatient hospital stay/stays; or
- Skilled nursing facility and inpatient hospital stays.

Disclosure Desk Reference for Provider Contact Centers, continued

These situations fall into the category of disclosing information needed to bill Medicare properly, and information can be released as long as all authentication elements are met.

Pending Claims

A pending claim is one that is being processed, or has been processed and is pending payment. CSRs can provide information about pending claims, including internal control number (ICN), pay date/amount or denial, as long as all authentication requirements are met.

Providers should note, however, that until payment is actually made or a remittance advice is issued, the information provided could change.

Deceased Beneficiaries

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, PCCs will comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

Final note: More information will be provided in a future MLN Matters article about authentication on and after May 23, 2007, the implementation date for the National Provider Identifier or NPI.

Additional Information

You can find more information about Provider Contact Center guidelines concerning authentication by going to *http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf* on the CMS website.

Attached to that CR, you will find the updated *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100.09), Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information); and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information).

If you have any questions, please contact your carrier, durable medical equipment (DME) regional carrier, DME Medicare Administrative Contractor (DME MAC), fiscal intermediary, or regional home health intermediary 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: MM5089
Related Change Request (CR) #: 5089
Related CR Release Date: July 21, 2006
Effective Date: October 1, 2006
Related CR Transmittal #: R16COM
Implementation Date: October 2, 2006

GENERAL MEDICAL REVIEW

Articles in this section apply to both Florida and Connecticut.

Lucentis (ranibizumab injection) for Neovascular Age-Related Macular Degeneration

Lucentis (ranibizumab injection) was FDA-approved on June 30, 2006 for the treatment of age-related macular degeneration (AMD).

When all program requirements are met, Medicare generally reimburses for a drug that is FDA-approved for the indication for which it is being used, and there are no applicable policies - such as a local coverage determination (LCD) or a national coverage determination (NCD) - that would preclude coverage. This is not an all-inclusive list.

Lucentis is FDA-approved for the treatment of AMD. Currently, there is no LCD on this subject matter in Florida, and we are unaware of an NCD that would restrict coverage for the FDA-approved indication. Although all services reimbursed by Medicare are subject to review, an overwhelming majority of claims are being paid based on these principles.

Providers billing for intravitreal Lucentis (ranibizumab injection) should use *CPT* code *67028* for the intravitreal injection and HCPCS code J3490 (unclassified drugs) for the Lucentis (ranibizumab injection). Please enter "Lucentis" in Item 19 of CMS 1500 Form or its electronic equivalent. The applicable ICD-9-CM code is 362.52 (exudative senile macular degeneration). When billing Medicare, the intravitreal injection and the drug injected should be billed on the same claim. Remember to use the appropriate modifiers when performing the service on both eyes.

Documentation in the medical record must support the following:

- The diagnosis of wet AMD (ICD-9 code 362.52) with leakage/fluid in the macula has been confirmed by optical coherence tomography (OCT) or fluorescein angiography.
- Actual dose administered.

Providers should not submit this information with the claim. First Coast Service Options, Inc. (FCSO) may request it separately with an additional documentation request (ADR) letter.

Luteinizing Hormone-Releasing Hormone (LHRH) Analogs

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.

Per the instructions in the coding guideline attached to the LCD, providers are required to submit documentation in the following situations:

- Providers wishing to be reimbursed at the higher amount can submit documentation that supports the medical necessity of the higher priced drug.
- 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 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.

FCSO's initial data analysis indicates that some 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.

Vertebral Fracture Assessment–*CPT* Code *76077*—Revised Article

Background

First Coast Service Options, Inc. (FCSO) currently has a local coverage determination (LCD) for bone mineral density studies. This LCD is based on 42 CFR, Section 410.31 and the *CMS Manual System*. Therefore, vertebral fracture assessment (VFA) (*CPT* code *76077*) is outside the scope of this LCD, and this LCD does not apply to it. It is the intent of this article to inform provider's about FCSO's approach to this service.

Description of the Service

Lateral spine dual energy X-ray absorptiometry (DXA), *CPT* code *76077*, or vertebral fracture assessment, is a relatively recently developed technique for imaging vertebral fractures that are not clinically evident. It assists in the diagnosis of prevalent vertebral fractures using less radiation than the anterior-posterior technique. If it is accurate in identifying vertebral fractures, when combined with bone mineral density measurement, it potentially could offer a method for more accurately determining risk of future fracture. Such risk assessment may help determine whether a patient is an appropriate candidate for pharmacologic treatment.

Regulatory Information

Medicare coverage of bone density measurements is defined in 42 CFR, Section 410.31 as reflected in First Coast Service Option, Inc. LCDs on this subject matter . There are five qualifying criteria:

- A patient with vertebral abnormalities as demonstrated by an X-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture.
- A patient being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.
- A patient with known primary hyperparathyroidism.
- A patient receiving (or expecting to receive) glucocorticoid (steroid) therapy greater than three months, on the equivalent dose of 30 mg cortisone or 7.5 mg prednisone or greater per day.
- A woman who has been determined by the physician or a qualified non-physician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.

The local contractor does not have discretion of decision or authority to expand or contract this list.

According to 42 CFR, Section 410.31, "Bone mass measurement…is performed for the purpose of identifying bone mass, detecting bone loss, or determining bone quality" and does not include a provision for diagnosing a fracture. Therefore, vertebral fracture assessment is outside the scope of Medicare bone mass measurement benefit, as defined by the law. It is a separate modality.

Contractor's (FCSO) Observations

It is the standard of practice to identify and evaluate vertebral fractures with traditional radiologic techniques. However, screening for detection of vertebral fractures is generally not performed. As a result, diagnosis occurs either incidentally or as a result of symptoms. Traditional radiologic evaluations for signs and symptoms have not been considered as a screening test. Importantly, screening for vertebral fractures is not a Medicare covered benefit. Therefore, VFA performed for screening for vertebral fractures is never covered.

Current literature has not demonstrated that treatment decisions based on VFA, along with bone mineral density measurements, have resulted in better patient outcomes than treatment based solely on bone mineral density and clinical risk factors. There is a lack of clinical trial evidence showing that patients with vertebral fractures on DXA but with bone mineral density levels above treatment thresholds benefit from pharmacologic treatment. There have not been an adequate number of closely controlled clinical trials conducted to date or studies focusing on comparison with other modalities generally available, and currently publications in peer-reviewed literature, as well as position statements by technology assessment organizations are not sufficient to issue a positive coverage statement by way of a local coverage determination (LCD).

FCSO Medicare will consider coverage of VFA under the following circumstance:

- When used as a diagnostic test for the evaluation of symptoms and findings suggestive of a vertebral fracture.

Please note: The medical record must reflect the rationale for selecting VFA over other time-tested techniques for each individual patient.

Limitations

- VFA is never covered when used as screening for vertebral fractures.
- VFA cannot be duplicative of other diagnostic modalities for a patient during an episode of illness.

Because in situations when there is no national coverage determination (NCD) or local coverage determination (LCD), services are evaluated individually based on Medicare general medical reasonableness and necessity criteria, claims for VFA will be given individual consideration on a case-by-case basis until appropriately designed and powered studies are published and evaluated.

Providers should not interpret the process of individual consideration as synonymous with coverage and payment by Medicare. This means only that the claims will be reviewed against the background of the presently available evidence and specific patient circumstances.

Vertebral Fracture Assessment–CPT Code 76077—Revised Article, continued

Any time there is a question whether Medicare medical reasonableness and necessity criteria would be met; we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed *CPT* code. For further details about CMS' Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*.

Please note that services that lead up to or are associated with noncovered services are not covered as well.

Billing and Coding

The applicable *CPT* code is *76077* – Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment.

Documentation

Providers should not submit any medical record documentation with the claim. FCSO will request this by means of an additional documentation request (ADR) letter. The required information will include details for the current episode of care about symptoms, signs, and findings suggestive of the presence of a vertebral fracture, other diagnostic modalities utilized, and the rationale for choosing VFA. Like any diagnostic test, the VFA must be specifically ordered by the treating physician, for which there must be documentation in the medical record.

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.

CONNECTICUT MEDICAL REVIEW

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

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

Effective and Notice Dates

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

Electronic Notification

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

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

More Information

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

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

Phone: 1-866-419-9455

Medical Review Table of Contents

Advance Notice Statement

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

CORRECTIONS TO LCD

J9000: Antineoplastic Drugs—LCD Correction

A revision to the local coverage determination (LCD) for antineoplastic drugs was published in the August 2006 *Medicare B Update!* (page 54). The effective date of June 19, 2006 for the addition of the following indications and ICD-9-CM codes for J9310 was incorrect. The correct effective date is February 28, 2006 for Rituximab (J9310).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section for J9310:

- Added the FDA approved indication for rheumatoid arthritis and verbiage of other approved indications based on the FDA label.

Under the "ICD-9 Codes that Support Medical Necessity" section for J9310 added the following diagnosis codes:

- 714.0 – Rheumatoid arthritis
- 714.1 – Felty's syndrome (Rheumatoid arthritis with splenoadenomegaly and leukopenia)
- 714.2 – Other rheumatoid arthritis with visceral or systemic involvement

This correction is effective for claims processed on or after August 21, 2006 for services rendered on or after February 28, 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.

NEW LCDS

J0740: Ganciclovir and Cidofovir—New LCD

Ganciclovir (cytovene IV) is a synthetic guanine derivative and an active antiviral agent for cytomegalovirus (CMV) infections. The ganciclovir (vitrasert) implant is a synthetic nucleoside analogue of 2'- deoxyguanosine, which inhibits assembly of virons. Ganciclovir is not a cure for CMV. Cidofovir (vistide) is an antiviral used to treat the symptoms of CMV infection of the eye. Cidofovir is available in IV form only. Cidofovir will not cure CMV infection.

Ganciclovir (J1570 and J7310)

Medicare will cover ganciclovir for the following FDA-approved indications:

IV form

- Cytovene-IV is indicated for the induction and maintenance in the treatment of CMV retinitis in immunocompromised patients, including patients with acquired immunodeficiency syndrome (AIDS).
- Cytovene-IV is also indicated for the prevention of CMV disease in transplant recipients at risk for CMV disease.

Implant form

- Ganciclovir (vitrasert) implant is indicated for CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS). The intravitreal implant is designed to release ganciclovir over a period of 5 to 8 months. The implant provides localized treatment only and will not have any effect on extraocular CMV infection.

Cidofovir (J0740)

Medicare will cover cidofovir (vistide) for the following FDA-approved indications:

- Cidofovir is indicated, in combination with probenecid, for the treatment of CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS).

This local coverage determination (LCD) was developed based on data analysis. Indications and limitations, utilization guidelines, documentation guidelines and appropriate ICD-9-CM codes were incorporated into this LCD for procedure codes J0740, J1570 and J7310. A coding guideline was also developed.

Effective Date

This new LCD will be 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.

J1080: Testosterone Cypionate and Testosterone Enanthate—New LCD

Testosterone cypionate and testosterone enanthate, for IM injection, are oil-soluble 17 (beta) cyclopentylpropionate esters of the androgenic hormone testosterone. Testosterone esters are less polar than free testosterone. Testosterone esters in oil, injected intramuscularly, are absorbed slowly from the lipid phase; thus, they can be given at intervals of 2 to 4 weeks.

FDA-approved indications covered by Medicare: Testosterone cypionate and testosterone enanthate are indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone:

- Primary hypogonadism (congenital or acquired)- testicular failure due to cyrptorchidism, bilateral torsion, orchitis, vanishing testes syndrome; or orchidectomy
- Hypogonadadotropic hypogonadism (congenital or acquired)- idiopathic gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma or radiation

In addition to the FDA approved indications, Medicare will cover testosterone cypionate and testosterone enanthate for the following off-label indication:

- Hypogonadism in patients who are infected with HIV, particularly those whose disease has progressed to AIDS and who have developed wasting syndrome. Wasting syndrome is an AIDS defining condition. Wasting is evidence of symptomatic HIV infection. Wasting syndrome is defined as unintentional weight loss > 10% and the presence of chronic weakness and documented fever lasting at least 30 days. Wasting is defined as unintentional weight loss >10%. Wasting syndrome and wasting must be differentiated from lipoatrophy, which is isolated fat loss and is seen in patients who are on a successful course of antiretroviral therapy.

This local coverage determination (LCD) was developed based on data analysis. Indications and limitations, utilization guidelines, documentation guidelines and appropriate ICD-9-CM codes were incorporated into this LCD for procedure codes J1070, J1080, J3120 and J3130. A coding guideline was also developed.

Effective Date

This new LCD will be effective for services rendered on or after October 30, 2006. The full text for this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* on or after this effective date.

J2325: Nesiritide (Natrecor®)—New LCD

Nesiritide was approved by the Food and Drug Administration (FDA) for the short-term intravenous treatment of patients with acutely decompensated congestive heart failure (CHF) who have dyspnea (shortness of breath) at rest or with minimal activity. Recent published studies of Nesiritide have highlighted safety concerns, specifically increased mortality and decreased renal function in patients treated with Nesiritide.

Because nesiritide is only indicated for acute decompensated heart failure, and because of the risks involved during its administration, a new local coverage determination (LCD) was developed to restrict the administration of this drug to inpatient admission, emergency department, or hospital outpatient observation settings. This LCD was presented to the Connecticut Carrier Advisory Committee on June 13, 2006.

This LCD includes ICD-9-CM diagnosis codes and indications and limitations of coverage for patients diagnosed with acutely decompensated CHF for the inpatient setting.

Effective Date

This LCD 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.

J9213: Interferon, Alpha 2-a (Roferon®-A)—New LCD

Interferon alfa-2a, recombinant (Roferon®-A) is a sterile protein product for use by injection. It is manufactured by recombinant DNA technology that employs a genetically engineered E. coli bacterium containing DNA that codes for the human protein. The mechanism by which interferon, alfa-2a or any other interferon, exerts antitumor or antiviral activity is not clearly understood. It is believed that direct antiproliferative action against tumor cells, inhibition of virus replication and modulation of the host immune response play important roles in antitumor and antiviral activity.

Currently, First Coast Service Options, Inc. (FCSO) has a coverage statement for interferon, alfa-2a in the local coverage determination (LCD) for interferon (J9212). Interferon, alfa-2a was evaluated for addition to the self-administered drug (SAD) list. However, the evaluation results revealed that intramuscular injection of this drug might be required for certain medical conditions. Therefore, this LCD was developed to define indication and limitation criteria and to provide utilization guidelines for interferon, alfa-2a. In addition, ICD-9-CM codes that support medical necessity have been identified.

Effective Date

This new LCD 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.

0145T: Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries—New LCD

Multislice or Multidetector Computed Tomography (MDCT) angiography with its advanced spatial and temporal resolution has opened up new possibilities in the imaging of the major vessels of the chest, including aorta, pulmonary arteries, and coronary arteries.

MDCT technology for cardiac and coronary artery assessment requires thin (less than 1 mm) slices 0.5 to 0.75 mm reconstructions, multiple simultaneous images (e.g. 40-64 or more slices) and cardiac gaiting (often requiring beta blockers for ideal heart rate). There is significant post processing, depending on the number of slices for image generation. For coronary artery imaging, the resulting images show a high correlation with stenotic lesions noted on diagnostic cardiac catheterization but more importantly, with atheromas on intracoronary ultrasound. Additionally, the technique may be helpful in defining the vascularity of chest or lung lesions.

CPT category III codes for Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries (*0144T-0151T*) were effective January 1, 2006. Prior to this CT angiography procedures were billed with procedure code *71275* or an unlisted procedure code. *CPT* category III codes are different from typical *CPT* codes in that they are for services that may have limited use by health care professionals, and the service or procedure may not have proven clinical efficacy in the peer-reviewed literature.

Note: *CPT* category III code *0144T* is locally noncovered as investigational, and is included in The List of Medicare Noncovered Services local coverage determination (LCD), effective January 1, 2006.

This LCD has been developed to provide indications and limitations of coverage and/or medical necessity and documentation requirements for *CPT* category III codes *0145T-0151T* and procedure code *71275*. In addition, ICD-9-CM codes that support medical necessity have been identified.

Effective Date

This LCD will be 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.

36470: Treatment of Varicose Veins of the Lower Extremities—New LCD

Varicose veins are caused by venous insufficiency as a result of valve reflux (incompetence). The venous insufficiency results in dilated, tortuous, superficial vessels that protrude from the skin of the lower extremities. Spider veins (telangiectasias) are dilated capillary veins that are most often treated for cosmetic purposes and are not covered by Medicare. Sclerotherapy (liquid or foam) is preformed for signs and symptoms of diseased vessels and can be used as an adjunct to surgical or ablative therapy (radiofrequency or laser). Sclerotherapy for cosmetic purposes is not considered medically reasonable and necessary. Ligation and stripping of varicose veins is a treatment option that aims to eliminate reflux at the saphenofemoral or saphenopopliteal junction. Endovenous radiofrequency and laser ablation is a minimally invasive alternative to vein ligation and stripping. Endovenous radiofrequency ablation (ERFA) (VENUS® Closure System) is FDA-approved for endovascular coagulation of blood vessels with superficial vein reflux. Endovenous laser ablation is FDA-approved for the treatment of varicose veins and varicosities associated with superficial reflux of the greater saphenous vein.

This new local coverage determination (LCD) replaces the retired LCD for endovenous ablation therapy of the saphenous vein (*36475*) and was developed based on data analysis. This LCD incorporates indications and limitations, documentation guidelines, utilization guidelines, ICD-9-CM codes that support medical necessity, ICD-9-CM codes that do not support medical necessity and a coding guideline for procedure codes *36470, 36471, 36475, 36476, 36478, 36479, 37700, 37718, 37722, 37735, 37760, 37765, 37766, 37780, 37799, 93965, 93970* and *93971*.

Effective Date

This new LCD will be effective for services rendered on or after October 30, 2006. The full text for this LCD may be viewed on the provider education website *http://www.connecticutmedicare.com* on or after this effective date.

61885: Vagal Nerve Stimulation (VNS) for Intractable Depression—New LCD

Vagal nerve stimulation (VNS) therapy involves the direct delivery of intermittent retrograde electrical impulses to the left vagus nerve via a surgically attached bi-polar electrode that has been subcutaneously tunneled to the nerve from a small electrical generator implanted in the left chest wall. Like a pacemaker, the device may be turned on and off or adjusted non-invasively.

The Food and Drug Administration (FDA) originally approved VNS for the treatment of refractory epilepsy. On July 15, 2005, the FDA granted premarket approval to Cyberonics, Inc. for their VNS therapy system for the adjunctive long-term treatment of chronic or recurrent depression for patients 18 years of age or older who are experiencing a major depressive episode and have not had an adequate response to four or more antidepressant treatments.

The current available evidence based on publications in peer-reviewed literature and other pertinent sources, is insufficient to permit conclusions regarding the efficacy and safety of VNS as an adjunct therapy in treatment-resistant major depression and bipolar disorder. Therefore, a local coverage determination (LCD) was developed to non-cover reimbursement for VNS therapy for intractable depression at this time.

The following *CPT* codes will not be covered for VNS when used for intractable depression:

61885 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61888 Revision or removal of cranial neurostimulator pulse generator or receiver
64573 Incision for implantation of neurostimulator electrodes; cranial nerve
64585 Revision or removal of peripheral neurostimulator electrodes
95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
95974 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour
95975 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

Effective Date

This LCD 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.

78459: Myocardial Imaging, Positron Emission Tomography (PET) Scan—New LCD

Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceutical) such as FDG (2-{flourine-18}-fluoro-2-dexoy-D-glucose), nitrogen N13 ammonia and rubidium RB-82.

This local coverage determination (LCD) is being developed to identify appropriate ICD-9-CM coding to meet the medical necessity guidelines for this type of scan, and to give further clarity to the documentation requirements section for providers billing these services.

Effective Date

This LCD 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.

82550: Creatine Kinase (CK), (CPK)—New LCD

Creatine kinase (CK or CPK) is an enzyme found in heart muscle (CK-MB), skeletal muscle and heart (CK-MM), and brain (CK-BB). The MM fraction is present in both cardiac and skeletal muscle, but the MB fraction is much more specific for cardiac muscle. Therefore, elevation in total CK is not specific for myocardial injury, because most CK is located in skeletal muscle. Elevations in total CK are possible from a variety of non-cardiac conditions, such as muscle disease, stroke, hypothyroidism, and side effects from the use of statin medications.

Statins are low-density lipoprotein (LDL) lowering drugs that are widely used in clinical practice. The use of statins may produce muscle toxicity under some circumstances. Therefore, it would be expected that a baseline measurement of CK would be done prior to initiating statin therapy, as well as, titration of statin therapy or with clinical signs and symptoms of myopathy (i.e., muscle discomfort, weakness, brown urine, etc.). However, medical literature does not support routine monitoring of CK in the absence of clinical signs and symptoms.

This local coverage determination (LCD) has been developed to define the indications and limitations of coverage, utilization, and documentation requirements for creatine kinase.

Effective Date

This new LCD will be 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.

86803: Hepatitis C Antibody in the ESRD and Non–ESRD Setting—New LCD

Hepatitis C virus is a leading cause of chronic liver disease. It is also the leading indication for liver transplantation. Complications from chronic liver disease include cirrhosis, hepatic decompensation and hepatocellular carcinoma. The incubation period of hepatitis C is approximately 7 weeks. Hepatitis C is an uncommon cause of acute hepatitis in the United States. It is not an easily transmitted disease. It is transmitted through contact with blood and blood products. The leading risk factor for hepatitis C infection is injection drug use, occupational exposure, sexual transmission, intranasal cocaine use, tattooing, body piercing and maternal-infant spread.

Medicare will consider testing for the hepatitis C antibody medically reasonable and necessary when performed for the purpose of identifying the presence of the hepatitis C virus (HCV) and testing is not performed for the purpose of routine screening.

The purpose of this local coverage determination (LCD) is to identify coverage criteria and utilization guidelines when testing for hepatitis C antibody.

Effective Date

This new LCD 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.

REVISIONS TO LCDS

J1566: Intravenous Immune Globulin—LCD Revision

The local coverage determination (LCD) for intravenous immune globulin was last revised January 1, 2006. Intravenous immune globulin is a solution of human immunoglobulin specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens. The use of intravenous immune globulin should be reserved for patients with serious defects of antibody function. The goal is to provide immunoglobulin G (IgG) antibodies to those who lack them.

The intent of the LCD revision is to provide updates to the following sections; "Indications and Limitations of Coverage and/or Medical Necessity", "ICD-9 Codes that Support Medical Necessity", and "Documentation Requirements". In addition coding guidelines were developed.

A new requirement for dual diagnoses was added for human immunodeficiency virus [HIV] disease (042).

For the pediatric population <13, there is a requirement for a dual diagnosis:

- 042, human immunodeficiency virus [HIV] disease **plus** V15.9, unspecified personal history presenting hazards to health
  OR
- 042, human immunodeficiency virus [HIV] disease **plus** V49.89, other specified conditions influencing health status.

For adults ≥13, there is a dual diagnosis requirement for administering IVIG for thrombocytopenia associated with HIV disease:

- primary diagnosis of 287.5, thrombocytopenia, unspecified and a secondary diagnosis of 042, human immunodeficiency virus [HIV] disease

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.

J9000: Antineoplastic Drugs—LCD Revision

This local coverage determination (LCD) for antineoplastic drugs was last updated on June 19, 2006. Since that time, the following revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-9 Codes that Support Medical Necessity" sections for the following HCPCS codes:

J9263 (oxaliplatin)

- Added the off-label indication of oxaliplatin for the treatment of advanced/metastatic gastric carcinoma in combination with irinotecan or fluorouracil with leucovorin or folinic acid.
- Added diagnosis code range 151.0 – 151.9 for J9263 (oxaliplatin).

J9350 (topotecan)

- Added the FDA-approved indication of topotecan in combination with cisplatin for the treatment of Stage IV-B, recurrent, or persistent carcinoma of the cervix, which is not amenable to curative treatment with surgery and/or radiation therapy.

Verbiage for other FDA-approved indications to correspond with the USP DI verbiage for J9350 (topotecan) was updated.

J9201 (gemcitabine)

- Added the FDA-approved indication of gemcitabine in combination with carboplatin for the treatment of patients with advanced ovarian cancer that has relapsed at least 6 months after completion of platinum-based therapy.

In addition, updated verbiage for other FDA-approved indications for J9201 to correspond with the USP DI verbiage. References were also updated.

Effective Date

The effective dates for these changes are:

- J9263 and J9350 are effective for services rendered on or after July 31, 2006.
- J9201 is effective for services rendered on or after July 14, 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.

J9015: Aldesleukin (Proleukin®, Interleukin-2, Recombinant, and RIL-2)—LCD Revision

Aldesleukin (J9015) is in the Antineoplastic Drugs (J9000) local coverage determination (LCD). The Antineoplastic Drugs LCD was last updated on July 31,2006. A revision was made to aldesleukin and was singularly submitted to the Connecticut Carrier Advisory Committee on June 13, 2006 due to the size of the Antineoplastic Drugs LCD and the fact that only aldesleukin was revised.

The only Food and Drug Administration (FDA) indications for aldesleukin are metastatic renal cell carcinoma and metastatic melanoma for adults. FDA label warnings state this drug should be administered in a hospital setting under the supervision of a qualified physician experienced in the use of anticancer agents. The recommended FDA high dosage is 600,000 IU/kg administered every 8 hours by a 15 minute IV infusion for a maximum of 14 doses, which is repeated following nine days of rest.

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, verbiage for the FDA-approved indications was changed stating aldesleukin is FDA-approved for treatment of adults with metastatic renal cell carcinoma, and treatment of adults with metastatic melanoma. In addition, the off-label indications of acute and chronic myeloid leukemia were added, as well as FDA dosages, warnings, and contraindications for aldesleukin. The "Documentation Requirements" section was revised to include "If a provider departs from the recommended high dose label recommendations and gives a reduced dosage (off-label) and/or different route of administration in an alternate setting, the rationale for such administration should be documented in the medical record."

Under the "ICD-9 Codes that Support Medical Necessity" section, diagnosis code 190.6 – malignant neoplasm of choroid (use this code for ocular melanoma) was added.

Effective Date

This 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

Vital Stim® Therapy uses a small current, passing it through external electrodes on the anterior neck to stimulate inactive or atrophied swallowing muscles. A request was received to consider this procedure for the treatment of swallowing dysfunction and/or oral function for feeding.

Based on the literature, this service is an emerging technology, and investigational for the treatment of dysphagia, therefore, this procedure was added to the "Local Noncoverage Decisions" section of The List of Medicare Noncovered Services local coverage determination (LCD). Since this procedure does not have a unique procedure code, this service should be billed with unlisted procedure code (*92700*).

Effective Date

This 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.

SKINSUB: Skin Substitutes—LCD Revision

The local coverage determination (LCD) for skin substitutes was last updated on January 1, 2006.

Since that time, a major revision was made to the LCD and presented at the Connecticut Carrier Advisory Committee on June 13, 2006. The final revisions included the addition of Integra, TransCyte, and OASIS products to the LCD. The skin substitutes were arranged in alphabetical order. The "Indications and Limitations of Coverage and/or Medical Necessity" section was updated to include these products, as well as a "Note" at the end of this section for preparation and application of graft codes with range of corresponding CPT codes. This "Note" was also added to the "Coding Guidelines" under "Other Comments." Under the "ICD-9 Codes that Support Medical Necessity" section, ICD-9-CM codes were added for OASIS, Integra, and TransCyte, and additional diagnosis codes were added for OrCel (J7343). Diagnosis code 707.10 (ulcer of lower limb, unspecified) was added to Xenograft. Documentation requirements were added for Integra and OASIS and general applicable FDA labeling requirements for all products. The "Sources of Information and Basis for Decision" section was updated.

Effective Date:

These revisions are 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.

VISCO: Viscosupplementation Therapy for Knee—LCD Revision

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised November 15, 2005.

This LCD revision is for the purpose of removing the brand name of all preparations of sodium hyaluronate and related substances. Providers are to use the HCPCS code that accurately describes the preparation they are administering; The HCPCS codes and their descriptors are as follows:

J3590 Unclassifed biologics (use for high molecular weight hyaluronan)

J7317 Sodium hyaluronate, per 20 to 25 mg dose for intra-articular injection

J7320 Hylan G-F 20, 16 mg, for intra-articular injection

In addition to the above changes, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was updated by adding statements defining medical reasonableness and necessity of drugs/biologicals and procedures, based on *Medicare Benefit Policy Manual* (100-2, Chapter 15, Section 50.2k) and the *Program Integrity Manual* (100-8, Chapter 13, Section 5.1), respectively. Also, a statement regarding the use of the appropriate HCPCS code when billing for a hyaluronic preparation was added to the coding guidelines.

This revision is effective for claims processed on or after August 21, 2006. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

0067T: Computed Tomographic Colonography—LCD Revision

Computed tomographic colonography (CT colonography) also known as virtual colonoscopy utilizes helical computed tomography of the abdomen and pelvis to visualize the colon lumen. The test requires colonic preparation similar to that required for conventional colonoscopy (instrument colonoscopy), and air insufflation to achieve colonic distention**.** When polyps are detected with CT colonography, patients could presumably undergo subsequent conventional colonography, which may require another bowel preparation. The American Cancer Society, the U.S. Preventive Services Task Force, the Centers for Medicare & Medicaid Services (CMS), nor, to date, any professional bodies endorse CT colonography for screening.

This local coverage determination (LCD) became effective January 1, 2006. Since that time, the LCD has been revised to expand coverage indications, identify equipment requirements, and define physician qualifications for performing CT colonography. Also, the "Documentation Requirements" and "Sources of Information and Basis for Decision" sections were updated.

Effective Date

This 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.

91110: Wireless Capsule Endoscopy—LCD Revision

Wireless capsule endoscopy utilizes the use of a small capsule containing a disposable light source, miniature color video camera, battery, antenna and a data transmitter. The patient swallows the capsule and images taken by the camera contained within the capsule are relayed to the data transmitter. The data transmitter is connected to a computer workstation where the images are downloaded, reviewed, and interpreted by the physician.

First Coast Service Options, Inc. (FCSO) developed a local coverage determination (LCD) for wireless capsule endoscopy of the *small bowel*, which has been in effect since March 24, 2003. The purpose of this LCD/Coding Guideline revision is to provide coverage guidelines for wireless capsule endoscopy of the *esophagus*.

Effective Date

This 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.

92250: Fundus Photography—LCD Revision

The latest revision for local coverage determination (LCD) fundus photography was effective October 1, 2005. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD has been revised to indicate a limitation of coverage as follows:

> "Fundus photography is considered medically reasonable and necessary when it is furnished by a qualified optometrist or ophthalmologist in the course of the evaluation and management of a retinal disorder or another condition that has affected the retina as outlined above. Therefore, the digital imaging systems for the detection and evaluation of diabetic retinopathy, used to acquire retinal images through a dilated pupil with remote interpretation, do not meet Medicare's reasonableness and necessity criteria for fundus photography."

The "Coding Guidelines" section of this LCD has also been revised accordingly:

> "Services billed for digital imaging systems for detection and evaluation of diabetic retinopathy used to acquire retinal images through a dilated pupil with remote interpretation should be billed using CPT code *92499* (Unlisted ophthalmological service or procedure)."

Effective Date

This 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.

RETIRED LCD

36475: Endovenous Ablation Therapy of the Saphenous Veins—LCD Retired

The local coverage determination (LCD) for endovenous ablation therapy of the saphenous veins (*36475*) is being retired. The decision to retire this LCD is based on data analysis and local standards of medical practice.

Effective Date

The LCD will be retired 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.

Upcoming Educational Events—Fourth Quarter 2006

Date	Event Description	Event Time	Event Type
September 13	**National Correct Coding Initiatives (NCCI) Webcast**–NCCI policies, using the two NCCI tables, and correct application of modifiers.	11:00 AM–12:30 PM	Webcast*
September 14	**Ask the Contractor Teleconference** (ACT)–National Provider Identifier and Provider Enrollment	11:30 AM–12:30 PM	Teleconference
September 20	**Hot Topics Live!**– Topics based on data analysis; session includes discussion of new initiatives and changes in the Medicare program.	8:30 AM–11:00 AM & 1:00 PM–3:30 PM (Two separate sessions)	In–Person Meeting (Location to be determined)

*Webcasting is our newest training approach, combining the best of in-person events, teleconferences, and web-based training into one venue! Webcasts may include online presentations, website demonstrations, handouts and interactive quizzes. Experience the interactivity of training online (using your own computer) with the convenience of listening to the trainer 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.
- 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 Florida Medicare intermediary. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education website *http://www.floridamedicare.com*. It's very easy to do. Simply go to the website, click on the "***eNews***" link on the navigational menu and follow the prompts.

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

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

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

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

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

Attention: Correspondence

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

Attention: Financial Services

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

Attention: Fraud and Abuse

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

Attention: Freedom of Information (FOIA)

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

Attention: Medical Review

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

Attention: MSP

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

Attention: Pricing/ Provider Maintenance

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

Attention: Resolutions

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

MAILING ADDRESS EXCEPTIONS

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

Redeterminations/Appeals

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

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

Hearings

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

Post Office Box for Appeals/Hearings:

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

Electronic Media Claims/EDI

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

Post Office Box for EDI:

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

Claims

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

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

CONNECTICUT MEDICARE PHONE NUMBERS

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

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

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

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

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

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

Electronic Funds Transfer Information
1-203-639-3219

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

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

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

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

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

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

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

Health Insurance Counseling Program
1-800-994-9422

Area Agency on Aging
1-800-994-9422

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

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

MEDICARE WEBSITES

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

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

FLORIDA MEDICAL REVIEW

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

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

Effective and Notice Dates

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

Electronic Notification

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

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

More Information

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

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

1-904-791-8465

Medical Review Table of Contents

Advance Notice Statement

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

CORRECTIONS TO LCD

J9000: Antineoplastic Drugs—LCD Correction

A revision to the local coverage determination (LCD) for Antineoplastic Drugs was published in the August 2006 *Medicare B Update!* (pg. 60). The effective date of June 19, 2006 for the addition of the following indications and ICD-9-CM codes for J9310 was incorrect. The correct effective date is February 28, 2006 for Rituximab (J9310).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section for J9310:

- Added the FDA approved indication for rheumatoid arthritis and verbiage of other approved indications based on the FDA label.

Under the "ICD-9 Codes that Support Medical Necessity" section for J9310 added the following diagnosis codes:

- 714.0 – Rheumatoid arthritis
- 714.1 – Felty's syndrome (Rheumatoid arthritis with splenoadenomegaly and leukopenia)
- 714.2 – Other rheumatoid arthritis with visceral or systemic involvement

This correction is effective for claims processed on or after August 21, 2006 for services rendered on or after February 28, 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.

NEW LCDS

0145T: Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries—New LCD

Multislice or Multidetector Computed Tomography (MDCT) angiography with its advanced spatial and temporal resolution has opened up new possibilities in the imaging of the major vessels of the chest, including aorta, pulmonary arteries, and coronary arteries.

MDCT technology for cardiac and coronary artery assessment requires thin (less than 1 mm) slices 0.5 to 0.75 mm reconstructions, multiple simultaneous images (e.g. 40-64 or more slices) and cardiac gaiting (often requiring beta blockers for ideal heart rate). There is significant post processing, depending on the number of slices for image generation. For coronary artery imaging, the resulting images show a high correlation with stenotic lesions noted on diagnostic cardiac catheterization but more importantly, with atheromas on intracoronary ultrasound. Additionally, the technique may be helpful in defining the vascularity of chest or lung lesions.

CPT category III codes for Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries (*0144T-0151T*) were effective January 1, 2006. Prior to this CT angiography procedures were billed with procedure code *71275* or an unlisted procedure code. *CPT* category III codes are different from typical *CPT* codes in that they are for services that may have limited use by health care professionals, and the service or procedure may not have proven clinical efficacy in the peer reviewed literature.

Note: *CPT* category III code *0144T* is locally noncovered as investigational, and is included in The List of Medicare Noncovered Services local coverage determination (LCD), effective January 1, 2006.

This LCD has been developed to provide indications and limitations of coverage and/or medical necessity and documentation requirements for *CPT* category III codes *0145T-0151T* and procedure code *71275* (computed tomography, chest). In addition, ICD-9-CM codes that support medical necessity have been identified.

Effective Date

This LCD will be 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.

36470: Treatment of Varicose Veins of the Lower Extremities—New LCD

Varicose veins are caused by venous insufficiency as a result of valve reflux (incompetence). The venous insufficiency results in dilated, tortuous, superficial vessels that protrude from the skin of the lower extremities. Spider veins (telangiectasias) are dilated capillary veins that are most often treated for cosmetic purposes and are not covered by Medicare. Sclerotherapy (liquid or foam) is preformed for signs and symptoms of diseased vessels and can be used as an adjunct to surgical or ablative therapy (radiofrequency or laser). Sclerotherapy for cosmetic purposes is not considered medically reasonable and necessary. Ligation and stripping of varicose veins is a treatment option that aims to eliminate reflux at the saphenofemoral or saphenopopliteal junction. Endovenous radiofrequency and laser ablation is a minimally invasive alternative to vein ligation and stripping. Endovenous radiofrequency ablation (ERFA) (VENUS® Closure System) is FDA-approved for endovascular coagulation of blood vessels with superficial vein reflux. Endovenous laser ablation is FDA-approved for the treatment of varicose veins and varicosities associated with superficial reflux of the greater saphenous vein.

This new local coverage determination (LCD) replaces the retired LCDs for sclerotherapy of varicose veins (*36470*) and endovenous ablation therapy of the saphenous vein (*36475*) and was developed based on data analysis. This LCD incorporates indications and limitations, documentation guidelines, utilization guidelines, ICD-9-CM codes that support medical necessity, ICD-9-CM codes that do not support medical necessity and a coding guideline for procedure codes *36470, 36471, 36475, 36476, 36478, 36479, 37700, 37718, 37722, 37735, 37760, 37765, 37766, 37780, 37799, 93965, 93970* and *93971*.

Effective Date

This new LCD will be 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.

61885: Vagal Nerve Stimulation (VNS) for Intractable Depression—New LCD

Vagal nerve stimulation (VNS) therapy involves the direct delivery of intermittent retrograde electrical impulses to the left vagus nerve via a surgically attached bi-polar electrode that has been subcutaneously tunneled to the nerve from a small electrical generator implanted in the left chest wall. Like a pacemaker, the device may be turned on and off or adjusted noninvasively.

The Food and Drug Administration (FDA) originally approved VNS for the treatment of refractory epilepsy. On July 15, 2005, the FDA granted premarket approval to Cyberonics, Inc. for their VNS therapy system for the adjunctive long-term treatment of chronic or recurrent depression for patients 18 years of age or older who are experiencing a major depressive episode and have not had an adequate response to four or more antidepressant treatments.

The current available evidence based on publications in peer-reviewed literature and other pertinent sources, is insufficient to permit conclusions regarding the efficacy and safety of VNS as an adjunct therapy in treatment-resistant major depression and bipolar disorder. Therefore, a local coverage determination (LCD) was developed to non-cover reimbursement for VNS therapy for intractable depression at this time.

The following *CPT* codes will not be covered for VNS when used for intractable depression:

61885 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

61888 Revision or removal of cranial neurostimulator pulse generator or receiver

64573 Incision for implantation of neurostimulator electrodes; cranial nerve

64585 Revision or removal of peripheral neurostimulator electrodes

95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

95974 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

95975 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

Effective Date

This LCD 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.

82550: Creatine Kinase (CK), (CPK)—New LCD

Creatine kinase (CK or CPK) is an enzyme found in heart muscle (CK-MB), skeletal muscle and heart (CK-MM), and brain (CK-BB). The MM fraction is present in both cardiac and skeletal muscle, but the MB fraction is much more specific for cardiac muscle. Therefore, elevation in total CK is not specific for myocardial injury, because most CK is located in skeletal muscle. Elevations in total CK are possible from a variety of non-cardiac conditions, such as muscle disease, stroke, hypothyroidism, and side effects from the use of statin medications.

Statins are low-density lipoprotein (LDL) lowering drugs that are widely used in clinical practice. The use of statins may produce muscle toxicity under some circumstances. Therefore, it would be expected that a baseline measurement of CK would be done prior to initiating statin therapy, as well as, titration of statin therapy or with clinical signs and symptoms of myopathy (i.e., muscle discomfort, weakness, brown urine, etc.). However, medical literature does not support routine monitoring of CK in the absence of clinical signs and symptoms.

This local coverage determination (LCD) has been developed to define the indications and limitations of coverage, utilization, and documentation requirements for creatine kinase.

Effective Date

This new LCD will be 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.

86803: Hepatitis C Antibody in the ESRD and Non–ESRD Setting—New LCD

Hepatitis C virus is a leading cause of chronic liver disease. It is also the leading indication for liver transplantation. Complications from chronic liver disease include cirrhosis, hepatic decompensation and hepatocellular carcinoma. The incubation period of hepatitis C is approximately 7 weeks. Hepatitis C is an uncommon cause of acute hepatitis in the United States. It is not an easily transmitted disease. It is transmitted through contact with blood and blood products. The leading risk factor for hepatitis C infection is injection drug use, occupational exposure, sexual transmission, intranasal cocaine use, tattooing, body piercing and maternal-infant spread.

Medicare will consider testing for the hepatitis C antibody medically reasonable and necessary when performed for the purpose of identifying the presence of the hepatitis C virus (HCV) and testing is not performed for the purpose of routine screening.

The purpose of this local coverage determination (LCD) is to identify coverage criteria and utilization guidelines when testing for hepatitis C antibody.

Effective Date

This new LCD 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.

J0740: Ganciclovir and Cidofovir—New LCD

Ganciclovir (cytovene IV) is a synthetic guanine derivative and an active antiviral agent for cytomegalovirus (CMV) infections. The ganciclovir (vitrasert) implant is a synthetic nucleoside analogue of 2'- deoxyguanosine, which inhibits assembly of virons. Ganciclovir is not a cure for CMV. Cidofovir (vistide) is an antiviral used to treat the symptoms of CMV infection of the eye. Cidofovir is available in IV form only. Cidofovir will not cure CMV infection.

Ganciclovir (J1570 and J7310)

Medicare will cover ganciclovir for the following FDA-approved indications:

IV form

- Cytovene-IV is indicated for the induction and maintenance in the treatment of CMV retinitis in immunocompromised patients, including patients with acquired immunodeficiency syndrome (AIDS).
- Cytovene-IV is also indicated for the prevention of CMV disease in transplant recipients at risk for CMV disease.

Implant form

- Ganciclovir (vitrasert) implant is indicated for CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS). The intravitreal implant is designed to release ganciclovir over a period of 5 to 8 months. The implant provides localized treatment only and will not have any effect on extraocular CMV infection.

Cidofovir (J0740)

Medicare will cover cidofovir (vistide) for the following FDA-approved indications:

- Cidofovir is indicated, in combination with probenecid, for the treatment of CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS).

This local coverage determination (LCD) was developed based on data analysis. Indications and limitations, utilization guidelines, documentation guidelines and appropriate ICD-9-CM codes were incorporated into this LCD for procedure codes J0740, J1570 and J7310. A coding guideline was also developed.

Effective Date

This new LCD will be 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.

J1080: Testosterone Cypionate and Testosterone Enanthate—New LCD

Testosterone cypionate and Testosterone enanthate, for IM injection, are oil-soluble 17 (beta)-cyclopentylpropionate esters of the androgenic hormone testosterone. Testosterone esters are less polar than free testosterone. Testosterone esters in oil, injected intramuscularly, are absorbed slowly from the lipid phase; thus, they can be given at intervals of 2 to 4 weeks.

FDA-approved indications covered by Medicare:

Testosterone cypionate and testosterone enanthate are indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone:

- Primary hypogonadism (congenital or acquired)- testicular failure due to cyrptorchidism, bilateral torsion, orchitis, vanishing testes syndrome; or orchidectomy.
- Hypogonadadotropic hypogonadism (congenital or acquired)- idiopathic gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma or radiation.

In addition to the FDA-approved indications, Medicare will cover Testosterone cypionate and testosterone enanthate for the following off-label indication:

- Hypogonadism in patients who are infected with HIV, particularly those whose disease has progressed to AIDS and who have developed wasting syndrome. Wasting syndrome is an AIDS defining condition. Wasting is evidence of symptomatic HIV infection. Wasting syndrome is defined as unintentional weight loss >10% and the presence of chronic weakness and documented fever lasting at least 30 days. Wasting is defined as unintentional weight loss >10%. Wasting syndrome and wasting must be differentiated from lipoatrophy, which is isolated fat loss and is seen in patients who are on a successful course of antiretroviral therapy.

This local coverage determination (LCD) was developed based on data analysis. Indications and limitations, utilization guidelines, documentation guidelines and appropriate ICD-9-CM codes were incorporated into this LCD for procedure codes J1070, J1080, J3120 and J3130. A coding guideline was also developed.

Effective Date

This new LCD will be 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.

J2325: Nesiritide (Natrecor®)—New LCD

The Food and Drug Administration (FDA) has approved nesiritide for the short-term intravenous treatment of patients with acutely decompensated congestive heart failure (CHF) who have dyspnea (shortness of breath) at rest or with minimal activity. Recent published studies of Nesiritide have highlighted safety concerns, specifically increased mortality and decreased renal function in patients treated with nesiritide.

Because nesiritide is only indicated for acute decompensated heart failure, and because of the risks involved during its administration, a new local coverage determination (LCD) was developed to restrict the administration of this drug to inpatient admission, emergency department, or hospital outpatient observation settings. This new LCD was presented to the Florida Carrier Advisory Committee on June 3, 2006.

This LCD includes ICD-9-CM diagnosis codes and indications and limitations of coverage for patients diagnosed with acutely decompensated CHF for the inpatient setting.

Effective Date

This LCD 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.

J9213: Interferon, Alpha 2-a (Roferon®-A)—New LCD

Interferon alfa-2a, recombinant (Roferon®-A) is a sterile protein product for use by injection. It is manufactured by recombinant DNA technology that employs a genetically engineered E. coli bacterium containing DNA that codes for the human protein. The mechanism by which interferon, alfa-2a or any other interferon, exerts antitumor or antiviral activity is not clearly understood. It is believed that direct antiproliferative action against tumor cells, inhibition of virus replication and modulation of the host immune response play important roles in antitumor and antiviral activity.

Currently, First Coast Service Options, Inc. (FCSO) has a coverage statement for interferon, alfa-2a in the local coverage determination (LCD) for interferon (J9212). Interferon, alfa-2a was evaluated for addition to the self-administered drug (SAD) list. However, the evaluation results revealed that intramuscular injection of this drug might be required for certain medical conditions. Therefore, this LCD was developed to define indication and limitation criteria and to provide utilization guidelines for interferon, alfa-2a. In addition, ICD-9-CM codes that support medical necessity have been identified.

Effective Date

This new LCD 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.

REVISIONS TO LCDS

J1566: Intravenous Immune Globulin—LCD Revision

The local coverage determination (LCD) for Intravenous Immune Globulin was last revised January 1, 2006. Intravenous Immune Globulin is a solution of human immunoglobulin specifically prepared for intravenous infusion. Immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens. The use of intravenous immune globulin should be reserved for patients with serious defects of antibody function. The goal is to provide immunoglobulin G (IgG) antibodies to those who lack them.

The intent of the LCD revision is to provide updates to the following sections; "Indications and Limitations of Coverage and/or Medical Necessity", "ICD-9 Codes that Support Medical Necessity", and "Documentation Requirements". In addition coding guidelines were developed.

A new requirement for dual diagnoses was added for human immunodeficiency virus [HIV] disease (042).

For the pediatric population < 13, there is a requirement for a dual diagnosis:

- 042, human immunodeficiency virus [HIV] disease **plus** V15.9, unspecified personal history presenting hazards to health **OR**
- 042, human immunodeficiency virus [HIV] disease **plus** V49.89, other specified conditions influencing health status.

For adults ≥13 there is a dual diagnosis requirement for administering IVIG for thrombocytopenia associated with HIV disease:

- primary diagnosis of 287.5, thrombocytopenia, unspecified and a secondary diagnosis of 042, human immunodeficiency virus [HIV] disease

Effective Date

This LCD revision is effective for services rendered on or after October 30, 2006. The full text for this LCD may be viewed through the provider education website *http://www.floridamedicare.com* on or after this effective date.

J9000: Antineoplastic Drugs—LCD Revision

This local coverage determination (LCD) for antineoplastic drugs was last updated on June 19, 2006. Since that time, the following revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-9 Codes that Support Medical Necessity" sections for the following HCPCS codes:

J9263 (oxaliplatin)

- Added the off-label indication of oxaliplatin for the treatment of advanced/metastatic gastric carcinoma in combination with irinotecan or fluorouracil with leucovorin or folinic acid.
- Added diagnosis code range 151.0-151.9 for J9263 (oxaliplatin).

J9350 (topotecan)

- Added the FDA approved indication of topotecan in combination with cisplatin for the treatment of Stage IV-B, recurrent, or persistent carcinoma of the cervix which is not amenable to curative treatment with surgery and/or radiation therapy.

Verbiage for other FDA approved indications to correspond with the USP DI verbiage for J9350 (topotecan) was updated.

J9201 (gemcitabine)

- Added the FDA-approved indication of gemcitabine in combination with carboplatin for the treatment of patients with advanced ovarian cancer that has relapsed at least 6 months after completion of platinum-based therapy.

In addition, updated verbiage for other FDA-approved indications for J9201 to correspond with the USP DI verbiage. References were also updated.

Effective Dates

The effective dates for these changes are:

- J9263 and J9350 are effective for services rendered on or after July 31, 2006.
- J9201 is effective for services rendered on or after July 14, 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.

J9015: Aldesleukin (Proleukin®, Interleukin-2, Recombinant, and RIL-2)—LCD Revision

Aldesleukin (J9015) is in the Antineoplastic Drugs (J9000) local coverage determination (LCD). The Antineoplastic Drugs LCD was last updated on July 31,2006. A revision was made to aldesleukin and was singularly submitted to the Florida Carrier Advisory Committee on June 3, 2006 due to the size of the Antineoplastic Drugs LCD and the fact that only aldesleukin was revised.

The only Food and Drug Administration (FDA) indications for aldesleukin are metastatic renal cell carcinoma and metastatic melanoma for adults. FDA label warnings state this drug should be administered in a hospital setting under the supervision of a qualified physician experienced in the use of anticancer agents. The recommended FDA high dosage is 600,000 IU/kg administered every 8 hours by a 15 minute IV infusion for a maximum of 14 doses, which is repeated following nine days of rest.

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, verbiage for the FDA-approved indications was changed stating aldesleukin is FDA-approved for treatment of adults with metastatic renal cell carcinoma, and treatment of adults with metastatic melanoma. In addition, the off-label indications of acute and chronic myeloid leukemia were added, as well as FDA dosages, warnings, and contraindications for aldesleukin. The "Documentation Requirements" section was revised to include "If a provider departs from the recommended high dose label recommendations and gives a reduced dosage (off-label) and/or different route of administration in an alternate setting, the rationale for such administration should be documented in the medical record."

Under the "ICD-9 Codes that Support Medical Necessity" section, diagnosis code 190.6 – malignant neoplasm of choroid (use this code for ocular melanoma) was added.

Effective Date

These revisions are 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

Vital Stim® Therapy uses a small current, passing it through external electrodes on the anterior neck to stimulate inactive or atrophied swallowing muscles. A request was received to consider this procedure for the treatment of swallowing dysfunction and/or oral function for feeding.

Based on the literature, this service is an emerging technology, and investigational for the treatment of dysphagia, therefore, this procedure was added to the "Local Noncoverage Decisions" section of The List of Medicare Noncovered Services local coverage determination (LCD). Since this procedure does not have a unique procedure code, this service should be billed with unlisted procedure code (*92700*).

Effective Date

This 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.

SKINSUB: Skin Substitutes—LCD Revision

The local coverage determination (LCD) for skin substitutes was last updated on January 1, 2006.

Since that time, a major revision was made to the LCD and presented at the Florida Carrier Advisory Committee on June13, 2006. The final revisions included the addition of Integra, TransCyte, and OASIS products to the LCD. The skin substitutes were arranged in alphabetical order. The "Indications and Limitations of Coverage and/or Medical Necessity" section was updated to include these products, as well as a "Note" at the end of this section for preparation and application of graft codes with range of corresponding CPT codes. This "Note" was also added to the "Coding Guidelines" under "Other Comments." Under the "ICD-9 Codes that Support Medical Necessity" section, ICD-9-CM codes were added for OASIS, Integra, and TransCyte, and additional diagnosis codes were added for OrCel (J7343). Diagnosis code 707.10 (ulcer of lower limb, unspecified) was added to Xenograft. Documentation requirements were added for Integra and OASIS and general applicable FDA labeling requirements for all products. The "Sources of Information and Basis for Decision" section was updated.

Effective Date:

These revisions are 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.

VISCO: Viscosupplementation Therapy for Knee—LCD Revision

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised November 15, 2005.

This LCD revision is for the purpose of removing the brand name of all preparations of sodium hyaluronate and related substances. Providers are to use the HCPCS code that accurately describes the preparation they are administering. The HCPCS codes and their descriptors are as follows:

J3590	Unclassifed biologics (use for high molecular weight hyaluronan)
J7317	Sodium hyaluronate, per 20 to 25 mg dose for intra-articular injection
J7320	Hylan G-F 20, 16 mg, for intra-articular injection

In addition to the above changes, the "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD was updated by adding statements defining medical reasonableness and necessity of drugs/biologicals and procedures, based on Medicare *Benefit Policy Manual* (100-2, Chapter 15, Section 50.2k) and the *Program Integrity Manual* (100-8, Chapter 13, Section 5.1), respectively. Also, a statement regarding the use of the appropriate HCPCS code when billing for a hyaluronic preparation was added to the coding guidelines.

Effective Date

This revision is effective for claims processed on or after August 21, 2006. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

0067T: Computed Tomographic Colonography—LCD Revision

Computed tomographic colonography (CT colonography) also known as virtual colonoscopy utilizes helical computed tomography of the abdomen and pelvis to visualize the colon lumen. The test requires colonic preparation similar to that required for conventional colonoscopy (instrument colonoscopy), and air insufflation to achieve colonic distention**.** When polyps are detected with CT colonography, patients could presumably undergo subsequent conventional colonography, which may require another bowel preparation. The American Cancer Society, the U.S. Preventive Services Task Force, the Centers for Medicare & Medicaid Services (CMS), nor, to date, any professional bodies endorse CT colonography for screening.

This local coverage determination (LCD) became effective January 1, 2006. Since that time, the LCD has been revised to expand coverage indications, identify equipment requirements, and define physician qualifications for performing CT colonography. Also, the "Documentation Requirements" and "Sources of Information and Basis for Decision" sections were also updated.

Effective Date

This 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.

43235: Diagnostic and Therapeutic Esophagogastroduodenoscopy—LCD Revision

The local coverage determination (LCD) for diagnostic and therapeutic esophagogastroduodenoscopy was last revised October 25, 2005. Since that time, an external request was received to add a diagnosis code for the removal of percutaneous gastrostomy tube (PEG) after the patient no longer has a diagnosis that supports the reason for placement of the PEG.

The LCD supports esophagogastroduodenoscopy (EGD) for assisting in the placement of a feeding tube. Therefore, it was determined that removal of the PEG is reasonable when it is no longer required. The LCD has been revised to add ICD-9-CM code V55.1 (Attention to artificial openings, gastrostomy) to the"ICD-9 Codes that Support Medical Necessity" section of the LCD. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was expanded to include follow-up for removal of the PEG. The "Utilization Guidelines" section of the LCD has been updated to include verbiage regarding provider qualification requirements when rendering this service.

Effective Date

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

64400: Peripheral Nerve Blocks—LCD Revision

Peripheral nerves blocks may be used for both diagnostic and therapeutic purposes. Diagnostically, a peripheral nerve block allows the clinician to isolate the specific cause of pain in an individual patient. The injection of a local anesthetic, with or without steroid may also provide an extended therapeutic benefit.

This local coverage determination (LCD) was revised to include indications and limitations of coverage and/or medical necessity and documentation requirements for postoperative pain management and preemptive analgesia.

Revisions include the following changes to the ICD-9-CM codes that support medical necessity:

Added:

719.41	Pain in shoulder region
719.42	Pain in upper arm
719.43	Pain in forearm
719.44	Pain in hand
719.45	Pain in pelvic region and thigh

Added: (continued

719.46	Pain in lower leg
719.47	Pain in ankle and foot
726.5	Enthesopathy of hip region
789.9	Other symptoms involving abdomen and pelvis

Extended range:

789.00-789.09	Abdominal pain

Deleted:

729.5	Pain in limb

In addition, the following *CPT* codes *64412, 64417, 64420, 64421,* and *64449* were added to the LCD.

Effective Date

These revisions are 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.

64640: Destruction by Neurolytic Agent; Interdigital Nerve of the Foot—Morton's Neuroma—LCD Revision

This local coverage determination (LCD) was effective on April 11, 2006. Since that time the LCD has been revised. First Coast Service Options, Inc. (FCSO) received several inquiries regarding the scope of this LCD and the scope of procedure code *64640*. FCSO recognizes that there are other peripheral nerves and branches that can be treated within the scope of procedure code *64640*.

The Indications and limitations section of this LCD was revised to state that the intent of this LCD is to establish local coverage criteria for the treatment of Morton's neuroma only.

The indications and limitations, ICD-9-CM codes, utilization guidelines, documentation requirements and the attached coding guideline apply only to the coverage criteria established in this LCD for procedure cod *64640* and the treatment of Morton's neuroma.

Effective Date

This revision is effective for services rendered on or after April 11, 2006. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

78459: Myocardial Imaging, Positron Emission Tomography (PET) Scan—LCD Revision

Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceutical) such as FDG (2-{flourine-18}-fluoro-2-dexoy-D-glucose), Nitrogen N13 ammonia and Rubidium RB-82.

This local coverage determination (LCD) was last revised on January 1, 2006. Since that time, this LCD has been revised to add the following ICD-9-CM codes to the "ICD-9 Codes that Support Medical Necessity" section of the LCD:

411.0	426.2	428.0
412	426.3	428.1
413.1	426.4	428.20 – 428.23
414.10	426.50 – 426.54	428.30 – 428.33
414.12	426.6	428.40 – 428.43
414.19	427.31	428.9

In addition, the "Documentation Requirements"' section of the LCD has been revised for clarification.

Effective Date

These revisions are 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.

91110: Wireless Capsule Endoscopy—LCD Revision

Wireless capsule endoscopy utilizes the use of a small capsule containing a disposable light source, miniature color video camera, battery, antenna and a data transmitter. The patient swallows the capsule and images taken by the camera contained within the capsule are relayed to the data transmitter. The data transmitter is connected to a computer workstation where the images are downloaded, reviewed, and interpreted by the physician.

First Coast Service Options, Inc. (FCSO) developed a local coverage determination (LCD) for wireless capsule endoscopy of the *small bowel*, which has been in effect since March 24, 2003. The purpose of this LCD/Coding Guideline revision is to provide coverage guidelines for wireless capsule endoscopy of the *esophagus*.

Effective Date

This 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.

92250: Fundus Photography—LCD Revision

The latest revision for local coverage determination (LCD) fundus photography was effective October 1, 2005. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD has been revised to indicate a limitation of coverage as follows:

> "Fundus photography is considered medically reasonable and necessary when it is furnished by a qualified optometrist or ophthalmologist in the course of the evaluation and management of a retinal disorder or another condition that has affected the retina as outlined above. Therefore, the digital imaging systems for the detection and evaluation of diabetic retinopathy, used to acquire retinal images through a dilated pupil with remote interpretation, do not meet Medicare's reasonableness and necessity criteria for fundus photography."

The "Coding Guidelines" section of this LCD has also been revised accordingly:

> "Services billed for digital imaging systems for detection and evaluation of diabetic retinopathy used to acquire retinal images through a dilated pupil with remote interpretation should be billed using *CPT* code *92499* (Unlisted ophthalmological service or procedure)."

Effective Date

This 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.

RETIRED LCD

36470: Sclerotherapy of Varicose Veins and 36475: Endovenous Ablation Therapy of the Saphenous Veins—LCD Retirement

The local coverage determinations (LCDs) for sclerotherapy of varicose veins (*36470*) and endovenous ablation therapy of the saphenous veins (*36475*) are being retired. The decision to retire these LCDs is based on data analysis and local standards of medical practice.

Effective Date

The LCDs will be retired effective for services rendered on or after October 30, 2006. The full text of these LCDs are available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

MEDICARE 101 for Part B

Join the Medicare Communication and Education Department

September 15, 2006

for a half-day educational extravaganza at the

Jacksonville Marriott

4670 Salisbury Road, Jacksonville, Florida 32256
904-296-2222

Session times are 1:00 p.m. to 5:00 p.m.!

Course	Description
Pre-Assessment	• Used to determine your current knowledge of the Medicare Program
Overview of Medicare	• Describe participation regulations • Identify enrollment forms applicable to your situation • Describe beneficiary eligibility requirements, premiums, and deductibles
CMS-1500	• Review the purpose • Explain mandatory claim submission rules and billing requirements • Explain transition to the CMS-1500 (08/05) • Review timeframes to transition to the CMS-1500 (08/05)
Post-Assessment	• Determines your knowledge of the Medicare Program after the session
Certificate of Completion	• A certificate of completion will be issued at the end of the session

Want to know more? Call us at 904-791-8103 or visit our website at *www.floridamedicare.com.* **To register on line, click on the Education Tab; Event List and choose the Part B session. There is no charge for this seminar.**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Note: This is a Part B basic course geared for medical office staff that are new to the Medicare billing process or for those employees needing a refresher course.

FIRST COAST
SERVICE OPTIONS, INC.

A CMS Contracted Intermediary & Carrier

FIRST COAST SERVICE OPTIONS, INC.

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Part B Teleconference Invitation

Thursday, September 14, 2006

11:30 a.m. – 12:30 p.m. (Eastern Standard Time)

The Medicare Communication and Education Department of First Coast Service Options, Inc. cordially invites you to attend:

"Ask the Contractor"

This teleconference is the latest installment of educational efforts designed to support and inform the provider community by answering the questions that are on your mind. The session will begin with a presentation on the following:

- **National Provider Identifier and Provider Enrollment**

Get first-hand answers to your questions on these topics by Medicare subject matter experts. Please join us from 11:30 a.m. – 12:30 p.m. for this very informative training session. Don't miss out on this opportunity to interact directly with the experts!

If you would like to participate in the teleconference:

(1) Register on line at *www.floridamedicare.com* by September 13, 2006. Don't wait! Space is limited to 50 phone lines. (To register, select Education and Training from the Site Map and continue to Event Registration Online.)

(2) Join the teleconference on September 14, 2006 by dialing 1-800-860-2442.

(3) The "Ask the Contractor" Teleconference presentation will be emailed to all registered participants the morning of September 13, 2006 along with an evaluation form. Please complete the evaluation form at the conclusion of the teleconference and fax it to 904-791-6035.

DON'T MISS OUT!

Stay on track with

"MEDICARE MADE EASY"

Join the Medicare Communication and Education Department at First Coast Service Options, Inc., for a one day educational extravaganza!

September 19, 2006

Wyndham Miami Airport
3900 Northwest 21st Street, Miami, FL 33142

Class schedules are as follows:
(Please mark only one class per time slot)

☐ **8:00 a.m. – 10:00 a.m.**
"Incident to" Services

☐ **10:15 a.m. – 12:15 p.m.**
Transitioning from UB-92 to UB-04

☐ **1:20 p.m. – 3:20 p.m.**
Podiatry Services

☐ **3:30 p.m. – 5:30 p.m.**
Provider Enrollment/NPI

☐ **8:00 a.m. – 10:00 a.m.**
Skilled Nursing Facility (SNF)

☐ **10:15 a.m. – 12:15 p.m.**
Correct Coding Initiative (CCI)

☐ **1:20 p.m. – 3:20 p.m.**
Claims Resolution

☐ **3:30 p.m. – 5:30 p.m.**
Radiology

The $89.00 registration fee includes sessions of your choice, lunch, and refreshments during break sessions.

Want to know more? Call us at 904-791-8103 or visit our website at *www.floridamedicare.com*.

For full class descriptors, visit the online registration form at *www.floridamedicare.com*.

Medicare Made Easy Registration Form

Wyndham Miami Airport
3900 Northwest 21st Street, Miami, FL 33142
Please contact hotel for directions and/or reservations (305) 871-3800

Registrant's Name _____

Telephone Number _____

Email Address _____

Fax Number _____

Provider's Name _____

Street Address _____

City, State, ZIP Code _____

Cost for Medicare Made Easy
1 day only — $89.00

FAXED REGISTRATION

Fax registration form to **(904) 791-6035.**

1. A confirmation and invoice will be faxed to you.
2. Make checks payable to: **FCSO Account #700390**
3. Mail the forms (after you have faxed them) and payment to:

Medicare Made Easy Registration
P.O. Box 45157
Jacksonville, FL 32231

Bring your confirmation notice to the event.

CANCELLATIONS AND REFUNDS

All cancellation requests must be received 7 days prior to the event. All refunds are subject to a $25.00 cancellation fee per person. (Rain checks will not be issued for cancellations.)

SUBSTITUTIONS

If you are unable to attend, your company may send one substitute to take your place for the entire seminar. Remember: Registration must be information of all changes.
Once you have signed in at the registration desk, substitutions will not be permitted during the remainder of the event.

CONFIRMATION NOTICE

Faxed registration: A confirmation notice will be faxed or e-mailed to you within 7 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Medicare Communication and Education), please contact us at **(904) 791-8103.**

On-line registration: When registering on-line for an education event, you will automatically receive your confirmation via e-mail notification.

FIRST COAST SERVICE OPTIONS, INC.

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Teleconference Invitation

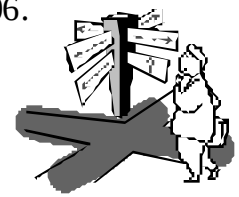
The Medicare Communication and Education Department of
First Coast Service Options, Inc. cordially invites you to participate!

Part B Quarterly Update Conference Call

What's New in Medicare for the 4th quarter 2006
Thursday, September 28, 2006

11:30 AM – 12:30 PM

This conference call will educate and inform providers by discussing changes that will be in effect in August, September, and October 2006.



Don't miss this informative session where you will learn about new Medicare initiatives and how to prevent common provider inquiries and claim denials!

If you would like to participate in the teleconference, please register by September 26, 2006. Space is limited to 100 phone lines.

How To Register:

- **Online** - Go to *www.floridamedicare.com* to complete and submit the online registration form (located under "Event List" on the left navigation bar of the Education page). A confirmation will be e-mailed to you upon successful completion of the form. Handouts and the evaluation form will be forwarded to you on September 27, 2006, via e-mail.
- **Fax** - For providers without Internet access, please call our Registration Hotline at 904-791-8103 to have a form faxed to you. Handouts and the evaluation form will be faxed to you the morning of the teleconference.

The teleconference phone number is 1-800-860-2442. On the day of the teleconference, please dial in a few minutes before 11:30 A.M.

FLORIDA MEDICARE PART B MAIL DIRECTORY

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

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

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

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

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

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

DURABLE MEDICAL EQUIPMENT (DME)

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

ELECTRONIC MEDIA CLAIMS (EMC)

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

MEDICARE PART B ADDITIONAL DEVELOPMENT

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

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

MISCELLANEOUS

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

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

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Medicare Communication and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

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

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

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

Medicare Claims for Railroad Retirees:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

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

FLORIDA MEDICARE PHONE NUMBERS

BENEFICIARY

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

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

PROVIDERS

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

For Seminar Registration Only (*not* toll-free)**:**
1-904-791-8103

EMC

Format Issues & Testing:
1-904-354-5977 option 4
Start-Up & Front-End Edits/Rejects:
1-904-791-8767 option 1
Electronic Funds Transfer
1-904-791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
PC-ACE Support:
1-904-355-0313
Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
Help Desk:
(Confirmation/Transmission):
1-904-905-8880 option 1

OCR

Printer Specifications/Test Claims:
1-904-791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare
1-866-270-4909

MEDICARE PART A

Toll-Free:
1-866-270-4909

Medicare Websites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

GENERAL EDUCATIONAL RESOURCES

Information in this section apply to both Florida and Connecticut.

Updated Versions of Web-Based Training Courses and Medicare Appeal Process Brochure now Available

The Centers for Medicare & Medicaid Services (CMS) has updated of the following free-of-charge educational products:

- Preventive services Web-based training courses
- Brochure on the Medicare appeal process.

Preventive Services Web-Based Training Courses

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

The course provides information about Medicare coverage for the following adult immunizations:

- Influenza
- Pneumococcal
- Hepatitis B

CMS has awarded 0.1 of CEUs (continued education units) to participants who successfully complete this program.

The updated Medicare Preventive Services Series: Part 2 Women's Health Web-based training course is now available on the Medicare Learning Network (MLN) Product Ordering Page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

The course provides information about Medicare coverage for the following preventive services:

- Mammography
- Pap test and pelvic exam
- Colorectal cancer screening
- Bone mass measurements

CMS has awarded 0.2 of CEUs to participants who successfully complete this program. The *Medicare Preventive Services: Part 3 Expanded Benefits* Web-based training course is now available on the Medicare Learning Network (MLN) Product Ordering Page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

The course provides information about Medicare coverage for the following preventive services:

- Initial preventive physical examinations
- Diabetes screenings
- Cardiovascular disease screenings
- Diabetes self management training
- Medical nutrition therapy and other diabetes supplies
- Colorectal, prostate, and glaucoma screenings
- Bone mass measurements.

CMS has awarded 0.2 of CEUs to participants who successfully complete this program.

The information presented in these Web-based training courses will be helpful for physicians, nurses, medical administrators and other health care professionals who provide these preventive services and screening to Medicare patients.

CMS has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, suite 615, Washington DC 20006.

The authors of these programs have nothing to disclose.

The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers

The brochure The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers has been updated and is now available in downloadable format on the MLN Publications page located at *http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf*.

This brochure provides an overview of the Medicare Part A and Part B administrative appeal process available to providers, physicians and other suppliers who provide services and supplies to Medicare beneficiaries. Print copies will be available in approximately six weeks.

Source: CMS Provider Education Resource 200608-04

Medicare Immunization Billing Quick Reference now Available

Quick Reference Information: Medicare Immunization Billing

This two-sided job aid gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. This product is available to view, download, and print from the CMS Medicare Learning Network Preventive Services Educational Products Web page located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

Print copies will be available in early Fall, 2006.

Source: CMS Provider Education Resource 200608-05

Updated Website Wheel now Available for Ordering

The Centers for Medicare & Medicaid Services (CMS) has updated the *CMS Website Wheel* document and is now available for ordering through the Medicare Learning Network website at *http://www.cms.hhs.gov/MLNProducts/Downloads/MLNCatalog0506.pdf*.

This website wheel is an informational resource tool that provides a variety of CMS Medicare related websites. The Web addresses are listed by topic. The available format is in hard copy only (ICN #006212).

Source: CMS Provider Education Resource 200608-06

Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program Facilitator Kit now Available

The *Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program Facilitator's Kit*, which includes everything facilitators, trainers, educators, and physicians need to prepare for and present a Medicare training course, is now available. To order your free *Facilitator's Kit*, visit the Medicare Learning Network at *http://www.cms.hhs.gov/mlngeninfo* on the Centers for Medicare & Medicaid Services website. Select "MLN Product Ordering Page" under the "Related Links Inside CMS" Section to place your order.

Provider Education Resources Listserv, Message 200608-08

August is National Immunization Awareness Month

While many consider this to be a time to ensure that children are immunized for school, it also provides a good opportunity to speak with your Medicare patients about their immunizations.

Medicare covers both the cost of pneumococcal and influenza vaccine and their administration by recognized providers. No beneficiary co-insurance or co-payment applies and a beneficiary does not have to meet his or her deductible to receive an influenza or pneumococcal immunization. Medicare also covers hepatitis B vaccination for persons at high or intermediate risk. The coinsurance or co-payment applies for hepatitis B vaccination after the yearly deductible has been met.

Despite Medicare coverage, the use of these benefits is not optimal. In 2004, Medicare survey data indicate a 73 percent influenza vaccination rate for facility and community-dwelling Medicare beneficiaries, and a 67 percent pneumococcal vaccination rate for the same population.

Additionally, dialysis patients are under-immunized. Vaccines are one of public health's great triumphs. With the exception of safe water, no other health strategy has had such a tremendous effect on reducing disease and improving health. Maintaining high immunization rates protects the entire community and is an important public health matter.

Why Immunize Adults? An average of 36,000 Americans die from influenza or its complications each year. The National Center for Health Statistics reported influenza and pneumonia to be the primary causes of death for more than 57,000 older adults in 2003.

Pneumococcal disease occurs year round and accounts for approximately 40,000 cases of invasive disease and 5,000 deaths per year in the United States.

For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Medicare will cover a booster pneumococcal vaccine for high-risk persons if five years have passed since their last vaccination.

What's New?

- Nursing home residents are especially vulnerable to influenza and pneumonia and their complications. **Beginning September 1, 2006,** influenza and pneumococcal vaccination assessments will be included as part of the minimum data set (MDS) for nursing homes.
- **As of January 2005,** all newly enrolled Medicare beneficiaries are covered for an initial physical examination that includes immunization for pneumococcal disease and influenza.
- **As of January 2005,** physicians can be paid for injections and immunizations administered to people with Medicare, even when administered during a visit, which includes other Medicare-covered services.
- **As of October 2002,** hospitals, long-term care facilities and home health agencies participating in Medicare and Medicaid programs can administer influenza and pneumococcal vaccinations according to a standing orders protocol without the need for a physician's examination or direct order.
- Quality Improvement Organizations in each state are working to increase immunization rates in hospitals, physicians' offices, home health care settings and nursing homes.

August is National Immunization Awareness Month, continued

How Can You Help? As a trusted source, your recommendation is the most important factor in increasing immunization rates among adults.

For More Information

For more information about Medicare's adult immunization benefits, billing Medicare for vaccinations, and other helpful information, visit the CMS website: *http://www.cms.hhs.gov/AdultImmunizations/01_Overview.asp#TopOfPage*.

National Immunization Awareness Month is the perfect time to remind patients, health care employees, family members, friends, co-workers and others to get up-to-date on their vaccinations. To paraphrase a quote from the great hockey player Wayne Gretzky, "Your patients will miss 100 percent of the shots they never take." Let's protect people with Medicare by making sure that each August they have received their lifetime pneumococcal immunization, they have been assessed for their risk for hepatitis B, and they have an appointment to obtain their influenza vaccination in the fall.

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

- The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.
- The CMS website provides information for each preventive service covered by Medicare. Click on *http://www.cms.hhs.gov*, select "Medicare", and scroll down to "Prevention".

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

As always, thanks so much for helping CMS spread the word about immunizations and all preventive services covered by Medicare.

Source: CMS Provider Education Resource 200608-02

Provider Educational Opportunities Available Now

First Coast Service Options, Inc. (FCSO) offers a variety of educational programs on a range of subjects using multiple delivery methods. The following is a listing of upcoming courses and events. You may obtain additional information for each of these courses through FCSO's dedicated Medicare websites at

Connecticut–*http://www.connecticutmedicare.com*
Florida–*http://www.floridamedicare.com*

Web-based Training Courses

These online courses are available 24 hours a day, seven days a week, at no charge, through our provider education website. After accessing *http://www.connecticutmedicare.com or http://www.floridamedicare.com,* click on "Education" on the top navigation menu. Select "eLearning" on the left navigation menu. Courses currently available are:

- Ambulance Services
- Beneficiary Name and Medicare Number Mismatch
- Chiropractic Services
- Comprehensive Error Rate Testing (CERT)
- Introduction to Global Surgery
- Medical Documentation Requests
- Modifier 24
- Modifier 25
- Modifier 58
- Modifier 78
- Modifier 79
- MSP Beyond the Basics
- National Correct Coding Initiative (NCCI)
- Part B Duplicate Claims
- Progressive Corrective Action (PCA)
- Split Care
- The Appeals Process
- Unprocessable Claims

Web-based Training Courses Under Development

The following Web-based training courses will be available in the near future:

- National Provider Identifier
- Provider Enrollment
- Evaluation and Management Coding
- Evaluation and Management Documentation
- Psychiatric Services

Be sure to check our provider education website regularly for these upcoming online courses

Provider Educational Opportunities Available Now, continued

Webcasts

Webcasts offer the opportunity to learn from your office while interacting with a member of the Provider Outreach and Education team. This educational format uses an Internet site to share presentations live while audio is provided through the telephone. These brief sessions are an excellent way to learn about important topics without having to leave the office. Since the first webcast offered in May, feedback has been overwhelmingly positive.

The following webcasts are scheduled for delivery during the month of September 2006:

- **Website Navigation**

  Florida – September 13, 2006
  Connecticut – September 8, 2006

- **Part B Small Provider – National Correct Coding Initiative**

  Florida – September 12, 2006
  Connecticut – September 13, 2006

To register online for the above webcasts access *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com*, click on "Education" on the top navigation menu. Select "Event List" on the left navigation menu, or use the following link:

Connecticut – *http://www.connecticutmedicare.com/edu_local_events_2%20Event%20List.asp*
Florida – *http://www.floridamedicare.com/edu_local_events_2%20Event%20List.asp*
Then, navigate to the date of the webcast and click on the event title to register.

Educational Seminars

For a list and calendar of upcoming educational events, and registration policies, access:

Connecticut – *http://www.connecticutmedicare.com/Education_Home.asp#TopOfPage*
Florida – *http://www.floridamedicare.com/Education.asp#TopOfPage*

A summary of these events is provided on pages 49-50 (CT) or pages 62-66 (FL) of this publication.

Providers Lacking Internet Access

Medicare providers lacking Internet access who are interested in learning about educational programs offered by FCSO may contact us by:

- Telephone

  Connecticut Provider Education Event Hotline – 1-203-634-5527
  Florida Provider Education Event Hotline – 1-904-791-8103

- Electronic-mail address

  Connecticut – *eventsct@fcso.com*
  Florida – *eventsfl@fcso.com*

FCSO *eNews* Notices

We encourage you to register for our *eNews* mailing lists to receive urgent, critical, and new information. By signing up, you will receive regular messages providing you with updates to the provider educational website (*www.connecticutmedicare.com* or *www.floridamedicare.com*) and key program alerts, critical program changes, seminar schedules, publications, and educational tips. Sign up today by clicking on "eNews" on the top navigational menu. Select "FCSO eNews Lists/Interest Groups" on the FCSO eNews Electronic Mailing List Service main page.

The following is the list of interest groups currently available:

- ❑ FL: Part B (General)
- ❑ CT: Part B (General)
- ❑ FL: Part B Anesthesia
- ❑ CT: Part B Anesthesia
- ❑ FL: Part B Cardiology
- ❑ CT: Part B Cardiology
- ❑ FL: Part B Chiropractic
- ❑ CT: Part B Chiropractic
- ❑ FL: Part B LMRP/LCD
- ❑ CT: Part B LMRP/LCD
- ❑ FL: Part B Vision
- ❑ FL: Ambulance
- ❑ CT: Ambulance
- ❑ FL: ASC (Ambulatory Surgical Center)
- ❑ CT: ASC (Ambulatory Surgical Center)
- ❑ FL: EDI (Technical)
- ❑ CT: EDI (Technical)
- ❑ CT: PC-ACE Pro32
- ❑ FL: Podiatry
- ❑ CT: Podiatry
- ❑ FL: Rehabilitation Services
- ❑ CT: Rehabilitation Services

If you have signed up for this service in the past but have not received **regular** *eNews* notices, we ask that you please use the "Comment Form" by accessing the "Contacts" section on the top navigational menu. Select "eNews Help" in the drop-down subject box, and indicate the interest groups for which you have registered in the "Comment" box. We are asking this to ensure your e-mail address is not one for which we are unable to deliver messages.

Because some organizations have enhanced their firewalls or security settings, we are not able to successfully transmit our *eNews* notices to individuals within those organizations. You may also wish to check with your organization's IT staff to determine how they can identify our organization as an allowable sender to your individual e-mail address.

ORDER FORM — 2006 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 BCBSFL – FCSO with the account number listed by each item.

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

QUANTITY	ITEM	ACCOUNT NUMBER	COST PER ITEM
❒	***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Hardcopy or CD-ROM distribution is limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers who meet these criteria must register to receive the *Update!* in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason can be shown why the electronic publication available free of charge on the Internet cannot be utilized. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published during calendar year 2006 (back issues will be sent upon receipt of order).	700395	$25.00 (Hardcopy) $20.00 (CD-ROM)
❒	**2006 Fee Schedule –** The revised Medicare Part B Physician and Non-Physician Practitioner Fee Schedule, effective for services rendered January 1, 2006, through December 31, 2006, is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Providers who do not have Internet access may purchase a hardcopy or CD-ROM. The Fee Schedule contains calendar year 2006 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	Hardcopy: $5.00 (CT) $10.00 (FL) CD-ROM: $6.00 (Specify CT or FL)

Please write legibly

Subtotal $ _____

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

Total $ _____

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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

MEDICARE B UPDATE!

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

*** ATTENTION BILLING MANAGER ***