

# Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

## Highlights In This Issue...

**Claims, Appeals, and Hearings**  
*Revised Form CMS-1500—Revised Timeline (08/05)* ..... 5

**Coverage/Reimbursement**  
*Medicare Contractor Annual Update of ICD-9-CM* ..... 11  
*New Current Procedural Terminology Code* ..... 12  
*Medicare Telehealth Services Update* ..... 15  
*Non-Physician Practitioner Payment for Care Plan Oversight* ..... 16  
*Changes Conforming to CR 3648 or Therapy Services* ..... 21  
*Therapy Caps Exception Process* ..... 23

**HIPAA—The Health Insurance Portability and Accountability Act**  
*Ending the HPIAA Contingency for Remittance Advice* ..... 26  
*Medicare Remit Easy Print (MREP) Update* ..... 27  
*Claim Status Category Code and Claims Status Code Update* ..... 29

**General Information**  
*Medicare Provider Enrollment Applications* ..... 33  
*National Provider Identifier Enumeration System—Countdown Reminder* ..... 33  
*NPI Changes for Transaction 835 and Standard Paper Remittance Advice* ..... 34  
*CMS Announces Proposed Changes to Physician Fee Schedule Methodology* . 36  
*Correcting Minor Clerical Errors or Omissions* ..... 38  
*Full Replacement of CR 3504—Online MSP Questionnaire* ..... 39  
*A/B MAC NEWS #1—First Contract for Part A/B Medicare Administrative Contractor To Be Awarded in Near Future* ..... 40  
*Medicare’s CWF Medicare Advantage Managed Care Data Exchange and Data Display Changes* ..... 42

### Features

<b>Connecticut and Florida</b>	
About the <i>Update!</i> .....	3
Claims .....	5
Coverage/Reimbursement ..	6
HIPAA and EMC .....	26
General Information .....	33
Educational Resources .....	66
2006 Part B Materials	
Order Form .....	69
<b>Medical Review</b>	
General .....	46
<b>Connecticut Only</b>	
Medical Review .....	52
<b>Florida Only</b>	
Medical Review .....	58

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 FCSSO eNews" link and follow the prompts. The *FCSSO eNews* is sent at least every other week, more frequently as required.

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

#### Routing Suggestions:

- Physician/Provider
- Office Manager
- Billing/Vendor
- Nursing Staff
- Other \_\_\_\_\_



# TABLE OF CONTENTS

Highlights In This Issue.....	1	<b>General Information</b>	
About the Connecticut and Florida Medicare B Update!.....	3	<b>Provider Enrollment</b>	
Advance Beneficiary Notices (ABNs).....	4	Medicare Provider Enrollment Applications.....	33
<b>Claims</b>		NPI Enumeration System-Countdown Reminder.....	33
Revised Form CMS-1500—Revised Timeline (08/05).....	5	Upcoming NPI Outreach Event.....	33
<b>Coverage/Reimbursement</b>		Stage 2 NPI Changes for Transaction 835, SPR Advice.....	34
<b>Ambulatory Surgical Centers</b>		<b>General Information</b>	
ASC Claims Processing Manual Clarification.....	6	CMS Proposed Changes to Physician Fee Schedule Methodology.....	36
<b>Competitive Acquisition Program</b>		Collection of Fee-for-Service Payments During Periods of Managed Care Enrollment.....	36
Supplemental Instruction for MLN Matters Article MM5079.....	8	Correcting Minor Clerical Errors or Omissions.....	38
<b>Diagnostic Service</b>		CMS Mailing Lists Fact Sheet.....	38
Requirements for Diagnostic X-ray, Lab; Clinical Psychologist Services.....	8	Free Print Format of Physician Guide Now Available.....	38
<b>Drugs and Biologicals</b>		Full Replacement of CR3504-Modifications to Online MSP Questionnaire.....	39
July ASP, Revisions to Jan/April ASP.....	9	Nine-Day Payment Hold.....	40
Annual Update of the ICD-9-CM.....	11	Hold on Medicare Payments.....	40
New Current Procedure Terminology Code.....	12	First Contract for a MAC Contractor to be Awarded.....	40
Non-Autologous Blood Derived Products for Chronic Non-Healing Wounds.....	13	Requests for Claims Status Information-Florida Only.....	41
Payment for Islet Cell Transplant in NIH-Sponsored Trails.....	14	CWF Medicare Advantage Managed Care Data Exchange and Display Changes.....	42
<b>Durable Medical Equipment</b>		MLN Products for Physicians.....	42
Enrollment of Manufacturers of Replacement Parts and Supplies for DMEPOS at an ASC.....	15	Free Teleconferences.....	43
<b>Evaluation and Management Services</b>		Review Statements Before Calling Medicare-Florida Only.....	43
Medicare Telehealth Services Update.....	15	July Prevention Awareness Message.....	44
Non-Physician Practitioner Payment for CPO.....	16	<b>General Medical Review</b>	
<b>Laboratory/Pathology</b>		Billing Guidelines for Anesthesia Services.....	46
Correction to CR4136: New Waived Tests.....	18	Billing and Coding for Unlisted Drugs and Biologicals.....	46
HCPCS – Correction for Caffeine Halothane Contracture Test for Malignant Hyperthermia Susceptibility.....	19	Inappropriate Use of Assistant Surgeon Modifiers.....	47
<b>Radiology</b>		Avastin for Neovascular Age-Related Macular Degeneration—Update.....	48
Allowance for Procedure Code R0070.....	19	Mobile Cardiac Outpatient Telemetry.....	49
<b>Surgery</b>		Moderate Conscious Sedation 99143—99150.....	50
Lumbar Artificial Disc Replacement.....	20	Angiojet Thrombolytic Therapy, 37799, 93799, 37184 – 37188.....	51
<b>Therapy Services</b>		<b>Connecticut Medical Review</b>	
Changes Conforming to CR 3648 for Therapy Services.....	21	Table of Contents.....	52
Therapy Caps Exception Process.....	23	Advance Notice Statement.....	52
<b>HIPAA and EMC</b>		New LCDs.....	53
Ending the HIPAA Contingency for Remit Advice.....	26	Revisions to LCDs.....	53
Important News Regarding HIPAA Contingency RA.....	27	Connecticut Medicare Part B Mail Directory, Phone Numbers, and Websites.....	57
MREP Version 1.8 Now Available.....	45	<b>Florida Medical Review</b>	
MREP Update.....	27	Table of Contents.....	58
Update to the Healthcare Provider Taxonomy Codes Version 5.1.....	28	Advance Notice Statement.....	58
Claim Status Category Code and Claim Status Code Update.....	29	New LCDs.....	59
Rules Governing Protection of Medicare Beneficiary Information.....	30	Revisions to LCDs.....	59
		Retirement of Existing LMRPs.....	64
		Florida Medicare Part B Mail Directory, Phone Numbers, and Websites.....	65
		<b>Educational Resources</b>	
		Medicare Coverage for Preventive Services.....	66
		Order Form – 2006 Part B Materials.....	69

## Medicare B Update!

Vol. 4, No. 5  
August 2006

### Publications Staff

Terri Drury  
Kimberly McCaw  
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  
PO. Box 45270  
Jacksonville, FL  
32232-5270

*CPT codes, descriptors, and other data only are copyright 2005 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. No fee schedules, basic units, relative values, or related listings are included in CPT. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein.*

*ICD-9-CM codes and their descriptions used in this publication are copyright© 2005 under the Uniform Copyright Convention. All rights reserved.*

### Third party Web sites:

This document contains references to sites operated by third parties. Such references are provided for your convenience only. FCSO does not control such sites, and is 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.

# 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](http://cms.hhs.gov/manuals/pm_trans/AB02114.pdf) and [http://cms.hhs.gov/manuals/pm\\_trans/AB02168.pdf](http://cms.hhs.gov/manuals/pm_trans/AB02168.pdf).

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

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

### ABN Modifiers

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

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

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

## "GA" Modifier and Appeals

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

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

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

#### Connecticut

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

#### OR

#### Florida

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

# CLAIMS

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

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

To receive copies of the revised form with the specifications needed for testing purposes, providers may contact TFP Data Systems at [JRMagdaleno@tfpdata.com](mailto:JRMagdaleno@tfpdata.com).

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

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

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

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

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

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

### To prevent the return of your paper claims:

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

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

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

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

For complete details, please see the official instruction issued to your carrier regarding this change at <http://www.cms.hhs.gov/transmittals/downloads/R1010cp.pdf>

Source: Publication 100-04, #1010, Change Request 5060

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

## AMBULATORY SURGICAL CENTERS

### Ambulatory Surgical Center Claims Processing Manual Clarification

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2006 Medicare B Update! pages 6-8.

**Note:** This article was revised on June 12, 2006, to reflect changes made to CR 5026 on June 9, 2006. The article was revised to reflect a new CR release date, Transmittal number and Web address for CR 5026. All other information remains the same.

#### Provider Types Affected

Providers and suppliers of ambulatory surgical center (ASC) services

#### Provider Action Needed

This article is for informational purposes. Change Request (CR) 5026 revises the *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services) and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) to clarify policy regarding the provision, coverage, and payment of services furnished in an ASC.

#### Background

Medicare conventionally reimburses ASCs in the form of a single payment that includes all “facility services” that the ASC furnishes in connection with a covered procedure. However, an ASC (perhaps as part of a medical complex that may include other entities, such as an independent laboratory, supplier of durable medical equipment, or a physician’s

office) may also furnish a number of covered items and services that are not considered facility services.

You should be aware that such entities, which are separate from the ASC, are covered separately under Part B. Further, in general, the items or services that these entities provide are not considered ASC services, and are therefore not included in the ASC payment, but are rather covered and paid for under the applicable Part B provisions.

Examples of such services include:

- Physicians’ services;
- Durable medical equipment (DME);
- Implantable DME;
- Prosthetic devices;
- Ambulance services;
- Leg, arm, back and neck braces;
- Artificial legs, arms and eyes; and
- Services of an independent laboratory.

More detail about each of these services can be seen in the table below.

#### Examples of Services Not Included in the ASC Facility Rate

Items or Services	Who Receives Payment	Submit Bills To
<p><b>Physicians’ services</b> Physicians who perform covered services in ASCs receive separate payment under Part B. Such services include:</p> <p>Anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patients’ recovery from the anesthesia;</p> <p>Routine pre- or post- operative services, such as office visits, consultations, diagnostic tests, suture removal, dressing changes, and other services which are usually included in the physician fee for a given surgical procedure.</p>	Physician	Carrier
<p><b>Non-implantable durable medical equipment (DME) to ASC patients for in home use.</b> ASCs who sell, lease, or rent items of DME to patients, are treated as DME suppliers.</p> <p>All of the ordinary DME-applicable rules and conditions apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	Supplier An ASC can be a supplier of DME if it has a DME supplier number from the National Supplier Clearinghouse.	DMERC
<p><b>Implantable DME and accessories</b> ASCs who furnish implantable DME items to patients, bill the local carrier for the surgical procedure and the implantable device.</p>	ASC	Carrier

*Ambulatory Surgical Center Claims Processing Manual Clarification, continued*

Items or Services	Who Receives Payment	Submit Bills To
<p><b>Non-implantable prosthetic devices</b> ASCs who furnish non-implantable prosthetic devices to patients, are treated as suppliers, and all the ordinary DME-applicable rules and conditions apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	<p>Supplier An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the National Supplier Clearinghouse.</p>	<p>DMERC</p>
<p><b>Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs [new technology intraocular lenses]), and accessories</b> ASCs may bill and receive separate payment for prosthetic devices (other than intraocular lenses [IOLs]) that are implanted, inserted, or otherwise applied by surgical procedures on the ASC list of approved procedures. The ASC bills the local Carrier and receives payment according to the DMEPOS fee schedule.</p> <p>An intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC is included in the facility payment rate.</p> <p>ASCs may receive additional payment for approved NTIOLs that are furnished in an ASC during or subsequent to certain cataract procedures.</p>	<p>ASC</p>	<p>Carrier</p>
<p><b>Ambulance services</b> ASCs who furnish ambulance services, may obtain approval as ambulance suppliers to bill covered ambulance services.</p>	<p>Certified ambulance supplier</p>	<p>Carrier</p>
<p><b>Leg, arm, back, and neck braces</b> These items of equipment are not included in the ASC facility payment amount, but are covered under Part B.</p> <p>ASCs who furnish these items to patients, are treated as suppliers, and all the rules and conditions ordinarily applicable to apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	<p>Supplier</p>	<p>DMERC</p>
<p><b>Artificial legs, arms, and eyes</b> These items of equipment are not included in the ASC facility payment rate, but are covered under Part B.</p> <p>ASCs who furnish these items to patients, are treated as suppliers, and all the rules and conditions ordinarily applicable to suppliers apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	<p>Supplier</p>	<p>DMERC</p>
<p><b>Services furnished by an independent laboratory</b> Only very limited numbers, and types, of diagnostic tests are considered ASC facility services and these are included in the ASC facility payment rate.</p> <p>Since coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics or hospitals is limited to facilities that meet the statutory definition of an independent laboratory, in most cases, diagnostic tests performed directly by an ASC are not considered ASC facility services (in fact are usually not covered under Medicare).</p> <p>ASC laboratories must be CLIA certified and will need to enroll with the carrier as a laboratory. Otherwise, the ASC makes</p>	<p>Certified lab. ASCs can receive lab certification and a CLIA number.</p>	<p>Carrier</p>

*Ambulatory Surgical Center Claims Processing Manual Clarification, continued***Additional Information**

You can find more information about services not included in the ASC facility rate (and the coverage of such services) by reviewing CR 5026, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R975CP.pdf> on the CMS website.

The revised *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services) and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) are attached to CR 5026.

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: MM5026

Related CR Release Date: June 9, 2006

Related CR Transmittal #: R975CP

Revised Related Change Request (CR) #: 5026

Effective Date: June 5, 2006

Implementation Date: June 5, 2006

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

## COMPETITIVE ACQUISITION PROGRAM

### Supplemental Instruction for MLN Matters Article MM5079

Change request 5079 provides instructions when a competitive acquisition program (CAP) vendor is not in service due to a disaster or catastrophe. When this occurs, physicians and practitioners may receive reimbursement based on the average sale price (ASP) payment methodology for the CAP drug services by applying modifier CR to the drug HCPCS code.

Since the modifier CR will allow the service using the ASP, the CAP modifiers J1 or J2 must not be included on the same detail line as the modifier CR. This will cause the claim to deny as unprocessable and appeal rights will not apply.

Source: Publication 100-04, Transmittal 953, Change Request 5079

## DIAGNOSTIC SERVICES

### Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; Clinical Psychologist Services

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

#### Provider Types Affected

Physicians, providers, and/or clinical psychologists who submit claims to Medicare carriers, for diagnostic psychological testing services.

#### Impact on Providers

- CR 4400 alerts providers that Medicare may now pay for the services of a clinical psychologist when they supervise the performance of diagnostic psychological testing.
- Under the physician supervision level of four, Medicare's physician supervision policy is modified so the policy does not apply when the procedure is furnished under the general supervision of a clinical psychologist.
- Medicare carriers are not required to retroactively process claims for the period between January 1, 2005, and the implementation date. Carriers are to reprocess claims that are brought to their attention that have been denied with dates of service on or after January 1, 2005.

#### Background

Diagnostic psychological testing may now be performed under the general supervision of a clinical psychologist. This change may be found in the revised *Medicare Benefit Policy Manual*, Chapter 15 - Covered Medical and Other Health Services, Section 160 - Clinical Psychologist Services.



**Requirements for Diagnostic X-Ray, Laboratory, and Other Diagnostic Tests; Clinical Psychologist Services, continued**

As a reminder, to qualify as a clinical psychologist (CP), a practitioner must meet the following requirements:

- Hold a doctoral degree in psychology; and
- Be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

**Implementation**

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

**Additional Information**

The revised *Medicare Benefit Policy Manual*, Chapter 15 - Covered Medical and Other Health Services, Sections 80 and 160 - Clinical Psychologist Services, is attached to CR 4400, which is the official instruction issued to your carrier regarding this change. CR 4400 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R51BP.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: MM4400

Related Change Request (CR) #: 4400

Related CR Release Date: June 23, 2006

Effective Date: January 1, 2005

Related CR Transmittal #: R51BP

Implementation Date: September 21, 2006

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

## DRUGS AND BIOLOGICALS

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

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

**Provider Types Affected**

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

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

CR 5110 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective July 1, 2006 through September 30, 2006, as well as revised payment files for the January 2006, and April 2006 Quarterly ASP Medicare Part B Drug Pricing Files.

**CAUTION – What You Need to Know**

Certain Medicare Part B drug payment limits have been revised and the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance quarterly. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR 5110.

**GO – What You Need to Do**

Make certain that your billing staffs are aware of this change.

**Background**

According to Section 303(c) of the Medicare Modernization Act of 2004 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis.

As mentioned in previous articles (see MM4319 at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf>), beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on **106 percent** of the average sales price (ASP).

The local Medicare contractor performs pricing for compounded drugs.

July 2006 Quarterly ASP, Eff July 1, 2006; Revisions to January and April 2006 Quarterly ASP Pricing Files, continued

### ESRD Drugs

Additionally, in 2006, all ESRD drugs furnished by both independent and hospital based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, are paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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

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

### Exceptions

There are exceptions to these general rules and those exceptions are outlined in MLN Matters article MM4319, which can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf> on the CMS website.

With regard to the exceptions listed in MM4319, note that the payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded.

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

### Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or other authorized practitioners) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to do so. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir, is determined under the ASP methodology.

Note that the use of the implantable pump or reservoir must be found medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician or other practitioner is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if:

- The medication administered is accepted as a safe and effective treatment of the patient's illness or injury;
- There is a medical reason that the medication cannot be taken orally; and
- The skills of the nurse are needed to infuse the medication effectively.

### How the ASP Is Calculated

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter:

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

The absence or presence of a HCPCS (Healthcare Common Procedure Coding System) code and its associated payment limit does not indicate Medicare coverage of the drug or biological.

Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The carrier processing your claim will make these determinations.

### Implementation

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

### Additional Information

The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 17, Drugs and Biologicals, contains information that is pertinent to MM5110. It is located at <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf> on the CMS website.

Quarterly Part B Drug Pricing files and information are also available at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice> on the CMS website.

CR 5110 is the official instruction issued to your Medicare carrier/RI/RHHI/DMERC regarding changes mentioned in this article. CR5110 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R974CP.pdf> on the CMS website.

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

MLN Matters Number: MM5110  
Related CR Release Date: June 9, 2006  
Related CR Transmittal #: R974CP

Related Change Request (CR) #:5110  
Effective Date: July 1, 2006  
Implementation Date: July 3, 2006

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

## Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification

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

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs))

### Provider Action Needed

#### STOP – Impact to You

Medicare has issued the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2006, as well as discharges on or after October 1, 2006, for institutional providers.

#### CAUTION – What You Need to Know

An ICD-9-CM code is required for all professional claims, e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers (ASCs), and for all institutional claims, but is **not required** for ambulance supplier claims.

#### GO – What You Need to Do

Be ready to use the updated codes on October 1, 2006. Please refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

### Background

This instruction is a reminder that Medicare carriers, DMERCs, FIs, and RHHIs will use the annual *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for:

- Dates of service on or after October 1, 2006; and
- Discharges on or after October 1, 2006 for institutional providers

Effective for dates of service on and after October 1, 2004, CMS no longer provided a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR 3094, dated February 6, 2004 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3094.pdf> on the CMS website).

### Implementation

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

### Additional Information

#### Publication of ICD-9-CM Codes

- The Centers for Medicare & Medicaid Services (CMS) places the new, revised, and discontinued codes at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage) on the CMS website. The update should be available at this site in June.
- The updated codes can also be viewed at the National Center for Health Statistics (NCHS) website at: <http://www.cdc.gov/nchs/icd9.htm>. This posting should be available at this site in June.
- Providers are also encouraged to purchase a new ICD-9-CM book or CDROM on an annual basis.

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service). Chapter 23 may be accessed at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS website.

To view CR 5142, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI, regarding changes mentioned in this article. CR 5142 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R990CP.pdf> on the CMS website.

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

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: MM5142

Related CR Release Date: June 23, 2006

Related CR Transmittal #: R990CP

Related Change Request (CR) #: 5142

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

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

*Third-party Web sites.* 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.

## New Current Procedural Terminology Code

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

### Provider Types Affected

All Medicare providers

### Provider Action Needed

#### STOP – Impact to You

Effective July 1, 2005, Medicare carriers and intermediaries must use the new *Current Procedural Terminology (CPT)* code 90714 (*Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals 7 years or older, for intramuscular use*) for services previously billed under CPT code 90718.

#### CAUTION – What You Need to Know

Effective for services on or after July 1, 2005, if you do not use the new *Current Procedural Terminology (CPT)* code 90714, reimbursements may be impacted. CR 4222 provides notification of this new CPT code for tetanus and diphtheria toxoids (see information below).

#### GO – What You Need to Do

Make sure that your billing staffs are aware of this new CPT code.

### Background

Effective July 1, 2005, the following vaccine CPT code is being added to the CPT system.

CPT code	90714
Short Descriptor	Td vaccine no prsrv >= 7 im
Long Descriptor	<i>Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individual 7 years or older, for intramuscular use</i>

**Note:** Your carriers and fiscal intermediaries will assign the CPT code 90714 to status indicator “E” in the Medicare physician fee schedule database. Deductible and coinsurance apply.

Effective July 1, 2005, the following vaccine are used:

- CPT code 90718 – *Tetanus and diphtheria toxoids (Td) absorbed for use in an individual seven years or older, for intramuscular use.*
- CPT 90714 – *Tetanus and diphtheria toxoids (T[d]) absorbed, preservative free, for use in individuals 7 years or older, for intramuscular use.*

### Additional Information

Medicare will not search its files to retract payment for claims already paid or to retroactively pay claims. However, carriers/intermediaries will adjust claims brought to their attention.

The official instruction issued to your carrier/intermediary is available on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R910CP.pdf>.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/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: MM4222

Related Change Request (CR) Number: 4222

Related CR Release Date: April 21, 2006

Related CR Transmittal Number: R910CP

Effective Date: July 1, 2005

Implementation Date: October 2, 2006

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

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

## Non-Autologous Blood Derived Products for Chronic Non-Healing Wounds

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

### Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for chronic non-healing wound related services furnished to Medicare beneficiaries.

### Impact on Providers

This article is based on Change Request (CR) 5123 which instructs Medicare contractors (carriers, FIs, and RHHIs) that claims submitted for **becaplermin**, a self-administered, non-autologous growth factor for chronic, non-healing, subcutaneous wounds **will remain noncovered**.

Becaplermin, Healthcare Common Procedure Coding System (HCPCS) **S0157**, is nationally noncovered because it is usually self-administered by the patient.

### Background

After releasing a national noncoverage determination (NCD) on autologous blood-derived products for chronic non-healing wounds in December of 2003, an error was printed in the NCD Manual.

To correct that error, the Centers for Medicare & Medicaid Services (CMS) is revising section 270.3 of the *National Coverage Determinations (NCD) Manual* (Publication 100-03, Chapter 1, Part 3, "Blood-Derived Products for Chronic Non-Healing Wounds") to accurately reflect the payment policy for non-autologous blood derived products for chronic non-healing wounds, effective April 27, 2006.

In this revision, the following sentence is being deleted:

"Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous non-healing wounds, will remain at local carrier discretion. Becaplermin is approved by the Food and Drug Administration."

The correct statement should read:

"Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous wounds, **will remain nationally non-covered** under Part B based on section 1861(s)(2)(A) and 1861(s)(2)(B) because this product is usually self-administered by the patient."

While CMS makes every effort to provide accurate and complete information, the erroneous coverage statement printed in the NCD Manual regarding nonautologous blood-derived products was not intended, and is not part of the Decision Memorandum (DM) posted on December 15, 2003. Non-autologous blood-derived products are not in the same class as the products referred to in the December 15, 2003, DM.

NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1060)(a)(4), effective May 1, 2005). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD (see section 1869(f)(1)(A)(i) of the Social Security Act).

### Additional Information

CR 5123 is the official instruction issued to your Medicare carrier or FI/RHHI regarding changes mentioned in this article. There are two transmittals for CR 5123. Transmittal 59, containing the NCD revision, is available at <http://www.cms.hhs.gov/Transmittals/downloads/R59NCD.pdf> on the CMS website. Transmittal 977, containing the Medicare claims processing instructions, is at <http://www.cms.hhs.gov/Transmittals/downloads/R977CP.pdf> on the CMS website.

If you have questions please contact your Medicare carrier/FI/RHHI at their tollfree 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: MM5123

Related Change Request (CR) #: 5123

Related CR Release Date: June 9, 2006

Effective Date: April 27, 2006

Related CR Transmittal #: R977CP and R59NCD

Implementation Date: July 10, 2006

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

## Payment for Islet Cell Transplantation in NIH-Sponsored Clinical Trials

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

### Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers and fiscal intermediaries [FIs])

### Provider Action Needed

#### **STOP – Impact to You**

The Centers for Medicare & Medicaid Services (CMS) is updating the modifier used for claims for islet cell transplantation and for routine follow-up care related to the transplantation in NIH-sponsored clinical trials.

#### **CAUTION – What You Need to Know**

Please note that effective for islet cell transplantation and routine follow-up services related to the islet cell transplantation on or after May 1, 2006, the modifier QV is no longer valid. The modifier QR (item or service provided in a Medicare-specified study) will replace the modifier QV for services on or after May 1, 2006.

#### **GO – What You Need to Do**

Refer to the *Background* and *Additional Information* sections of this article for more information. Be ready to use the new modifier QR for payment of islet cell transplantation and routine follow-up care when appropriate.

### Background

As a result of section 733 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173), for services performed/discharges on or after October 1, 2004, Medicare covers islet cell transplantation for patients with type I diabetes who are participating in an NIH-sponsored clinical trial. The islet cell transplantation may be done alone or in combination with kidney transplantation.

### Additional Information

Effective for services on or after May 1, 2006, Medicare will accept the modifier QR for payment on claims for patients who participate in an NIH-sponsored clinical trial in conjunction with:

- Islet cell transplantation; and
- Routine follow-up care related to islet cell transplantation, when:
- Performed in an outpatient department of a hospital; and
- Billed on type of bill (TOB) 13x or 85x.

For additional information, please refer to MM3385, “MMA-Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial,” which may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3385.pdf> on the CMS website. Also, refer to the *Medicare National Coverage Determination Manual*, publication 100-03, Chapter 1, Part 4, Section 260.3.1 “Islet Cell Transplantation in the Context of a Clinical Trial (Effective October 1, 2004),” located at [http://www.cms.hhs.gov/manuals/downloads/ncd103c1\\_Part4.pdf](http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf) on the CMS website.

CR 5140 is the official instruction issued to your Medicare carrier or FI regarding changes mentioned in this article, and the manual attachment to CR 5140, the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 32, “Billing Requirements for Special Services,” Section 70 “Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial.” CR 5140 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R986CP.pdf> on the CMS website.

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

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

MLN Matters Number: MM5140

Related Change Request (CR) #: 5140

Related CR Release Date: June 16, 2006

Effective Date: May 1, 2006

Related CR Transmittal #: R986CP

Implementation Date: July 31, 2006

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

## DURABLE MEDICAL EQUIPMENT

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

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

All manufacturers currently enrolled in the Medicare program and billing a carrier for orthotic, prosthetic and/or miscellaneous DME will be notified that their enrollment will be terminated within 120 days after carrier's notification. This notification will include the option to enroll as a DMEPOS supplier or non-implantable DMEPOS through the NSC within the 120-day timeframe and NSC contact information.

Source: CMS Joint Signature Memorandum 06465, dated May 31, 2006

## EVALUATION AND MANAGEMENT SERVICES

### Medicare Telehealth Services Update

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

#### Provider Types Affected

Providers who bill Medicare carriers and fiscal intermediaries (FIs) for Telehealth services

#### Provider Action Needed

##### **STOP – Impact to You**

When billing for telehealth services provided on or after January 1, 2006, do not use current procedure terminology (CPT) codes 99261- 99263 (hospital inpatient follow-up consultations) or 99271-99275 (confirmatory consultations). These codes no longer exist, and using them could impact your reimbursement.

##### **CAUTION – What You Need to Know**

The American Medical Association has deleted CPT codes 99261 – 99263 (hospital inpatient follow-up consultations) and codes 99271 – 99275 (confirmatory consultations). Effective January 1, 2006, these CPT codes no longer exist and were removed from the physician fee schedule.

##### **GO – What You Need to Do**

Make sure that your billing staffs are aware that CPT codes 99261- 99263 and 99271-99275 are no longer usable for telehealth services.

#### Background

CR 5122, from which this article is taken, is issued to alert you that, effective January 1, 2006, the AMA has deleted the following CPT codes:

- 99271 – 99275 (Confirmatory consultation); and
- 99261 – 99263 (Follow-up inpatient consultation).

Thus, the CPT codes that describe these services (hospital inpatient follow-up consultations – 99261 through 99263 and confirmatory consultations – 99271 through 99275) no longer exist.

In response, also effective January 1, 2006, CMS has removed confirmatory consultation and inpatient follow-up consultation from the list of Medicare telehealth services as referenced in the *Medicare Benefit Policy Manual* (Publication 100-02) and the *Medicare Claims Processing Manual* (Publication 100-04). The relevant sections of these Manuals (Publication 100-02, Chapter 15, Section 270.2 [List of Medicare Telehealth Services] and Publication 100-04 Chapter 12, Section 190.3 [List of Medicare Telehealth Services]) have been revised to reflect these policy changes.

As displayed in Table 1 below, office and other outpatient consultations and initial inpatient consultations are included in Medicare telehealth consultations as described by CPT codes 99241 through 99255. The table displays the current Medicare telehealth services and CPT and HCPCS codes.

*Medicare Telehealth Services Update, continued***Table 1: Current Medicare Telehealth Services and Associated CPT/HCPCS Codes**

Service	CPT/HCPCS Codes
Consultations	99241 - 99255 as of January 1, 2006
Office or other outpatient visits	99201 - 99215
Individual psychotherapy	90804 - 90809
Pharmacologic management	90862
Psychiatric diagnostic interview examination	90801
End Stage Renal Disease (ESRD) related services	G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318
Individual Medical Nutrition Therapy	G0270, 97802, and 97803

**Additional Information**

You can find more information about current Medicare telehealth services and the associated CPT/HCPCS codes in CR 5122, located at <http://cms.hhs.gov/Transmittals/downloads/R53BP.pdf> for the changes to Publication 100-02, Chapter 15, Section 270.2 (List of Medicare Telehealth Services) and at <http://www.cms.hhs.gov/Transmittals/downloads/R997CP.pdf> for the changes to Publication 100-04, Chapter 12, Section 190.3 (List of Medicare Telehealth Services).

If you have any questions, please contact your carrier/FI at their toll-free number, which may be found at <http://www.cms.hhs.gov/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: MM5122

Related CR Release Date: July 7, 2006

Related CR Transmittal #: R997CP and R53BP

Related Change Request (CR) #: 5122

Effective Date: January 1, 2006

Implementation Date: August 7, 2006

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

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

**Non-Physician Practitioner Payment for Care Plan Oversight**

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

**Provider Types Affected**

Non-Physician Practitioners (NPPs) and suppliers billing Medicare carriers for home health CPO services.

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

This article is based on Change Request (CR) 4374 which clarifies the policy associated with NPPs billing for physician home health care plan oversight (CPO).

**CAUTION – What You Need to Know**

The manual revision in CR 4374 effectuates a revision to the policy that the same provider that signs the plan of care does not have to be the same provider that bills for physician care plan oversight. Effective January 1, 2005, NPPs must meet certain conditions to be eligible for payment for home health care plan oversight services even though they may not sign the plan of care. This CR clarifies those conditions.

CR 4374 clarifies the policy associated with NPPs billing for physician hospice CPO and clarifies the HCPCS codes for CPO. It temporarily waives the requirement to include the Home Health Agency (HHA) or hospice provider number on a CPO claim since there is currently no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number. CR 4374 also states that the physician who bills CPO must be the same physician who signs the plan of care.

**GO – What You Need to Do**

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

**Background**

Physician CPO is paid under the Medicare Physician Fee Schedule (MPFS), and due to a provision in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 12, Section 180), Non-Physician Practitioners (NPPs) have been prohibited from billing for this service in a home health setting.

The current manual section (Section 180) provides that the physician who signs the plan of care for home health services must be the same person that bills for physician CPO. Since only a physician can sign the plan of care for home health services, NPPs have been unable to bill for physician home health CPO.



**Non-Physician Practitioner Payment for Care Plan Oversight, continued**

Under the final physician fee schedule rule, published in the *Federal Register* on November 15, 2004, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs), practicing within the scope of state law, may bill for CPO.

The intention of the Centers for Medicare & Medicaid Services (CMS), as outlined in later portions of the *Medicare Claims Processing Manual*, was to allow NPPs to bill for physician CPO within their state scope of practice. The current inconsistency in Section 180 will not allow NPPs to be paid for this service.

CR 4374 revises the policy that states that the same provider that signs the plan of care does not have to be the same provider that bills for physician CPO.

In addition, the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 11, Section 40.1.3.1) has been revised to clarify CPO billing requirements for beneficiaries who have elected the hospice benefit.

Currently there is no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number required for a CPO claim. For this reason, the requirement to include the HHA or hospice provider number on a CPO claim is temporarily waived until a new version of this electronic standard format is adopted under HIPAA and includes a place to provide the HHA and hospice provider numbers for CPO claims.

For services furnished on or after January 1, 2005, your carrier will allow NPPs to bill for physician home health CPO even though they cannot 1) certify a patient for home health services and 2) sign the plan of care.

For beneficiaries who have elected the hospice benefit, physicians or NPPs who have been identified by a beneficiary to be his or her attending physician may submit claims for CPO.

**Note: For physicians or NPs who are employed by a hospice agency, CPO is not separately payable.**

CR 4374 instructs your carrier to:

- Pay for physician home health CPO services (HCPCS code G0181) when billed by an NPP for dates of service on or after January 1, 2005;
- Pay for physician home health plan CPO services (HCPCS code G0181) no more than once per calendar month per patient;
- Pay for physician hospice CPO services (HCPCS code G0182 with GV modifier) when billed by a nurse practitioner for dates of service on or after January 1, 2005;
- Pay for physician hospice CPO services under HCPCS code G0182 no more than once per calendar month per patient;
- Re-open and adjust any erroneously denied claims with practitioner CPO services brought to their attention; and
- Not require the provider numbers of the home health agency or hospice for CPO claims effective for dates of service on or after January 1, 2005.

**Implementation**

The implementation date for CR 4374 is October 2, 2006.

**Additional Information**

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R999CP.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: MM4374

Related CR Release Date: July 14, 2006

Related CR Transmittal #: R999CP

Related Change Request (CR) #: 4374

Effective Date: January 1, 2005

Implementation Date: October 2, 2006

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

**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.

## LABORATORY/PATHOLOGY

**Correction to CR 4136: New Waived Tests**

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

**Note:** CR 5131 corrects an incorrect *Current Procedural Code (CPT)* mentioned in the third sentence of the second paragraph in the background section of the Recurring Update Notification attachment for CR 4136. Only this sentence has been revised. All other information remains as it is written in CR 4136.

**Note:** This article was revised on July 11, 2006, to show that the effective date is January 1, 2006 and the implementation date at the top of this page is July 24, 2006. These dates were inadvertently transposed on the original article.

**Provider Types Affected**

All providers and suppliers billing Medicare carriers for laboratory tests

**Background**

CR 5131 corrects an incorrect *Current Procedural Code (CPT)* mentioned in the third sentence of the second paragraph in the background section of the recurring update notification attachment for CR 4136.

**Key Points**

This article and CR 5131 identifies the correction issued by the Centers for Medicare & Medicaid Services (CMS) regarding the “Waived Tests:”

- *CPT* code **82271** was **incorrectly listed** in the second paragraph of the background section of the recurrent update notification attachment of CR 4136 as not requiring a modifier QW. The *CPT* code should have been **82272** and it does not require a modifier QW.
- All other information that outlines which tests require the modifier QW and which do not require the modifier QW remains the same as listed in CR 4136.

(The Web address for MLN Matters article MM4136 related to CR 4136 is <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4136.pdf> on the CMS website.)

**Implementation**

The effective date for this instruction was January 1, 2006, and the correction by CR 5131 will be implemented on July 24, 2006.

**Additional Information**

The official instruction, CR 5131, issued to your Medicare carrier regarding this change may be found at <http://www.cms.hhs.gov/transmittals/downloads/R988CP.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: MM5131 *Revised*      Related Change Request (CR) #: 5131  
 Related CR Release Date: June 23, 2006      Effective Date: January 1, 2006  
 Related CR Transmittal #: R988CP      Implementation Date: July 24, 2006

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

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

**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.

## Healthcare Common Procedure Coding System Correction for the Caffeine Halothane Contracture Test for Malignant Hyperthermia Susceptibility

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

### Provider Types Affected

Providers billing Medicare carriers for laboratory tests

### Provider Action Needed

#### STOP – Impact to You

Effective January 1, 2006, you do not have to include a Clinical Laboratory Improvement Amendments (CLIA) number on claims that you submit for *CPT code 89049* [*Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report*].

#### CAUTION – What You Need to Know

CR 5113 provides that *CPT code 89049* is not considered a test under CLIA. Therefore, performing this test does not necessitate that a facility have any CLIA certificate, nor require a CLIA number on claims for its use.

#### GO – What You Need to Do

Make sure that your billing staffs are aware that they do not have to include a CLIA number on claims for *CPT code 89049*.

### Background

The CLIA regulations require a facility to be appropriately certified for each test that it performs. Therefore, laboratory claims are currently edited at the CLIA certificate level to ensure that Medicare and Medicaid only pay for laboratory tests that are performed in facilities with valid, current CLIA certificates.

This being said, CR 5113, from which this article is taken, notifies carriers of one HCPCS correction for code *89049* [*Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpre-*

*tation and report*]. While, currently, *CPT code 89049* is subject to CLIA edits and has a laboratory certification (LC) code of 610 (histopathology), CR 5113 provides that this HCPCS code is not considered a test under CLIA.

Therefore, effective January 1, 2006, carriers will remove CLIA edits for *CPT code 89049*, including the LC code 610, and will not require a CLIA number on claims submitted by facilities for the *CPT code 89049*.

You should be aware that your carriers are not required to search their files to either retract payment or retroactively pay claims processed before this change is made. However, they will adjust claims brought to their attention.

### Additional Information

You can find more information about billing for *CPT code 89049* (*Caffeine halothane contracture test [CHCT]*) for malignant hyperthermia susceptibility, including interpretation and report] by going to CR 5113, located at <http://www.cms.hhs.gov/Transmittals/downloads/R984CP.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: MM5113  
 Related Change Request (CR) #: 5113  
 Related CR Release Date: June 16, 2006  
 Effective Date: January 1, 2006  
 Related CR Transmittal #: R984CP  
 Implementation Date: October 2, 2006

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

## RADIOLOGY

### Allowance for Procedure Code R0070

The allowance for the portable X-ray transportation procedure code R0070 has been increased to \$100.88 for claims processed on or after July 3, 2006.

The ambulance inflation factor (AIF) for 2006 was used to adjust the allowance. The AIF factor will also be used to adjust the allowance of R0070 annually starting January 2007.

## SURGERY

## Lumbar Artificial Disc Replacement

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

### Provider Types Affected

All physicians and providers who bill Medicare carriers and fiscal intermediaries (FIs) for lumbar artificial disc replacement (LADR)

### Providers Action Needed

This article and Change Request (CR) 5057 provide specific information regarding the new national coverage determination (NCD) for LADR. The message is three pronged:

- 1) Effective May 16, 2006, the LADR with the Charite lumbar artificial disc is not covered by Medicare for beneficiaries over 60 years of age, i.e., on or after the beneficiary's 61st birthday;
- 2) Medicare coverage under the investigational device exemption (IDE) and/or clinical trial policy for other lumbar artificial discs is not impacted by this decision and such coverage continues if the billing requirements are met and the appropriate codes are submitted; and
- 3) For patients 60 years of age and younger, there is no NCD, leaving such determinations to continue to be made by the local contractors.

### Background

The Centers for Medicare & Medicaid Services (CMS), upon completion of a national coverage analysis (NCA) for LADR, determined that LADR with the Charite lumbar artificial disc is not reasonable and necessary for Medicare patients over 60 years of age and is, therefore, noncovered for this patient population. For Medicare beneficiaries 60 years of age and younger, there is no NCD, leaving such determinations to be made by the local Medicare carrier or FI.

This NCD focuses on the LADR with the Charite lumbar artificial disc because it is the only United States Food and Drug Administration (FDA) approved lumbar artificial disc at this time. The FDA has approved the use of the Charite artificial disc for spine arthroplasty in skeletally mature patients with degenerative or discogenic disc disease (DDD) at one level for L4 to S1.

The addition of section 150.10 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4), effective May 1, 2005). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

### Billing Requirements

The following are the billing requirements for LADR according to the revised *Medicare Claims Processing Manual*, Chapter 32, Section 170, which is effective May 16, 2006.

- Assuming the providers bill separately, physicians and hospitals need to **issue the appropriate liability notice**, (advance beneficiary notice (ABN) or hospital issued notice of non-coverage (HINN), to beneficiaries over 60 years of age who choose to have this procedure using the Charite lumbar artificial disc.
- The following language should be included in the ABN:
- Under the "Items or Service" Section: Lumbar Artificial Disc Replacement (LADR) with the Charite Lumbar Artificial Disc.
- Under the "Because" Section: After a national coverage analysis (NCA), Medicare issued a national coverage determination (NCD) (Section 150.10 of *Medicare NCD Manual*) that stated that LADR with the Charite Lumbar Artificial Disc is not reasonable and necessary for Medicare beneficiaries over 60 years of age. Therefore, LADR with the Charite lumbar artificial disc is noncovered for beneficiaries over 60 years of age.

Medicare never pays for this service for this Medicare population.

- Hospitals need to have a **beneficiary who is over 60 years of age sign a HINN** if he/she wishes to have the procedure done when a Charite lumbar artificial disc is used in the procedure. If the beneficiary is not informed prior to admission that he or she is financially liable for the admission, the provider is liable.

### Information for Providers Billing Carriers

- For patients over 60 years of age. Claims submitted with category III Codes 0091T (Single interspace, lumbar) and/or 0092T (Each additional interspace) will be denied unless performed under an approved IDE/clinical trial. (**Note:** The Charite lumbar artificial disc is the only artificial disc approved by the Food and Drug Administration, therefore the procedure (0091T or 0092T) would be using the Charite unless under an IDE/clinical trial.)
- For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, claims submitted with 0091T or 0092T and the modifier QA will be allowed and normal claims processing criteria for IDEs/clinical trials will be followed.

*Lumbar Artificial Disc Replacement, continued***Information for Providers Billing FIs**

For patients over 60 years of age, claims submitted with ICD-9-CM procedure code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral) is never payable and will be denied unless performed under an approved IDE/clinical trial.

For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, the FI will pay for LADR only when submitted with ICD-9 procedure code 84.65 with condition code 30 and diagnosis code V70.7 when submitted on type of bill (TOB) 11x.

- For services submitted on TOB 11x in critical access hospitals (CAH), the payment will be 101% of reasonable cost.
- For services submitted on TOB 11x from inpatient hospitals, including Indian health services (IHS) inpatient hospitals, will be paid under IPSS based on the DRG.
- For services submitted/performed on TOB 11x, IHS CAHs will be paid under 101% facility specific per diem rate.

**Medicare Summary Notice (MSN) and Claim Adjustment Reason Code Messages for Denied Claims**

- The following MSN: 21.24 will be issued: “This service is not covered for patients over age 60.” along with a claim adjustment reason code such as: 96 “Non covered charge(s).”

**Implementation**

The implementation date for this instruction is July 17, 2006, for claims submitted to carriers and October 1, 2006, for claims submitted to Medicare FIs. But, in both instances, the change applies to services provided on or after May 16, 2006.

**Additional Information**

The official instructions issued to your Medicare carrier and intermediary regarding this change are in two transmittals for CR 5057. Transmittal R60NCD contains the NCD instructions and may be found at

<http://www.cms.hhs.gov/Transmittals/downloads/R60NCD.pdf> on the CMS website. The claims processing instructions are in Transmittal R992CP, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R992CP.pdf>.

If you have questions, please contact your Medicare intermediary or 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: MM5057

Related Change Request (CR) #: 5057

Related CR Release Date: June 23, 2006

Effective Date: May 16, 2006

Related CR Transmittal #: R60NCD and R992CP

Implementation Date: July 17, 2006 (carriers); October 1, 2006 (FIs)

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

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

## THErapy SERVICES

### Changes Conforming to Change Request 3648 or Therapy Services

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2006 Medicare B Update! pages 38-39.*

**Note:** This article was revised on June 15, 2006, to reflect changes made to CR 4014, which was re-issued on June 14, 2006. The transmittal number, CR release date, and the Web address for viewing CR 4014 were revised. All other information remains the same.

**Provider Types Affected**

Physicians, suppliers, and providers billing Medicare carriers including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for therapy services

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

This article is based on Change Request (CR) 4014, which updates language in the *Medicare National Coverage Determinations Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) by changing the term “speech therapy” to “speech-language pathology.”

*Changes Conforming to Change Request 3648 or Therapy Services, continued***CAUTION – What You Need to Know**

To conform to changes in CR 3648, CR 4014 removes from the *Medicare Claims Processing Manual* (Publication 100-04) the requirement to include the date last seen by a physician for outpatient services provided by a physical or occupational therapist or speech-language pathologist.

Requirements for therapy services incident to a physician have not been changed.

**GO – What You Need to Do**

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

**Background**

The Centers for Medicare & Medicaid Services (CMS) is updating language in the *Medicare National Coverage Determinations (NCD) Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) as follows: The term “speech therapy” is being changed to “speech-language pathology.”

In addition, CMS is changing requirements in Chapter 1 of the *Medicare Claims Processing Manual* where therapists are to provide information on CMS-1500 (Health Insurance Claim Form) and the UB-92 claim form concerning the date last seen by the physician to conform with instructions in CR 3648, Transmittal 36, dated June 24, 2005; subject: Publication 100-02, Chapter 15, Sections 220 and 230 Therapy Services. CR 3648 may be found at

<http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf> on the CMS website.

Health Insurance Portability and Accountability Act (HIPAA) guidelines require the following information only when it impacts the payer’s adjudication process:

- Date last seen; and
- The unique provider identification number (UPIN) of the physician.

Medicare payment is not impacted by this information except when the service is provided “incident to” the services of a physician’s or non-physician practitioner’s (NPP), in which case it is required. CR 4014 updates instructions in CR 3648 (related to claims for services “incident to” a physician’s/NPP’s service) by acknowledging that:

- The “incident to” service can be identified only on prepay or post pay review;
- Manual review of all therapy claims is not required; and
- “Incident to” policies have not changed and still apply to therapy services.

CR 4014 also clarifies selected business requirements in CR 3648 to indicate that some contractor actions:

- Will occur on prepay or post pay review. For example, compare the following:
  - Business Rule (BR) 3648.8 – Contractors shall pay for therapy services only when the service qualifies as a therapy service and the service is furnished by qualified professionals, or qualified personnel as defined in the manuals; with
  - BR 4014.8 – On prepay or post pay review of outpatient therapy claims for services provided on or after July 25, 2005, contractors shall pay for physical therapy and occupational therapy services only when the service is furnished by qualified professionals, or qualified personnel as defined in the appropriate Medicare manuals.
- Should not be applied to services “incident to.” (e.g., BR 3648.3 – Medicare contractors shall not deny therapy claims based on missing documentation of a visit to the physician on prepay or post pay review).

CR 3648 omitted the requirement for a physician visit when therapy services are billed. This change omits the requirement that the physician visit be documented on the claim.

This change does not affect the requirements for services billed “incident to” a physician.

Therefore, when a therapy service is billed “incident to,” the following requirements remain in effect because they are required by “incident to” policies:

- An initial physician visit (date last seen); and
- Identification of the ordering (and supervising) physicians/NPPs.

**Implementation**

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

**Additional Information**

CR 3648 (Transmittal 36 dated June 24, 2005, subject Pub. 100-02, Chapter 15, Sections 220 and 230 Therapy Services) may be reviewed at [http://www.cms.hhs.gov/manuals/pm\\_trans/R36BP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R36BP.pdf) on the CMS website.

The MLN Matters article, MM3648 may be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3648.pdf> on the CMS website.

For complete details, please see the official instructions (CR 4014) issued to your carrier/intermediary regarding this change. There are two transmittals for CR 4014, the NCD, transmittal 55 is available at

<http://www.cms.hhs.gov/Transmittals/downloads/R55NCD.pdf>. Transmittal 941 is the *Medicare Claims Processing Manual* update, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R980CP.pdf> on the CMS website.

*Changes Conforming to Change Request 3648 or Therapy Services, continued*

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS 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: MM4014 *Revised*

Related Change Request (CR) #: 4014

Related CR Release Date: June 14, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R980CP and R55NCD

Implementation Date: October 2, 2006

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

## Therapy Caps Exception Process

*CMS has issued the following "MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Third Quarter 2006 Medicare B Update! pages 65-67.*

**Note:** This article was revised on July 3, 2006, to modify the transmittal number and Web address for the change made to the Medicare Benefit Policy Manual. All other information remains the same.

### Provider Types Affected

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

### Key Points

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

Outpatient rehabilitation services include:

- **Physical therapy** – including outpatient speech-language pathology: Combined annual limit for 2006 is \$1,740; and
- **Occupational therapy** – annual limit for 2006 is \$1,740.
- In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, **exceptions to therapy caps for services provided during calendar year 2006**, if these services meet certain qualifications as medically necessary services (Section 1833(g)(5) of the Social Security Act).\
- The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.
- Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:
  - Meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR 4364) for exception from the therapy cap; or
  - Meet specific criteria for exception, in addition to those listed in the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.
- Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

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

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

*Changes Conforming to Change Request 3648 or Therapy Services, continued***Background**

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

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

**Additional Information****Billing Guidelines**

- **Modifier KX** – You must include modifier KX on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
- **Separate requests** – You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received **before** the cap is exceeded because the patient is liable for denied services based on caps.
- **Subsequent requests during the same episode of care** – To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of additional therapy treatment days, not to exceed 15, **each time** the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.
- When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using modifier KX. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

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

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

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

**Documentation**

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

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

- The *Medicare Benefit Policy Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf> on the CMS website;
- The *Medicare Claims Processing Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf>.
- The *Medicare Program Integrity Manual*, located on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf>.

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

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



*Changes Conforming to Change Request 3648 or Therapy Services, continued*

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

When reviewing documentation, Medicare contractors will:

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

**Medicare Contractor Decisions**

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

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

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

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

medically necessary will be denied as a benefit category denial.

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

**Notification**

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

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

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

**Revised Medicare Summary Notice (MSN) Messages**

The MSN messages (17.13; 38.18) are revised to inform beneficiaries about the therapy caps and approved medically necessary exceptions. These notices are also part of CR 4364.

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

- the Medicare Benefit Policy Manual revision at <http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf> on the CMS website;
- the *Medicare Claims Processing Manual* revision, located on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf>.
- the *Medicare Program Integrity Manual* revision, located on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf>.

If you have any questions, contact your Medicare contractor at their toll free number, which is available on the CMS website at <http://www.cms.hhs.gov/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: MM4364 *Revised*

Related Change Request (CR) #: 4364

Related CR Release Date: February 15, 2006

Effective Date: January 1, 2006

Related CR Transmittal #: R52BP, R140PI, R855CP

Implementation Date: No later than March 13, 2006

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

# **HIPAA - THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

---

---

## **Ending the HIPAA Contingency for Remittance Advice**

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

### **Provider Types Affected**

All providers and suppliers who bill Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), and fiscal intermediaries (FIs), including regional home health intermediaries [RHHIs])

### **What You Need to Know**

Effective October 1, 2006, Medicare will send only HIPAA-compliant electronic remittance advice (ERA) transactions (transaction 835 version 004010A1) to all ERA receivers.

### **Background**

In 2003, the Centers for Medicare & Medicaid Services (CMS) addressed compliance with the HIPAA transaction and code sets, and encouraged health plans (such as Medicare) to:

- Intensify their efforts toward compliance;
- Assess the readiness of their provider communities; and
- Determine the need to implement contingency plans to maintain the flow of payments while continuing toward compliance.

Consistent with that guidance, Medicare has aggressively worked with providers to achieve HIPAA compliance. Effective October 16, 2003, in order to ensure the continuation of normal program operations, CMS implemented a contingency plan through which Medicare continued to accept and send both HIPAA-compliant and non-HIPAA transactions from/to trading partners.

CMS ended the contingency plan that addressed **inbound** claims on October 1, 2005, and at that time began denying non-compliant electronic claims.

Now, CMS is moving to end the contingency plan for ERA transactions. Currently, 99% of all ERA receivers (providers, clearinghouses, billing agencies, and others who receive ERAs on behalf of providers) are receiving the HIPAA compliant ERA.

Further, the overall compliance rate for all Medicare providers in May 2006 was 96 percent. (The rate for professional providers was 97 percent and for institutional providers was 93 percent.)

Therefore, CMS announces that, effective October 1, 2006; it will end the contingency plan for the remittance advice transaction.

After that date, your carriers, FIs, DMERCs, DME MACs, and RHHIs will send only HIPAA-compliant remittance advice (transaction 835) to all ERA receivers. In doing so, Medicare will stop sending ERA in any version other than the standard HIPAA version (835 version 004010A1), or in any other format (e.g., NSF).

### **Additional Information**

You may find more information about HIPAA at <http://www.cms.hhs.gov/HIPAAGenInfo/> on the CMS website.

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> 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: SE0646

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #:

Implementation Date: N/A

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

## Important News Regarding HIPAA Contingency for Remittance Advice

The Centers for Medicare & Medicaid Services (CMS) has announced that its contingency plan for the HIPAA compliant transaction 835, or electronic remittance advice, will expire on **October 1, 2006**. A Special Edition *MLN Matters* article has been developed to help the Medicare fee-for-service provider community prepare for this change. You can access the article on the CMS website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0646.pdf>.

Source: Provider Education Resources Listserv, Message 200607-06

## Medicare Remit Easy Print—Version 1.8

Medicare Remit Easy Print (MREP) - Version 1.8 is now available for download.

Source: CMS Joint Signature Memorandum 06497, June 15, 2006

## Medicare Remit Easy Print Update

CMS has issued the following “MLN Matters article. *Information for Medicare Fee-for-Service Health Care Professionals. Provider Types Affected*

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), for services provided to Medicare beneficiaries.

### Provider Action Needed

#### **STOP – Impact to You**

This article is based on Change Request (CR) 5032 which advises providers to use Medicare Remit Easy Print (MREP) software to read and print the Health Insurance Portability and Accountability Act (HIPAA) compliant electronic remittance advice (ERA) for accounts reconciliation and crossover claims submission to secondary/tertiary payers.

#### **CAUTION – What You Need to Know**

CR 5032 also includes instructions for Medicare’s system maintainer (VIPS) to update MREP software with additional functionalities, and directs carriers and DMERCs to test and communicate to the end users about the software update.

#### **GO – What You Need to Do**

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

## Background

The Centers for Medicare & Medicaid Services (CMS) developed MREP software as tool providers can use to read and print an ERA in a human readable format. The format is based on the current standard paper remittance (SPR) format. Providers who use the MREP software package can:

- Print paper documentation that can be used to reconcile accounts receivable; and
- Create document(s) that can be included with claim submissions to coordination of benefits (COB) payers.

The MREP software became available on October 11, 2005, to providers (Part B and DMERC) through their respective Medicare carrier/DMERC, and it was updated this year in April and July.

CR 5032 further encourages providers to use the MREP software to read and print the Health Insurance Portability and Accountability Act (HIPAA) compliant ERA for accounts reconciliation and crossover claims submissions to secondary/tertiary payers.

CMS created a process to receive suggestions from providers, Medicare contractors, and CMS staff in order to continuously improve and enhance MREP’s functionality and effectiveness. A summary listing of the improvements to be implemented in the October 2006, update of MREP is included in the *Additional Information* section of this article.

**Note:** This update to MREP software includes suggestions for improvements received before the cut off date of March 15, 2006.

Beginning June 1, 2006, Medicare contractors and DMERCs (and later DMACs) will start suppressing the issuance of SPRs to providers/suppliers, billing agents, clearing houses, or other entities representing providers, who also have been receiving ERA transactions for 45 days or more. MREP is an option for providers to print their own remittances at their own computer.

After the October 2006 update, annual updates of MREP will be provided every October unless a critical error affecting production needs to be corrected. The software will also be updated three times a year to implement the claim adjustment reason and remittance advice remark code changes.

See Special Edition MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf> on the CMS website for options for providers affected by this change.

## Implementation

The implementation date for CR 5032 is October 2, 2006. Your carrier/DMERC will post a notice to their website on or after October 2, 2006, to alert you that the new version of the MREP software is available for download and that the software includes the latest version of the claim adjustment reason codes and remittance advice remark codes.

**Medicare Remit Easy Print Update, continued****Additional Information**

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R927CP.pdf> on the CMS website.

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

**List of Improvements To Be Implemented in October 2006****Synopsis of Change**

- A provider would like to have the Provider ID added after the Payee Name. This way, when they have multiple providers and provider locations, they can sort them easier. The Provider ID will be displayed after the Payee Name on the MREP Main Page.
- New report/listing of accounts NOT FORWARDED to supplemental or crossovers.
- A new report is added to show "Late Filing."
- A new report will be created showing only those items with coinsurance.
- Print reason/remark codes on same page as Remittance; or, can there be a check box that will either print the codes or not? The MREP software is being changed to include a check box to allow the user to have the remit print with or without the reason/remark codes.
- The program should automatically import the 835 file. CMS is looking into this possibility or identifying and displaying the 835 file and path.
- Searchable "Help" menu and Index. The analysis is underway to determine the appropriate level of a help facility.

MLN Matters Number: MM5032

Related Change Request (CR) #: 5032

Related CR Release Date: April 28, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R927CP

Implementation Date: October 2, 2006

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

**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 First Quarter 2006 Medicare B Update! page 51.*

**Note:** This article was revised on June 22, 2006, to reflect Web addresses that conform to the new CMS website. 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 version 5.1 HPTC update.

**CAUTION – What You Need to Know**

CR 4072 advises your carrier and/or DMERC to obtain the Healthcare Provider Taxonomy Code 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 healthcare 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 non-medical 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).

### Update to the Healthcare Provider Taxonomy Codes Version 5.1, continued

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
- Available for purchase, an electronic representation of the list, 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 3, 2005.

### Additional Information

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

- 170300000X
- 171000000X
- 171011002X
- 171011003X

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 any questions, please contact your carrier/DMERC 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

Medlearn Matters Number: MM4072  
 Related CR Transmittal #: R694CP  
 Implementation Date: October 30, 2005

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

---



---

## Claim Status Category Code and Claim Status Code Update

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

### Provider Types Affected

Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, durable medical equipment regional carriers [DMERCs], fiscal intermediaries [FIs], and regional home health intermediaries [RHHIs])

### Provider Action Needed

#### **STOP – Impact to You**

This article is based on Change Request (CR) 5137, which provides the October 2006 updates of the claim status codes and claim status category codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHIs).

#### **CAUTION – What You Need to Know**

Medicare contractors are to use codes with the “**new as of 10/06**” designation and prior dates, and they must inform affected providers of the new codes. CR 5137 applies to Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277.

#### **GO – What You Need to Do**

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

### Background

Claim Status Category codes indicate the general category of a claim’s status (accepted, rejected, additional information requested, and so on). Further detail is provided by the claim status code(s).

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use claim status category and claim status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction.

The Health Care Code Maintenance Committee maintains the claim status category and claim status codes. The Committee meets at the beginning of each X12 trimester meeting and makes decisions about additions, modifications, and retirement of existing codes.

The updated claim status category and claim status codes list is posted three times a year (after each Health Care Code Maintenance Committee X12 trimester meeting) at the Washington Publishing Company website at <http://www.wpc-edi.com/codes>. At this website, select “Claim Status Codes” or “Claim Status Category Codes” to access the

**Claim Status Category Code and Claim Status Code Update, continued**

updated code list. Included in the code lists are specific details, including the date when a code was added, changed or deleted. All code changes approved in June 2006 are to be listed to this website approximately thirty days after the meeting concludes. For this update, Medicare will begin using the codes in place as of October 2006 in claim status responses issued on or after October 2, 2006.

**Implementation**

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

**Additional Information**

For complete details, please see CR 5137, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI regarding changes mentioned in this article.

CR 5137 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R987CP.pdf> on the CMS website.

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

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: MM5137

Related Change Request (CR) #: 5137

Related CR Release Date: June 23, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R987CP

Implementation Date: October 2, 2006

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

## Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information

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

**Provider Types Affected**

Physicians, providers, suppliers, and clearinghouses who bill Medicare fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs), and who use the HIPAA 270/271 beneficiary eligibility transaction data in a real-time environment via the Centers for Medicare & Medicaid Services (CMS) AT&T communication Extranet.

**Background**

CMS is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)

This article is a reminder to physicians/providers/suppliers of the importance of protecting Medicare beneficiary information and to use it only for authorized purposes. Be sure all your representatives and employees who have authorized access to this information are aware of the importance of protecting that information as well.

**Key Points of CR 5138**

Change Request (CR) 5138 reiterates the responsibilities of users in obtaining, disseminating, and using beneficiary's Medicare eligibility data. The following key points outline those responsibilities:

**EDI Enrollment**

The Medicare electronic data interchange (EDI) enrollment process must be executed by each physician/provider/supplier that submits/receives EDI either directly to or from Medicare or through a third party, such as a clearinghouse.

Each physician/provider/supplier that uses EDI, either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare, must sign the EDI Enrollment Form and submit it to the carrier, DMERC, or FI with whom EDI transactions will be exchanged before any transaction is conducted.

Physicians/providers/suppliers should remember that they agreed to use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of information are authorized and all beneficiary-specific data is protected from improper access. Acting on behalf of the beneficiary, physicians/providers/suppliers/users of Medicare data are expected to use and disclose protected health information according to the CMS regulations. The HIPAA Privacy Rule mandates the protection and privacy of all health information.

**Authenticating Data Elements for HIPAA 270/271 Eligibility Data**

Authenticating data elements for HIPAA 270/271 Eligibility Data must be provided by the inquirer (physician, provider, supplier, or other authorized third party) prior to the release of any beneficiary-specific eligibility information and must include:

- Beneficiary last name (must match the name on the Medicare card);
- Beneficiary first name or first initial (must match the information on the Medicare card);
- Assigned Medicare Claim Number (also referred to as the Health Insurance Claim Number (HICN) including both alpha and numerical characters; and
- Date of birth.

*Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information, continued***Medicare Beneficiary as First Source of Health Insurance Eligibility Information**

The Medicare beneficiary should be your first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare beneficiary, remind them to bring, on the day of their appointment, all health insurance cards showing their health insurance coverage. This will not only help you determine who to bill for services rendered, but also provide you with the proper spelling of the beneficiary's first and last name and identify their Medicare Claim Number as reflected on the Medicare Health Insurance card. It is important to use the name as shown on the Medicare card.

If the beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, encourage them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) may call 1-800-808-0772 to request a replacement Medicare Health Insurance card from RRB.

**Authorized Purposes for Requesting Medicare Beneficiary Eligibility Information**

In conjunction with the intent to provide health care services to a Medicare beneficiary, authorized purposes include the following:

- Verify eligibility for Part A or Part B of Medicare;
- Determine beneficiary payment responsibility with regard to deductible/coinsurance;
- Determine eligibility for services such as preventive services;
- Determine if Medicare is the primary or secondary payer;
- Determine if the beneficiary is in the original Medicare plan or a Part C plan (Medicare Advantage); and
- Determine proper billing.

Medicare eligibility data is only to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

In order to obtain access to eligibility data, as a physician/provider/supplier you will be responsible for the following:

- Before you request Medicare beneficiary eligibility information and at all times thereafter, you will ensure sufficient security measures to associate a particular transaction with the particular employee.
- You will cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry.
- You will promptly inform CMS or one of CMS's contractors (your carrier/DMERC/RHHI/FI) in the event you identify misuse of "individually identifiable" health information accessed from the CMS database.
- Each eligibility inquiry will be limited to requests for Medicare beneficiary eligibility data with respect to a patient currently being treated or served by you, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

**Note:** Medicare health benefit beneficiary eligibility inquiries are monitored. Providers identified as demonstrating aberrant behavior (e.g., high inquiry error rate or high ratio of eligibility inquiries to claims submitted) may be contacted to verify proper use of the system, made aware of educational opportunities, or when appropriate referred for investigation of possible fraud and abuse or violation of HIPAA privacy law.

**Criminal Penalties' Provisions**

Remember that a number of statutes provide for severe criminal and civil penalties for misuse of information, including:

**1. Trading Partner Agreement Violation**

42 U.S.C. 1320d-6 authorizes criminal penalties against a person who, "knowingly and in violation of this part ... (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person."

Offenders shall "(1) be fined not more than \$50,000, imprisoned not more than 1 year, or both; (2) if the offense is committed under false pretenses, be fined not more than \$100,000, imprisoned not more than 5 years, or both; and (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than \$250,000, imprisoned not more than 10 years, or both."

**2. False Claim Act**

Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim.

**3. Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

HHS may impose civil money penalties on a covered entity of \$100 per failure to comply with a Privacy Rule requirement. That penalty may not exceed \$25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year. A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of \$50,000 and up to one-year imprisonment. The criminal penalties increase to \$100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to \$250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. Criminal sanctions will be enforced by the Department of Justice.

### *Rules Governing Provider/Clearinghouse Protection of Medicare Beneficiary Eligibility Information, continued*

#### **Implementation**

The implementation date for this instruction is July 24, 2006.

#### **Additional Information**

CR 5138, the official instructions issued to your Medicare FI, carrier, RHHI, and DMERC regarding this change, may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R991CP.pdf> on the CMS website. The revised section Chapter 31—*ANSI X12N Formats Other than Claims or Remittance of the Medicare Claims Processing Manual* is attached to CR 5138.

If you have questions, please contact your Medicare FI, carrier, RHHI, or DMERC 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: MM5138

Related Change Request (CR) #: 5138

Related CR Release Date: June 23, 2006

Effective Date: July 24, 2006

Related CR Transmittal #: R991CP

Implementation Date: July 24, 2006

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

#### **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.



## PROVIDER ENROLLMENT

### Medicare Provider Enrollment Applications

The CMS-855 Medicare enrollment applications on the CMS forms Web page can now be completed online in a PDF format or downloaded and completed by hand. All the CMS-855 forms have been posted to the CMS Forms Internet website:

<http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage>

(Note: The Provider Enrollment website has a reference link “All CMS Forms” which takes you to the main CMS Forms list link above, but does not link directly to each individual form.)

The direct link for each form in the PDF fillable format is as follows:

CMS 855A (06/06) <http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf>

CMS 855B (06/06) <http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf>

CMS 855I (06/06) <http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf>

CMS 855R (06/06) <http://www.cms.hhs.gov/cmsforms/downloads/cms855r.pdf>

Once you have completed the application(s), please send the forms and supporting documentation to one of the addresses below:

#### Connecticut

Medicare Part B CT Correspondence  
Provider Enrollment Department  
PO Box 45010  
Jacksonville, FL 32232-5010

#### Florida

First Coast Service Options, Inc.  
Medicare Part B Provider Enrollment  
PO Box 44021  
Jacksonville, FL 32231-4021

If you have any questions, you may contact the appropriate carrier at

Connecticut (866) 535-6790 (Provider Enrollment)

Florida (866) 454-9007 (Medicare B Customer Service)

### National Provider Identifier Enumeration System—Countdown Reminder

Countdown has begun; do you have your national provider identifier (NPI)? Don't risk disruption to your cash flow – Get your NPI now! National provider identifiers (NPIs) will be required on claims sent on or after May 23, 2007. **Every** healthcare provider needs to get an NPI! Learn more about NPI and how to apply by visiting the CMS website at <http://www.cms.hhs.gov/NationalProvIdentStand/>.

This page also contains a section for Medicare fee-for-service (FFS) providers with helpful information on the Medicare NPI implementation. A countdown clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at <http://www.wedi.org/npioi/index.shtml>.

Source: CMS Joint Signature Memorandum 06468, May 30, 2006

### Upcoming NPI Outreach Event

The Centers for Medicare & Medicaid Service (CMS) and the Workgroup for Electronic Data Interchange (WEDI) are working together to ensure that all healthcare providers are educated and informed on the new National Provider Identifier (NPI). As such the following upcoming outreach event, sponsored by WEDI, that healthcare providers may find helpful:

#### WEDI NPI Industry Forum IV: NPI Is Knocking At Your Door—Will You Let It In?

August 15th and 16th at the Hyatt Fair Lakes in Fairfax, VA

<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=1EFC0000000A>

Please note that there is a cost to participate in this event. To learn more about this event, as well as the latest news on WEDI NPI outreach, visit <http://www.wedi.org/npioi/index.shtml> on the Web.

Source: CMS Learning Resource, Message 200606-13

## **Stage 2 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22—Remittance Advice**

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

### **Provider Types Affected**

All Medicare physicians, providers, suppliers, and billing staff who submit claims for services to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) and durable medical equipment administrative contractors [DME MACs])

### **Background**

This article instructs the shared system maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant electronic remittance advice (ERA) – transaction 835, and standard paper remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007.

The Centers for Medicare & Medicaid Services (CMS) has defined legacy provider identifiers to include OSCAR, National Supplier Clearinghouse (NSC), provider identification numbers (PIN), National Council of Prescription Drug Plans (NCPDP) pharmacy identifiers, and unique physician identification numbers (UPINs). CMS's definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as employer identification numbers (EINs) or Social Security Numbers (SSNs). Medicare has published CR 4320 (<http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf>) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via direct data entry screens, or on paper claim forms.

Providers need to be aware that these instructions that impact contractors will also impact the content of their SPR, ERA, and their PC print and MREP software.

The following dates outline the regulations from January 2006 forward and are as follows:

- **January 3, 2006 – October 1, 2006:** Medicare rejects claims with only NPIs and no legacy number.
- **October 2, 2006 – May 22, 2007:** Medicare will accept claims with a legacy number and/or an NPI, and will be capable of sending NPIs in outbound transaction e.g., ERA
- **May 23, 2007 – Forward:** Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

Medicare providers may want to be aware of the following Stage 2 scenarios so that they are compliant with claims regulations and receive payments in a timely manner.

### **Key Points**

**During Stage 2**, if an NPI is received on the claim, it will be cross-walked to the Medicare legacy number(s) for processing. The crosswalk may result in:

**Scenario I:** Single NPI cross-walked to single legacy number

**Scenario II:** Multiple NPIs cross-walked to single Medicare legacy number

**Scenario III:** Single NPI cross-walked to multiple Medicare legacy numbers

**Note:** The SPR for institutional providers would include NPI information at the claim level. NPI information for professional providers and suppliers would be sent at the service level.

CMS will adjudicate claims based upon Medicare legacy number(s) even when NPIs are received and validated. The remittance advice (RA) may be generated for claims with the same legacy numbers but and different NPIs. These claims with different NPIs will be rolled up and reported in a single RA accompanied by one check or electronic funds transfer (EFT).

During stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers.

The companion documents will be updated to reflect these changes and the updated documents will be posted at [http://www.cms.hhs.gov/ElectronicBillingEDITrans/11\\_Remittance.asp#TopOfPage](http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage) on the CMS website.

### **Scenario I – Single NPI cross-walked to single legacy number:**

- 1 ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed.
- 2 SPR: Insert the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
- 3 PC Print Software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

*Stage 2 NPI Changes for Transaction 835, and SPR Advice, and Changes in Chapter 22—Remittance Advice, continued*

- 4 MREP software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

**Scenario II: Multiple NPIs cross-walked to single Medicare legacy number:**

- 1 ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the specific NPIs at the claim and/or at the service level, if needed. The specific NPI associate with the claim(s)/service lines included in the ERA will need to be identified using additional information provided on the claim.
- 2 SPR: Insert the legacy number at the header level. Add the specific NPIs at the claim and/or at the service level, if needed.
- 3 PC Print software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.
- 4 MREP software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

**Scenario III: Single NPI cross-walked to multiple Medicare legacy numbers:**

- 1 ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the appropriate legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed. (Under this scenario, if there are 50 claims with the same NPI and that NPI crosswalks to 5 legacy numbers, we will issue 5 separate RAs and 5 separate checks/EFTs per each legacy number.
- 2 SPR: Insert the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
- 3 PC Print software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
- 4 MREP software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

**Implementation**

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

**Additional Information**

The official instructions issued to your Medicare FI, Carrier, RHHI, DMERC, or DME MAC regarding this change can be found at <http://www.cms.hhs.gov/transmittals/downloads/R996CP.pdf> on the CMS website. The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* is attached to CR 5081

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

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

The MLN Matters article that provides additional information about Stage 1 Use of NPI is at the following address is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf> on the CMS website.

MLN Matters Number: MM5081  
 Related Change Request (CR) #: 5081  
 Related CR Release Date: June 30, 2006  
 Effective Date: October 1, 2006  
 Related CR Transmittal #: R996CP  
 Implementation Date: October 2, 2006

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

**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.

**GENERAL INFORMATION**

---

---

## **CMS Announces Proposed Changes To Physician Fee Schedule Methodology**

### ***Substantial Increases In Payments For Time Spent With Patients***

The Centers for Medicare & Medicaid Services (CMS) issued a notice proposing changes to the Medicare Physician Fee Schedule (MPFS) that will improve the accuracy of payments to physicians for the services they furnish to Medicare beneficiaries. The proposed notice includes substantial increases for “evaluation and management” services, that is, time and effort that physicians spend with patients in evaluating their condition, and advising and assisting them in managing their health. The changes reflect the recommendations of the Relative Value Update Committee (RUC) of the American Medical Association.

The proposed notice will appear in the June 29 *Federal Register*. Comments will be accepted until August 21, 2006. CMS responses to public comments on the proposals in this notice will be combined with those for the upcoming MPFS notice of proposed rulemaking in a final MPFS rule scheduled for publication this fall. If adopted, the RVU revisions in this proposed notice would be fully implemented for services to Medicare beneficiaries on or after January 1, 2007, while the practice expense revisions would be phased in over a four-year period.

To view the entire press release, go to <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1887>.

To view the display copy of the proposed notice (CMS-1512-PN), go to <http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS1183724>

To view more MPFS information, go to <http://www.cms.hhs.gov/PhysicianFeeSched/> on the CMS website.

Source: CMS Learning Resource, Message 200606-11

---

---

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

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2006 Medicare B Update! pages 48-49.*

**Note:** This article was revised on July 6, 2006, to reflect revisions made to CR 5105, which CMS released on July 3, 2006. The transmittal number, CR release date, and Web address for accessing CR 5105 have been changed. In addition, some references to MA (Medicare Advantage) have been changed to refer to managed care plans. All other information remains the same.

### **Provider Types Affected**

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

### **Impact on Providers**

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

### **Background**

The Centers for Medicare & Medicaid Services (CMS) pays for a beneficiary’s medical services more than once when a specific set of circumstances occurs.

When CMS data systems recognize a beneficiary has enrolled in a MA organization, the MA organization receives capitation payments for the Medicare beneficiary. In some cases, enrollments with retroactive payments are processed.

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

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

### **Overview of the MA plan Enrollment Process**

When an MA plan enrollment is processed retroactively:

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

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

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

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

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

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

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

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

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

**Note:** To associate plan identification numbers with the plan name, go to [http://www.cms.hhs.gov/HealthPlansGenInfo/claims\\_processing\\_20060120.asp#TopOfPage](http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage) on the CMS website.

In summary, CMS issued CR 5105 to:

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

## Implementation

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

## Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC, intermediary, or RHHI regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R100FM.pdf> on the CMS website.

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

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

MLN Matters Number: MM5105 *Revised*

Related Change Request (CR) #: 5105

Related CR Release Date: July 3, 2006

Effective Date: October 1, 2003

Related CR Transmittal #: R100FM

Implementation Date: June 26, 2006

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

### Correcting Minor Clerical Errors or Omissions

#### Did you know ...

Did you know that minor errors or omissions could be corrected outside of the appeals process?

#### How...

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

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

Minor clerical errors or omissions that may be corrected and resubmitted:

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

***\*Resubmit ONLY the denied service(s)! Resubmitting the entire claim will create a duplicate denial.***

#### Avoid process delays...

Correcting and resubmission of minor clerical errors or omissions is the preferred and most efficient method for addressing denials that process and do not receive an approved amount.

Written or telephone clerical error reopenings are appropriate for services that process and received an approved amount. Minor clerical errors or omissions that must be requested via the telephone or in writing include the following:

- Number of services (NB) billed
- Submitted charge amount
- Date of service (DOS)
- Add, change or delete certain modifiers
- Procedure code; excluding codes requiring documentation on the initial submission or codes being upcoded

***Please remember, correcting and resubmitting minor clerical errors or omissions are the preferred and most efficient method for addressing denials that process and do not receive an approved amount. Determine if the error can be corrected and resubmitted prior to writing in or calling to request a clerical error reopening.***

### The CMS Mailing Lists Fact Sheet

The Centers for Medicare & Medicaid Services' (CMS) electronic mailing lists can help you with your Medicare business. This method enables you to receive updates about the latest CMS initiatives.

For more details, download the Fact Sheet from the following url: [http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists\\_FactSheet.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf).

Hardcopies can also be ordered by going to the MLN Products Ordering Page at:

[http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) and then click on the first item under "Informational Resources".

Source: CMS Joint Signature Memorandum 06504, dated June 22, 2006

### Free Print Format of the Medicare Physician Guide Now Available

The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals is now available in print format free of charge from the Medicare Learning Network at <http://www.cms.hhs.gov/mlngeninfo> on the Centers for Medicare & Medicaid Services (CMS) website. Select "MLN Product Ordering Page" under the Related Links Inside CMS section to place your order.

Source: Provider Education Resources Listserv, Message 200607-09

#### 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.

## Full Replacement of and Rescinding Change Request 3504—Modification to Online Medicare Secondary Payer Questionnaire

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2006 Medicare B Update! pages 76-77.

**Note:** This article was revised on June 15, 2006, because CR 4098, on which this article is based, has been superseded by CR 5087. To view modifications to the online Medicare Secondary Payer Questionnaire that are effective as of September 11, 2006, please see MLN Matters article MM5087, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5087.pdf> on the CMS website.

### Provider Types Affected

Medicare providers who, upon inpatient or outpatient admissions of Medicare beneficiaries, use a questionnaire to determine other insurance coverage that may be primary to Medicare.

### Provider Action Needed

#### STOP – Impact to You

CR 4098 clarifies recent changes made to the “Medicare Secondary Payer Questionnaire.”

#### CAUTION – What You Need to Know

This CR identifies all of the changes that were made to CR 3504 *and* makes additional changes to the model questionnaire. These changes will assist providers in identifying other payers that may be primary to Medicare.

#### GO – What You Need to Do

Please refer to the *Background* and *Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified.

### Background

The Centers for Medicare & Medicaid Services (CMS) received information that a prior instruction (CR 3504) did not specifically mention all of the changes that were made to the “Medicare Secondary Payer (MSP) Questionnaire.” CR 4098 identifies all of the changes made as part of CR 3504 and makes additional changes to the model questionnaire.

The *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1, available as an attachment to CR 4098, provides a model: “Admission Questions to Ask Medicare Beneficiaries.”

The model contains questions that may be printed out and used as a guide to help identify other payers. (The website for accessing CR 4098 is provided in the *Additional Information* section of this article.)

The following bullets identify the changes within the model MSP Questionnaire:

- **Parts IV and V** of the model questionnaire adds the response: “No, Never Employed.”
- In **Parts IV, V, and VI** of the model questionnaire, providers should use “Policy Identification Number” to mean a number that is sometimes referred to as the health insurance benefit package number.

- **Parts IV, V, VI** of the model questionnaire adds “Membership Number” and it refers to the unique identifier assigned to the policyholder/patient.
- **Part V**, question 2 of the model questionnaire uses “spouse” instead of “family member.”
- **Part V**, question 4 changes the model questionnaire to read:

*Are you covered under the group health plan of a family member other than your spouse? \_\_\_\_\_Yes \_\_\_\_\_No.*  
*Name and address of your family member’s employer:\_\_\_\_\_*

- **Part V** of the old question 4 is changed to ask whether the beneficiary is covered under a group health plan (GHP) and a question number 5 is added to gather the pertinent information about the GHP.
- In **Part VI**, question 6 now reads: “Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?”

Providers who use the model questionnaire to elicit MSP information from their Medicare patients should take special note of these changes.

### Implementation

The implementation date for the instruction is January 21, 2006.

### Additional Information

The official instructions issued to your Medicare carrier or intermediary regarding this change and the model questionnaire can be found at <http://www.cms.hhs.gov/transmittals/downloads/R41MSP.pdf> on the CMS website.

If you have questions, please contact your carrier/intermediary at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS 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: MM4098 *Revised*  
Related Change Request (CR) #: 4098  
Related CR Release Date: October 21, 2005  
Effective Date: January 21, 2006  
Related CR Transmittal #: 41  
Implementation Date: January 21, 2006

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

### 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 Provider Education Resource 200607-01  
CMS Joint Signature Memorandum 06549, July 12, 2006

### Hold on Medicare Payments

A brief hold will be placed on ALL Medicare claims resulting in payment (including associated SPRs, MSNs, and ERAs) for the last 9 days of the federal fiscal year. Payments will be held from September 22 through September 30, 2006. These claims and all associated correspondence will be released on October 2, 2006.

Source: Publication 100-04, Transmittal 944, Change Request 5047

### A/B MAC NEWS #1—First Contract for a Part A/Part B Medicare Administrative Contractor To Be Awarded in Near Future

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

#### Provider Types Affected

All Medicare physicians, providers, and practitioners that bill Medicare fiscal intermediaries (FIs) or carriers for their services, especially those in the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming

#### Background

Section 911 of the Medicare Modernization Act (MMA) requires the Secretary to implement Medicare Contracting Reform by 2011. The law mandates that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by fiscal intermediaries and carriers in administering the Medicare fee-for-service program.

Medicare Contracting Reform will:

- Improve administrative services within the fee-for-service claims processing environment by reducing the number of contracts, focusing on correct claims payment and creating performance incentives related to timeliness, accuracy, and quality of services to CMS and to providers of services to Medicare beneficiaries;
- Lead to more efficiency and greater accountability among companies performing claims administration and provider education, and services by promoting competition and basing awards on good performance;
- Generate operational savings to the federal government and taxpayers through consolidation and competition of large and high value contracts with Medicare Contracting Reform, providers of health care in the original Medicare program can expect:
- Better educational and training resources on correct claims submission, Medicare coverage rules, and Medicare payment rules;
- Easier communications with a single A/B Medicare Administrative Contractor (MAC) serving as the point-of-contact for both Part A and Part B claims administration and payment;
- Increased payment accuracy and consistency in payment decisions resulting from CMS' increased focus on financial management by MACs; and
- An opportunity for input in evaluation of their MAC's performance through satisfaction surveys conducted by CMS.

#### Key Points for Providers

CMS soon will announce the result of the first full and open competition for a Part A/Part B Medicare Administrative Contractor (A/B MAC) conducted as part of the agency's Medicare Contracting Reform implementation strategy. This award will be for a single fee-for-service claims processing contract that will combine the workloads for a multi-state jurisdiction currently serviced both by FIs and carriers.

This first A/B MAC award will be for Jurisdiction 3, which includes the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming. Jurisdiction 3 represents three percent of the national fee-for-service Medicare claims volume.



**A/B MAC NEWS #1 - First Contract for a Part A/Part B MAC To Be Awarded in Near Future, continued**

With this contract award, CMS will begin to achieve efficiencies and administrative savings through the consolidation of the traditional cost-reimbursable contracts and by implementing improved contracting processes quickly.

The request for proposal (RFP) for the Jurisdiction 3 A/B MAC was released in September 2005. Full implementation of the new contractor is scheduled for July 2007. CMS will work with the current carriers and FIs in Jurisdiction 3, whose contracts will end with the MAC implementation, to ensure a smooth transfer of records and information to the new Jurisdiction 3 A/B MAC.

The carriers and FIs whose contracts will end are Montana Blue Cross Blue Shield, Wyoming Blue Cross, Arizona Blue Cross, and Noridian Administrative Services. CMS recognizes with gratitude the strong commitment by these corporations to serving the Medicare program for more than 40 years.

The Jurisdiction 3 A/B MAC contract award will be the first of 15 A/B MAC contracts. Each of these contracts will be for the administration of both the Medicare Part A and Part B benefits in a specified geographic jurisdiction of the country. (See the *Additional Information* section of this article for the Web page containing a map showing the 15 jurisdictions.) All 15 contracts are to be awarded, and all A/B MACs are to be operational, by October 2011.

CMS has extensive experience in overseeing the successful transfer of Medicare claims processing work from one contractor to another. The agency is committed to ensuring that the implementation of the new A/B MAC environment will be as seamless as possible for the Medicare providers and beneficiaries.

CMS will devote full resources and manage the A/B MAC contract implementation so as to ensure continuity, accuracy, and timeliness in claims processing and issuance of payments. In Jurisdiction 3, CMS plans to implement the new A/B MAC contract by transferring the claims processing workload from the current contractors incrementally (rather than all at once) to ensure that neither providers nor beneficiaries will be adversely affected.

**Additional Information**

Information on the Jurisdiction 3 A/B MAC procurement, including the scope of work to be performed, is available on the Federal Business Opportunities website at

<http://www1.fbo.gov/spg/HHS/HCFA/AGG/CMS%2D2005%2D0016/Attachments.html>

A map displaying the 15 A/B MAC jurisdictions is available on the Medicare Contracting Reform website at [http://www.cms.hhs.gov/MedicareContractingReform/05\\_A\\_BMACJurisdictions.asp#TopOfPage](http://www.cms.hhs.gov/MedicareContractingReform/05_A_BMACJurisdictions.asp#TopOfPage) on the CMS website. Individual fact sheets and data on each jurisdiction are also available there.

Suppliers may want to consult *MLN Matters* article SE0628 to see how Medicare Contracting Reform affects durable medical equipment regional carriers (DMERCs). That article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0628.pdf> on the CMS website.

MLN Matters Number: SE0642

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

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

**Requests for Claim Status Information Must be Referred to the Interactive Voice Response Unit—Florida Only**

**W**e have recently received a large volume of calls from providers refusing to utilize the Interactive Voice Response (IVR) Unit. The IVR is a self-help tool that allows providers to quickly obtain information on the status of their Medicare claims.

Federal regulations and guidelines require Medicare contractors to refer providers to the Interactive Voice Response (IVR) Unit to obtain claim status information. The specific requirements are outlined on the Centers for Medicaid & Medicare Services (CMS) website at <http://www.cms.hhs.gov/> in the *Medicare Contractor Beneficiary & Provider Communication Manual* (100-09), Chapter 6 – Provider Customer Service Program – Section 50-1.

In accordance with the CMS mandate, our customer service representatives (CSRs) must continue to refer providers back through the IVR for claim status information. The mandate also states that we are required to identify and contact providers who continually call the CSR service line to obtain such information. In the future, we will be contacting those providers to offer further education.

**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.

## Medicare's Common Working File Medicare Advantage Managed Care Data Exchange and Data Display Changes

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 provide services to Medicare beneficiaries enrolled under a Medicare Advantage Managed Care (Part C)

### Impact on Providers

CR 5118 provides notice that effective January 2006, Medicare Part C plan contract numbers can begin with a character other than an "H."

As a result of changes in the assignment of Medicare Part C plan contract numbers, the entire five-position alpha/numeric Medicare Part C plan contract number will be provided to the common working file (CWF), which is a key file used by Medicare systems to provide beneficiary information to providers.

Currently, the CWF places an "H" in front of the Part C plan number, since prior to January 1, 2006, all plan numbers began with an "H." Once this change is implemented, the correct and complete plan contract numbers will then be on the CWF and will be given to providers when they inquire about Medicare beneficiaries.

### Background

CWF contains data indicating when a beneficiary is enrolled under a Medicare Part C contract. Medicare Part C contracts are Medicare Advantage Managed Care Plans that provide Part A and B benefits for beneficiaries enrolled under the contract. CWF receives this Part C data on a data feed from the Enrollment Database (EDB), another Medicare database. Effective January 1, 2006, Part C contract numbers can begin with a letter other than "H" and the Medicare CWF is being modified to handle this change, so correct numbers are sent to providers as part of beneficiary information.

To associate plan identification numbers with the plan name, go to [http://www.cms.hhs.gov/HealthPlansGenInfo/claims\\_processing\\_20060120.asp#TopOfPage](http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage) on the CMS website.

The number that will appear on CWF will begin with "H." For the following 11 plans, the alpha prefix is actually an "R." Prior to October, when using the Web page look-up tool, make sure to replace the "H" with an "R." The 11 plans are the following:

R3175 R5566 R5863  
R5287 R5595 R5941  
R5342 R5674 R9943  
R5553 R5826

### Implementation

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

### Additional Information

CR 5118 is the official instruction issued to your Medicare carrier/durable medical equipment regional carrier (DMERC) or fiscal intermediary (FI) regarding changes mentioned in this article. CR 5118 may be found at

<http://www.cms.hhs.gov/Transmittals/downloads/R995CP.pdf> on the CMS website.

If you have questions please contact your Medicare carrier/FI/DMERC 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: MM5118	Related Change Request (CR) #: 5118
Related CR Release Date: June 30, 2006	Effective Date: October 1, 2006
Related CR Transmittal #: R995CP	Implementation Date: October 2, 2006

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

## Medicare Learning Network Products for Physicians

The following are products which are available on the Medicare Learning Network (MLN) website.

The *Facilitator's Guide*, which provides facilitators with everything needed to prepare for and conduct a Medicare Program training course and is a companion to the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*, is now available in downloadable format on the MLN Publication Page located at <http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp> on the Centers for Medicare & Medicaid Services (CMS) website.

The *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* in CD-ROM format is available free of charge from the MLN Product Ordering Page located at

<http://www.cms.hhs.gov/mlngeninfo/> on the CMS website.

Source: CMS Learning Resource, Message 200606-12

---

---

## **Southern Healthcare Administrative Regional Process Presents Free Teleconferences**

Please feel free to join in a free audio conference sponsored by Atlanta and Dallas CMS Regions regarding the “NPI Panel Discussion”.

For more information about this call and future teleconference dates and topics, please see below:

### **Electronic Health Records – Physician Perspective**

1:00 – 2:00 PM ET, Wednesday, August 16, 2006

Conference ID Number – 2512447

Dr. Jim Morrow with the North Fulton Family Medicine will discuss choosing an EHR system. He will share his experiences and lessons learned.

### **Electronic Health Records – RHIO Perspective**

1:00 – 2:00 pm ET, Wednesday, August 23, 2006

Conference ID Number – 2512465

Liesa Jenkins, Executive Director of CareSpark, will provide an overview of CareSpark and of its experience in improving the health of people in Northeast TN and Southwest VA through collaborative use of health information.

**SPECIAL NOTE:** Please call 877-203-0044 fifteen minutes prior to call start time and provide the conference ID number.

*Call sponsored by CMS Regions IV and VI*

Source: Provider Education Resources Listserv, Message 200607-10

---

---

## **The Importance of Reviewing Your Medicare Statement Before Calling Medicare—Florida Only**

We have recently begun to receive a large volume of unnecessary calls from agencies representing or acting on behalf of Medicare providers.

Many of the calls are related to requests for information that can be found on the provider’s Medicare remittance notice (MRN) or electronic remittance advice (ERA) statements, which are mailed each time a Medicare claim is processed. Some callers are also inquiring about checks that have already been received and cashed by the provider.

Providers and agency representatives are encouraged to thoroughly review MRN and ERA statements before calling Medicare for assistance. The statements include information such as:

- Claim control numbers
- Specific procedure codes billed on claims
- Billed amounts
- Allowed amounts
- Paid amounts for each service billed
- Reason codes or remark codes (which clarify why a service was denied or paid at an amount lower than the fee schedule)

We are taking steps to identify providers who frequently call our Medicare customer service (CSR) line for information that is outlined on their MRN or ERA statements. We will contact those customers to provide further education. Additional action will be taken (as needed) to help providers understand how these types of calls impact the response time of the Medicare customer service CSR Line.

## Together We Can Close the Prevention Gap—July Prevention Awareness Message

Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. Although chronic diseases are among the most common and costly health problems, they are also some of the most preventable. Over the years Medicare has continued to expand the range of preventive services for which it pays and now provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):

- Cardiovascular Disease Screening
- Cancer Screenings
  - Breast (mammography)
  - Cervical & vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- Diabetes Screening
- Self-management training
- Medical nutrition therapy
- Supplies
- Initial Preventive Physical Exam (IPPE) (“Welcome to Medicare” Physical Exam)
  - Bone Mass Measurements
- Adult Immunizations
  - Influenza (flu)
  - Pneumococcal polysaccharide vaccine (PPV)
  - Hepatitis B virus (HBV)
- Glaucoma Screening
- Smoking and Tobacco-Use Cessation Counseling Services

While the number of Medicare-covered preventive services is higher than ever, we are finding that many beneficiaries are not taking advantage of the full range of services for which they may be eligible. Some of the reasons for this underutilization include beneficiaries:

- Not knowing that Medicare covers these services.
- Being afraid to talk with their physician or not knowing how or what questions to ask.
- Not understanding the value of prevention, early detection and treatment.
- Fearing the pain that may occur during the preventive service procedure.
- Fearing the results of the preventive service procedure.

In addition, there may be physical and social barriers that prevent Medicare beneficiaries from obtaining preventive services.

### How Can You Help?

Regardless of the reason for your Medicare patient not using a service, you are in a key role to help address this problem. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare are aware that Medicare provides coverage for preventive services that could save their lives. You can help by doing the following:

- Talk with your patients about their risk for disease and the value of prevention and early detection, and encourage utilization of appropriate Medicare-covered preventive services.
- Perform or provide referrals for the appropriate preventive services
- Follow-up with patients on all screening results, even negative ones
- Provide information about appropriate lifestyle modifications that support a healthy lifestyle

### For More Information

CMS has developed a variety of educational products and resources to help healthcare professionals and their staff become familiar with coverage, coding, billing, and reimbursement for 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](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp) - *TopOfPage*.

***Together We Can Close the Prevention Gap—July Prevention Awareness Message, continued***

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 a trusted source of patient health care information, your recommendation is one of the most important factors in increasing the utilization of preventive services covered by Medicare. We hope that you will join with CMS as we strive to close the prevention gap and encourage appropriate utilization of preventive services. It could save seniors’ lives.

Thank you so much for your help!

Source: CMS Provider Education Resource 200607-05

**Sign up to our eNews electronic mailing list**

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

# GENERAL MEDICAL REVIEW

Articles in this section apply to both Florida and Connecticut.

## Billing Guidelines for Anesthesia Services

First Coast Service Options, Inc. (FCSO) has noted a significant increase in claims development due to providers billing multiple anesthesia codes for the same operative session, and surgeons billing for both anesthesia and the surgical procedure for the same operative session.

The following information is to provide awareness and clarification to providers and billers of anesthesia services to eliminate these claim filing errors.

### Anesthesia for Multiple Surgeries

Payment may be made for the anesthesia services provided during multiple or bilateral surgery procedures. When billing anesthesia services associated with multiple or bilateral surgeries, report *only* the anesthesia procedure with the highest base unit. Report the total time in minutes for all procedures on *one detail line item*.

#### Incorrect

Date of Service	Procedure Code	Units
05/10/2006	00140QZ	60
05/10/2006	00140QZ	30

#### Correct

Date of Service	Procedure Code	Units
05/10/2006	00140QZ	90

### Administration of Anesthesia by the Surgeon

Reimbursement for anesthesia performed by the operating surgeon is included in the allowance of the surgical procedure rendered during the same operative session. Separate payment is not allowed when surgeon performs the surgical procedure *and* performs local or surgical anesthesia. *No claim should be submitted for the anesthesia service.*

#### Incorrect

Date of Service	Procedure Code	Provider	Units
05/10/2006	15823RT	D12345	010
05/10/2006	15823LT	D12345	010

Date of Service	Procedure Code	Provider	Units
05/10/2006	00140QZ	D12345	60

#### Correct

Date of Service	Procedure Code	Provider	Units
05/10/2006	15823RT	D12345	010
05/10/2006	15823LT	D12345	010

Source: Medicare Claims Processing Manual, Chapter 12, Section 50(e)

*Italicized and/or quoted material is excerpted from the American Medical Association Current Procedural Terminology. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.*

## Billing and Coding for Unlisted Drugs and Biologicals

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

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

### Billing and Coding

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

Please note that Medicare does not process claims using the National Drug Code (NDC) number.

Please follow the instructions below when filing claims to Medicare Part B for drugs and biologicals with unlisted procedure codes for (e.g., J3490, J3590):

#### Item 19 or the electronic equivalent

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

#### Item 24 or the electronic equivalent

- **24D** Procedure code (e.g., J3490, J3590)
- **24G** Enter number of units as **1**

When billing Medicare, the procedure code for the injection and the drug injected should be billed on the same claim.

Providers should not submit any additional information with the claim. FCSO may request it separately with an additional documentation request (ADR) letter, as necessary.

Any time there is a question whether Medicare's medical reasonableness and necessity criteria would be met; we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed HCPCS codes. If and when a denial should be received, providers may collect from the beneficiary based on fee schedule. For further details about CMS' Beneficiary Notices Initiative

**Billing Guidelines for Anesthesia Services, continued**

(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 noncovered as well.

**Pricing**

**Background:** Section 303(c) of the Medicare Modernization Act of 2003 (MMA) revises the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Per the MMA, beginning January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the average sales price (ASP) methodology. The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

**Beginning January 1, 2005,** the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. CMS will update the payment allowance limits quarterly. There are exceptions to this general rule as summarized below.

- (1) The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the average wholesale price (AWP) reflected in the published compendia as of October 1, 2003, regardless of whether or not the durable medical equipment is implanted. The payment allowance limits will not be updated in 2005. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP.
- (2) The payment allowance limits for drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the contractors follow the methodology specified in Chapter 17, Drugs and Biologicals, of the *Medicare Claims Processing Internet Only Manual* for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest brand or median generic WAC. At the contractors' discretion, contractors may contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS website. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting contractor or via posting an MS Excel file on the CMS website.
- (3) The payment allowance limits for new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.

On or after December 19, 2005, revised April 2005, July 2005, and October 2005 ASP and NOC payment files and the January 2006 ASP and NOC files will be available for download. The revised April 2005 payment allowance limits apply to dates of service April 1, 2005 through June 30, 2005. The revised July 2005 payment allowance limits apply to dates of service July 1, 2005 through September 30, 2005. The revised October 2005 payment allowance limits apply to dates of service October 1, 2005 through December 31, 2005. The January 2006 payment allowance limits apply to dates of service January 1, 2006 through March 31, 2006.

The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

Note that the absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations. (CMS Change Request 4140, dated February 15, 2006)

---



---

## Inappropriate Use of Assistant Surgeon Modifiers

An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. (Note that a nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under state law can also serve as an assistant at surgery). The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service.

- A recent review of services performed by physician assistants, specialty 97, during the time period of July through December 2005, has revealed that there has been erroneous billing of modifiers 80, 81, and 82 with surgical procedures. Medicare considers the following nonphysician practitioners: advanced registered nurse practitioners (ARNPs), physician assistants (PAs), and clinical nurse specialists (CNSs). Medicare does not recognize registered nurse first assistants (RNFAs) as providers at the current time, and services of this type are not payable by Medicare.

The following information applies to these modifiers:

- 80 – Assistant Surgeon: Surgical assistant services may be identified by adding the modifier 80 to the usual procedure code (pertains to *physician's* services). This modifier describes an assistant surgeon providing full assistance to the primary surgeon. This modifier is not intended for use by nonphysician providers.

### *Inappropriate Use of Assistant Surgeon Modifiers, continued*

- 81 – Assistant Surgeon: Minimal surgical assistance may be identified by adding the modifier 81 to the usual procedure code (pertains to *physician* services only) and describes an assistant surgeon providing minimal assistance to the primary surgeon. This modifier is not intended for use by nonphysician providers. This modifier is generally used in the private insurance industry and is not commonly used in Medicare billing.
- 82 – Assistant surgeon (when a qualified resident surgeon is not available in a teaching facility) and also applies to *physician* services only. The unavailability of a qualified resident surgeon is a prerequisite for use of this modifier and the service must have been performed in a teaching facility. The circumstance that a resident surgeon was not available must be documented in the medical record. This modifier is not intended for use by nonphysician providers.
- AS – describes a nonphysician provider as assistant at surgery. This would include services provided by physician assistants, nurse practitioners, or clinical nurse specialists.

### Payment Information

The modifier AS must be on claims for nonphysician providers as assistants at surgery. The carrier shall pay covered PA assistant at surgery services at 85 percent of the 16 percent of the physician fee schedule amount (i.e., 10.4 percent). Reimbursement for nonphysician practitioners is calculated as follows:

- Services rendered by nonphysician practitioners are reimbursed at 85 percent of the Medicare physician fee schedule (MPFS) amount.
- Services for assistant-at-surgery charges are reimbursed at 85 percent of 16 percent of the MPFS amount for the *surgery* (16 percent of the MPFS amount is allowed for a *physician* performing as a surgical assistant).

Effective for claims received as of July 1, 1999, claims submitted by these nonphysician practitioners will be processed on the basis of their PIN (provider identification number) and not the previously deleted HCPCS modifiers (AK, AL, AN, AU, AV, AW, AY). These previously deleted modifiers described services such as those that were performed in a team environment, such as team visits to beneficiaries in nursing facilities with services performed by both a physician and advanced registered nurse practitioner or physician assistant for the same beneficiary on the same or different dates of service. The services billed on or after July 7, 1999 will be priced based on the PIN (or the NPI, when effective) at the correct percentage of the physician fee schedule for the service date submitted.

All nonphysician practitioners who act as assistants at surgery should remember to append the AS modifier to the procedure code that accurately reflects the performed service. You will report the same procedure codes that are used to report the surgeon's service, and append modifier AS (physician assistant [PA], nurse practitioner [NP], or clinical nurse specialist [CNS] services for assistant at surgery). Please be aware that Medicare does not currently recognize registered nurse first assistants (RNFAs) as qualified Medicare providers.

More information related to this article may be found at: <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

Please see sections 20.4.3; 100.1.7, A-D; 110.

[http://www.floridamedicare.com/partb\\_updates\\_archive\\_November\\_December%201999%20Update!.pdf](http://www.floridamedicare.com/partb_updates_archive_November_December%201999%20Update!.pdf)

---

---

## Intravitreal Bevacizumab (Avastin®) for Neovascular Age-Related Macular Degeneration—Update

*This information was previously published in the Third Quarter 2006 Medicare B Update! page 146.*

**NOTE:** The documentation requirements under the first bullet were revised: The diagnosis of wet AMD (ICD-9 code 362.52) with leakage/fluid in the macula must have been confirmed by optical coherence tomography (OCT) or fluorescein angiography, as opposed to fluorescein angiography only, as had been communicated in the previous publication.

Bevacizumab, FDA-approved for intravenous use in combination with intravenous 5-fluorouracil-based chemotherapy, is indicated for first-line treatment of patients with metastatic carcinoma of the colon or rectum. The United States Pharmacopeia (USP) supports one unlabeled indication: advanced/metastatic non-squamous non-small cell lung cancer.

Early observations indicate that bevacizumab may be useful in the treatment of age-related macular degeneration (AMD). Ophthalmologists have been using intravitreal bevacizumab increasingly in the treatment of wet AMD. Even though the intravitreal administration looks promising and may be cost effective, there are still a number of concerns, specifically about safety. Currently, publications in peer-reviewed literature are not sufficient to support a positive coverage statement by means of a local coverage determination (LCD).

Until appropriately designed and powered studies are published and evaluated, bevacizumab for the treatment of AMD will be considered on an individual case-by-case basis.

HCPCS code J9035 (Injection, bevacizumab, 10 mg) does not apply to the intravitreal administration, as a pharmacist has processed the agent. Providers billing for intravitreal bevacizumab should use CPT code 67028 for the intravitreal injection and HCPCS code J3490 (unclassified drugs) for the bevacizumab. Please enter "Intravitreal bevacizumab" in Item 19 of CMS 1500 Form or its electronic equivalent. The applicable ICD-9 code is 362.52 (exudative senile macular degeneration of retina).



***Intravitreal Bevacizumab (Avastin®) for Neovascular Age-Related Macular Degeneration—Update, continued***

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.
- The patient does not have any contraindications to bevacizumab.
- The patient has been thoroughly educated about the benefits and risks of this therapy and that it is being used “off-label.”
- Actual dose administered.

When billing Medicare, the intravitreal injection and the drug injected should be billed on the same claim. Remember to use the appropriate modifiers when performing the service on both eyes.

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

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

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

---

## Mobile Cardiac Outpatient Telemetry

**M**obile cardiac outpatient telemetry is a real-time, outpatient cardiac monitoring system that is automatically activated and requires no patient intervention to either capture or transmit an arrhythmia when it occurs. Upon arrhythmia detection, the ECG waveform is transmitted by standard telephone line or wireless communications to a receiving center monitoring the patient and reporting significant findings according to the physician’s patient-specific, pre-determined criteria.

At this point in time, there is no assigned CPT code for this service, nor is there a local or national coverage determination (LCD or NCD) that specifically addresses this procedure. In the absence of a LCD or NCD, this service is being evaluated individually in regards to meeting Medicare’s medical reasonableness and necessity criteria. Providers rendering this service need to know and follow these guidelines:

- This service must be billed with CPT code 93799 (unlisted cardiovascular service or procedure), as currently there is no designated code.
- When billing “globally” (without modifier 26 and TC appended) for the professional and the technical component, the provider must have performed the physician review and interpretation as well as the recording and monitoring (includes receipt of transmissions and analysis).
- When billing for the professional component, which is physician review and interpretation only, CPT code 93799 with modifier 26 appended shall be used.
- When billing for the technical component, CPT code 93799 with modifier TC appended shall be used.
- Only the provider who performs the recording, receipt of transmissions, monitoring, and analysis can bill for the technical component. Generally, a centralized monitoring facility headquartered and reimbursed elsewhere provides the technical component. In this situation, the interpreting physician cannot bill for the technical component.
- This service is reimbursable per entire monitoring episode, expected to last between 7 and 30 days, and not per ECG strip or per day.
- The medical record must support the medical necessity for the test, such as symptoms and findings and the rationale why this modality was chosen over others.
- Documentation in the medical record must include a summarized interpretation and report for the duration of time the device had been worn (i.e. episode). Signing a computer generated report does not suffice for this purpose.
- Medicare does not expect the need for repeating this test sooner than after six months. The rationale and medical necessity for any repeat evaluation, regardless of frequency, must be documented in the medical record.
- The date of service to be used is the date the physician completed the interpretation and report of the monitoring period.

Providers should not submit any medical record documentation with the initial claim. Upon receipt of the claim, First Coast Service Options, Inc. (FCSO) will solicit additional documentation by means of an additional documentation request (ADR) letter.

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

**Moderate Conscious Sedation 99143—99150**

Moderate conscious sedation (procedure codes 99143 – 99150) is new for 2006 and was effective January 1, 2006. In this article, First Coast Service Options, Inc. (FCSO) will clarify how to bill these services and under what circumstances there is coverage.

Per the *AMA CPT 2006 Current Procedural Terminology, Professional Edition*, moderate conscious sedation is described as a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care (00100-01999).

When providing moderate sedation, the following services are included and NOT reported separately:

- Assessment of the patient (not included in intraservice time);
- Establishment of IV access and fluids to maintain patency, when performed;
- Administration of agent(s);
- Maintenance of sedation;
- Monitoring of oxygen saturation (94760-94762), heart rate and blood pressure and
- Recovery (not included in intraservice time).

Intraservice time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.

Moderate conscious sedation (procedure codes 99143 – 99150), continues to include all six possible routes of administration; intramuscular, intravenous, oral, rectal, intranasal and inhalation.

**Regulatory information (NCD or LCD information)****The Internet-Only Manual (IOM) Publication 100-04, Chapter 12, Section 50 A**

50 - Payment for Anesthesiology Services (Rev. 1, 10-01-03) B3-15018, General Payment Rule describes when there is coverage for 99143-99145. The fee schedule amount for physician anesthesia services furnished on or after January 1, 1992 is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is listed in section 50.K, Exhibit 1. The way in which time units are calculated, is described in section 50.G. CMS releases the conversion factor annually. Carriers may not allow separate payment for the anesthesia service performed by the physician who also furnishes the medical or surgical service. In that case, payment for the anesthesia service is made through the payment for the medical or surgical service. For example, carriers may not allow separate payment for the surgeon's performance of a local or surgical anesthesia if the surgeon also performs the surgical procedure. Similarly, separate payment is not allowed for the psychiatrist's performance of the anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs the electroconvulsive therapy.

**Billing and Coding Guidelines**

- Do not report 99143-99145 in conjunction with codes listed in CPT4 Appendix G
- Do not report 99148-99150 in conjunction with codes listed in CPT4 Appendix G when performed in the non-facility setting.
- When a second physician other than the healthcare professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting (e.g., hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility) for the procedures listed in CPT4 Appendix G, the second physician reports 99148-99150.
- When procedure codes 99148-99150 are performed by the second physician in the non-facility setting (e.g., physician office, freestanding imaging center), they should not be reported.
- Procedure codes 99148-99150 performed in an institutional setting can be paid in addition to the codes listed in CPT4 Appendix G
- 99143-99145 procedure codes are included in other services based on Publication 100-04, Chapter 12, Section 50.

**Documentation requirements**

Documentation in the anesthesia/operative/procedure report should include the rationale that supports the need for the second physician to administer moderate conscious sedation (procedure codes 99148-99150) as opposed to the surgeon providing the services.

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

---

---

## Angiojet Thrombolytic Therapy, 37799, 37184—37188

*This supersedes information previously published in the Third Quarter 2006 Medicare B Update! page 142.*

### Background

For service performed in 2005, First Coast Service Options, Inc. (FCSO) has seen an increased billing of Angiojet Thrombolytic Therapy. This article is to describe the service and outline coverage. This therapy can be performed on peripheral or coronary vessels. Angiojet Thrombolytic Therapy has not been FDA approved for use in the carotid vessels.

### Description of Service

The AngioJet shoots jets of high-speed saline solution through tiny openings in the tip of a surgical instrument called a catheter. Plaque and clots then dissolve into small pieces that are vacuumed back through the catheter. Unlike earlier technology, the AngioJet removes the clot entirely, eliminating the possibility that tiny pieces could move downstream and cause additional complications. Because Angiojet destroys blood clots (also known as thrombi), the Angiojet System is classified as a type of *thrombolytic therapy*. It is important for the beneficiary to be thoroughly educated about the benefits and risks of this modality.

### Regulatory Information

At this point and time, there is no national coverage determination (NCD) about this service, and FCSO. has not published a local coverage determination (LCD).

### Billing and Coding

For dates of service before January 1, 2006, when billing a peripheral AngioJet procedure, CPT code 37799 (unlisted procedure, vascular surgery) would most likely be used. The description “AngioJet” should be noted in Item 19 of the Form CMS-1500 or the free form line of electronic claims.

When billing for dates of service on or after January 1, 2006, use 37184, 37185, 37186, 37187 or 37188 for a peripheral mechanical thromboectomy procedure.

When AngioJet is applied in the coronary arteries, the applicable CPT IV code is 92973, percutaneous transluminal coronary thrombectomy.

### 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, as appropriate.

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

# 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 ..... 52

**New LCD**

J7504: ATGAM (Lymphocyte Immune Globulin, Antithymocyte Globulin [Equine]) ..... 53

**Revisions to LCDs**

Botulinum Toxins ..... 53

EPO: Epoetin alfa ..... 53

J9000: Antineoplastic Drugs ..... 54

J9212: Interferon ..... 54

97001: Physical Medicine and Rehabilitation ..... 54

NCSVCS: The List of Medicare Noncovered Services ..... 55

NCSVCS: The List of Medicare Noncovered Services ..... 55

NCSVCS: The List of Medicare Noncovered Services ..... 55

NESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) ..... 56

**Additional Information**

Self-Administered Drug (SAD) List ..... 56

---

**Advance Notice Statement**

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

## NEW LCDs

**J7504: ATGAM (Lymphocyte Immune Globulin, Antithymocyte Globulin [Equine])—New LCD**

ATGAM is a nonpasteurized, purified, concentrated and sterile gamma globulin, primarily monomeric IgG, from hyperimmune serum of horses immunized with human thymus lymphocytes. ATGAM mainly exhibits immunosuppressive activity; inhibiting cell mediated immune responses, such as allograft rejection and delayed hypersensitivity reactions. ATGAM reduces the number of circulating T lymphocytes measured by the E-rosette inhibition assay.

This local coverage determination (LCD) was developed based on data analysis for procedure code J7504 and for carrier consistency. Indications and limitations, utilization guidelines, documentation guidelines and appropriate ICD-9-CM codes were incorporated into this LCD. A coding guideline was also developed.

**Effective Date**

This LCD will be effective for services rendered on or after September 29, 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.

## REVISIONS TO LCDs

**Botulinum Toxins—LCD Revision**

The latest revision for local coverage determination (LCD) Botulinum Toxins was effective May 2, 2005. Since that time, this LCD has been revised to expand coverage for Botulinum toxin type B (Myobloc®) to include treatment of spasticity caused by stroke or brain injury. The following ICD-9-CM codes have been added to the “ICD-9 Codes that Support Medical Necessity” section of the LCD for procedure code J0587 (Botulinum toxin type B [Myobloc®]): 342.10–342.12, 344.00–344.09, 344.1, 344.2, 344.30–344.32, 344.40–344.42, 344.5, 438.20–438.22, 438.30–438.32, 438.40–438.42 and 754.1. The “Indications and Limitations of Coverage and/or Medical Necessity” and “Sources of Information and Basis for Decision” sections have been revised accordingly.

In addition, the “Coding Guidelines” LCD attachment has been revised to include information regarding the use of CPT codes 46505 and 64650 when performed in conjunction with procedure code J0585 (Botulinum toxin type A [Botox®]).

**Effective Date**

This revision is effective for services rendered on or after May 8, 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.

*Italicized and/or quoted material is excerpted from the American Medical Association Current Procedural Terminology. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.*

**EPO: Epoetin Alfa—LCD Revision**

This local coverage determination (LCD) was last updated on January 13, 2006. Since that time the LCD has been revised. Based on requests from outside sources, the list of ICD-9-CM codes was revised to include the following new ICD-9-CM codes for procedure code J0885 (non-ESRD)- 273.3 (Macroglobulinemia) and 285.21 (Anemia in chronic kidney disease). For procedure code J0885 (ESRD not on dialysis) the following ICD-9-CM code was added as appropriate: 585.5 (Chronic kidney disease, Stage V). The coding guideline attachment was revised as appropriate for these changes.

**Effective Date**

This revision is effective for services rendered on or after June 19, 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.

---

**J9000: Antineoplastic Drugs—LCD Revision**

The local coverage determination (LCD) for antineoplastic drugs was last updated on March 1, 2006. Since that time, the following revisions were made to the “Indications and Limitations of Coverage and/or Medical Necessity” section for the following HCPCS codes:

**J9170 (Docetaxel)**

Added the FDA approved indication for treatment of patients with advanced gastric adenocarcinoma, including adenocarcinoma of the gastroesophageal junction, who have not received prior chemotherapy for advanced disease.

**J9263 (Oxaliplatin)**

- The word “complete” was added in front of “resection of primary tumor” for the FDA approved adjunctive treatment of stage III colon cancer patients, to correspond with the USP DI verbiage.
- Under the off-label indications for Oxaliplatin, added the following indication:  
“Oxaliplatin will be considered as medically necessary in combination with other FDA approved (“on-label”) or compendia supported chemotherapy drugs for the treatment of pancreatic carcinoma in accordance to the clinical practice guidelines in oncology – v.1.2006, National Comprehensive Cancer Network (NCCN) protocols.”

**J9310 (Rituximab)**

- 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, the following additional diagnosis codes were added to the following HCPCS codes:

**J9045 (Carboplatin) for treatment of melanoma**

190.6 Malignant neoplasm of choroid (melanoma of the choroid)

197.7 Secondary malignant neoplasm of liver, specified as secondary (metastatic melanoma to the liver)

**J9263 (Oxaliplatin)**

157.0–157.9 Malignant neoplasm of pancreas

**J9310 (Rituximab)**

714.0 Rheumatoid arthritis

714.1 Felty’s syndrome (Rheumatoid arthritis with splenomegaly and leukopenia)

714.2 Other rheumatoid arthritis with visceral or systemic involvement

The “Sources of Information and Basis for Decision” section was also updated.

**Effective Date**

This revision is effective for services rendered on or after June 19, 2006. The full text of this LCD is available through our provider education website at <http://www.connecticutmedicare.com> on or after this effective date.

---

**J9212: Interferon—LCD Revision**

This local coverage determination (LCD) was last updated on March 27, 2006. Since that time the LCD has been revised. Based on requests from outside sources, the indications and limitations section of the LCD for procedure codes J9213, J9214 and J9215 have been revised. These sections were updated to include the off-label coverage for peritoneum cancer as medically reasonable and necessary. The list of ICD-9-CM codes was revised to include the following new ICD-9-CM codes for procedure codes J9213, J9214 and J9215:

158.8 and 158.9.

**Effective Date**

This revision is effective for services rendered on or after June 26, 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.

---

**97001: Physical Medicine and Rehabilitation—LCD Revision**

This local coverage determination (LCD) was last updated on April 11, 2006. Since that time the LCD has been revised. Change Request 4364, dated February 13, 2006 states that contractors shall require providers to document services in accordance with CMS Internet Only Manual (IOM) Pub 100-2, chapter 15, Section 220.3 and Pub 100-4, Chapter 5, Section 10.2. The language from the IOM appears under the Documentation Requirements section of the LCD. In addition to this language the following statement appears: “First Coast Service Options requires that progress reports be documented weekly”. After further clarification of the business requirements found in CR 4364, this statement has been removed from the LCD.

**Effective Date**

This revision is effective for claims processed on or after May 10, 2006 for services rendered on or after January 1, 2006. The full text for this LCD may be viewed on the provider education website <http://www.connecticutmedicare.com> on or after this effective date.

## NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for The List of Medicare Noncovered Services was last revised on January 1, 2006. Based on Change Request (CR) 5013, dated April 28, 2006, the Centers for Medicare & Medicaid Services (CMS) has determined that evidence is adequate to conclude that laparoscopic adjustable gastric banding is reasonable and necessary for Medicare beneficiaries who meet the following criteria: a body mass index (BMI)  $\geq 35$ , have at least one co-morbidity related to obesity and have been previously unsuccessful with medical treatment for obesity. The medical documentation should reflect this information.

Therefore, procedure code 43770 (*Laparoscopy, surgical, gastric restrictive procedure, placement of adjustable gastric band [gastric band and subcutaneous port components]*) has been removed from “The List of Medicare Noncovered Services” LCD, as well as the following procedure codes, which are related to procedure code 43770.

- 43771 *revision of adjustable gastric band component only*
- 43772 *removal of adjustable gastric band component only*
- 43773 *removal and replacement of adjustable gastric band component only*
- 43774 *removal of adjustable gastric band and subcutaneous port component*

### Effective Date

This revision is effective for services rendered on or after February 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.

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

## NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for The List of Medicare Noncovered Services was last revised on February 21, 2006. Change Request 5102, dated May 26, 2006, includes additional category III CPT codes to be added to the Medicare Physician Fee Schedule Database (MPFSDB).

At this time, this LCD is being revised to add the following category III CPT codes to the “Local Noncoverage Decisions” section of the LCD for electrical gastric stimulation.

- 0155T *Laparoscopy, surgical, implantation or replacement of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*
- 0156T *Laparoscopy, surgical, revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*
- 0157T *Laparotomy, implantation or replacement of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*
- 0158T *Laparotomy, revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*

### Effective Date

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

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

## NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the List of Medicare Noncovered Services - NCSVCS was previously revised on July 1, 2006. Since CPT code 90849 (*Multiple-family group psychotherapy*) is not considered to be medically necessary, as it does not meet the criteria for direct patient intervention and interaction. It is being added to the “Local Noncoverage Decisions” section of The List of Medicare Noncovered Services LCD.

### Effective Date

This revision is effective for claims processed on or after August 7, 2006. The full text of this LCD is available through our provider education website at <http://www.connecticutmedicare.com> on or after this effective date.

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

---

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

This local coverage determination (LCD) was last updated on January 13, 2006. Since that time the LCD has been revised. Based on requests from outside sources, the list of ICD-9-CM codes was revised to include the following new ICD-9-CM codes for procedure code J0881 (non-renal)- 273.3 (macroglobulinemia) and 285.21 (anemia in chronic kidney disease).

For procedure code J0881 (ESRD not on dialysis) the following ICD-9-CM code was added as appropriate: 585.5 (chronic kidney disease, Stage V). The coding guideline attachment was revised as appropriate for these changes.

The indications and limitations section of the LCD was revised based on new FDA approved labeling information related to dosing for cancer patients with chemotherapy-associated anemia. The recommended starting dose for Aranesp administered once every three weeks for this indication is 500 mcg.

**Effective Date**

This revision is effective for services rendered on or after June 19, 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.

---

**ADDITIONAL INFORMATION**

---

**Self-Administered Drug (SAD) List—Revision**

The Center for Medicare and Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Providers may read the instructions in their entirety in the *Medicare Benefit Policy Manual*, Chapter 15, Section 50.2.

The following drugs have been added to the Connecticut Part B Self Administered Drug (SAD) List.

J3110 Injection, teriparatide, 10 mcg (Forteo®)

J2354 Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg (Sandostatin®)

The evaluation of drugs for addition to the SAD list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

**Effective Date**

This revision is effective for services rendered on or after September 1, 2006. The SAD list may be viewed in its entirety through our provider education website at <http://www.connecticutmedicare.com> on or after this effective date.



**CONNECTICUT  
MEDICARE PART B  
MAIL DIRECTORY**

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

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

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

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

**Attention: Correspondence**

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

**Attention: Financial Services**

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

**Attention: Fraud and Abuse**

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

**Attention: Freedom of Information (FOIA)**

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

**Attention: Medical Review**

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

**Attention: MSP**

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

**Attention: Pricing/  
Provider Maintenance**

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

**Attention: Resolutions**

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

**MAILING ADDRESS  
EXCEPTIONS**

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

**Redeterminations/Appeals**

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

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

**Hearings**

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

**Post Office Box for Appeals/Hearings:**

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

**Electronic Media Claims/EDI**

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

**Post Office Box for EDI:**

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

**Claims**

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

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

**CONNECTICUT  
MEDICARE PHONE  
NUMBERS**

**Provider Services**

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

**Beneficiary Services**

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

**Electronic Data Interchange (EDI)**

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

**PC-ACE® PRO-32**

1-203-639-3160, option 2

**Marketing and Reject Report Issues**

1-203-639-3160, option 4

**Format, Testing, and Remittance Issues**

1-203-639-3160, option 5

**Electronic Funds Transfer Information**

1-203-639-3219

**Hospital Services**

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

**Durable Medical Equipment**

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

**Railroad Retirees**

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

**Quality of Care**

Peer Review Organization  
1-800-553-7590

**OTHER HELPFUL  
NUMBERS**

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

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

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

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

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

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

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

**MEDICARE  
WEBSITES**

**PROVIDER  
Connecticut**

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

**BENEFICIARIES**

**Centers for Medicare & Medicaid  
Services**  
<http://www.medicare.gov>

# FLORIDA MEDICAL REVIEW

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

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text LCDs on our provider education website,

<http://www.floridamedicare.com>. Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part B Medical Policy section.

### Effective and Notice Dates

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

### Electronic Notification

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

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

### More Information

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 .....	58
<b>New LCD</b>	
J7504: AGTAM (Lymphocyte Immune Globulin, Antithymocyte Globulin [Equine]) .....	59
<b>Revisions to LCDs</b>	
Botulinum Toxins .....	59
EPO: Epoetin alfa .....	59
J9000: Antineoplastic Drugs .....	60
J9212: Interferon .....	60
NCSVCS: The List of Medicare Noncovered Services .....	61
NCSVCS: The List of Medicare Noncovered Services .....	61
NESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP®]) .....	61
THERSVCS: Therapy and Rehabilitation Services .....	61
43644: Surgical Management of Morbid Obesity .....	62
80076: Hepatic (Liver) Function Panel .....	62
92285: External Ocular Photography .....	62
93798: Cardiac Rehabilitation Programs .....	63
<b>Additional Information</b>	
Self-Administered Drug (SAD) List .....	63
<b>Retired LCD</b>	
PHPPROG: Psychiatric Partial Hospitalization Program ...	64

## Advance Notice Statement

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

**NEW LCD****J7504: ATGAM (Lymphocyte Immune Globulin, Antithymocyte Globulin [Equine])—New LCD**

**A**TGAM is a nonpasteurized, purified, concentrated and sterile gamma globulin, primarily monomeric IgG, from hyperimmune serum of horses immunized with human thymus lymphocytes. ATGAM mainly exhibits immunosuppressive activity; inhibiting cell mediated immune responses, such as allograft rejection and delayed hypersensitivity reactions. ATGAM reduces the number of circulating T lymphocytes measured by the E-rosette inhibition assay.

This local coverage determination (LCD) was developed based on data analysis for procedure code J7504. Indications and limitations, utilization guidelines, documentation guidelines and appropriate ICD-9-CM codes were incorporated into this LCD. A coding guideline was also developed.

**Effective Date**

This LCD will be effective for services rendered on or after September 29, 2006. The full text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date.

**REVISIONS TO LCDs****Botulinum Toxins—LCD Revision**

**T**he latest revision for local coverage determination (LCD) botulinum toxins was effective May 2, 2005. Since that time, this LCD has been revised to expand coverage for botulinum toxin type B (Myobloc®) to include treatment of spasticity caused by stroke or brain injury. The following ICD-9-CM codes have been added to the “ICD-9 Codes that Support Medical Necessity” section of the LCD for procedure code J0587 (Botulinum toxin type B [Myobloc®]): 342.10–342.12, 344.00–344.09, 344.1, 344.2, 344.30–344.32, 344.40–344.42, 344.5, 438.20–438.22, 438.30–438.32, 438.40–438.42 and 754.1. The “Indications and Limitations of Coverage and/or Medical Necessity” and “Sources of Information and Basis for Decision” sections have been revised accordingly.

In addition, the “Coding Guidelines” LCD attachment has been revised to include information regarding the use of CPT codes 46505 and 64650 when performed in conjunction with procedure code J0585 (Botulinum toxin type A [Botox®]).

**Effective Date**

This revision is effective for services rendered on or after May 8, 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.

*Italicized and/or quoted material is excerpted from the American Medical Association Current Procedural Terminology. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.*

**EPO: Epoetin Alfa—LCD Revision**

**T**his local coverage determination (LCD) was last updated on January 13, 2006. Since that time the LCD has been revised. Based on requests from outside sources, the list of ICD-9-CM codes was revised to include the following new ICD-9-CM codes for procedure code J0885 (non-ESRD)- 273.3 (macroglobulinemia) and 285.21 (anemia in chronic kidney disease). For procedure code J0885 (ESRD not on dialysis) the following ICD-9-CM code was added as appropriate: 585.5 (chronic kidney disease, stage V). The coding guideline attachment was revised as appropriate for these changes.

**Effective Date**

This revision is effective for services rendered on or after June 19, 2006. The full text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date.

---

**J9000: Antineoplastic Drugs—LCD Revision**

The local coverage determination (LCD) for antineoplastic drugs was last updated on March 1, 2006. Since that time, the following revisions were made to the “Indications and Limitations of Coverage and/or Medical Necessity” section for the following HCPCS codes:

**J9170 (Docetaxel)**

Added the FDA approved indication for treatment of patients with advanced gastric adenocarcinoma, including adenocarcinoma of the gastroesophageal junction, who have not received prior chemotherapy for advanced disease.

**J9263 (Oxaliplatin)**

- The word “complete” was added in front of “resection of primary tumor” for the FDA approved adjunctive treatment of stage III colon cancer patients, to correspond with the USP DI verbiage.
- Under the off-label indications for Oxaliplatin, added the following indication:  
“Oxaliplatin will be considered as medically necessary in combination with other FDA approved (“on-label”) or compendia supported chemotherapy drugs for the treatment of pancreatic carcinoma in accordance to the clinical practice guidelines in oncology – v.1.2006, National Comprehensive Cancer Network (NCCN) protocols.”

**J9310 (Rituximab)**

- 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, the following additional diagnosis codes were added to the following HCPCS codes:

**J9045 (Carboplatin) for treatment of melanoma**

Under the “ICD-9 Codes that Support Medical Necessity” section, the following additional diagnosis codes were added:

190.6 Malignant neoplasm of choroid (melanoma of the choroid)

197.7 Secondary malignant neoplasm of liver, specified as secondary (metastatic melanoma to the liver)

**J9263 (Oxaliplatin)**

Under the “ICD-9 Codes that Support Medical Necessity” section, the following additional diagnosis codes were added:

157.0 – 157.9 Malignant neoplasm of pancreas

**J9310 (Rituximab)**

Under the “ICD-9 Codes that Support Medical Necessity” section, the following additional diagnosis codes were added:

714.0 Rheumatoid arthritis

714.1 Felty’s syndrome (Rheumatoid arthritis with splenomegaly and leukopenia)

714.2 Other rheumatoid arthritis with visceral or systemic involvement

The “Sources of Information and Basis for Decision” section was also updated.

**Effective Date**

This revision is effective for services rendered on or after June 19, 2006. The full text of this LCD is available through our provider education website at <http://www.floridamedicare.com> on or after this effective date.

---

**J9212: Interferon—LCD Revision**

This local coverage determination (LCD) was last updated on March 27, 2006. Since that time the LCD has been revised. Based on requests from outside sources, the indications and limitations section of the LCD for procedure codes J9213, J9214 and J9215 have been revised. These sections were updated to include the off-label coverage for peritoneum cancer as medically reasonable and necessary. The list of ICD-9-CM codes was revised to include the following new ICD-9-CM codes for procedure codes J9213, J9214 and J9215:

158.8, 158.9

**Effective Date**

This revision is effective for services rendered on or after June 26, 2006. The full text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date.

## NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for The List of Medicare Noncovered Services was last revised on April 11, 2006. Change Request 5102, dated May 26, 2006, includes additional category III codes to be added to the Medicare Physician Fee Schedule Database (MPFSDB).

At this time, this LCD is being revised to add new Category III CPT codes to the “Local Noncoverage Decisions” section of the LCD for electrical gastric stimulation. These new codes will replace unlisted code 43999 (Gastric Electrical Stimulation) under the “Procedures” section in the LCD.

*0155T Laparoscopy, surgical, implantation or replacement of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*

*0156T Laparoscopy, surgical, revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*

*0157T Laparotomy, implantation or replacement of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*

*0158T Laparotomy, revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)*

### Effective Date

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

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

## NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the List of Medicare Noncovered Services was previously revised on July 1, 2006. Since that time, it was determined CPT code 90849 (*Multiple-family group psychotherapy*) is not considered to be medically necessary, as it does not meet the criteria for direct patient intervention and interaction. Therefore, CPT code 90849 is being added to the “Local Noncoverage Decisions” section of The List of Medicare Noncovered Services LCD.

### Effective Date

This revision is effective for services rendered on or after August 7, 2006. The full text of this LCD is available through our provider education website at <http://www.floridamedicare.com> on or after this effective date.

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

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

This local coverage determination (LCD) was last updated on January 13, 2006. Since that time the LCD has been revised. Based on requests from outside sources, the list of ICD-9-CM codes was revised to include the following new ICD-9-CM codes for procedure code J0881 (non-renal)- 273.3 (macroglobulinemia) and 285.21 (anemia in chronic kidney disease). For procedure code J0881 (ESRD not on dialysis) the following ICD-9-CM code was added as appropriate: 585.5 (chronic kidney disease, Stage V). The coding guideline attachment was revised as appropriate for these changes.

The indications and limitations section of the LCD was revised based on new FDA approved labeling information related to dosing for cancer patients with chemotherapy-associated anemia. The recommended starting dose for Aranesp administered once every three weeks for this indication is 500 mcg.

### Effective Date

This revision is effective for services rendered on or after June 19, 2006. The full text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date.

## THERSVCS: Therapy and Rehabilitation Services—LCD Revision

This local coverage determination (LCD) was last updated on April 11, 2006. Since that time, the LCD has been revised. Change Request 4364, dated February 13, 2006 states that contractors shall require providers to document services in accordance with the Centers for Medicare & Medicaid Services Internet Only Manual (IOM) Pub 100-2, chapter 15, Section 220.3 and Pub 100-4, Chapter 5, Section 10.2. The language from the IOM appears under the Documentation Requirements section of the LCD. In addition to this language the following statement appears: “First Coast Service Options requires that progress reports be documented weekly”. After further clarification of the business requirements found in CR 4364, this statement has been removed from the LCD.

### Effective Date

This revision is effective for claims processed on or after May 10, 2006 for services rendered on or after January 1, 2006. The full text for this LCD may be viewed on the provider education website <http://www.floridamedicare.com> on or after this effective date.

---

**43644: Surgical Management of Morbid Obesity—LCD Revision**

The local coverage determination (LCD) for surgical management of morbid obesity was last revised February 21, 2006. Based on Change Request (CR) 5013, dated April 28, 2006, CMS provides criteria for coverage of bariatric surgery by Medicare. In order to meet Medicare coverage guidelines, the following criteria must be documented in the medical records:

- a body mass index (BMI) of 35 or greater,
- at least one co-morbidity related to obesity; and
- previously unsuccessful medical treatment of morbid obesity.

Therefore, the following procedure codes will be covered when submitted with appropriate ICD-9-CM codes; V85.35, V85.36, V85.37, V85.38, V85.39, V85.4, or 278.01 **and** an obesity related co-morbidity. ICD-9-CM codes V85.35, V85.36, V85.37, V85.38, V85.39 and, V85.4 have been identified as secondary diagnosis codes and should not be billed as the primary diagnosis.

- 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)*  
43645 *with gastric bypass and small intestine reconstruction to limit absorption*  
43845 *Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50-100 cm common channel) to limit absorption (biliopancreatic diversion to duodenal switch)*  
43846 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb 150 cm or less) Roux-en-Y gastroenterostomy*  
43847 *with small intestine reconstruction to limit absorption*  
43770 *Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)*

In addition, the following procedure codes, which are related to procedure code 43770, are also covered.

- 43771 *revision of adjustable gastric band component only*  
43772 *removal of adjustable gastric band component only*  
43773 *removal and replacement of adjustable gastric band component only*  
43774 *removal of adjustable gastric band and subcutaneous port component*

**Effective Date**

This revision is effective for services rendered on or after February 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.

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2005 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

---

**80076: Hepatic (Liver) Function Panel—LCD Revision**

The local coverage determination (LCD) for hepatic (liver) function panel was last revised October 1, 2005. In that revision ICD-9-CM code V58.69 was identified as a secondary diagnosis code in error. Therefore, the LCD has been revised to correct this error by removing the asterisk which indicated ICD-9-CM code V58.69 as a secondary diagnosis code and that it should not be billed as the primary diagnosis.

**Effective Date**

This revision is effective for services rendered on or after October 1, 2005. The full text of this LCD is available through our provider education website at <http://www.floridamedicare.com> on or after this effective date.

---

**92285: External Ocular Photography—LCD Revision**

The local coverage determination (LCD) for External Ocular Photography was effective for services rendered on or after April 11, 2005. Since that time, this LCD has been revised to add ICD-9-CM code 238.2 (Neoplasm of uncertain behavior of skin) to the “ICD-9 Codes that Support Medical Necessity” section of the LCD.

**Effective Date**

This revision is effective for services rendered on or after May 8, 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.

---

## 93798: Cardiac Rehabilitation Programs—LCD Revision

The local coverage determination for cardiac rehabilitation programs was last updated on August 23, 2005. Since that time, the national coverage determination indications (NCD Pub. 100-03, Section 20.10) have been expanded based on CMS Change Request 4401, dated April 21, 2006. The LCD was revised to include three additional indications for beneficiaries who have had:

- 1) Heart valve repair/replacement;
- 2) Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
- 3) Heart or heart-lung transplant.

The following ICD-9-CM codes were added to the “ICD-9 codes that Support Medical Necessity” section of the LCD.

V42.1	Heart replaced by transplant
V42.2	Heart valve replaced by transplant
V42.6	Lung replaced by transplant
V43.3	Heart valve replaced by other means
V45.82	Percutaneous transluminal coronary angioplasty status

According to the ICD-9-CM book, diagnosis codes V42.1, V42.2, V42.6, V43.3, and V45.82 are secondary diagnosis codes and should not be billed as a primary diagnosis.

In addition, language was added for clarity and the window of time during which services must be rendered has been extended.

### Effective Date

This revision is effective for services rendered on or after March 22, 2006. The full text of this LCD is available through our provider education website at <http://www.floridamedicare.com> on or after this effective date.

## ADDITIONAL INFORMATION

## Self-Administered Drug (SAD) List—Revision

The Center for Medicare and Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician’s service. The instructions also provide contractors a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Providers may read the instructions in their entirety in the *Medicare Benefit Policy Manual*, Chapter 15, Section 50.2. The following drugs have been added to the Florida Part B Self Administered Drug (SAD) List.

J3110	Injection, teriparatide, 10 mcg (Forteo®)
J2354	Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg (Sandostatin®)

The evaluation of drugs for addition to the SAD list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs

### Effective Date

This revision is effective for services rendered on or after September 1, 2006. The SAD list may be viewed in its entirety through our provider education website at <http://www.floridamedicare.com> on or after this effective date.

**RETIRED LCD**

---

**PHPPROG: Psychiatric Partial Hospitalization Program—Retired LCD**

The local coverage determination (LCD) for psychiatric partial hospitalization program (PHPPROG) was last revised January 1, 2006. Since that time, based on data analysis and local standards of medical practice, it was determined to retire the current LCD. The coverage guidelines for this LCD are outlined in the CMS national regulations, and in the current Medicare Part A Psychiatric Partial Hospitalization Program (APHPROG) LCD.

Coverage guidelines for these services may be found at <http://www.floridamedicare.com>, under the Medicare Part A local coverage determination for Psychiatric Partial Hospitalization Program. Local coverage determinations may also be found under the individual *CPT* codes that apply to services rendered.

**Effective Date**

The retirement of this LCD is effective for services rendered on or after April 25, 2006.



**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](http://www.floridamedicare.com)

**Centers for Medicare & Medicaid  
Services**

[www.cms.hhs.gov](http://www.cms.hhs.gov)

**BENEFICIARIES**

**Centers for Medicare & Medicaid  
Services**

[www.medicare.gov](http://www.medicare.gov)

### PREVENTIVE SERVICES

## Medicare Provides Coverage for Many Preventive Services and Screenings

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Third Quarter 2006 Medicare B Update! pages 137-139.*

**Note:** This article was revised on June 30, 2006, to remove references to the “Flu Billing” videos, which are no longer available on the CMS website.

### Provider Types Affected

All Medicare fee-for-service physicians, providers, suppliers, and other health care professionals who provide and bill for preventive services and screenings provided to Medicare beneficiaries.

### Provider Action Needed

This article serves as a reminder that we need your help to ensure that Medicare beneficiaries receive the preventive services they need. Become familiar with the preventive services and screenings covered by Medicare. Help the Centers for Medicare & Medicaid Services (CMS) spread the news about the many preventive services and screenings covered by Medicare.

Talk with your Medicare patients about preventive services and screenings and encourage use of those services, where appropriate. Order and use the educational products developed by CMS to educate your staff about these benefits. The information found in these products will also help you communicate with your patients about Medicare preventive benefits.

### Introduction

Medicare provides coverage for many diseases that are preventable through immunization or amendable through early detection, treatment, and lifestyle changes. This special edition MLN Matters article informs health care professionals about the preventive services and screenings covered by Medicare and highlights the educational and informational products developed by CMS for health care professionals to promote awareness and increase appropriate utilization of these services. **Medicare provides coverage for the following preventive services and screenings (subject to certain eligibility and other limitations):**

- Adult Immunizations
  - Influenza (flu)
  - Pneumococcal polysaccharide vaccine (PPV)
  - Hepatitis B virus (HBV)
- Bone Mass Measurements
- Cancer Screenings
  - Breast (mammography)
  - Cervical & vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- Cardiovascular Disease Screening
- Diabetes Screening
  - Self-Management Training
  - Medical Nutrition Therapy
  - Supplies
- Glaucoma Screening
- Initial preventive physical exam (IPPE) (“Welcome to Medicare” Physical Exam)
- Smoking and Tobacco-Use Cessation Counseling Services

CMS needs your help to get the word out about the many preventive services and screenings covered by Medicare. Each of these benefits presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing certain diseases.

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about preventive services and screenings. As a trusted source, your recommendation is the most important factor in increasing the use of appropriate preventive services.

*Medicare Provides Coverage for Many Preventive Services and Screenings, continued*

Talk to your Medicare patients about the benefits of preventive medicine, detecting disease earlier when outcomes are best, reducing infectious disease, and improving the quality of their lives.

**Educational Products and Informational Resources for Health Care Professionals**

CMS has developed a variety of educational products to:

- Help increase your awareness of Medicare’s coverage of disease prevention and early detection
- Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible
- Give you resources to help you effectively file claims.

Print products may be ordered, free of charge, from the Medicare Learning Network (MLN). All print products are available to download and view on line and may be reprinted or redistributed as needed. Some print products are only available as a download and will be notated as such.

**Product Ordering Instructions**

To order a product, free of charge, access this link:

[http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5).

*You may click on the title of the publications below to view them online.*

**Brochures**

***The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals*** – This series of tri-fold brochures provides an overview of Medicare’s coverage for preventive services and screenings including the new benefits: diabetes and cardiovascular disease screenings and the initial preventive physical examination (IPPE). (See *Expanded Benefits* brochure.)

- Adult Immunizations [PDF 279KB]
- Bone Mass Measurements [PDF 269KB]
- Cancer Screenings [PDF 295KB]
- Expanded Benefits [PDF 255KB]
- Glaucoma Screening [PDF 242KB]
- Smoking and Tobacco-Use Cessation Counseling Services [PDF, 562KB] (available in download only at this time)

**Guides**

***The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals [PDF 2MB]*** – This guide provides information on Medicare’s preventive benefits including coverage, frequency, risk factors, billing and reimbursement. (May 2005. See the errata sheet for corrections identified since May 2005 printing.)

***Determining a Medicare Beneficiary’s Eligibility for Medicare Preventive Services [PDF 304KB]*** – This guide provides information on interpreting the Medicare beneficiary preventive services “next eligible date” data and is intended to supplement the educational materials already available for the HIQA, HIQH, HUQA, ELGA, ELGB and ELGH eligibility inquiry screens used to access common working file (CWF) records. (September 2005; Available in download only)

**Medicare Preventive Services CD ROM**

***Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals*** – This CD ROM contains The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals; six brochures: 1) Expanded Benefits, 2) Glaucoma Screenings, 3) Cancer Screenings, 4) Bone Mass Measurements, 5) Adult Immunizations, and 6) Smoking and Tobacco-Use Cessation Counseling Services; and a Quick Reference Information: Medicare Preventive Services chart.

These resources are useful for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals that bill Medicare for preventive services. (See errata sheets for corrections identified since May 2005 printing of these products. See product ordering instructions above.)

**Quick Reference Information Chart**

***Quick Reference Information: Medicare Preventive Services [PDF 74KB]*** – This two-sided laminated chart gives a quick reference to Medicare’s preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and co-payment/coinsurance and deductible information for each benefit. (May 2005. See errata sheet for corrections identified since May 2005 printing.)

**Web-Based Training Courses**

***Web-Based Training Modules (WBTs)*** – Three Web-based training courses covering coding, billing, coverage and reimbursement for Medicare preventive services and screenings. (To access these WBT courses, go to the MLN Products Web page at <http://www.cms.hhs.gov/MLNProducts/>, scroll to the bottom of the page to “Links Inside CMS” and click on Web-based training modules.

### *Medicare Provides Coverage for Many Preventive Services and Screenings, continued*

#### **Web Page**

**MLN Preventive Services Web Page** – This Medicare Learning Network (MLN) Web page, for Medicare fee-for-services health care professionals, provides links to all of the provider/supplier specific preventive services educational and informational products mentioned in this article.

#### **Other Useful Provider Resources**

Other useful provider resources include the following:

**Prevention Toolkit** – This online toolkit contains resources that you may find useful when talking to your patients about Medicare preventive benefits.

**Immunizations Toolkit** – This online toolkit contains printable resources that nursing home providers can use to help improve the influenza and pneumococcal immunization rates among their residents, staff, and volunteers.

#### **CMS Prevention Web Pages**

CMS has created individual Web pages for each of the preventive services and screenings covered by Medicare. For additional information visit <http://www.cms.hhs.gov/home/medicare.asp> and scroll down to the Prevention section.

#### **Medicare Learning Network (MLN)**

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's Web page on the CMS website at <http://www.cms.hhs.gov/MLNGenInfo>.

We encourage you to order and use these provider-specific products to:

- Increase your awareness of preventive services covered by Medicare
- Equip you to talk with your patients about Medicare-covered preventive services and encourage utilization of these potentially life saving benefits
- Help you file preventive services claims more effectively.

**Note:** These products have been developed for you, the health care professional.

Provider-specific products are not meant for distribution to Medicare beneficiaries. See below for where to obtain beneficiary specific information.

#### **Preventive Benefit Information for Medicare Beneficiaries**

Medicare beneficiaries may obtain information about Medicare preventive benefits by going to <http://www.medicare.gov/> and clicking on "Preventive Services."

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

MLN Matters Number: SE0630 *Revised*

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

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

**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
<input type="checkbox"/>	<p><b>Medicare B Update! Subscription</b> – The <i>Medicare B Update!</i> is available free of charge online at <a href="http://www.connecticutmedicare.com">http://www.connecticutmedicare.com</a> and <a href="http://www.floridamedicare.com">http://www.floridamedicare.com</a>. 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.</p> <p><b>Beginning with publications issued after June 1, 2003</b>, providers who meet these criteria must register to receive the <i>Update!</i> in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason can be shown why the electronic publication available free of charge on the Internet cannot be utilized. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published during calendar year 2006 (back issues will be sent upon receipt of order).</p>	700395	<p>\$25.00 (Hardcopy)</p> <p>\$20.00 (CD-ROM)</p>
<input type="checkbox"/>	<p><b>2006 Fee Schedule</b> – 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 <a href="http://www.connecticutmedicare.com">http://www.connecticutmedicare.com</a> and <a href="http://www.floridamedicare.com">http://www.floridamedicare.com</a>. 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 <i>Medicare B Update!</i> Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.</p>	700400	<p>Hardcopy: \$5.00 (CT) \$10.00 (FL)</p> <p>CD-ROM: \$6.00 (Specify CT or FL)</p>

**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 \***

