

Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

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

Routing Suggestions:

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



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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

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THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida Medicare B Update!

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

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

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

Who Receives the Update?

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

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

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

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

Clear Identification of State-Specific Content

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

Publication Format

The *Update!* is arranged into distinct sections.

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

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

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

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

Advance Beneficiary Notices (ABNs)

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

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

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

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

New Patient Liability Notice

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

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

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

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

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

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

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

Quarterly Update to Correct Coding Initiative Edits, Version 12.2, Effective July 1, 2006

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

Provider Types Affected

Physicians billing Medicare carriers

Provider Action Needed

This is a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of Correct Coding Initiative (CCI) edits will be effective on July 1, 2006.

Physicians may view the current CCI edits and the current mutually exclusive code (MEC) edits at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> on the Centers for Medicare & Medicaid (CMS) website.

The website will be updated with the version 12.2 edits as soon as they are effective.

Background

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

The latest package of CCI edits, version 12.2, is effective on July 1, 2006. This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables:

- Column 1/Column 2 Correct Coding Edits table
- MEC Edits table

Additional Information

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

MLN Matters Number: MM5064

Related Change Request (CR) #: 5064

Related CR Release Date: May 26, 2006

Effective Date: July 1, 2006

Related CR Transmittal #: R965CP

Implementation Date: July 3, 2006

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

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.

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>Physicians’ services 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>Non-implantable durable medical equipment (DME) to ASC patients for in home use. 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>Implantable DME and accessories ASCs who furnish implantable DME items to patients, bill the local carrier for the surgical procedure and the implantable device.</p>	ASC	Carrier

Examples of Services Not Included in the ASC Facility Rate, continued

Items or Services	Who Receives Payment	Submit Bills To
<p>Non-implantable prosthetic devices 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>	Supplier. An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the national supplier clearinghouse.	DMERC
<p>Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs [new technology intraocular lenses]), and accessories 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>	ASC	Carrier
<p>Ambulance services ASCs who furnish ambulance services, may obtain approval as ambulance suppliers to bill covered ambulance services.</p>	Certified ambulance supplier	Carrier
<p>Leg, arm, back, and neck braces 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>	Supplier	DMERC
<p>Artificial legs, arms, and eyes 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>	Supplier	DMERC
<p>Services furnished by an independent laboratory 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 arrangements with a covered laboratory or laboratories for laboratory services. If the ASC has a certified independent laboratory, the laboratory itself bills the carrier.</p>	Certified lab. ASCs can receive lab certification and a CLIA number.	Carrier
<p>Procedures NOT on the ASC list Physicians bill the carrier for the procedures and any implantable prosthetics/DME, using the ASC as the place of service</p>	Physician	Carrier

*Examples of Services Not Included in the ASC Facility Rate, 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/R942CP.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.pdf> on the CMS website.

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

MLN Matters Number: MM5026

Related Change Request (CR) #: 5026

Related CR Release Date: May 5, 2006

Effective Date: June 5, 2006

Related CR Transmittal #: R942CP

Implementation Date: June 5, 2006

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CARDIOLOGY SERVICES

Nesiritide for Treatment of Heart Failure Patients

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

Note: This article was revised on May 19, 2006, to clarify some of the language regarding the use of nesiritide in the “Key Points” section of the article.

Provider Types Affected

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

Key Points

- Effective for dates of service on or after March 2, 2006, the Centers for Medicare & Medicaid Services (CMS) will deny coverage of Nesiritide for the treatment of chronic heart failure in Medicare beneficiaries. For billing guidelines about the noncovered use of nesiritide, please refer to the *Additional Information* section of this article.
- CMS has determined that there is insufficient evidence to conclude that the use of nesiritide for the treatment of chronic heart failure is reasonable and necessary for Medicare beneficiaries in any setting.
- This determination does not change local contractor discretion for treatment of acute(ly) decompensated heart failure consistent with the FDA labeled indication in Medicare beneficiaries who may have underlying chronic heart failure. Nor does it affect local contractor discretion for other off-label uses of nesiritide in Medicare beneficiaries who may have underlying chronic heart failure.
- For claims submitted to FIs, the requirement to deny nesiritide for chronic heart failure will only affect 13x and 85x type of bill (TOBs).
- 11x and 12x TOBs should be rejected.
- CMS recommends that FIs create medical policy parameters to deny outpatient claims for nesiritide for chronic heart failure in the absence of acutely decompensated heart failure.
- CMS recommends that FIs reject inpatient claims where the primary diagnosis is chronic heart failure in the absence of acutely decompensated heart failure (11x and 12x) when billed with nesiritide for chronic heart failure.
- For inpatient claims where the beneficiary is admitted with a primary diagnosis other than heart failure and nesiritide is administered under a DRG payment, the administration of nesiritide should not be the sole basis for denial of the entire inpatient claim.
- The provider will be held liable unless occurrence code 32 is present on the claim, or modifier GA is present on the line on an outpatient bill when nesiritide is used to treat chronic heart failure without documented evidence of acute decompensation.
- All other indications for the use of nesiritide not otherwise indicated as noncovered (other off-label uses or uses consistent with the current Food and Drug Administration (FDA) indication for intravenous treatment of patients with acutely decompensated congestive heart failure (CHF) who have dyspnea at rest or with minimal activity) are left to local contractor (carrier or FI) discretion.
- This addition to Chapter 1, Section 200.1, of the *Medicare National Coverage Determinations Manual*, (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act (the Act).

Nesiritide for Treatment of Heart Failure Patients, continued

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

Background

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

In addition, an independent advisory panel of cardiac experts sponsored by Scios, manufacturer of Natrecor® (nesiritide), recommended that *“The use of nesiritide should be strictly limited to patients presenting to the hospital with acutely decompensated congestive heart failure who have dyspnea at rest ..”*

Additional Information

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

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

MLN Matters Number: MM4312 *Revised*

Related CR Release Date: April 7, 2006

Related CR Transmittal #: R218OTN and R51NCD

Related Change Request (CR) #: 4312

Effective Date: March 2, 2006

Implementation Date: May 22, 2006

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Payment for Carotid Artery Stenting Post Approval Extension Studies

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

Provider Types Affected

Physicians or providers submitting claims to carriers or fiscal intermediaries (FIs) for carotid artery stenting (CAS) post approval extension studies.

Impact on Providers

This article is based on Change Request (CR) 5088, which informs providers that the Centers for Medicare & Medicaid Services (CMS) has determined that all extension studies must be reviewed by the Food and Drug Administration (FDA).

The FDA will issue an acknowledgement letter stating that the extension study is scientifically valid and will generate clinically relevant post-market data. Upon receipt of this letter and review of the extension study protocol, the CMS will issue a letter to the study sponsor indicating that Medicare will cover the study under review.

Background

CMS issued CR 3489 (Transmittal 314, dated October 12, 2004;

<http://www.cms.hhs.gov/transmittals/Downloads/R25NCD.pdf>) to provide Medicare contractors (carriers and/or FIs) with instructions for processing claims for CAS procedures performed in FDA-approved post-approval studies. As the post-approval studies began to end, CMS received requests to extend their coverage.

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

- **Reason Code 50:** These are noncovered services because this is not deemed a “medical necessity” by the payer.
- **Remark Code M76:** Missing/incomplete/invalid diagnosis or condition.
Contractors shall apply the following Medicare summary notice messages:
- **15.20:** The following policy [NCD 200.1] was used when we made this decision.
- **15.4:** The information provided does not support the need for this service or item.

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

Relevant Links

CR 4312 is the official instruction issued to your FI or carrier, regarding changes mentioned in this article. There are two transmittals related to CR 4312. One is transmittal number R51NCD, which relates to the NCD. It may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R51NCD.pdf> on the CMS website.

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

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

Payment for Carotid Artery Stenting Post Approval Extension Studies, continued

CMS reviewed the extension requests and has determined that patients participating in post-approval extension studies are also included in the currently covered population of patients participating in FDA-approved post-approval studies (*Medicare National Coverage Determinations Manual*, Pub. 100-3, Chapter 1, Part 1, Section 20.7; available at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf on the CMS website).

To grant approval for post-approval studies, the FDA reviews each study protocol, and once approval is granted, the FDA issues a formal approval letter to the study sponsor.

Extensions of post-approval studies are not subject to approval by the FDA because they surpass the post-approval study requirements identified in the conditions of approval for post-approval studies. Therefore, since the FDA cannot approve these extension studies, individual post-market approval (PMA) numbers cannot be issued to separately identify each study. Currently, in order to receive reimbursement for procedures performed as part of a carotid artery stenting post-approval study, providers must include the FDA-issued PMA number on each claim to indicate participation in a specific study.

CMS has determined that the FDA must review all extension study protocols. If the FDA determines the extension study protocol is scientifically valid, the FDA will:

- Issue an acknowledgement letter stating that the extension study protocol is scientifically valid; and
- Generate clinically relevant post-market data.

CMS will issue a letter to the study sponsor indicating that Medicare will cover the study under review upon receipt of the FDA's:

- Acknowledgement letter; and
- Review of the extension study protocol indicating the study protocol is scientifically valid.

Because an individual PMA number cannot be assigned by the FDA to each extension study, these studies will use the PMA number assigned to the original FDA-approved post-approval study (i.e., CAPTURE 2 shall use the PMA number assigned to CAPTURE 1).

To receive Medicare coverage for patients participating in post-approval extension studies, providers should follow the process for informing Medicare contractors of their participation as established in CR 3489 (Transmittal 314, dated October 12, 2004; <http://www.cms.hhs.gov/transmittals/Downloads/R25NCD.pdf>) There is also an MLN Matters article related to CR 3489 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf> on the CMS website.

Providers should submit to their Medicare contractor:

- The FDA acknowledgement letter;
- The CMS letter providing coverage for the extension study to their contractor; and
- Any other materials their Medicare contractor would require for FDA-approved post-approval studies.

In response, the provider's Medicare contractor will issue a letter assigning an effective date for each facility's participation in the extension study.

Providers:

- Should follow the billing instructions from CR 3489 (Transmittal 314, dated October 12, 2004);
- May bill for procedures performed in the extension study for dates of service on and after the assigned effective date; and
- Must bill using the most current ICD-9 CM procedure codes when billing FIs.

For example, when billing a CAS extension study with dates of service July 1, 2006 through July 15, 2006, the provider should bill the most current ICD-9 CM procedure codes 00.61 and 00.63 (instead of the 39.50 and 39.90 procedure codes published in CR 3489).

Please note that:

- Providers participating in the Capture 2 post-approval extension study must submit copies of two letters to their local contractor, i.e., an FDA acknowledgement letter and a CMS coverage letter;
- After receiving the above letters, the Medicare contractor will issue a letter to the provider assigning an effective date for participation in the extension study;
- Providers may bill for procedures performed in the extension study for dates of service on and after the assigned effective date;
- Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention; and
- Providers should continue to follow the guidelines for processing post approval study claims as directed in CR 3489, Transmittal 314, issued October 15, 2004.

Implementation

The implementation date for this instruction is June 12, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R951CP.pdf> on the CMS website.

Payment for Carotid Artery Stenting Post Approval Extension Studies, 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.pdf> on the CMS website.

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

MLN Matters Number: MM5088

Related Change Request (CR) #: 5088

Related CR Release Date: May 12, 2006

Effective Date: February 28, 2006

Related CR Transmittal #: R951CP

Implementation Date: June 12, 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 Carotid Artery Stenting Post Approval Extension Studies - Supplemental to Change Request 5088

The purpose of this instruction is to inform providers participating in the carotid artery stenting (CAS) post approval extension studies of the appropriate address to submit required documentation.

MLN Matters article MM5088 indicates:

“To receive Medicare coverage for patients participating in post-approval extension studies, providers should submit to their Medicare contractor:

- The FDA acknowledgement letter;
- The CMS letter providing coverage for the extension study to their contractor; and
- Any other materials their Medicare contractor would require for FDA-approved post-approval studies.

In response, the provider’s Medicare contractor will issue a letter assigning an effective date for each facility’s participation in the extension study.”

Send required documentation to:

Connecticut

First Coast Service Options, Inc.
Attn: Neil Sandler, MD
321 Research Parkway
Meriden, CT 06450

Florida

First Coast Service Options, Inc.
Medical Policy – 19T
532 Riverside Avenue
Jacksonville, Florida 32202

The entire MLN Matters article may be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5088.pdf> on the CMS website.

Source: Publication 100-04, Transmittal 951, Change Request 5088

COMPETITIVE ACQUISITION PROGRAM

Competitive Acquisition Program for Part B Drugs Physician Election

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

Provider Types Affected

Physicians billing Medicare carriers for certain Part B drugs and biologicals under the Medicare CAP program

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4404, which provides instruction for physicians who wish to elect the competitive acquisition program (CAP) to obtain certain Medicare Part B drugs and biologicals.

CAUTION – What You Need to Know

Physicians will be given an opportunity to elect to participate in the CAP on an annual basis, and practitioners who elect to participate in the CAP will be required to remain in the program at least one calendar year except under certain circumstances.

Physicians who elect to participate in the CAP will be required to complete a CAP election agreement.. In 2006, the election period will occur from May 8, 2006, to June 2, 2006, and the term of election will run from July 1 to December 31, 2006.

GO – What You Need to Do

See the *Background Section* of this article for further details regarding the physician election of the CAP program for Part B drugs and biologicals.

*Competitive Acquisition Program for Part B Drugs Physician Election, continued***Background**

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 303 (d) (<http://www.cms.hhs.gov/CompetitiveAcquisforBios/>)) requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system (PPS) basis.

Beginning with drugs administered **on or after July 1, 2006**, physicians will be given a choice between:

- Buying and billing these drugs under the average sales price (ASP) system; or
- Obtaining these drugs from CAP vendors selected in a competitive bidding process.
- For 2006 the CAP approved vendor is Bioscrip, vendor identification number Q103.
http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage

Note: For purposes of the CAP, a physician includes individuals defined under the Social Security Act (Section 1861(r); http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) and other practitioners who are authorized to provide physician services under 1861(s) and who can, within their state's scope of practice, prescribe and order drugs covered under Medicare Part B.

This article is based on Change Request (CR) 4404, which in addition to including the final physician election agreement included as an attachment, provides information and instructions for the implementation of the CAP pertaining to the physician election process as outlined in: CR 4064 (Transmittal 777, dated December 9, 2005; <http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf>); and CR 4309 (Transmittal 839, dated February 6, 2006; <http://www.cms.hhs.gov/transmittals/downloads/R839CP.pdf>).

The MLN Matters article corresponding to CR 4064 may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>; and the article corresponding to CR 4309 may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf> on the CMS website.

In order to implement the annual physician election process, the Centers for Medicare & Medicaid Services (CMS) instructed your carrier in CR 4064 to:

- Accept physician election applications immediately following the posting of approved CAP vendors on the CMS website;
- Create an initial list of all the physicians and practitioners **who have elected to participate** in CAP;
- Forward this information to the designated CAP vendor carrier Noridian; and
- Repeat this process annually.

Annual Physician Election Process

Physicians will be given an opportunity to elect to participate in the CAP on an annual basis, and practitioners who elect to participate in the CAP will be required to remain in the program at least one calendar year. The CAP physician election form is included with CR 4404 and may be found online at

http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage.

Participating physicians who wish to continue their participation in CAP for subsequent years would do so by submitting an abbreviated agreement, which would also permit the practitioners to change approved CAP vendor or CAP drug category.

CAP Participating Physician Requirements

Physicians who elect to participate in the CAP will be required to complete a CAP election agreement (final attached to CR 4404) assuring full and continued compliance with the participating CAP physician requirements per Title 42 CFR (*Code of Federal Regulations*) Part 414 Section 908 (<http://www.gpoaccess.gov/cfr/retrieve.html>) of Medicare regulations.

If a physician makes the decision to participate in the CAP, payment for the administration of any CAP drug or biological may be made only on an assignment related basis. Additional details are available in the *Medicare Claims Processing Manual*, Chapter 17, Sections 100-100.8.2, which are included in Attachment A of CR 4404.

Application Process

Physicians who would like to participate in the program can obtain the following information at http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp on the CMS website:

- The CAP physician election form;
- The list of the approved CAP vendors; and
- The specific National Drug Codes (NDCs) that the vendors will provide.

Once the election agreement is completed, it must be submitted to the practitioner's local Medicare carrier. **The physician election process for 2006 shall operate from May 8 to June 2.**

For subsequent calendar years, CMS anticipates that the physician election process will be between October 4 and November 15 of each calendar year to meet operational timeframes for CAP vendors and claim processing contractors.

Note: The CAP election agreement must be postmarked by June 2 for 2006 election period. The 2006 CAP operational period will be for July 1- December 31, 2006.

Group Election

When members in a group practice bill Medicare using the group's PIN, they must commit as a group practice to elect to participate in the CAP. In order for a physician to "buy and bill" separately from the group he or she must not have reassigned his or her benefits to the group, and must be billing using his or her individual PIN.

Competitive Acquisition Program for Part B Drugs Physician Election, continued

If a physician in that situation elects to participate in the CAP as an individual, he or she would complete the CAP physician election form with his or her individual PIN, and other requested information.

Mid-Year Changes

Physicians are permitted to select another approved CAP vendor or leave the CAP in mid-year if any one of the following occurs:

- The approved CAP vendor selected by the physician leaves the program;
- The participating physician leaves a group practice, or a new physician enters a group practice that had selected the approved CAP vendor;
- The participating physician relocates to another competitive acquisition area (although multiple CAP competitive areas are anticipated, there is one drug category and one geographic area for the 2006 through 2008 contract period); or
- The physician is newly enrolled in the Medicare program and elects to participate in the CAP within 90 days of enrollment; or
- The approved CAP vendor refuses to ship to the participating CAP physician because the conditions of 42 CFR section 414.914(h) were met, the physician may withdraw from the CAP category for the remainder of the year upon notice to CMS and the approved CAP vendor.

CAP Physician Election Agreement

The final CAP physician election agreement is included as an attachment to CR 4404. Providers interested in participating in the CAP must download the form from the CAP website and complete pages 1, 5, and 6 of the agreement. If a physician has more than one practice location additional copies of page 6 must be submitted. For group practices all physician members who will be participating in the CAP and billing under the group PIN must be listed, however only one election agreement should be submitted for each group practice. An authorized representative must sign the form on behalf of the individual or group practice members on page 5. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider or must hold a position of similar status or authority within the provider's organization.

In summary, CR 4404 instructs your carrier to receive the CAP physician election agreement forms submitted by physicians who wish to participate in the CAP in their area either during the annual election process or because of a mid-year change.

Please note that:

- Claims submitted by a physician for CAP drugs with a date of service after the effective date the physician disenrolled from the CAP will be processed as ASP claims.
- Claims submitted by the vendor for CAP drugs with a date of service prior to the effective date the physician disenrolled from the CAP will be processed as CAP claims.

Implementation

The implementation date for this instruction is May 30, 2006.

Additional Information

Attached to CR 4404 is the Competitive Acquisition Program (CAP) Physical Election Agreement for Medicare Part B Drugs.

For complete details, please see CR 4044 at <http://www.cms.hhs.gov/Transmittals/downloads/R932CP.pdf> on the CMS website.

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

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

The list of CAP drugs may be found at

http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage

MLN Matters Number: MM4404

Related Change Request (CR) #: 4404

Related CR Release Date: April 28, 2006

Effective Date: April 28, 2006

Related CR Transmittal #: R932CP

Implementation Date: May 30, 2006

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Additional Requirements for the Competitive Acquisition Program for Part B Drugs and Biologicals

CMS has issued the following MLN Matters article. *Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Third Quarter 2006 Medicare B Update! pages 41-42.*

Note: This article was revised on May 8, 2006, to show that the 2006 election period runs from May 8, 2006, to June 2, 2006.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

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

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

Note: For 2006, the first CAP year will run from July 1, 2006, through December 31, 2006. In subsequent years, it will run annually on a calendar year basis.

MMA, Section 303 (d) may be found at <http://www.cms.hhs.gov/MMAUpdate/> on the CMS website.

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

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

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

Providing a Drug from Physician's Stock

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

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

Physician Election and Information Transfer between Carriers and the Designated Carrier for CAP Claims For this first CAP year, by May 1, 2006, CMS will post on its website:

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

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

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

Additional Requirements for the Competitive Acquisition Program for Part B Drugs and Biologicals, continued**Additional Requirements Regarding the CAP**

Additional instructions and more complete details about the CAP requirements for Part B drugs can be found in CR 4309 and its attachments.

Some of these important requirements to remember are as follows:

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

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

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R866CP.pdf> on the CMS website. In addition, you may wish to review CR 4064 at <http://www.cms.hhs.gov/Transmittals/downloads/R777CP.pdf> and its related article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf> on the CMS website.

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

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

MLN Matters Number: MM4309 *Revised* Related Change Request (CR) #: 4309

Related CR Release Date: February 17, 2006 Effective Date: July 1, 2006

Related CR Transmittal #: R866CP Implementation Date: July 3, 2006, except as otherwise specified in the article.

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Competitive Acquisition Program Fact Sheet

Visit http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage to download the Beneficiary Fact Sheet for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals. Physicians who elect to participate in the CAP are required to provide the CAP Beneficiary Fact Sheet to Medicare beneficiaries who are receiving certain Part B physician-administered drugs.

Source: CMS Joint Signature Memorandum 06475, dated June 5, 2006

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

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Third Quarter 2006 Medicare B Update! pages 45-48.

Note: This article was revised on May 8, 2006, to reflect that the election period for physicians to participate in the CAP this year will run from May 8, 2006, to June 2, 2006.

Provider Types Affected

Physicians billing Medicare carriers for Part B drugs and approved CAP vendors billing the designated carrier

Provider Action Needed

STOP – Impact to You

From May 8, 2006 to June 2, 2006, Medicare physicians will be given the opportunity to elect to participate in the Competitive Acquisition Program (CAP) for claims paid on or after July 1, 2006. Participating CAP physicians will obtain Medicare Part B covered drugs from selected drug categories through the CAP. Until further notice, there is only one drug category in the CAP. (**Note:** Exact dates of the physician election period will be announced on the comp bid website [<http://www.cms.hhs.gov/CompetitiveAcquisforBios>] and via a list serv notice).

CAUTION – What You Need to Know

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

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

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

GO – What You Need to Do

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

Background

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

Physicians (and other practitioners who provide physician services that include the authority to prescribe and order Medicare Part B drugs) wishing to participate in the CAP program in 2006 must elect to do within 45 days of

the date that the election information is posted on the CMS website.

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

How Drugs Are Selected For CAP

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

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

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

How Approved CAP Vendors Are Selected

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

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

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

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

Obtaining Drugs in the CAP

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

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

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

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

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

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

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

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

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

In those cases, the participating CAP physician may:

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

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

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

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

Physician Billing

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

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

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

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

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

- A prescription/order number for each CAP drug administered;
- The HCPCS code for each CAP drug administered along with the new “J1” no pay modifier;
- The HCPCS code(s) that include the administration of each CAP drug on separate lines.

Note: On paper claims, the prescription numbers will be in Item 19. When physicians submit claims for the administration of CAP drug(s) that have been administered in an emergency situation and required “emergency restocking” from the approved CAP vendor, the claim should be submitted with the:

- Prescription/order number for each CAP drug administered;
- HCPCS code for each administered CAP drug along with the new “J1” no-pay modifier and also on that same line, the new “J2” modifier denoting “Competitive Acquisition Program, (CAP) restocking of emergency drugs after emergency administration;” and
- HCPCS code(s) that include the administration of each CAP drug on separate lines.

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

- Physicians should use only the new “J3” modifier denoting “Competitive Acquisition Program (CAP), drug not available through CAP as written, reimbursed under the average sales price methodology.”

Physicians who elect CAP should note:

- The administration services and the no-pay lines must be on the same claim or your carrier will return the claim as unprocessable and you will see a remittance advice reason code of 16 denoting claim lacks information which is needed for adjudication.
- The Medicare carrier will identify them as physicians who elected to participate in CAP and who will not be paid for the drugs obtained from the approved CAP vendor.

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

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

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

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

Vendor Billing

The approved CAP vendor will bill the:

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

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

Note: Payment to the approved CAP vendor for the drug is conditioned on verification that the drug was administered to the Medicare beneficiary.

Proof that the drug was administered shall be established by matching the participating CAP physician's claim for drug administration with the approved CAP vendor's claim for the drug in the Medicare claims processing system by means of a prescription number on both claims. When they are matched in the claims processing system, the approved CAP vendor will be paid in full.

Until drug administration is verified, the approved CAP vendor may not bill the beneficiary and/or his third party insurance for any applicable coinsurance and deductible.

Implementation

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

Additional Information

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

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

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

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

MLN Matters Number: MM4064 *Revised*

Related Change Request (CR) #: 4064

Related CR Release Date: December 9, 2005

Effective Date: July 1, 2006

Related CR Transmittal #: R777CP

Implementation Date: July 3, 2006

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

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

Provider Types Affected

Physicians submitting claims to carriers for services to Medicare beneficiaries under the Competitive Acquisition Program (CAP)

Impact on Providers

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

Background

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

CAP—Creation of Automated Tables for Provider Information, Expansion of CAP Fee Schedule File Layout..., continued

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

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

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

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

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

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

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

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

CAP Drugs and Drug Categories

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

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

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

Changes to the Drug List

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

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

Payment Amount

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

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

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

CAP—Creation of Automated Tables for Provider Information, Expansion of CAP Fee Schedule File Layout..., continued**Disaster Contingency**

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

Claims for Railroad Retirement Board (RRB) Beneficiaries

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

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R953CP.pdf> on the CMS website.

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

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

MLN Matters Number: MM5079

Related Change Request (CR) #: 5079

Related CR Release Date: May 19, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R953CP

Implementation Date: October 2, 2006

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Competitive Acquisition Program for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies and Other Issues Proposed Rule

Overview

Providers and suppliers that furnish certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to Medicare beneficiaries under Medicare Part B will have an opportunity to participate in a competitive acquisition program (the “Medicare DMEPOS Competitive Bidding Program”). This program will improve the effectiveness of Medicare’s payments for certain DMEPOS, reduce beneficiary out-of-pocket expenses, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services. Today the Centers for Medicare & Medicaid Services (CMS) issued a rule describing the proposed methodologies for selecting the areas in which the program will be first implemented and the items to be included in the program and for determining payments under the program, among other provisions. This fact sheet identifies some key elements but please refer to the proposed rule for a full discussion of the issues involved.

Legislative Background

Section 302(b) (1) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) requires the Secretary to establish and implement the Medicare DMEPOS Competitive Bidding Program. This program will change the way that Medicare pays for DMEPOS under Part B of the Medicare program by utilizing bids submitted by DMEPOS suppliers to establish Medicare payment amounts.

The MMA requires that competitive bidding programs be established and implemented in areas throughout the United States but provides the Secretary with the authority to phase in competitive bidding programs. Competition under the program would be phased in beginning in 2007 in 10 of the largest metropolitan statistical areas (MSAs), in 80 of the largest MSAs in 2009, and in other areas after 2009. Areas that may be exempt from competitive acquisition of DMEPOS include rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service.

The Secretary may also determine which items will be part of the competitive acquisition program, focusing first on the highest cost and volume items and services or those items and services that have the largest savings potential.

The MMA requires suppliers to achieve and maintain compliance with CMS DMEPOS quality standards in order to submit a bid and be awarded a contract to become a contract supplier for certain DMEPOS in competitive bidding areas. CMS will establish the new DMEPOS quality standards through program instructions and post them on the CMS website.

The MMA also requires the Secretary to establish a Program Advisory and Oversight Committee (PAOC) to provide advice and assistance to the Secretary in implementing the Medicare DMEPOS Competitive Bidding Program. The PAOC members were appointed by the Secretary and represent a broad mix of relevant industry, consumer, and government entities.

CAP—Creation of Automated Tables for Provider Information, Expansion of CAP Fee Schedule File Layout..., continued

CMS has presented numerous issues to the PAOC on the development and implementation of this program and utilized their expertise, knowledge and experience to formulate the proposed methodologies.

Proposed Program

Under the proposed rule, suppliers in a competitive bidding area would submit bids for selected items using a request for bid form provided by CMS. The CMS would use this information to select winning suppliers.

Selection of Competitive Bidding Areas

CMS proposed to select the first 10 competitive bidding areas by looking at a combination of factors including the total population in an area, total Medicare spending in the area on DMEPOS items, per beneficiary spending, and the number of suppliers per beneficiary. However, we proposed to exclude the three MSAs with a population of more than 9 million (New York, NY; Los Angeles, CA; and Chicago, IL) from the 2007 implementation to allow us to obtain additional experience with competitive acquisition before implementing the program in the areas with the largest population. The proposed rule provides illustrative data on the top 50 metropolitan statistical areas (MSA) but we propose to use the most recent data available to actually select the sites under the proposed methodology.

Selection of Competitive Acquisition Items and Services

The MMA gives CMS discretion to phase in items for bidding based on high cost and volume or largest savings potential. CMS proposes to group similar items used for treatment into product categories, such as hospital beds and accessories, so that beneficiaries will be able to receive all related items in the product category from one supplier to minimize disruption of services. CMS proposes to identify the 20 top product categories in terms of total Medicare spending, from which the items or groups of items for inclusion in the bidding process would be selected for the first phase of the program. The bid items may vary by competitive bidding areas.

Bidding

Under the proposed rule, suppliers in a competitive bidding area would submit bids for product categories and CMS would determine the winning suppliers based on these bids. The rule proposes a specific methodology for determining winning bid amounts based on the total capacity needed to meet Medicare demand for DMEPOS items in the area. The Medicare payment amounts would be the median of the winning suppliers' bids for selected items. Suppliers whose bids are lower than the Medicare payment amount set under the competitive bidding program could offer a rebate to beneficiaries.

Suppliers

Suppliers must have a Medicare supplier billing number to submit claims for Medicare payment. In addition, all suppliers must be accredited by a CMS-approved accreditation organization to ensure they meet applicable quality standards. Failure to meet the standards can result in the revocation or suspension of billing privileges and the inability to participate in the Medicare Competitive Bidding Program.

The proposed rule provides an opportunity for suppliers to develop a network to collectively bid to furnish items

included in a product category under the Medicare Competitive Bidding Program.

This provision would provide important assistance to small suppliers. We also proposed a grandfather provision to allow suppliers who are not selected to participate in the Medicare Competitive Acquisition Program to continue to serve their existing customers.

Impact on Medicare Beneficiaries

The DMEPOS competitive bidding program would have a significant positive impact on Medicare beneficiaries by reducing their out-of-pocket costs. Beneficiary co-payments would be reduced due to lower Medicare DMEPOS prices set through competition. Additionally, beneficiaries may receive rebate offers from the selected contracted suppliers. Because contracted suppliers would be accredited as meeting quality standards, beneficiaries would be assured access to quality medical equipment and DMEPOS supplier services.

Tips for the Public

The proposed rule seeks public comment on a number of key elements of the DMEPOS Competitive Bidding Program. Key elements include:

- The proposed methodology for selecting the ten MSAs for 2007.
- Alternatives to defining competitive bidding areas.
- The proposed methodologies for determining whether an area within an urban area that has a low population density is not competitive.
- Standards for exempting particular rural areas from competitive bidding.
- Methodologies for setting the single payment amount.
- The proposed approach for calculating market demand and estimating supplier capacity.
- Best method of weighting individual items within a product category to determine the composite bid.
- Financial standards evaluation criteria and required documentation.
- Additional options to ensure that small suppliers have opportunities to be considered for participation in the program.
- A process to determine items and/or HCPCS codes for identifying off-the-shelf (OTS) orthotics subject to competitive bidding.
- The proposed rebate process outlined and how to handle those cases in which the rebates would exceed the co-payment amount.

The proposed rule outlines additional requirements that include: 1) application processes to become a CMS approved accreditation organization for the purpose of applying CMS new quality standards for all DMEPOS suppliers; 2) a new fee schedule for home dialysis supplies and equipment that are still paid on a reasonable charge basis; 3) clarification of Medicare policy on the scope of the statutory eyeglass coverage exclusion; and 4) implementation of a revised methodology for calculating fee schedule amounts for new DMEPOS items.

The proposed rule is on display today at the Office of the Federal Register and will be published in the May 1, 2006, Federal Register. Public comments will be accepted until June 30, 2006, and a final rule will be published later this year.

Extension of the Competitive Acquisition Program Physician Election Period

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

Provider Types Affected

Physicians who wish to bill Medicare carriers for certain Part B drugs and biologicals under the Medicare Competitive Acquisition Program (CAP) and have not yet elected to participate in the program.

Background

The Centers for Medicare & Medicaid Services (CMS) has announced an extension of the election period for physician enrollment in the CAP for Part B Drugs and Biologicals. The initial physician election period from May 8 - June 2, 2006, was established on April 27, 2006.

The physician election period has been extended until June 30, 2006.

CMS is taking this action to provide physicians with a greater opportunity to evaluate the program and determine if the program is right for them. For the list of MLN Matters articles that describe the CAP in detail please see the *Additional Information* section of this article.

Key Points

This special edition article outlines the key implementation points as follows:

- CAP claims processing will start as planned on July 1, 2006, for physicians who submitted their forms by June 2, 2006.
- CMS is extending the election period until June 30, 2006. During this period all physicians, as defined by Change Request (CR) 4404, who have not already submitted election forms to their local carriers can elect to participate in CAP. (CR 4404 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R932CP.pdf> on the CMS website.)
- The effective date for elections postmarked by June 30 will be August 1, 2006.

Completed election forms must be returned by mail to the physician's local carrier.

- By July 28, the approved CAP vendor, Bioscrip Inc., will contact any physicians who submit their election forms during this extended period, to let them know that they may begin ordering CAP drugs as of August 1, 2006.

Additional Information

Further information regarding the CAP program is available at

http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage on the CMS website. Also, additional MLN Matters articles are available as follows:

- MLN Matters MM4064 provides a complete overview of the CAP and background material for SE0639. It may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf> on the CMS website.
- MLN Matters MM4309 builds on the business requirements outlined in MM4064, related to SE0639, and may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf> on the CMS website.
- MLN Matters MM4404, which relates to CR 4044, may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4404.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.pdf> on the CMS website.

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

MLN Matters Number: SE0639

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: August 1, 2006

Related CR Transmittal #: N/A

Implementation Date: N/A

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DRUGS AND BIOLOGICALS**Drug Administration Coding and Payment Policy – Update to Pub. 100-04 Medicare Claims Processing Manual**

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

Provider Types Affected

Physicians and providers billing Medicare carriers for drug administration procedures

Providers Action Needed

This article and Change Request (CR) 5028 provide specific information regarding the interim G codes that were adopted in 2005 and operational until 2006 when the new *Current Procedural Terminology (CPT)* codes become operational. In **2006 CPT codes replace the interim G codes**. Beginning in 2006 physicians will follow *CPT* coding guidelines and select codes that best represent the underlying service. Implementation of these revised coding guidelines will help Medicare make prompt and correct payments for drug administration services.

Under the Medicare Modernization Act (MMA), drug administration codes included three categories of services for which there were no work relative value units as of October 1, 2003:

- Hydration
- Therapeutic, prophylactic, and diagnostic injections and infusions
- Chemotherapy administration

The MMA established work relative value units for these codes and provided transitional payment adjustments in 2004 and 2005. Carriers have and may continue to pay for these services under the Medicare Physician Fee Schedule.

Background

The purpose of this CR is to incorporate in the *Medicare Claims Processing Manual* the payment policy and claims processing instructions previously included in Transmittal 129, CR 3631 (2005 Drug Administration Coding Revisions) issued on December 10, 2004, and Transmittal 148, CR 3818 (Revised Coding Guidelines for Drug Administration Codes), issued on April 15, 2005.

Implementation

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

Additional Information

The official instructions issued to your Medicare carrier regarding this change may be found at

<http://www.cms.hhs.gov/Transmittals/downloads/R968CP.pdf> on the CMS website.

The address for Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 30.5. (Internet Only Manual), is <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> on the CMS website.

Transmittal 129, CR 3631 (2005 Drug Administration Coding Revisions), issued on December 10, 2004, may be viewed at <http://new.cms.hhs.gov/transmittals/Downloads/R129OTN.pdf> on the CMS website.

The MLN article MM3631 may be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3631.pdf> on the CMS website.

Transmittal 148, CR 3818 (Revised Coding Guidelines for Drug Administration Codes) issued on April 15, 2005, may be viewed at <http://new.cms.hhs.gov/Transmittals/downloads/R148OTN.pdf> on the CMS website.

The MLN article MM3818 may be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3818.pdf> on the CMS website.

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

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

Medlearn Matters Number: MM5028

Related Change Request (CR) #: 5028

Related CR Release Date: May 26, 2006

Effective Date: June 26, 2006

Related CR Transmittal #: R968CP

Implementation Date: June 26, 2006

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Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus Vaccine Claims and Acceptance of CPT Code 90660 for the Reporting of the Influenza Virus Vaccine

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

Provider Types Affected

Physicians and providers billing Medicare carriers and fiscal intermediaries (FIs) for influenza and/or PPV vaccines and vaccine administration

Providers Action Needed

This article and Change Request (CR) 5037 provide specific information regarding payment for Influenza and/or PPV vaccines and their administration. Effective for dates of service on or after October 1, 2006, the following are the new instructions:

- **Report diagnosis code V06.6** on claims that contain influenza virus and/or PPV **vaccines and their administration** when the purpose of the visit was to **receive both** vaccines.
- Continue reporting **diagnosis code V03.82** on **claims that contain only PPV vaccine** and its administration.
- Continue reporting **diagnosis code V04.81** on **claims that contain only influenza virus** vaccine and its administration.
- Use **CPT code 90660** on claims when **billing for** influenza virus vaccine, live, for intranasal use.
- Neither a deductible nor a coinsurance will be applied to influenza virus vaccine, CPT code *90660*, and its administration.
- Use **HCPCS code G0008** when billing for the **administration of code 90660**.

Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its policy regarding payment for influenza and/or PPV vaccines and its administration.

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Currently, providers are required to report diagnosis codes V03.82 for PPV and its administration and diagnosis code V04.81 for influenza virus vaccine and its administration. This instruction allows the reporting of diagnosis code V06.6 in place of V03.82 and V04.81 when reporting influenza virus and/or PPV vaccines when the purpose of the visit was to receive both vaccines. In addition, this instruction requires Medicare carriers/FIs to accept claims containing CPT code *90660* for the influenza virus vaccine.

Implementation

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

Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R921CP.pdf> on the CMS website.

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.pdf> on the CMS website.

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

MLN Matters Number: MM5037
 Related Change Request (CR) #: 5037
 Related CR Release Date: April 28, 2006
 Effective Date: October 1, 2006
 Related CR Transmittal #: R921CP
 Implementation Date: October 2, 2006

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DURABLE MEDICAL EQUIPMENT

Correction to 2006 Jurisdiction List

The 2006 Jurisdiction List was published in the Third Quarter 2006 *Medicare Part B Update!* (pages 28-37). Due to a formatting issue with the original list, the following is being republished. We apologize for the inconvenience.

HCPCS	DESCRIPTION	JURISDICTION
A4206 - A4209	Medical, Surgical, and Self- Administered Injection service (not separately payable)	Carrier if incident to a physician's. If other supplies DME REGIONAL carrier.
E1399	Miscellaneous DME	Local carrier if implanted DME. If other, DME REGIONAL carrier.

Source: Publication 100-04, Transmittal 893, Change Request 4363

EVALUATION AND MANAGEMENT SERVICES

Payment for Evaluation and Management Services Provided During Global Period of Surgery

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

Provider Types Affected

Physicians and qualified nonphysician practitioners (NPP) who bill Medicare carriers for their services

Key Points

- The Centers for Medicare & Medicaid Services (CMS) has clarified the documentation requirements and policy requirements for the use of *CPT* modifier 25 used with E/M services. Please refer to the manual attachment to CR 5025, *The Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.6, for revisions regarding the use of *CPT* modifier 25.
- Physicians and qualified nonphysician practitioners (NPP) should use *CPT* modifier 25 to designate a significant, separately identifiable E/M service provided by the same physician/qualified NPP to the same patient on the same day as another procedure or other service with a global fee period.
- *Common Procedural Terminology (CPT)* modifier 25 identifies a significant, separately identifiable evaluation and management (E/M) service. It should be used when the E/M service is above and beyond the usual pre- and postoperative work of a procedure with a global fee period performed on the same day as the E/M service.
- Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service with a global fee period. Modifier 25 is added to the E/M code on the claim.
- Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified NPP in the patient's medical record to support the need for modifier 25 on the claim for these services, even though the documentation is not required to be submitted with the claim.
- Your carrier will not retract payment for claims already paid or retroactively pay claims processed prior to the implementation of CR 5025. But, they will adjust claims brought to their attention.
- Carriers will not pay for an E/M service reported with a procedure having a global fee period unless *CPT* modifier -25 is appended to the E/M service to designate it as a significant and separately identifiable E/M service from the procedure. Such payment will be denied with the following messages:

Claim Adjustment Reason Code

97 – Payment is included in the allowance for another service/procedure.

Remittance Advice Remark Code

M144 – Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

Additional Information

CR 1250, Transmittal A-00-40, July 20, 2000, *Further Information on the Use of Modifier 25 in Reporting Hospital Outpatient Services*, can be found at <http://new.cms.hhs.gov/transmittals/downloads/A0040.pdf> on the CMS website. This article provides information that is especially helpful for emergency department use of modifier 25.

Payment for Evaluation and Management Services Provided During Global Period of Surgery, continued

CR 1725, Transmittal A-01-80, June 29, 2001, *Use of Modifier -25 and Modifier -27 in the Hospital Outpatient Prospective Payment System (OPPS)*, may be found at <http://new.cms.hhs.gov/Transmittals/Downloads/A0180.pdf> on the CMS website.

CR 5025 is the official instruction issued to your carrier regarding changes mentioned in this article, MM5025. CR 5025 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R954CP.pdf> on the CMS website.

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

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

MLN Matters Number: MM5025
Related CR Release Date: May 19, 2006
Related CR Transmittal #: R954CP

Related Change Request (CR) #: 5025
Effective Date: June 1, 2006
Implementation Date: August 20, 2006

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LABORATORY/PATHOLOGY

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

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

Provider Types Affected

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

Impact on Providers

This article is based on Change Request (CR) 5108, which communicates requirements to Medicare contractors (carriers and FIs) notifying them of changes to the laboratory edit module and to update the laboratory edit module for changes in laboratory national coverage determination (NCD) code lists for July 2006.

Background

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

The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the *Medicare Claims Processing Manual* (Pub.100-4), Chapter 16, §120.2; <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf>). These changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs, and several of the listed changes correct *Current Procedural Terminol-*

ogy (CPT) codes to reflect the current CPT update.

CR 5108 informs your Medicare carrier and FI about changes in the laboratory NCD code lists for July 2006 that require updating of the laboratory edit module.

The key change being made to the NCD code lists for July 2006 is that CPT code 83704 (*Quantitation of lipoprotein particle numbers and lipoprotein particles subclasses*) is being added to the list of HCPCS/CPT codes covered by Medicare for the Lipids Testing NCD.

Implementation

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

Additional Information

For complete details, please see the official instruction (CR 5108) issued to your carrier/intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R959CP.pdf> on the CMS website.

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

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

MLN Matters Number: MM5108
Related Change Request (CR) #: 5108
Related CR Release Date: May 26, 2006
Effective Date: July 1, 2006
Related CR Transmittal #: R959CP
Implementation Date: July 3, 2006

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MEDICARE PHYSICIAN FEE SCHEDULE/DATABASE

July Update to the 2006 Medicare Physician Fee Schedule Database

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

Provider Types Affected

Physicians, providers, suppliers submitting claims to carriers or fiscal intermediaries (FIs) for services paid under the Medicare Physician Fee Schedule (MPFS) provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5102, which amends payment files issued to your carrier/intermediary that were based on the November 21, 2005, MPFS Final Rule. Attachment 1 of CR 5102 also includes new category II and category III codes.

Background

The Social Security Act (Section 1848(c)(4); http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

CR 5102:

- Amends payment files issued to your carrier/intermediary based upon the November 21, 2005, Medicare physician fee schedule (MPFS) final rule; and
- Includes new category II and category III codes.

CR 5102 also instructs that your carrier/intermediary should:

- Give providers 30 days notice before implementing the revised payment amounts identified in CR 5102 (attachment 1) in accordance with the Medicare Claims Processing Manual (Pub 100-4, Chapter 23, Section 30.1; <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>). Note that unless otherwise stated in CR 5102, changes will be retroactive to January 1, 2006;
- Not search their files to either retract payment for claims already paid or to retroactively pay claims; and
- Adjust claims brought to their attention.

Changes to Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) codes

CPT/ HCPCS Code	ACTION
95991	Non-Facility RVU = 1.50
G0978	Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t2 or t3a† gleason 8-10 or psa > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases
G9125	Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and /or bcr-abl positive; blast phase not† in hematologic, cytogenetic, or molecular remission
G9127	Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and /or bcr-abl positive; extent of disease unknown, under evaluation, not listed (for use in a Medicare-approved demonstration project)

July Update to the 2006 Medicare Physician Fee Schedule Database, continued

included in the July Update to the 2006 MPFS Database (CR 5102 [Attachment 1]) are as follows:

In addition, effective July 1, 2006, a number of **category II codes** will be added to the MPFSDB with a status indicator of “M”. Rather than repeat all those category II codes in this article, we refer you to Attachment 1 of CR 5102, which contains the codes and their descriptors. CR 5102 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R963CP.pdf> on the CMS website.

The long descriptor for **category II code 1000F** has been revised. The new descriptor is **effective for services performed on or after January 1, 2005** (date code was implemented).

Category II Code	<i>1000F</i>
Long Descriptor:	<i>Tobacco use assessed (CADI, CAPI, COPDI, DM4, PVI)</i>

The descriptors for **category II code 4015F** have been revised. The new descriptors are **effective for services performed on or after January 1, 2006** (date code was implemented).

Category II Code	<i>4015F</i>
Long Descriptor (Revised):	<i>Persistent asthma, preferred long term control medication or acceptable alternative treatment, prescribed (Asthma1)</i>
Short Descriptor:	<i>Persist asthma medicine ctrl</i>

Also, note that G code (G8085) was inadvertently not included in the April update. G8085 is added with a status indicator of “M” and is effective for services on or after January 1, 2006. The long descriptor for G8085 is “End-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula.”

Effective July 1, 2006, the category III codes of *0155T-0161T* will be added to the MPFSDB. The descriptors and other indicators for these codes may also be found in attachment 1 of CR 5102.

Implementation

The implementation date for CR 5102 is July 3, 2006

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R963CP.pdf> on the CMS website.

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.pdf>

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

MLN Matters Number: MM5102

Related Change Request (CR) #: 5102

Related CR Release Date: May 26, 2006

Effective Date: January 1, 2006

Related CR Transmittal #: R963CP

Implementation Date: July 3, 2006

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PREVENTIVE SERVICES

Correct Reporting of Diagnosis Codes on Screening Mammography Claims

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

Provider Types Affected

All providers billing Medicare carriers and fiscal intermediaries (FIs) for screening mammography claims

Providers Action Needed

This article and Change Request (CR) 5050 provide specific information regarding the reporting of diagnostic codes on screening mammography claims. The following are the instructions:

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSIX12 837) on claims that contain ONLY SCREENING mammography services.
- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSIX12 837 and field 21 of CMS-1500 or Loop 2300 of the ANSIX12 837) on claims that contain OTHER services in addition to a screening mammography.

In addition, CR 5050 updates Chapter 18, Section 20.4 of the *Medicare Claims Processing Manual* for FI processed claims as follows:

- It removes 12x type of bill (TOB) from the list of applicable TOBs for diagnostic mammography;
- It adds HCPCS code G0202 to the list of valid codes for the billing of screening mammography; and
- It adds HCPCS codes G0204 and G0206 to the list of valid codes for the billing of diagnostic mammographies.

MLN Matters Number: MM5050

Related CR Release Date: April 28, 2006

Related CR Transmittal #: R916CP

Related Change Request (CR) #: 5050

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

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Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its reporting requirements to allow other diagnosis codes and a screening mammography submitted on the same claim.

Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. This CR adjusts that requirement.

Implementation

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

Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf> on the CMS website. The revised Section 20.4 of Chapter 18 of the *Medicare Claims Processing Manual* is attached to CR 5050.

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.pdf> on the CMS website.

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

New Preventive Services Web-Based Training Course Now Available

The Medicare Preventive Services: Part 3 Expanded Benefits Web-based training (WBT) course is now available.

This WBT provides information about Medicare's coverage for the three new services added to the Medicare program in 2005, as a result of the Medicare Modernization Act of 2003; initial preventive physical exam (a.k.a. "Welcome to Medicare" physical exam), diabetes and cardiovascular disease screenings. The course also includes information on diabetes self-management training, medical nutrition therapy and other diabetes supplies, colorectal, prostate, and glaucoma screenings and bone mass measurements. The information presented in this course will be helpful for physicians, nurses, medical administrators and other health care professionals who provide these preventive services and screenings to Medicare patients. This course is the third

in a series of three Web-based training courses developed by CMS as part of a comprehensive program designed to promote awareness and increase utilization of preventive benefits and to help those who bill Medicare for these services to file claims effectively.

The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington DC 20006. CMS has awarded .2 of CEU's (continuing education units) to participants who successfully complete this program.

The authors of this program have nothing to disclose.

You may access the Medicare Preventive Services Series: Part 3 Expanded Benefits WBT at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1.

Source: Provider Education Resources Listserv, Message 200605-12

National Men's Health Week

In conjunction with National Men's Health Week and in commemoration of Father's Day (June 18), the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join with us as we strive to heighten the awareness of prevention and encourage early detection and treatment of disease. Medicare now provides coverage for preventive screenings for heart disease, stroke, diabetes and cancer – four of the leading diseases that significantly impact the health of men. Medicare provides payment for a full range of preventive services specific for men's health that aim to prevent disease from developing or prevent serious complications of disease.

Although Medicare is now providing better benefits, many men with Medicare are not yet taking full advantage of them, leaving significant gaps in prevention. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease or even that they may already have a condition that preventive services are intended to detect. With your help we can begin to close the prevention gap.

How Can You Help? As a trusted source, your recommendation is the most important factor in increasing the use of preventive and screening services. We need your help to ensure that men with Medicare are aware of these covered benefits and that they are encouraged to take advantage of the preventive services for which they may be eligible.

For Patients New to Medicare – When appropriate, provide the *Welcome to Medicare Visit*. This one time exam, which must be received within the first 6 months of the beneficiary's Medicare Part B effective date, is an excellent opportunity to orient new beneficiaries to Medicare, assess risk factors for disease, discuss lifestyle modifications that support a healthy lifestyle and may reduce the complication of disease, and encourage utilization of preventive screenings through referral for appropriate services. Remember to follow-up with patients on all screening results, even negative ones ? every one likes to hear good news.

Established Patients – Remember to talk with your patients about their risk for disease and the importance and value of prevention, detection, early treatment, and lifestyle modifications. Encourage appropriate utilization of preventive services for which they may be eligible and provide follow-up on all screening results and continue to promote a prevention-oriented lifestyle.

Working together we can begin to:

- increase awareness of prevention, and early detection and treatment of disease affecting men's health,
- prevent and reduce serious complications of disease,
- reduce mortality for many diseases effecting men,
- improve the health and quality of life of men,
- ensure that men with Medicare take advantage of preventive benefits they may be eligible for, and
- ultimately, save health care dollars.

Educational Products and Resources for Health Care Professionals

CMS has developed a variety of educational products and resources to help health care professionals and their staff becomes familiar with the coverage of and payment for the array of preventive and screening 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 page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS website.
- The CMS website also has a prevention website which contains a section on each of the preventive services. Click on <http://www.cms.hhs.gov>, select "Medicare", and scroll down to "Prevention".
- For products to share with your Medicare patients go to <http://www.medicare.gov> on the Web.

Men's health conditions do not simply affect men. Wives, mothers, daughters, and sisters are all impacted, making men's health a family matter. Encourage your patients to take advantage of Medicare-covered preventive services – it could save their life.

Thank you for joining with CMS to spread the message about prevention, early detection and treatment. For more information about National Men's Health Week visit <http://www.menshealthweek.org/> on the Web.

Source: Provider Education Resources Listserv, Message 200606-06

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.

Men's Health Prevention Awareness Continues

National Men's Health Week and Father's Day are over, but that doesn't mean that your prevention awareness messages to your patients should stop! CMS invites you to join with us as we strive to close the prevention gap by spreading the word to your patients that Medicare provides coverage for many preventive services and screenings that are meant to prevent disease from developing, detect disease early, identify risks for disease, reduce serious complications and provide early treatment when outcomes are more favorable.

What Can You Do To Help?

We still need your help to ensure that men with Medicare are aware of the many preventive and screening services covered by Medicare and that they are encouraged to take advantage of the preventive services for which they may be eligible. We ask that you:

- (1) Become familiar with the preventive services for which Medicare provides payment.
- (2) Ensure that your staff is educated about coverage, eligibility, frequency, coding, claim filing, and reimbursement requirements for these services.
- (3) Remember to talk with your patients about their risk for disease and the importance and value of prevention, detection, early treatment, and lifestyle modifications.
- (4) Encourage appropriate patient utilization of preventive services for which they may be eligible and
- (5) Provide follow-up on all screening results and continue to promote a prevention-oriented lifestyle.

As men increase their knowledge of their risk for disease and the benefits of prevention, they will be able to make more informed decisions about the use of preventive services, treatment options, and appropriate lifestyle modifications.

Source: Provider Education Resources Listserv, Message 200606-10

For More Information...

CMS has developed a variety of educational products and resources to help health care professionals and their staff become more familiar with the coverage of and payment for the array of preventive and screening 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 page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS website.
- The CMS website also has a prevention website which contains a section on each of the preventive services. Click on <http://www.cms.hhs.gov>, select "Medicare", and scroll down to "Prevention".
- For products to share with your Medicare patients go to <http://www.medicare.gov> on the Web. And effective immediately, beneficiaries can find out which regular checkups they may have missed by calling (800) MEDICARE — (800) 633-4227 — or by visiting <http://www.medicare.gov/health/overview.asp>.

We hope you will use these resources to assist you in communicating with your patients about Medicare preventive benefits.

Remember – Men's health conditions do not simply affect men. Wives, mothers, daughters, and sisters are all impacted, making men's health a family matter. Encourage your patients to take advantage of Medicare-covered preventive services – it could save their life.

Thank you for joining with CMS to spread the message about prevention, early detection and treatment.

RADIOLOGY

Payment for Positron Emission Tomography Scans in CMS-Approved Clinical Trials and Coverage with Evidence Development - Use of Modifiers QR and QV

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

Provider Types Affected

Physicians and other providers who bill Medicare carriers and fiscal intermediaries (FI) for the use of FDG PET scans for oncology and dementia/neurodegenerative diseases.

Provider Action Needed

STOP – Impact to You

Effective January 28, 2005, for certain FDG PET indications (listed in the *Background* section below), rather than the modifier **QV** previously required, you must use the modifier **QR** on all carrier claims to identify that this service is provided in a Medicare-specified study.

CAUTION – What You Need to Know

CR 5124 revises Transmittal 527 (CR 3741) to require that you use the appropriate CPT code and the modifier **QR** (item or service provided in a Medicare-specified study), rather than the modifier **QV** (other than inpatient), on carrier claims for services for dementia and neurodegenerative diseases, and a broad range of cancer indications listed as "coverage with evidence development."

Payment for PET Scans in CMS-Approved Clinical Trials, continued

Claims submitted to FIs must contain the principal diagnosis code, the appropriate CPT code, and V70.7 diagnosis code. In addition, CMS has entered into an agreement with the Academy of Molecular Imaging (AMI) in which AMI collects data for a broad range of cancers through the National Oncologic PET Registry (NOPR). The NOPR, which began accepting patients on May 8, 2006, satisfies Medicare's requirement that the FDG PET provider and Medicare beneficiary participate in a prospective clinical study in order for the services to be considered reasonable and necessary. NOPR information and registration materials are available at its website, provided in the *Additional Information* section below.

GO – What You Need to Do

Make sure that your billing staffs are aware of these coding changes for FDG PET services in your Medicare claims.

Background**Positron Emission Tomography (PET)**

Positron emission tomography (PET) is a noninvasive imaging procedure that assesses perfusion and the level of metabolic activity in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images obtained by detecting radioactivity from a radioactive tracer substance (radionuclide), 2-[F-18] fluoro-D-glucose (FDG).

Refer to Publication 100-03, the *National Coverage Determinations (NCD) Manual*, section 220.6, for coverage instructions that indicate conditions under which a PET scan is performed. The manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS website.

Covered FDG PET Scans

For cancers listed as “coverage with evidence development” in section 220.6 of the NCD Manual, CMS has determined that (effective for services performed on or after January 28, 2005) FDG PET scans are reasonable and necessary only when the provider is participating in, and patients are enrolled in:

- A clinical trial that meets the requirements of Food and Drug Administration (FDA) category B investigational device exemption (42 CFR 405.201); or
- An FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management.

CR 3741, released April 15, 2005, indicated that there is adequate evidence to conclude that an FDG PET scan for the detection of pre-treatment metastases (i.e., staging) in newly-diagnosed cervical cancer (after conventional imaging that is negative for extra-pelvic metastasis), is reasonable and necessary as an adjunct test, and it expanded coverage to include FDG PET for certain indications of cervical cancer.

CR 3741 also designated **QV** as the correct modifier to be used in carrier claims for beneficiaries participating in CMS-approved clinical trials utilizing FDG PET scans for dementia and neurodegenerative diseases.

CR 5124, upon which this article is based, revises CR 3741 to provide that (effective for services on or after January 28, 2005) you will be reimbursed for the use of FDG PET services for:

- Dementia and neurodegenerative disease (see NCD Manual (100.03) section 220.6.13);
- Certain indications for cancers of the cervix, lung (including small cell), esophagus, colon and rectum, head and neck, breast, thyroid, brain, ovary, pancreas, and testes; and lymphoma, melanoma, and soft tissue sarcoma (as listed in sections 220.6.2-220.6.7 and 220.6.10-220.6.14); and
- All other cancer indications not previously specified (as listed in section 220.6.15);
- **Only** if these scans were performed as part of a Centers for Medicare & Medicaid Services (CMS)-approved clinical trial.

In fact, be aware that FDG PET scans for all cancer indications listed in section 220.6 as “coverage with evidence development” remain nationally non-covered unless they are performed in conjunction with a CMS-approved clinical trial.

Using Appropriate CPT Code and QR Modifier

In line with the requirement for including these patients in clinical trials, you must submit all (other than inpatient) FDG PET claims to your carriers using the appropriate CPT code and the **QR** modifier, which was created for use on Part B claims (and other outpatient claims) to identify items/services that are covered when provided in a Medicare-specified study.

You may no longer use the **QV** modifier when a beneficiary undergoes an FDG PET scan in a facility participating in a Medicare-approved study specified by the above-referenced NCDs.

National Oncologic PET Registry (NOPR)

You should also be aware that CMS contracted with the Academy of Molecular Imaging (AMI) to establish the NOPR, a national, Internet-based data registry that reports on oncologic FDG PET scans received by Medicare beneficiaries as outlined in the NCD.

Reporting data to the NOPR for the oncologic FDG PET scan indications listed in section 220.6 as “coverage with evidence development” is a requirement of Medicare coverage. Without appropriately reported data, Medicare may be unable to approve claims and/or may be required to take action to recoup payments already made if data reporting discrepancies are discovered through post-payment claims analysis.

Remember that you are responsible for ensuring that data is accurately reported to the NOPR and that claims are accurately submitted. CMS recommends that you contact NOPR so that your facility may provide expanded oncologic FDG PET benefits under the NCD.

Payment for PET Scans in CMS-Approved Clinical Trials, continued

When submitting such claims to your FIs, you should use the appropriate principal diagnosis code, the appropriate CPT code, and ICD-9 code V70.7 in the second diagnosis position on the CMS-1450 (UB-92), or the electronic equivalent.

Finally, note that effective for PET scan claims with dates of service on or after January 28, 2005 until implementation of CR 5124 on June 19, 2006, your carriers and FIs do not need to search their files to either retract erroneous payment for claims already paid or to retroactively pay claims incorrectly processed, unless you bring those claims to their attention.

Additional Information

You may find more information about FDG PET scans in patients undergoing Medicare-approved clinical trials by going to CR 5124, located at <http://www.cms.hhs.gov/Transmittals/downloads/R956CP.pdf> on the CMS website.

Additionally, you might want to look at the *National Coverage Determinations (NCD) Manual*, sections 220.6, 220.6.2 - 220.6.7, 220.6.10 - 220.6.12, 220.6.14, and 220.6.15 for important information regarding FDG PET for oncology.

The transmittal that conveyed the above NCD is available at

<http://www.cms.hhs.gov/Transmittals/downloads/R31NCD.pdf> on the CMS website.

A related Medicare Claims Processing Manual transmittal is available at

<http://www.cms.hhs.gov/Transmittals/downloads/R527CP.pdf> on the CMS website.

A related MLN Matters article appears at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3741.pdf> on the same site.

Information and registration materials are available at NOPR's website: <http://www.cancerPETregistry.org>.

A regularly updated list of NOPR's Medicare approved facilities is located at

<http://www.cms.hhs.gov/MedicareApprovedFacilities/NOPR/list.asp#TopOfPage> on the CMS website.

NOPR may also be reached at 800-227-5463, extension 4859, or 215-717-0859. If you have any questions, please contact your carrier or FI at their toll-free number, which may be found at

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

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

MLN Matters Number: MM5124

Related CR Release Date: May 19, 2006

Related CR Transmittal #: R956CP

Related Change Request (CR) #: 5124

Effective Date: January 28, 2005

Implementation Date: June 19, 2006

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SURGERY**Bariatric Surgery for Morbid Obesity**

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services related to bariatric surgery

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

This article is based on Change Request (CR) 5013, which modifies the *Medicare National Coverage Determination Manual* (NCDM, Sections 40.5 and 100.1) and adds section 150 to Chapter 32 of the *Medicare Claims Processing Manual* to be consistent with the new Centers for Medicare & Medicaid Services (CMS) policy for bariatric surgery.

CAUTION – What You Need to Know

Effective for services on or after February 21, 2006, Medicare will cover open and laparoscopic Roux-en Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB) and open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS) if certain criteria are

met and the procedure is performed in an approved facility.

In addition, effective for services performed on or after February 21, 2006, Medicare has decided that open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding are nationally non-covered for Medicare.

GO – What You Need to Do

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

Background

Bariatrics is the branch of medicine dealing with obesity, and bariatric surgery can be an effective treatment for patients who have been unsuccessful with diet and exercise and have comorbid conditions such as:

- Coronary artery disease;
- Diabetes; and
- Sleep apnea.

Bariatric Surgery for Morbid Obesity, continued

Bariatric surgery procedures are performed to treat many co morbid conditions associated with obesity, and two types of surgical procedures are employed:

- Malabsorptive surgical procedures divert food from the stomach to a lower part of the digestive tract where the normal mixing of digestive fluids and adsorption of nutrients cannot occur; and
- Restrictive surgical procedures restrict the size of the stomach and decrease intake.

Some surgeries combine both of these types of procedures, and brief descriptions of bariatric surgery procedures are included in the *Additional Information* section of this article. Also, see the *Medicare National Coverage Determinations Manual* (Pub. 100-03, Chapter 1, Part 2, Section 100.1 (Bariatric Surgery for Morbid Obesity [Effective February 21, 2006], Subsection A [General]), attached to CR 5013.

Note: Bariatric surgery is recommended only for individuals with health concerns related to their obesity

CMS has determined the evidence is adequate to conclude that:

- **If** a Medicare beneficiary has documented in their medical record that they:
- Have a body-mass index (BMI) > 35, with at least one co-morbidity related to obesity; **and**
- Have been previously unsuccessful with medical treatment for obesity;
- **Then** the following procedures (performed on or after February 21, 2006) are considered reasonable and necessary:
 - Open and laparoscopic Roux-en-Y gastric bypass (RYGBP);
 - Laparoscopic adjustable gastric banding (LAGB); and
 - Open and laparoscopic biliopancreatic diversion (BPD) with duodenal switch (DS).

Approved Facilities

In addition, CMS has determined that covered bariatric surgery procedures are reasonable and necessary **only** when performed at facilities certified by:

- The American College of Surgeons ([ACS] <http://www.facs.org/cqi/bscn/>) as a Level 1 Bariatric Surgery Center (BSC; program standards and requirements in effect on February 15, 2006); or
- The American Society for Bariatric Surgery ([ASBS] <http://www.asbs.org/>) as a Bariatric Surgery Center of Excellence (BSCO; program standards and requirements in effect on February 15, 2006).

A list of approved facilities and their approval dates will be listed and maintained on the CMS coverage website at <http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage>. This information will also be published in the *Federal Register*.

When services are performed in an unapproved facility, Medicare will deny the claim with a claim reason adjustment code of 58. (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.)

For providers to avoid liability for charges when services are performed in an unapproved facility, physicians must have the beneficiary sign an advanced beneficiary notice (ABN), and hospitals, including critical access hospitals, must have the beneficiary sign a Hospital Issued Notice of Non-coverage (HINN).

Non-Covered Procedures

The evidence is not adequate to conclude that the following bariatric surgery procedures are reasonable and necessary; therefore, the following procedures are noncovered for all Medicare beneficiaries:

- Open vertical banded gastroplasty
- Laparoscopic vertical banded gastroplasty
- Open sleeve gastrectomy
- Laparoscopic sleeve gastrectomy
- Open adjustable gastric banding.

Changes in Manuals

The *Medicare Claims Processing Manual* (Pub.100-04, Chapter 32 (Billing Requirements for Special Services), Section 150 (Billing Requirements for Bariatric Surgery for Morbid Obesity)) is being added to reflect the new coverage for bariatric surgery.

In addition, the *Medicare National Coverage Determination Manual* (NCDM, Pub. 100-03, Chapter I, Sections 40.5 and 100.1) are being modified to be consistent with the new CMS policy for bariatric surgery. These revisions are attached to CR 5013.

The revision of the NCDM will include a reference to the covered surgical procedures, and revise the obesity policy with the final bariatric surgery policy.

The modified obesity policy will read as follows (changes bolded and italicized):

“Obesity may be caused by medical conditions such as hypothyroidism, Cushing’s disease, and hypothalamic lesions or can aggravate a number of cardiac and respiratory diseases as well as diabetes and hypertension. Non-surgical services in connection with the treatment of obesity are covered when such services are an integral and necessary part of a course of treatment for one of these medical conditions. ***Certain designated surgical services for the treatment of obesity are covered for Medicare beneficiaries who have a BMI = 35, have at least one co-morbidity related to obesity and have been previously unsuccessful with the medical treatment of obesity.***”

Treatments **for obesity alone** remain noncovered, and the following noncoverage determinations in the *National Coverage Determination Manual* (NCDM, Chapter 1, Part 2; http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf) remain unchanged:

- Section 100.8 (Intestinal Bypass Surgery); and
- Section 100.11 (Gastric Balloon for Treatment of Obesity).

Bariatric Surgery for Morbid Obesity, continued**Additional Instructions**

CR 5013 further instructs your carrier and/or fiscal intermediary to:

- Accept the following Healthcare Common Procedure Coding System (HCPCS) as of February 21, 2006:
 - 43770 Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components)
 - 43644 Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
 - 43645 Laparoscopy with gastric bypass and small intestine reconstruction to limit absorption. (Do not report 43645 in conjunction with 49320, 43847.)
 - 43845 Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
 - 43846 Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less Roux-en-Y gastroenterostomy. (For greater than 150 cm, use 43847)(For laparoscopic procedure, use 43644)
 - 43847 with small intestine reconstruction to limit absorption
- Accept HCPCS codes 43770, 43644, 43645, 43845, 43846 and 43847 submitted with at least one of the following diagnosis codes: V85.35; V85.36; V85.37; V85.38; V85.39; V85.4; or 278.01. (Claims will be denied without an appropriate diagnosis code.);
- Accept International Classification of Diseases, Ninth Revision (ICD-9) procedure codes 44.38, 44.39, 44.95, 43.89, 45.51, and 45.91, when the following diagnosis codes are reported: V85.35; V85.36; V85.37; V85.38; V85.39; V85.4; and 278.01. (Claims will be denied without an appropriate diagnosis code and none of the V diagnosis codes for BMI = 35 or 278.01 for morbid obesity can be the principal diagnosis on an inpatient Medicare claim); and
- Accept the following ICD-9 procedure codes as of February 21, 2006:
 - 44.38 Laparoscopic gastroenterostomy (laparoscopic Roux-en-Y)
 - 44.39 Other Gastroenterostomy (open Roux-en-Y)
 - 44.95 Laparoscopic gastric restrictive procedure (laparoscopic adjustable gastric band and port insertion).

MLN Matters Number: MM5013
 Related CR Release Date: April 28, 2006
 Related CR Transmittal #: R931CP and R54NCD

Related Change Request (CR) #: 5013
 Effective Date: February 21, 2006
 Implementation Date: May 30, 2006 for physician claims billed to carriers, and October 2, 2006, for hospital claims billed to FIs

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Important Note: There is not a distinction between laparoscopic and open biliopancreatic diversion (BPD) with duodenal switch (DS) for the inpatient setting. The codes would apply to the open approach as follows:

- 43.89 Other partial gastrectomy;
- 45.51 Isolation of segment of small intestine; and
- 45.91 Small to small intestinal anastomosis.

Should claims be denied for failure to have the appropriate diagnosis code, the carrier/FI will use claim adjustment reason code 167 to denote "This/these diagnosis(es) is (are) not covered."

Note that 44.68 (Laparoscopic gastroplasty [vertical banded gastroplasty]) is noncovered for Medicare effective February 21, 2006.

Additional Fiscal Intermediary Billing Requirements

The FI will pay for Bariatric Surgery only when the services are submitted on type of bill (TOB) of 11x.

The type of facility and setting determines the basis of payment:

- For services performed in inpatient hospitals, TOB 11x, IPPS payment is based on the DRG.
- For services performed in CAH inpatient hospitals, TOB 11x, on 101% of facility specific per visit rate.
- For services performed in IHS inpatient hospitals TOB 11x under IPPS based DRG.
- For services performed in IHS critical access hospitals, TOB 11x, under 101% facility specific per diem rate.

Implementation

The implementation date for CR 5013 is May 30, 2006 for physician claims billed to Medicare carriers and October 2, 2006, for hospital claims billed to FIs.

Additional Information

For complete details, please see the official instruction, CR 5013, issued to your carrier/intermediary regarding this change. There will be two parts to this CR, one for the NCD and one for the claims processing instruction. The NCD, which includes descriptions of the Bariatric Surgery procedures, is at <http://www.cms.hhs.gov/Transmittals/downloads/R54NCD.pdf> and the claims processing instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R931CP.pdf> on the CMS website.

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

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

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

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

Provider Types Affected

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

Key Points

- This article is based on CR 5022, which contains instructions (summarized below) that must be implemented to correctly process carotid stenting claims.
- The Centers for Medicare & Medicaid Services (CMS) has additionally updated the carotid artery stenting (CAS) facilities "approved facilities" website link in Publication 100-03, *The National Coverage Determinations Manual*. The list is now available at <http://www.cms.hhs.gov/MedicareApprovedFacilities/CASF/list.asp> on the CMS website.
- Claims that are being billed for Category B IDE studies and post approval studies, per CR 1660 (effective July 1, 2001) and CR 3489 (effective October 12, 2004), respectively, are not subject to the same billing requirements as indicated in CR 3811 (Effective March 17, 2005).

The links to CR 1660 and the Medicare Learning Network (MLN) articles relating to CR 3489 and CR 3811 can be found in the *Related Links* section below.

- CMS created a new section in the *Medicare Claims Processing Manual* specific to carotid stents. Please refer to this new section in the manual attachment to CR 5022, (Publication 100-04, *The Medicare Claims Processing Manual*, Chapter 32, Sections 150.1-150.3) for more information about PTA for implanting the carotid stent. (This includes information on CR 1660, CR 3489 and CR 3811.)

Background

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

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

Category B IDE Study Claims and Post-approval Study Claims

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

- Billed under a Category B IDE study (identified by a six-digit IDE number preceded by a "G," i.e., G123456); or a

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

CAS with Embolic Protection Claims

- Effective for dates of service on or after March 17, 2005, CAS with embolic protection claims will be paid only if they are from facilities listed on the approved list (see <http://www.cms.hhs.gov/MedicareApprovedFacilities/CASF/list.asp>).
- CAS with embolic protection claims from non-approved facilities will be rejected rather than denied. (CR 3811)
- Effective for dates of service on or after March 17, 2005, CAS with embolic protection claims that contain **procedure code 37216** (transcatheter placement of intravascular stent(s) without distal embolic protection) will **not** be paid. CMS has deemed procedure code 37216 a noncovered service for Medicare purposes.

Related Links

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

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

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

CR 5022 is the official instruction issued to your FI or carrier regarding changes mentioned in this article, MM5022. CR 5022 may be found by going to Transmittal 911CP at <http://www.cms.hhs.gov/Transmittals/downloads/R911CP.pdf> for the claims processing instructions and to Transmittal 53NCD for the NCD Manual section, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R53NCD.pdf> on the CMS website.

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

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

MLN Matters Number: MM5022

Related Change Request (CR) #: 5022

Related CR Release Date: April 21, 2006

Effective Date: March 17, 2005

Related CR Transmittal #: R911CP and R53NCD

Implementation Date: October 2, 2006

Pancreas Transplants Alone

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

Provider Types Affected

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

25023, 25031, 25033, 25041, 25043, 25051, 25053, 25061, 25063, 25071, 25073, 25081, 25083, 25091, and 25093.

Background

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

Key Points

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

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

Billing and Claims Processing

- The following ICD-9 CM codes will be recognized by FIs and carriers for pancreas transplantation alone for beneficiaries with type I diabetes when billed with **HCPCS 48554**: 25001, 25003, 25011, 25013, 25021,

- Carriers and FIs who receive claims for PA services that were performed in an **unapproved facility** should use the following messages upon the reject or denial:
- **Medicare Summary Notice MSN Message** – MSN code 16.2 (*This service cannot be paid when provided in this location/facility*)
- **Remittance Advice Message** – Claim adjustment reason code 58 (*Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service*)
- Carriers and FIs who receive claims for PA services that are **not billed using the covered diagnosis/procedure codes listed** above should use the following messages upon the reject or denial:
- **Medicare Summary Notice MSN Message** – MSN code 15.4 (*The information provided does not support the need for this service or item*)
- **Remittance Advice Message** – Claim adjustment reason code 11 (*The diagnosis is inconsistent with the procedure*)
- Modification of the current coverage policy on pancreas transplants can be found in Publication 100-03, Section 260.3 and claims processing information is located in Publication 100-04, Chapter 3, Section 90.5.1. The location of this information is listed in the *Additional Information* section of this article.

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

Implementation

The implementation date for this instruction is no later than:

- July 3, 2006, for carriers; and
- October 2, 2006, for FIs.

Additional Information

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

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

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

MLN Matters Number: MM5093

Related CR Release Date: May 19, 2006

Related CR Transmittal #: R56NCD and R957CP

Related Change Request (CR) #: 5093

Effective Date: April 26, 2006

Implementation Date: July 3, 2006 for carriers; October 2, 2006 for FIs

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THErapy SERVICES

Changes Conforming to Change Request 3648 for Therapy Services

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

Provider Types Affected

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

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 or nonphysician practitioners (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 postpay 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 256, 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 postpay 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.

Changes Conforming to Change Request 3648 for Therapy Services, continued

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 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/R941CP.pdf> on the CMS website.

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

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

MLN Matters Number: MM4014

Related CR Release Date: May 5, 2006

Related CR Transmittal #: R941CP and R55NCD

Related Change Request (CR) #: 4014

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

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VISION**Additional \$50 Payment for New Technology Intraocular Lenses Furnished in Ambulatory Surgical Centers**

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

Note: This article was revised on May 4, 2006, to correct the citation to the SSA law applicable to this change. Also, language was added to show that any subsequent IOLs recognized by CMS as being a member of the reduced spherical aberration subset will receive the same payment adjustment effective upon CMS recognition and continuing for the balance of the 5-year period.

Provider Types Affected

Approved ambulatory surgery centers (ASC) that bill Medicare for the insertion of new technology intraocular lenses (NTIOLs)

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

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare will pay you an additional \$50 for NTIOLs that the Centers for Medicare & Medicaid Services (CMS) recognizes as category 3 (Reduced Spherical Aberration).

CAUTION – What You Need to Know

Your carrier will pay you an additional \$50 for the insertion of NTIOL category 3; Advanced Medical Optics (AMO) Tecnis® IOL, model numbers Z9000, Z9001, and ZA9003 (characteristic: improved contrast sensitivity). In addition, any subsequent IOLs recognized by CMS as being a member of the reduced spherical aberration subset will receive the same payment adjustment effective upon CMS recognition and continuing for the balance of the 5-year period. Effective for all NTIOL category 3 claims with dates of service on and after February 27, 2006, through February 26, 2011, Medicare-approved ASCs are eligible for the additional \$50 when billed using HCPCS code Q1003 along with procedure codes 66982, 66983, 66984, 66985, or 66986.

GO – What You Need to Do

Make sure that your billing staffs are aware of this additional NTIOL payment and the required HCPCS code Q1003.

Additional \$50 Payment for New Technology Intraocular Lenses Furnished in Ambulatory Surgical Centers, continued**Background**

Section 141(b) of the Social Security Act Amendments of 1994 (SSAA 1994) requires that CMS establish a process for designating particular IOLs as “new technology,” and therefore eligible for additional payment. A final rule, published in the *Federal Register* (FR) on June 16, 1999 (64 FR 32198), established: (1) the process for adjusting payment amounts for NTIOLs that ASCs furnish; (2) an initial flat rate payment adjustment of \$50; and, (3) a 5-year payment adjustment period beginning when CMS recognizes the first of a new IOL subset or class.

CR 4361, from which this article is taken, announces the approval of NTIOL category 3 (as defined in the FR at 71 FR 4586, dated January 27, 2006) which applies to Advanced Medical Optics (AMO); Tecnis® IOL model numbers Z9000, Z9001, and ZA9003 (characteristic: improved contrast sensitivity). Additionally, any subsequent IOLs having the same characteristics as the first IOL recognized for payment will receive the same adjustment for the remainder of the 5-year period. This category and the associated \$50 NTIOL Medicare payment adjustment will expire on February 26, 2011.

The payment adjustment is allowed when Medicare-approved ASCs (place of service 24) insert a category 3 NTIOLs and submit HCPCS code Q1003 (created for this purpose) on the same claim as the surgical insertion procedure (66982, 66983, 66984, 66985, or 66986). HCPCS code Q1003 is already established and listed in the HCPCS file, and the Medicare Claims Processing Manual, chapter 14, Sections 10.2 & 40.3, have been updated to reflect this change.

Additional Information

Please be aware that carriers will deny payment for Q1003 when submitted by ASCs not approved by Medicare. If denied, the carrier will use MSN 16.2 (This service cannot be paid when provided in this location/facility) and claims adjustment reason code 58 (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service).

Carriers will return as unprocessable claims for NTIOLs with Q1003 alone or with a procedure code other than 66982, 66983, 66984, 66985, or 66986. When such claims are returned, use claim adjustment reason code 16 (Claim/service lacks information needed for adjudication. Additional information is supplied using remittance advice codes whenever appropriate), remittance advice remark code M67 (Missing/Incomplete/Invalid other procedure codes) and remark code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information).

Further, they will deny payment if submitted for services rendered after the discontinued date (February 26, 2011). If denied, they will use MSN 21.11 (This service was not covered by Medicare at the time you received it) and claims adjustment reason code 27 (Expenses incurred after coverage terminated).

Lastly, contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention with dates of service on and after February 27, 2006.

You may find more information about approval of the \$50 additional payment for NTIOL Category 3 by reviewing CR 4361, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R914CP.pdf> on the CMS website. The revised *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.2 (10.2 - Ambulatory Surgical Center Services on ASC List) and 40.3 (Payment for Intraocular Lens (IOL)) are attached to CR 4361.

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

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

MLN Matters Number: MM4361 *Revised*

Related Change Request (CR) #: 4361

Related CR Release Date: April 21, 2006

Effective Date: February 27, 2006

Related CR Transmittal #: R914CP

Implementation Date: May 22, 2006

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

Additional Clarification of CR 3816 Business Requirements—Low Vision Rehabilitation Demonstration

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

Provider Types Affected

Physicians and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for treatment provided to beneficiaries under the Low Vision Rehabilitation Demonstration Project

Providers Action Needed

This article is based on Change Request (CR) 5023 and this article actually revises the article for CR 3816 by providing specific information clarifying billing instructions as directed in the Administrative Simplification Compliance Act (ASCA). Be aware that:

- National Provider Identification (NPI) numbers replace physician UPIN numbers by May 23, 2007.
- CR 3816 for the Low Vision Rehabilitation Demonstration states that **providers** are to document the plan of care by indicating the date the plan was developed or reviewed in Block 19 (Reserved for Local Use) of the CMS-1500 or its electronic equivalent.
- This is no longer necessary for claims submission for the Low Vision Rehabilitation Demonstration.
- **Facilities** must document the date the plan of care was established or reviewed using occurrence code 17 on CMS-1450 or its electronic equivalent.
- This is no longer necessary for claims submission for the low vision rehabilitation demonstration.

Background

According to CR 3816, the date the plan of care was established was to be placed in Block 19 of the CMS 1500 form. However, there is no place for this information in the electronic claims form. Therefore, this requirement has been removed; whether submitting a paper claim or an electronic claim by providers or facilities.

In addition, although the business requirements in CR 3816 mention use of remittance advice messages, and the background makes reference to using the most appropriate Medicare summary notice (MSN) messages unless specified

otherwise in the business requirements, there is no corresponding reference to the remittance advice message in the background.

Please note that your carrier/FI will use the most appropriate remittance advice and remark codes when denying a claim unless otherwise specified in CR 3816.

Implementation

The implementation date for the instruction is July 28, 2006.

Additional Information

For details of enforcement of the ASCA, please see related MLN Matters article MM3440, "Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims," at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3440.pdf> on the CMS website.

To view the MLN Matters article related to CR 3816, go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3816.pdf> on the CMS website.

The official instructions issued to your intermediary or carrier regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R46DEMO.pdf> on the CMS website.

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.pdf> on the CMS website.

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

MLN Matters Number: MM5023
 Related Change Request (CR) #: 5023
 Related CR Release Date: April 28, 2006
 Effective Date: July 28, 2006
 Related CR Transmittal #: R46DEMO
 Implementation Date: July 28, 2006

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Information on Additional Payment for NTIOLs to Ambulatory Surgical Centers

Per transmittal R914CP (change request 4361) dated April 21, 2006, effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare will pay an additional \$50 to ambulatory surgical centers (ASCs) for new technology intraocular lenses (NTIOLs) that CMS recognizes as belonging to NTIOL Category 3 (Reduced Spherical Aberration).

Information regarding the lenses that are classified in NTIOL Category 3 is posted at http://www.cms.hhs.gov/CoverageGenInfo/09_NTIOLs.asp.

Additional information about NTIOLs is posted at <http://www.cms.hhs.gov/center/coverage.asp>.

Or, refer to Pub 100-04, *Medicare Claims Processing*, Chapter 14, Section 40.3, which can be accessed on the following Web page: <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>.

Source: Provider Education Resources Listserv, Message 200605-25

HIPAA - THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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 (RA) 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 Medicare Remit Easy Print (MREP) software as tool providers can use to read and print an electronic remittance advice (RA) 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 electronic RA 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 standard paper remittance advices (SPRs) to providers/suppliers, billing agents, clearing houses, or other entities representing providers, who also have been receiving electronic remittance advice (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.

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/apps/contacts/> on the CMS website.

*Medicare Remit Easy Print Update, continued***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

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Medicare Remit Easy Print Version 1.8 Now Available

Version 1.8 includes many improvements, including the latest version of the Claim Adjustment Reason Codes and the Remittance Advice Remark Codes, as well as:

- A new Coordination of Benefits (COB) report showing claims that were crossed over;
- An import functionality for the Claim Adjustment Reason Codes and Remittance Advice Remark Code updates, so a full version does not need to be reinstalled for code updates only;
- An enhanced search functionality, including for the date of service;
- An enhanced Deductible/Coinsurance report to show both deductible and coinsurance amounts greater than zero, as well as those claims with only the coinsurance dollar amount greater than zero;
- More claim detail on the reports;
- When a service line is denied, the number of submitted units will display. The paid units will display when a service line is paid;
- Display of check date instead of 835 production transaction date; and
- A late filing charge correction

In addition, there are some changes to the User Guide and install/uninstall instructions. Remember you can save time and money by taking advantage of FREE Medicare Remit Easy Print software available to view and print the HIPAA compliant 835!"

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

NATIONAL PROVIDER IDENTIFIER

Do you have your National Provider Identifier number yet?

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

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

NPI Timeline

Electronic claim submitters only

January 3, 2006 – October 1, 2006 NPI optional and Medicare numbers required

October 2, 2006 – May 22, 2007 NPI and Medicare number

May 23, 2007 – Forward NPI only

Small health plans have until May 23, 2008

Important Note!

Paper claim submitters

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

EDI Information

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

Florida: www.floridamedicare.com

Connecticut: www.connecticutmedicare.com

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

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

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

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

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

National Provider Identifier Information

Background: The National Provider Identifier (NPI) will replace the provider identification numbers that providers use today in the HIPAA standard transactions that they conduct with health plans. Those transactions include the electronic claim, eligibility inquiry and response, claim status inquiry and response, payment and remittance advice, prior authorization/referral, and coordination of benefits transactions.

Providers who conduct any of those electronic transactions must have their NPIs and be ready to use them to identify themselves, and possibly other providers, in those transactions before May 23, 2007. That is only a year from now. Some health plans might be ready to accept NPIs much earlier than next May. The health plans with whom you do business will inform you as to when you may begin using your NPIs in these electronic transactions.

- CMS reminds health care providers that they need to obtain their NPIs.
- Today, approximately 530,000 providers who are individuals and organizations have obtained their NPIs.
- Providers can obtain NPIs by:
 - “ Going to the web at <https://nppes.cms.hhs.gov> and filling out their application on line.
 - “ Obtaining a paper application form, filling it out, and mailing it to the NPI enumerator. They can obtain the paper application form (CMS-10114) by downloading it from <http://www.cms.hhs.gov/forms> or by calling the NPI enumerator at 1-800-465-3203 and requesting a copy.

National Provider Identifier Information, continued

- “ Submitting an application through Electronic File Interchange (EFI). EFI allows an approved organization, after obtaining the permission of a provider, to send the provider’s NPI application data to us in an electronic file.
- Medicare organization providers are required by the NPI final rule to determine if they have subparts and if those subparts should have their own NPIs. Many enrolled Medicare providers are actually subparts of other enrolled Medicare providers who are their “parents.” In January 2006, Medicare posted a paper about the subpart concept and its effect on Medicare organization providers (downloadable from <http://www.cms.hhs.gov/NationalProvIdentStand>, click on “Medicare NPI Implementation” on the left). Medicare encourages its enrolled organization providers to become familiar with the contents of that paper if they have not already done so, and to use that paper in making decisions concerning subparts and their assignment of NPIs.
- Providers and suppliers are required to include their NPI on the 04/2006 version of the CMS-855 Medicare enrollment application when they apply to enroll in Medicare.
- Medicare will accept either the Medicare provider number (the legacy provider number) or the NPI and the Medicare provider number (both numbers) on the claims it receives from providers through October 2, 2006.
- Beginning October 2, 2006, and continuing through May 22, 2007, Medicare will accept the NPI or the Medicare provider number (legacy provider number) on the claims it receives from providers. If there is any issue with the provider’s NPI and no Medicare provider number is included on the claim, the provider might not be paid. Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare provider number (the legacy provider number) as a secondary identifier until May 22, 2007.
- CMS has posted many documents related to the NPI, including Medicare’s timetable for implementation of the NPI, on its NPI Web page: <http://www.cms.hhs.gov/NationalProvIdentStand>. We urge you to visit that website and become familiar with the NPI and how it will be used, if you have not already done so.
- We encourage all organizations and associations to inform their members about the need to obtain, test, and use the NPI.

Source: CMS Provider Education Resources Listserv, Message 200605-22

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

Facilitating Your Medicare Enrollment

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately.**

Initially, these applications will be available only from the CMS provider enrollment website. The link for that CMS website is listed in the *Additional Information* section of this article.

Key Points

This Special Edition provides additional information regarding the submission of a Medicare enrollment application.

All Provider Enrollment Applications

To ensure timely processing of your application, make certain to completely fill out the application and provide all required supporting documentation at the time of filing.

Section 17 of the Medicare enrollment application lists the types of supporting documentation that you will need to submit with your enrollment application. In addition to providing the documentation previously required, all applicants are required to:

- Submit their National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application; and

National Provider Identifier Enumeration System—Countdown Reminder, continued

- Complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT – making a change to their enrollment information.

To obtain a list of specific supporting documentation that you must submit with your enrollment application, contact the designated Medicare fee-for-service contractor serving your area before submitting your application.

Contractor Request for Additional Information

At any time during the enrollment process, your carrier or FI may request documentation to support or validate information that you have reported on your application. Applicants are responsible for providing this documentation in a timely manner. Failure to provide documentation in a timely manner may delay your enrollment into the Medicare program.

Applications Received Through June 2, 2006

Medicare contractors will continue to accept the 11/2001 version of the Medicare enrollment applications through June 2, 2006, as long as the application is complete and contains the NPI notification from NPES. In addition, providers and suppliers who choose to use the 11/2001 version of the 855 will be required to complete and submit Section 1 or Section 4 (completed by the provider) of the 04/06 version of the CMS-855. Providing this information will ensure that Medicare is able to link existing Medicare identification number(s) to the NPI that the provider or suppliers plan to use for billing purposes.

Specifically, physician assistants and providers reassigning all of their benefits must complete Section 1, as this is where NPI data is reported. All other providers must furnish the NPI and Medicare Identification Number in Section 4 of the CMS-855; this is the only data that must be reported in Section 4.

Applications Received On or After June 5, 2006

All applications received on or after June 5, 2006, must be filed using the 04/06 version of the CMS-855 and contain all supporting documentation, including the NPI notification and the CMS-588.

Additional Information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit <http://www.cms.hhs.gov/MedicareProviderSupEnroll> on the CMS website.

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

Special Edition article SE0612 and SE0632 contain helpful information about the Medicare enrollment process. You may review the article on the CMS website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf>, and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0632.pdf>, respectively, on the CMS website.

MLN Matters Number: SE0634

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

On **May 1, 2006**, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately.**

Initially, these applications will be available only from the CMS provider enrollment website. The link for that CMS website is listed in the *Additional Information* section of this article.

Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see *Key Points* below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

Key Points

This special edition outlines the significant revisions to the Medicare enrollment applications and they are as follows:

Enhancements

- Improved the application's aesthetics via a more visually appealing format, larger font, clarified headings, and the use of plain language;
- Revised cover page to include instructions that help applicants submit the correct enrollment application, inform applicants where to mail the application, and provide information on the documents that must be furnished with the enrollment application;
- Added tips on how to avoid delays in the enrollment process; and
- Redesigned Section 17 (Supporting Documentation) to make it easier for providers and suppliers to know which documents must be submitted with an enrollment application.

Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications, continued**Significant Changes**

- Require the submission of the National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application;
- Require that providers and suppliers complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT – making a change to their enrollment information; and,
- Removed Sections 9 (Electronic Claims Submission Information), 10 (Staffing Companies), and 11 (Surety Bonds) from the application. In addition, information regarding overpayments no longer must be submitted.

Application-Specific Changes for Physicians and Non-Physician Practitioners (CMS-855I)

- A sole proprietor who incorporates (and who is the sole owner of that business) only needs to complete the CMS 855I form. In the past, such suppliers had to complete the CMS 855B, CMS 855I and CMS 855R.

However, the person will still need to report information about the practice, such as the legal business name and adverse legal history.

Application-Specific Changes for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)

- Removed the requirement to collect crewmember and certain vehicle information from ambulance companies in Attachment 1 of the application.

- Revised the independent diagnostic testing facility information contained in Attachment 2 of the application.

Application-Specific Changes for Institutional Providers (CMS-855A)

- Eliminated questions dealing with fiscal intermediary preferences. This change implements section 911(d) (2) (B) of the Medicare Modernization Act.

See MLN Matters article SE0582 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0582.pdf> for further information.

Additional Information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit <http://www.cms.hhs.gov/MedicareProviderSupEnroll> on the CMS website.

Special Edition article SE0612 contains helpful information about the Medicare enrollment process. You may review the article on the CMS website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf> on the CMS website.

MLN Matters Number: SE0632
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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Revised CMS 855 Medicare Provider Enrollment Applications

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised CMS 855 Medicare provider enrollment applications. As part of the revised enrollment process, initial enrollees and existing enrollees making changes to their enrollment information must include their National Provider Identifier (NPI) number and a copy of the National Plan and Provider Enumeration System (NPPES) NPI notification with the enrollment application. No initial application can be approved and no updates to existing enrollment information can be made without this NPI information.

All health care providers and suppliers who bill Medicare are required to obtain their NPI in advance of enrolling in or changing their Medicare enrollment data.

If you are an individual or sole proprietor, who furnishes health care, you are eligible for one and only one NPI. If you are an individual who is a health care provider and who is incorporated, you may need to obtain an NPI for yourself and an NPI for your corporation or LLC. If you are an organization that furnishes health care, you may determine that you have components, called “subparts,” that need their own NPI. For additional information about the NPI, please go to <http://www.cms.hhs.gov/NationalProvIdentStand/>.

If you have not yet obtained your NPI number, CMS encourages you to do so soon. This applies even if you are not enrolling or making a change to your Medicare enrollment information. An information sheet designed to provide basic information about the NPI, including the three different ways to apply for your NPI is available at http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/EnrollmentSheet_WWWWH.pdf.

Whatever method you use to obtain your NPI, be sure to keep this information, share it with your health care partners, and update your information with NPPES whenever any of the information used to get your NPI changes.

Starting May 23, 2007, the NPI will replace all of your existing provider numbers that you use to bill Medicare, Medicaid, and other health care payers. Although this date is still a year away, you should begin sharing this information with Medicare, other payers, and your other health care partners in order to make the transition to NPI as smooth as possible.

For more information about the revised provider enrollment process, please contact your Medicare contractor or go to <http://www.cms.hhs.gov/MedicareProviderSupEnroll>.

Source: CMS Provider Education Resources Listserv, Message 200605-16

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.

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 MA 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 which 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 MA plan enrollment period are identified by Medicare's common working file (CWF); and
- An informational unsolicited response (IUR) record is created.
- In essence, the retroactive enrollment triggers a search for fee-for-service claims that were incorrectly paid for services rendered when the beneficiary was covered by the MA plan. If such claims are found, the system generates an adjustment and initiation by Medicare systems of overpayment recovery procedures. The current policy/procedures, as outlined in CR 2801 (Transmittal AB-03-101, dated July 18, 2003) and CR 5105, dictates that:
 - Claims paid in error (due to enrollment or disenrollment corrections) will be adjusted, and
 - Medicare contractors will initiate overpayment recovery procedures.

Note: CR 2801 (Transmittal AB-03-101, dated July 18, 2003) can be found at

<http://www.cms.hhs.gov/Transmittals/Downloads/AB03101.pdf> on the CMS website:

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

A variety of the CMS systems issues over the past 18 months have prompted CMS to recently synchronize MA enrollment and disenrollment information for the period September 2003 to April 2006. As a result, providers may have claims that were affected by this synchronization. To see 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 MA 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 MA plan on the date of service;
 - That the provider should bill the managed care plan;
 - What the plan identification number is; and
 - Where to find the plan name and address associated with the plan number on the CMS website.
- For providers who bill FIs, the adjustment will occur automatically and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly.

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

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

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* (Pub.100-06, Ch. 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/R97FM.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.pdf> on the CMS website.

MLN Matters Number: MM5105

Related Change Request (CR) #: 5105

Related CR Release Date: May 26, 2006

Effective Date: October 1, 2003

Related CR Transmittal #: R97FM

Implementation Date: June 26, 2006

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Medicare Policy Regarding 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.

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.

Background

Once the Centers for Medicare & Medicaid Services (CMS) data system recognizes a beneficiary has enrolled in a MA organization, the MA organization receives capitation payments for the beneficiary. In some cases, enrollments with retroactive dates are processed. The result is that Medicare may pay for the services rendered during a specific period twice; once for the specific service which was paid by the fee-for-service Medicare contractor and secondly by the MA payment systems in the monthly capitation rate to the plan. Change Request 5105 and MLN Matters 5105 (see <http://www.cms.hhs.gov/MLNArticles/downloads/MM5105.pdf>) describe how CMS ensures that any fee-for-service claims that are approved for payment erroneously are adjusted and overpayments recovered by Medicare carriers and/or FIs.

A variety of CMS systems issues over the past 18 months prompted CMS to recently synchronize Medicare Advantage enrollment and disenrollment information. As a result, providers may have claims that were affected by this synchronization in one of two ways, both of which are addressed below.

Scenario 1. Claims Paid in Error

About 386,000 claims for about 100,000 beneficiaries enrolled in MA organizations have been identified as having been paid on a fee-for-service basis by FIs or carriers during this time. FIs and carriers will, over the next 6 months, adjust these claims and seek overpayments.

Where such an overpayment is recovered from a provider, 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 MA plan for payment.

Providers who bill carriers:

The carrier will alert you via letter or alternate method of the following:

- The beneficiary was in a MA plan on the date of service;
- You should bill the managed care plan;
- The plan identification number; and
- Where to find the plan name and address associated with the plan number on the CMS Internet site.

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

GENERAL INFORMATION

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

The number that will appear on the contractor notices will begin with 'H'. For the following 11 plans, the alpha prefix is actually an 'R'. A technical correction will be made in CMS systems in October 2006. Prior to October, when using the Web page look up tool, make sure to replace the 'H' with an 'R'. The 11 plans are:

R3175	R5674
R5287	R5826
R5342	R5863
R5553	R5941
R5566	R9943
R5595	

MA Plans have been notified:

MA plans know that the resynchronization may result in an increase in payment requests from providers who had claims previously paid, but subsequently overturned by fee-for-service FIs and carriers. Whenever CMS reverses fee-for-service payments as a result of confirmed retroactive enrollment in an MA plan, the provider must bill the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary. The Medicare beneficiary call center representatives at 1-800-MEDICARE have been trained to answer beneficiary inquiries that may arise in these situations.

Scenario 2. Claims Denied in Error

Because CMS has synchronized Medicare Advantage enrollment and disenrollment information, it is possible that fee-for-service claims were previously denied because the beneficiary was incorrectly identified as being a member of an MA plan. If a provider believes past claims have been denied in error due to problems in enrollment and disenrollment information, those claims can now be resubmitted. For any Part B services, the 10% reduction for timely filing will be waived.

Additional Information

For more information regarding the manualization of this policy, see the MLN Matters article at <http://www.cms.hhs.gov/MLNArticles/downloads/MM5105.pdf> on the CMS website.

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

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

MLN Matters Number: SE0638
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: 5105
Effective Date: N/A
Implementation Date: N/A

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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

Quarterly Medicare Summary Notice Printing Cycle

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries

Impact on Providers

This article is based on Change Request (CR) 5062, which instructs Medicare contractors (carriers, DMERCs, FIs, and RHHIs) to print and mail no-pay Medicare summary notices (MSNs) on a quarterly schedule (rather than the current monthly schedule).

Background

Current Centers for Medicare & Medicaid Services (CMS) instructions require all Medicare contractors to issue a MSN to each beneficiary for whom a claim was processed during the last 30 days (possibly for services received more than 30 days ago) to inform the beneficiary of the disposition of all claims (i.e., a record of services received, the status of any deductibles, and appeal rights).

In an effort to reduce overall operating costs, CR 5062 instructs your intermediary/carrier to change from their current monthly (30 day) no-pay MSN mailing schedule to a quarterly (90 day) no-pay MSN mailing schedule. All MSN information should continue to print; however, summations will occur on a quarterly basis as opposed to a monthly basis.

No-Pay MSNs are the standard, system-generated MSNs produced for beneficiaries in which Medicare did not issue payment to the beneficiary for the respective claim. Beneficiaries often need these MSNs in order to obtain payment from another payer/insurer.

In those situations where a no-pay MSN is needed or lost by a beneficiary, they can request a no-pay MSN by calling 1-800 Medicare. On-demand requests will be generated and mailed once the request is made.

In summary, CR 5062 provides the following instructions:

- Beginning no later than October 1, 2006, Medicare contractors will issue no-pay MSNs on a quarterly/90-day mailing cycle as opposed to the previous monthly/30-day mailing cycle;
- MSNs with checks will continue to be mailed out as processed; and
- If a beneficiary requests a monthly no-pay MSN (as opposed to the quarterly MSN), then Medicare contractors must generate and mail out the MSN at the time of the request.

Implementation

The implementation date for the instruction is June 12, 2006, for carriers, July 3, 2006, for DMERCs, and September 1, 2006 for FIs.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R955CP.pdf> on the CMS website.

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

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

MLN Matters Number: MM5062
 Related CR Release Date: May 12, 2006
 Related CR Transmittal #: R955CP

Related Change Request (CR) #: 5062
 Effective Date: Carriers-June 12, DMERCs July 1, FIs- September 1
 Implementation Date: Carriers, June 12, DMERCs, July 3, FIs-Sept. 1

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Remittance Advice Reminder

Are you receiving an electronic remittance advice (ERA)? Have you tried Medicare Remit Easy Print (MREP) Software? As of June 1, 2006, if you have been receiving **both** an ERA, either directly from your Medicare carrier/DMERC or indirectly from a clearinghouse, billing agent, or other entity representing you, **and** a SPR from your carrier/DMERC for 45 days or more, **you will no longer be mailed an SPR** by your carrier/DMERC, in accordance with Change Request (CR) 4376. Check out Special Edition MLN Matters article SE0627 that outlines some of the options available to providers who will no longer receive the SPR directly from their carrier/DMERC. The article is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf> on the CMS website.

For more information about MREP software or about receiving a HIPAA-compliant ERA, please contact your Medicare carrier or DMERC, or go to their website. Medicare Part B Electronic Data Interchange (EDI) Helpline phone numbers are available at <http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartBEDIHelpline.pdf> on the CMS website.

Source: Provider Education Resources Listserv, Message 200605-19

Understanding The Remittance Advice Guide Now Available in CD ROM

The Medicare Learning Network is pleased to announce that Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers is now available on CD ROM.

Copies of this CD ROM may be ordered, free of charge, through the Medicare Learning Network's (MLN) Product Ordering Page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website. This publication may also be downloaded and viewed online at the following url <http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=keyword&filterValue=remit&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=> on the MLN publications page.

The Web version of the "RA Guide" may be reprinted or redistributed as needed. Hard copies of the "RA Guide" will be available later this spring.

Source: Provider Education Resources Listserv, Message 200605-06

Announcing the Revised Medicare Physician Guide

The revised *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (previously titled Medicare Resident & New Physician Guide: Helping Health Care Professionals Navigate Medicare) 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 website. The guide will be available in print format in approximately six weeks.

Source: Provider Education Resources Listserv, Message 200605-20

Hold on Medicare Payments—Full Replacement of CR4349

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

Provider Types Affected

Providers and physicians who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) for their services

Key Points

- A brief hold will be placed on Medicare payments for ALL claims (e.g., initial claims, adjustment claims, and Medicare Secondary Payer (MSP) claims) for the last **nine** days of the federal fiscal year, i.e., September 22, 2006-September 30, 2006.
- In essence, no payments on claims will be made from September 22-30, 2006. Providers need to be aware of these payment delays, which are mandated by section 5203 of the Deficit Reduction Act (DRA) of 2006.
- Accelerated payments using normal procedures will be considered
- No interest will be accrued or paid, and no late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.
- All claims held as a result of this one-time policy that would have otherwise been paid on one of these 9 days will be paid on October 2, 2006.

Additional Information

This policy applies only to claims subject to payment. It does not apply to full denials and no pay claims. It also does not apply to periodic interim payments, home health request for anticipated payments; cost reports settlements, and other non-claim payments.

Additionally, Medicare contractors will continue to apply the fourteen-day electronic claim payment floor and the 29-day paper claim payment floor. On a case-by-case basis, Medicare FIs, RHHIs or carriers may make adjustments, after October 1, 2006, for extenuating circumstances raised by a provider. For example, adjustments may be made to not charge a provider interest on an overpayment for those days for which offsets could not be made due to the hold of payments required by this DRA provision.

Full Replacement of CR4349, Hold on Medicare Payments. CR4349 Is Rescinded, continued

Please note that:

- Payments will not be staggered; and
- No advance payments during the nine day hold will be allowed.

CR 5047 is the official instruction issued to your FI, RHHI, or carrier regarding changes mentioned in this article. CR 5047 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R944CP.pdf> on the CMS website.

Please refer to your local FI/RHHI or carrier if you have questions about this issue.

To find their toll free phone number, go to

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

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

MLN Matters Number: MM5047

Related Change Request (CR) #: 5047

Related CR Release Date: May 10, 2006

Effective Date: September 22, 2006

Related CR Transmittal #: R944CP

Implementation Date: July 3, 2006

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Modifications to Online Medicare Secondary Payer Questionnaire: This CR Rescinds and Replaces CR 4098

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

Provider Types Affected

Medicare physicians/providers/suppliers that, upon providing services to a Medicare patient, use a questionnaire to determine other insurance coverage that may be primary to Medicare

Provider Action Needed

STOP – Impact to You

Questions have arisen over Part V of the model Medicare Secondary Payer Questionnaire.

CAUTION – What You Need to Know

CR 5087 provides clarification regarding Part V, provides major revisions to other parts of the model Medicare Secondary Payer Questionnaire, and rescinds and replaces CR 4098.

GO – What You Need to Do

You should replace any previous versions of the model questionnaire with the new version, available as an attachment to CR 5087.

Background

In 1980, Congress enacted provisions that made Medicare the secondary payer to certain additional primary plans (group health plans, workers' compensation plans, liability insurance, or no-fault insurance). To help you identify such Medicare Secondary Payer (MSP) situations, CMS has developed a model Medicare Secondary Payer Questionnaire (found in IOM 100.05 (Medicare Secondary Payer Manual) Chapter 3, Section 20.2.1). You can use this model questionnaire as a guide, at each inpatient and outpatient admission, to help identify other payers that may be primary to Medicare. CR 4098 (released October 21, 2005) made changes to this model questionnaire that has generated several questions, specifically regarding PART V (Disability).

In response, CR 5087 (from which this article is taken) incorporates the changes that were made in CR 4098, modifies the changes previously made to PART V to address the questions that have arisen, and makes additional changes to other parts of the model questionnaire to improve the wording and sequencing of questions in these parts.

The changes to the model questionnaire are too numerous to list here. As such, please refer directly to the revised section in the *Medicare Secondary Payer (MSP) Manual*, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1 (Admission Questions to Ask Medicare Beneficiaries) which contains the complete, updated model questionnaire. The changes are identified in redline and italics.

Please keep in mind the following:

1. This questionnaire is a model. Other questions may be added to help identify other payers that may be primary to Medicare.
2. If you choose to use this model questionnaire, please be aware that it was developed to be used in sequence. The Instructions listed after the questions are to direct the patient to the next appropriate question to facilitate transition between questions.

Modifications to Online MSP Questionnaire: This CR Rescinds and Replaces CR 4098, continued

Additional Information

You may find more information about the Medicare Secondary Payer Questionnaire by viewing CR 5087 at <http://www.cms.hhs.gov/Transmittals/downloads/R53MSP.pdf>. Attached to the CR is the revised section of the *Medicare Secondary Payer (MSP) Manual*, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements),

Section 20.2.1 (Admission Questions to Ask Medicare Beneficiaries) which contains the complete, updated model questionnaire.

If you have any questions, please contact your carrier (including durable medical equipment regional carrier), fiscal intermediary, or regional home health intermediary at their toll-free number, which may be found at

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

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

MLN Matters Number: MM5087

Related Change Request (CR) #: 5087

Related CR Release Date: June 9, 2006

Effective Date: September 11, 2006

Related CR Transmittal #: R53MSP

Implementation Date: September 11, 2006

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Do Not Forward Initiative—Reminder

As part of the Do Not Forward (DNF) Initiative, the Centers for Medicare & Medicaid Services (CMS) has instructed Medicare carriers and DMERCs to use “return service requested” envelopes for all provider remittance advice mailings.

This requirement applies to the provider Medicare checks and remittance advices. When a provider check or remittance advice is returned to the carrier because of “return service requested”, the following will occur:

- The carrier will flag the provider number as DNF.
- Provider Enrollment will be notified of provider’s new status.
- The carrier will stop sending paper checks and remittance advices to the provider.
- Electronic fund transfers will be stopped.

Only upon verification and update of all the provider’s addresses will the flag be removed. Not only will the “pay to” address be verified, but also all “provider location” addresses will be verified. It is important that providers notify Medicare **immediately** of any change of address by complete.

Once the DNF flag has been removed, the carrier will:

- Pay any funds held due to DNF
- Reissue any remittance notices held due to DNF

Source: Publication 100-04, Chapter 22, Section 50.1.

Clinical Laboratory Improvement Amendments Brochure

The Clinical Laboratory Improvement Amendments (CLIA) brochure has been updated and is now available in downloadable format on the Medicare Learning Network’s (MLN) Products page located at <http://www.cms.hhs.gov/MLNProducts/downloads/CLIABrochure.pdf>.

The brochure includes an overview of CLIA, why it is important, how test methods are categorized, enrollment information, as well as information regarding the five types of laboratory certificates. A hard copy of the brochure will be available early this summer and will be available for ordering on the MLN publications page at

<http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp>.

Source: Source: Provider Education Resources Listserv, Message 200606-05

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.

Coverage of Prescription Niacin Products Under Part D for 2006

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

Provider Types Affected

Physicians and other providers who prescribe medications for Medicare patients under Medicare Part D

Key Points

- On April 11, 2006, the Centers for Medicare & Medicaid Services (CMS) informed Medicare Part D prescription drug coverage plans, via a memorandum titled “**CMS Clarification of Coverage of Prescription Niacin Under Part D**,” that was issued over the Health Plan Management System (HPMS), that prescription niacin products (Niaspan®, Niacor®) can be a covered Part D drug for treatment of dyslipidemic therapy and may be included on Medicare prescription drug plan formularies. Medicare prescription drug plans have the option of covering those drugs immediately.
- For the remainder of contract year 2006, Medicare Part D plans may put prescription niacin products (Niaspan®, Niacor®) on their formularies, but they are not required to do so. As a result, enrollees may obtain coverage of prescription niacin products either as a formulary drug or as a non-formulary drug through the exceptions process.
- For contract year 2007, prescription niacin products (e.g., Niaspan® and Niacor®) used at dosages much higher than appropriate for nutritional supplementation should be considered for formulary inclusion similar to all other Medicare Part D drugs.
- Please refer to the *Additional Information* section of this Special Edition article for specific information regarding two methods for Part D Medicare beneficiary enrollees to obtain prescription niacin products for the remainder of 2006

Background

The prescription niacin products are used therapeutically for the treatment of dyslipidemia at much higher dosages than are appropriate for nutritional supplementation. They do not serve as a nutritional supplement or to address a vitamin deficiency. For these reasons, CMS has decided that prescription niacin products should not be considered a prescription vitamin for purposes of Medicare Part D coverage.

Prescription niacin products are not universally excluded from coverage under the Medicare prescription drug program. This reverses an earlier February 3, 2006 decision by CMS that prescription niacin products (Niaspan®, Niacor®) are prescription vitamins and therefore are excluded from the definition of a Medicare Part D drug under the statute.

Additional Information

Prescribing Prescription Niacin products (Niaspan®, Niacor®) for the Remainder of 2006

For Medicare beneficiaries in plans that INCLUDE prescription niacin products on their formulary:

- If prescription niacin products **are not subject** to prior authorization – a Medicare prescriber writes a prescription for the prescription Niacin product and the Part D enrollee has the prescription filled at a local retail pharmacy or a mail order pharmacy. If the enrollee is a resident of a long term care facility, the prescription will be filled by the long term care pharmacy serving that facility.
- If prescription niacin products **are subject** to prior authorization—the Medicare prescriber must file a prior authorization request on behalf of the enrollee.

Each Medicare Part D plan has its own form, available on the plans’ websites (some plans have specific forms for particular drugs; others use a standard prior authorization form).

- Plans must approve or inform the enrollee why they have disapproved a prior authorization request within 72 hours. An enrollee or an enrollee’s physician can request an “expedited coverage determination” for a decision within 24 hours if the enrollee’s health, life, or ability to regain maximum function may be seriously jeopardized by waiting 72 hours for a decision.
- If a Medicare Part D plan disapproves a prior authorization request (i.e., makes an “adverse coverage determination”), the enrollee has the right to request a redetermination from the plan sponsor (see below).

For plans that **do not** have prescription niacin products (Niaspan®, Niacor®) on their formularies:

- If a Medicare beneficiary is currently taking a prescription niacin product and is enrolled in a Medicare Part D plan that does not include prescription niacin products on its formulary, the beneficiary can now ask for an exception to get coverage for a prescription niacin product (see below).
- If a Medicare beneficiary who is currently taking a prescription Niacin product enrolls in a Medicare Part D plan that does not include prescription niacin products on its formulary, the plan is required to have a process to ensure the enrollee’s smooth transition into the plan and to allow the enrollee time to obtain medically necessary exceptions to the plan’s formulary.
- Many Medicare Part D plans have adopted a “first fill” policy that will allow enrollees to have their first prescription for the prescription niacin product filled even if prescription niacin product are not on the plan’s formulary. This will allow Medicare beneficiaries who have been stabilized on a prescription niacin product to continue taking it while they request exceptions.
- The transition process is a very temporary solution, however, and enrollees and providers should not delay pursuing exceptions. Prescribers may advise enrollees to contact their plans for more information about their plan’s transition process.

Coverage of Prescription Niacin Products Under Part D for 2006, continued

Exceptions and Appeals

If a physician prescribes a non-formulary drug for an enrollee, the enrollee or physician must request an exception, which is a type of coverage determination, to obtain the non-formulary drug for the enrollee. If the plan sponsor's coverage determination is unfavorable, the enrollee may appeal the plan sponsor's decision.

Exceptions

An enrollee or an enrollee's physician has the right to request an **exception** for coverage of non-formulary prescription niacin products. The enrollee's prescribing physician should submit a statement supporting the exception request. The Part D plan must notify the enrollee of its decision within 72 hours after receiving the physician's supporting statement. If the enrollee or physician requests an expedited decision, the plan sponsor must notify the enrollee of its decision within 24 hours after receiving the physician's supporting statement if the plan determines, or the enrollee's physician indicates, that applying the 72-hour timeframe may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

The plan must grant the exception if it determines that the requested drug is medically necessary, consistent with the physician's statement. The Medicare provider physician's statement must state that the exception is medically necessary to treat the Medicare beneficiary enrollee's disease or medical condition because all of the covered Medicare Part D drugs on any tier of the plan's formulary for treatment of the same condition would not be as effective as prescription niacin products, would have adverse effects, or both.

Appeals

If a plan sponsor issues an adverse coverage determination, the decision may be appealed. There are five successive levels of appeal.

- If a plan sponsor issues an unfavorable coverage determination, the enrollee has the right to request a standard or expedited **redetermination** with the plan sponsor within 60 calendar days from the date of the notice of the plan sponsor's adverse coverage determination. Enrollees or their prescribing physician can submit written evidence and legal arguments for coverage of prescription niacin products during the redetermination process. The plan sponsor must notify the enrollee of its decision within seven calendar days after receiving a standard request, or 72 hours after receiving an expedited request.
- If the plan sponsor's redetermination decision is unfavorable, the enrollee has the right to request **reconsideration** by the independent sponsor review entity (IRE) that contracts with CMS. This request must be submitted in writing within 60 calendar days from the date of the notice of the plan sponsor's adverse redetermination decision. The IRE must solicit the views of the prescribing physician orally or in writing and must notify the enrollee of its decision within seven calendar days after receiving a standard request, or 72 hours after receiving an expedited request.
- If the IRE denies the request for coverage and the amount remaining in controversy is at least \$110, the Medicare beneficiary enrollee has the right to request a **hearing before an administrative law judge (ALJ)**. The request must be filed in writing within 60 calendar days from the date of the notice of the IRE's adverse reconsideration determination.
- If the ALJ's decision is unfavorable, the enrollee has the right to request a review by the **Medicare Appeals Council**. The request must be filed in writing within 60 calendar days from the date of the notice of the ALJ's adverse decision.
- If the MAC issues an adverse decision, the enrollee has the right to request judicial review of the ALJ's decision by **filing a civil action in U.S. District Court** if the amount remaining in controversy is at least \$1,090. The request must be filed in writing within 60 calendar days from the date of the notice of the MAC's adverse decision.

For additional information, CMS has a number of MLN Matters special edition articles on the new drug program, especially the fourth and fifth articles in the MLN Matters series about Medicare's new prescription drug coverage.

SE0537, *New Educational Products Available*, is the fourth article in the series and may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0537.pdf> on the CMS website.

SE0541, *More Web-based Educational Products Available on Medicare Prescription Drug Coverage*, is the fifth article in the series. It is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0541.pdf> on the CMS website.

MLN Matters Number: SE0626	Related Change Request (CR) #: N/A
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Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens—Update to Section 1011

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

Provider Types Affected

Physicians, hospitals, and ambulance services that provide emergency health services to undocumented aliens.

Impact on Providers

STOP – Impact to You

You may not be receiving funds that are available to you for services you furnish to undocumented aliens, and the Centers for Medicare & Medicaid Services (CMS) is providing this special edition article to inform and/or remind you about these available funds.

CAUTION – What You Need to Know

The Medicare Prescription Drug Improvement and Modernization Act (MMA) (Section 1011) provides \$250 million each year for fiscal years (FY) 2005-2008 for payments to eligible providers for emergency health services given to undocumented and other specified aliens. You may be eligible to receive some of these funds.

GO – What You Need to Do

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

Background

CMS previously issued MLN Matters Special Edition article SE0535 (MMA – CMS' Implementation of Section 1011 of the Medicare Modernization Act – Federal Funding of Emergency Health Services Furnished to Undocumented Aliens) to inform physicians, hospitals, and ambulance services about the federal funding available to help pay for services furnished to undocumented aliens. (See SE0535 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0535.pdf> on the CMS website.)

Because some providers may not be utilizing these available funds, CMS is issuing this additional special edition article to inform (and remind) providers about the funds that are available for emergency health services furnished to undocumented aliens.

The MMA (Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens) provides \$250 million each year for fiscal years (FY) 2005-2008 for payments to eligible providers for emergency health services given to undocumented and other specified aliens:

- Two-thirds of the funds are divided among all 50 states and the District of Columbia, based on their relative percentages of undocumented aliens; and
- One-third of the funds are divided among the six states with the largest number of undocumented alien apprehensions.

Note: Current state allocations of these funds may be viewed at

http://www.cms.hhs.gov/UndocAliens/04_state_alloc.asp#TopOfPage on the CMS website.

From the respective state allotments, payments are made directly to enrolled hospitals, physicians, and ambulance providers for some or all of the costs of providing emergency health care (required under Section 1867) and related hospital inpatient services, outpatient services, and ambulance services provided to eligible individuals.

As of May 1, 2006, nationally, over 9,000 provider enrollment applications have been approved. The first Section 1011 payment to providers was issued on February 27, 2006, totaling nearly \$25.5 million, and the next quarterly payment to providers was scheduled for May 29, 2006.

TrailBlazer Health Enterprises, LLC, is the national contractor for the Section 1011 program and is the only contractor for processing all requests for Section 1011 provider payments. So, if you want to request 1011 payments, you must do so by enrolling with TrailBlazer and then submit your requests to TrailBlazer. **Do NOT submit requests for 1011 payment to your regular fiscal intermediary or carrier.** To learn more about the Section 1011 program, or to enroll as a provider, see the TrailBlazer website at <https://www.trailblazerhealth.com/section1011/>.

TrailBlazer may also be contacted directly by telephone at (866) 860-1011.

Additional Information

Additional information regarding Section 1011 of the MMA and CMS' policy for the implementation and administration of this program may be found at <http://www.cms.hhs.gov/UndocAliens/> on the CMS website.

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Related CR Release Date: N/A	Effective Date: N/A
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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 Requirements for Low Vision Rehabilitation Demonstration Billing

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Second Quarter 2006 Medicare B Update! pages 70-74.

Note: Please note that MLN Matters article MM5023 contains updated information regarding remittance advice and remark codes and regarding the use of provider identifiers, especially UPINs and the National Provider Identifier. MM5023 is based on CR 5023, released on April 28, 2006. To see MM5023, go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5023.pdf> on the CMS website.

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

Physicians, providers, and suppliers should note that the Centers for Medicare & Medicaid Services (CMS) is:

- implementing an outpatient vision rehabilitation demonstration project in selected areas across the country to examine the impact of standardized Medicare coverage for vision rehabilitation services; and
- extending coverage under Part B for the same services to provide vision rehabilitation that would otherwise be payable when provided by an occupational or physical therapist if they are now provided by a vision rehabilitation professional under the general supervision of a qualified physician.

This demonstration project will last for five years through March 31, 2011, and is limited to services provided in specific demonstration locales. These areas are New Hampshire, New York City (all five boroughs), North Carolina, Atlanta, Kansas, and Washington State.

Background

The Secretary of the Department of Health and Human Services is directed to carry out an outpatient vision rehabilitation demonstration project as part of the FY 2004 appropriations conference report to accompany Public Law HR 2673. This demonstration project will examine the impact of standardized Medicare coverage for vision rehabilitation services provided in the home, office, or clinic, under the general supervision of a physician. The services may be supplied by the following:

- Physicians;
- Occupational therapists;
- Certified low vision therapists;
- Certified orientation and mobility specialists; and
- Certified vision rehabilitation therapists.

Under this low vision rehabilitation demonstration, Medicare is extending coverage under Part B for the same rehabilitation services to treat vision impairment that would otherwise be payable when provided by an occupational or physical therapist if they are now provided by a certified vision rehabilitation professional under the general supervision of a qualified physician.

This demonstration will last for five years through March 31, 2011, and is limited to services provided specifically in New Hampshire, New York City (all 5 boroughs), North Carolina, Atlanta, Kansas, and Washington State.

Payment for vision rehabilitation services under this demonstration may be made to:

- Either the qualified physician who is supervising the occupational therapist or certified vision rehabilitation professional; or an occupational therapist in private practice; or
- A qualified facility, such as a rehabilitation agency or clinic that has a contractual relationship with the certified vision rehabilitation professional; and
- Where the services are furnished under the individualized written plan of care.

Payment for these services will be made under the physician fee schedule even when such services are billed by a facility. They are not subject to bundling under the outpatient prospective payment system (OPPS).

Under this low vision rehabilitation demonstration, Medicare will cover low vision rehabilitation services to people with a medical diagnosis of moderate or severe vision impairment that is not correctable by conventional methods or surgery (i.e., cataracts).

Services will be provided under an individualized, written plan of care developed by a qualified physician or qualified Occupational Therapist in Private Practice (OTPP) that is reviewed at least every 30 days by a qualified physician.

The plan of care must attest that vision rehabilitation services are medically necessary and the beneficiary receiving vision rehabilitation is capable of receiving rehabilitation and deriving benefit from such services, and should include:

- An initial assessment that documents the level of visual impairment;
- Specific measurable goals to be fulfilled during rehabilitation and the criteria by which the goals will be measured;
- The location where the rehabilitation services will be conducted;
- Description of specific rehabilitative services to be directed toward each goal provided during the course of rehabilitation; and
- A reasonable estimate of the amount of treatment necessary to reach the goals.

New Requirements for Low Vision Rehabilitation Demonstration Billing, continued

Rehabilitative services will be conducted within a three-month period of time, in intervals appropriate to the patient’s rehabilitative needs, and will not exceed 36 units of 15 minutes each, or 9 hours total.

Rehabilitation will be judged completed when the treatment goals have been attained and any subsequent services would be for maintenance of a level of functional ability, or when the patient has demonstrated no progress on two consecutive visits.

All services covered under this demonstration are one-on-one, face-to-face services. Group services will not be covered.

Vision rehabilitation services will be furnished in an appropriate setting, including the home of the individual receiving the services, as specified in the plan of care and can be provided by the following:

- A qualified physician as defined in the Social Security Act (Section 1861r (1) and (4)) and who is an ophthalmologist or a doctor of optometry;
- A qualified occupational therapist in private practice;
- A qualified occupational therapist who is an employee of the physician; or
- A certified vision rehabilitation professional including low vision therapists, orientation and mobility specialists, and vision rehabilitation therapists who have received certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

Occupational therapists employed by the physician and certified vision rehabilitation professionals may furnish services while under the general supervision of a qualified physician.

General supervision means that the physician does not need to be “on premises” nor in the immediate vicinity of the rehabilitation services as would be the case with “incident to” requirements stated in Section 2050 of the *Medicare Carriers Manual*.

Payment for vision rehabilitation services will be made to the qualified physician under the Medicare physician fee schedule (MPFS) or to a facility, including the following:

- Hospitals;
- Comprehensive outpatient rehabilitation facilities (CORF);
- Other rehabilitation agencies or clinics; or
- Facilities that bill Medicare for providing occupational therapy, through which services are furnished under an individualized, written plan of care.

Occupational therapists in private practice may also submit claims under their own provider number for providing low vision rehabilitation services. However, for occupational therapists in private practice who are participating in the low vision rehabilitation demonstration, claims submitted must contain the same information as on a physician’s claim form and must use the demonstration “G” code for occupational therapists (G9041) for the claim to be considered.

Occupational therapists in private practice may not supervise therapy assistants or certified low vision rehabilitation professions, nor may they submit claims for the services of these individuals under the demonstration.

Certified vision rehabilitation professionals provide services pursuant to a plan of care and under the general supervision of the qualified physician who develops the plan of care. However, if the certified vision rehabilitation professional has a contractual arrangement with the facility where services are furnished, the facility may submit the bill for services.

Payment to practitioners and facilities will be made using the MPFS with jurisdictional pricing; vision services covered under the demonstration provided in a hospital outpatient setting will not be paid under the OPFS system.

Payment for services under this demonstration is limited to low vision rehabilitation. E&M services are not billable under the demonstration.

Vision impairment refers to significant vision loss from disease, injury or degenerative condition that cannot be corrected by conventional means, such as medication or surgery.

The impairment must be manifest by one or more of the conditions listed in the following table:

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnostic codes included

Levels of Vision Impairment	Description
Moderate Visual impairment	Best-corrected visual acuity is less than 20/60 in the better eye (including a range of 20/70 to 20/160)
Severe visual impairment (legal blindness)	Best-corrected visual acuity is less than 20/160 including 20/200 to 20/400; or visual field diameter is 20 degrees or less (largest field diameter for Goldman isopter III4e, 1/100 white test object or equivalent) in the better eye.
Profound visual impairment (moderate blindness)	Best-corrected visual acuity is less than 20/400, or visual field is 10 degrees or less.
Near-total visual impairment (severe blindness)	Best-corrected visual acuity is less than 20/1000, or visual field is five degrees or less.
Total visual impairment (total blindness)	No light perception

GENERAL INFORMATION

New Requirements for Low Vision Rehabilitation Demonstration Billing, continued

in the following table will be used to support medical necessity for coverage under the demonstration.

ICD-9-CM Code	Description	ICD-9-CM Code	Description
368.41	Scotoma involving central area	369.13	Better Eye: Severe Vision Impairment
368.45	Generalized contraction or constriction		Lesser Eye: Near-Total Vision Impairment
368.46	Homonymous Bilateral Field Defect	369.14	Better Eye: Severe Vision Impairment
368.47	Heteronymous Bilateral Field Defect		Lesser Eye: Profound Vision Impairment
369.01	Better Eye: Total Vision Impairment	369.16	Better Eye: Moderate Vision Impairment
	Lesser Eye: Total Vision Impairment		Lesser Eye: Total Vision Impairment
369.03	Better Eye: Near-Total Vision Impairment	369.17	Better Eye: Moderate Vision Impairment
	Lesser Eye: Total Vision Impairment		Lesser Eye: Near-Total Vision Impairment
369.04	Better Eye: Near-Total Vision Impairment	369.18	Better Eye: Moderate Vision Impairment
	Lesser Eye: Near-Total Vision Impairment		Lesser Eye: Profound Vision Impairment
369.06	Better Eye: Profound Vision Impairment	369.22	Better Eye: Severe Vision Impairment
	Lesser Eye: Total Vision Impairment		Lesser Eye: Severe Vision Impairment
369.07	Better Eye: Profound Vision Impairment	369.24	Better Eye: Moderate Vision Impairment
	Lesser Eye: Near-Total Vision Impairment		Lesser Eye: Severe Vision Impairment
369.08	Better Eye: Profound Vision Impairment	369.25	Better Eye: Moderate Vision Impairment
	Lesser Eye: Profound Vision Impairment		Lesser Eye: Moderate Vision Impairment
369.12	Better Eye: Severe Vision Impairment		
	Lesser Eye: Total Vision Impairment		

Most rehabilitation is short-term and intensive, and sessions are generally conducted over a consecutive 90-day period of time with intervals appropriate to the patient's rehabilitative needs.

Patients usually receive therapy one or two times per week, and not less frequently than once every two weeks. The sessions are generally 30-60 minutes in duration.

The physician should document periodic follow-up and evaluation at least every 30 days during the course of the rehabilitation.

For the purposes of this demonstration, vision rehabilitation services will not be subject to physical or occupational therapy caps.

CMS established four different series of temporary demonstration, or "G", codes to accommodate rehabilitation services for low vision. Each code series will correspond to the low vision rehabilitation professional that provided the service and will be included in the official instruction issued to your carrier/intermediary.

That instruction, CR 3816, may be viewed by going to <http://www.cms.hhs.gov/Transmittals/2005Trans/List.asp#TopOfPage> on the CMS website.

From that Web page, look for CR 3816 and CR 4294, and click on the files for those CRs. **Example "G" codes** include the following:

- Code G9041 for services provided by a qualified occupational therapist;
- Code G9042 for services provided by a certified orientation and mobility specialist;
- Code G9043 for services provided by a certified low vision rehabilitation therapist, and
- Code G9044 for services provided by a certified vision rehabilitation therapist.

Payable places of service (POS) for Part B claims include the following:

- Office (11)
- Home (12)
- Assisted living facility (13)
- Group home (14)
- Custodial care facility (33)
- Independent clinic (49)

In addition, facilities that are qualified to submit claims include the following:

- Outpatient hospital clinics (TOB 13x);
- Outpatient CAH clinics (TOB 85x);
- Comprehensive outpatient rehabilitation facilities (CORFs) (TOB 75x); and
- Freestanding rehabilitation clinics (TOB 74x).

Fiscal intermediaries (FIs) will use the claim related condition code 79 to indicate when services are provided outside the facility. When no condition code appears it will indicate that rehabilitation services were provided in the facility. Providers will be required to indicate either no code or code 79 on claims.

Facility claims will also use the revenue code 0949 (other rehabilitation services) in addition to the demonstration G-code, which indicates the type of professional who provided the rehabilitation service.

This will apply to all institutional settings and CAH outpatient departments. CAHs that elect to use method II billing will use revenue code 0969 or revenue code 0962, whichever is most appropriate.

Carriers will accept and process claims from qualified physicians when those claims include:

- An appropriate ICD-9-CM code that supports medical necessity;
- An appropriate rehabilitation ("G") code for the demonstration; and
- Evidence of a written plan of care that specifies the type and duration of the rehabilitative services being furnished.

The plan of care and date can be indicated in block 19 (Reserved for Local Use) of the CMS 1500. Facilities will use occurrence code 17 for the date the plan of care was established or reviewed.

Qualified physicians, occupational therapists, and low vision professionals practicing in designated demonstration areas may provide low vision rehabilitation services to eligible residents of the demonstration areas.

Approved demonstration locales are limited to the following; New Hampshire, New York City (all 5 Boroughs),

New Requirements for Low Vision Rehabilitation Demonstration Billing, continued

North Carolina, Atlanta, Kansas, and Washington State.

Providers should note that the residence of the beneficiary receiving services and the physician or facility providing the services must be in the same approved demonstration locale (state or metropolitan area) as determined by matching primary residence and primary practice zip codes.

Implementation

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

Additional Information

As mentioned above, CMS will establish four different series of temporary demonstration, or “G”, codes to accommodate rehabilitation services for low vision. Each code series will correspond to the low vision rehabilitation professional that provided the service and will be included in the official instruction issued to your carrier/intermediary.

You can view the official instruction issued to your carrier/intermediary for complete details regarding this change. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/2005Trans/List.asp#TopOfPage> on the CMS website. Search for 3816 and 4294 and click on the file for those CRs.

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

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

MLN Matters Number: MM3816 *Revised* Related Change Request (CR) #: 3816
 Related CR Release Date: June 7, 2005 Effective Date: April 1, 2006
 Related CR Transmittal #: R25DEMO Implementation Date: April 3, 2006

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May Is National Osteoporosis Awareness and Prevention Month

The Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to remind health care professionals that Medicare provides coverage of bone mass measurements once every 24 months (more often if medically necessary) for people with Medicare at risk for osteoporosis.

Osteoporosis (often called the “silent disease” because bone loss occurs without symptoms) is responsible for an estimated 1.5 million fractures annually – an event that often leads to a downward spiral in physical health and quality of life, including losing the ability to walk, stand up, or dress, and can lead to premature death. Twenty percent of senior citizens who suffer a hip fracture die within one year.

According to the US Surgeon General’s 2004 report *Bone Health and Osteoporosis: A Report of the Surgeon General*, due to the aging of the population and the previous lack of focus on bone health, the number of hip fractures in the United States could double or triple by the year 2020. The report found that many patients were not being given appropriate information about prevention; and many patients were not having appropriate testing to diagnose osteoporosis or establish osteoporosis risk.

What Can You Do?

National Osteoporosis Awareness and Prevention Month presents an excellent opportunity for you to promote prevention, detection, and treatment of osteoporosis.

- 1) Become familiar with Medicare’s coverage for bone mass measurements.
- 2) Talk with your patients about their risks for osteoporosis and prevention.
- 3) Encourage utilization of bone mass measurements for eligible Medicare patients.

Osteoporosis can be prevented. As a health care professional, you play a critical role in helping your patients maintain strong, healthy bones throughout their life. Please join with CMS in spreading the word about prevention and early detection of osteoporosis and encouraging the utilization of bone mass measurements for eligible Medicare patients.

For More Information

Special Edition MLN Matters Article SE0630 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0630.pdf> – provides information about the array of preventive services and screenings for which Medicare provides payment and lists the many resources developed by CMS to educate health care professionals about these services.

U.S. Department of Health and Human Services. *Bone Health and Osteoporosis: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Office of the Surgeon General, 2004. This document may be downloaded from the Department of Health and Human Services website at <http://www.hhs.gov/surgeongeneral/library/bonehealth/>.

The National Osteoporosis Foundation <http://www.nof.org> – to learn more about National Osteoporosis Awareness and Prevention Month.

Source: CMS Provider Education Resources Listserv, Message 200605-14

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.

Announcing New IVR Features

First Coast Service Options, Inc. (FCSO) strives to provide you, our customers, quick access to information and service to help you better manage your work. In keeping with our continuous service improvements, we are proud to announce the addition of new features to our Provider Interactive Voice Response Unit (IVR). You will now be able to use new speech recognition technology; as well as, the familiar touch-tone format, while navigating through the IVR to retrieve needed information. You can continue to access the IVR by dialing the same toll free number (877) 847-4992.

Authentication

Please have the following information available for authentication, to protect the privacy of all individuals (HIPAA requirement), to access patient eligibility, deductible and claims information via the IVR.

- Provider Number
- Provider Name
- Beneficiary Medicare Number
- Beneficiary Name as printed on the Red, White, and Blue Medicare Card
- Beneficiary Date of Birth
- Date of Service (If applicable)

Speech Recognition

This new feature has been added under all the menu options where authentication is required, and can be used when responding in the IVR. In order to optimize results when speaking, we offer the following tips:

- Use a telephone with a handset or headset
- Avoid using a speakerphone or cell phone
- Avoid calling from areas with loud background noise
- Speak the requested information clearly

Note: After two unsuccessful attempts of voicing the requested information, you will be required to key the information on the third attempt.

Touch Tone Tips

In the event the system does not accept the spoken information, touch-tone is still available and can be used under all menu options. In order to receive the desired results, when using touch-tone, we offer the following tips:

- Enter dates in the following format (MMDDYYYY)
- Press * to signal you are entering an alpha suffix or letter.
- Press the key that includes the letter, then the corresponding number that denotes where the letter is located on the number key.
- Press the pound (#) sign after all desired letters have been keyed to end your entry.

Additional assistance is available throughout the IVR and/or on the Provider IVR Operating guide, which is available at: <http://www.floridamedicare.com>.

“WE WILLKEEPYOU UPDATED”

**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>

EDUCATIONAL RESOURCES

Upcoming Educational Events—Fourth Quarter 2006

Date	Event Description	Event Time	Event Type
July 12	CT Medicare Website Overview and Navigation Tips —Basic navigation of the CT Medicare website including recent enhancements based on user feedback.	2:00 PM–3:30 PM	Webcast*
July 26	Home Health —Qualifications for coverage, certification/recertification and plan of care requirements.	1:00 PM–2:00 PM	Teleconference
August 8	Hot Topics —Topics based on data analysis; session includes discussion of new initiatives and changes in the Medicare program.	1:00 PM–2:30 PM	Teleconference
August 23	Ask the Contractor Teleconference (ACT) —Topic to be determined	12:00 PM–1:00 PM	Teleconference
September 6	Provider Outreach & Education Advisory Group (POE AG) Meeting —2007 education initiatives planning session. For membership information, visit the POE AG (formerly PCOM AG) page on www.connecticutmedicare.com .	8:30 AM–10:30 AM	In-Person Meeting (Location to be determined)
September 14	National Correct Coding Initiatives (NCCI) Webcast —NCCI policies, using the two NCCI tables, and correct application of modifiers.	11:00 AM–12:30 PM	Webcast*
September 20	Hot Topics Live! — Topics based on data analysis; session includes discussion of new initiatives and changes in the Medicare program.	8:30 AM–11:00 AM & 1:00 PM–3:30 PM (Two separate sessions)	In-Person Meeting (Location to be determined)

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

Please Note:

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

**FLORIDA MEDICARE
PART B MAIL
DIRECTORY**

CLAIMS SUBMISSIONS

Routine Paper Claims

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

Participating Providers

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

Chiropractic Claims

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

Ambulance Claims

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

Medicare Secondary Payer

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

ESRD Claims

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

COMMUNICATIONS

Redetermination Requests

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

Fair Hearing Requests

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

Administrative Law Judge Hearing

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

Status/General Inquiries

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

Overpayments

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

**DURABLE MEDICAL EQUIPMENT
(DME)**

DME, Orthotic or Prosthetic Claims

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

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and

Inquiries

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

**MEDICARE PART B ADDITIONAL
DEVELOPMENT**

Within 40 days of initial request:

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

Over 40 days of initial request:

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

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

MISCELLANEOUS

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

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

Provider Change of Address:

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

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

Provider Education:

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

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

For Seminar Registration:

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

Limiting Charge Issues:

For Processing Errors:

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

For Refund Verification:

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

Medicare Claims for Railroad

Retirees:

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

Fraud and Abuse

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

**FLORIDA
MEDICARE
PHONE NUMBERS**

BENEFICIARY

Toll-Free:

1-800-MEDICARE

Hearing Impaired:

1-800-754-7820

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

PROVIDERS

Toll-Free

Customer Service:
1-866-454-9007

Interactive Voice Response (IVR):

1-877-847-4992

For Seminar Registration Only (not toll-free):

1-904-791-8103

EMC

Format Issues & Testing:

1-904-354-5977 option 4

Start-Up & Front-End Edits/Rejects:

1-904-791-8767 option 1

Electronic Funds Transfer

1-904-791-8016

Electronic Remittance Advice, Electronic

Claim Status, & Electronic Eligibility:

1-904-791-6895

PC-ACE Support:

1-904-355-0313

Marketing:

1-904-791-8767 option 1

New Installations:

(new electronic senders; change of address or phone number for senders):

1-904-791-8608

Help Desk:

(Confirmation/Transmission):

1-904-905-8880 option 1

OCR

Printer Specifications/Test Claims:

1-904-791-8132

DME, Orthotic or Prosthetic Claims

Palmetto GBA Medicare

1-866-270-4909

MEDICARE PART A

Toll-Free:

1-866-270-4909

Medicare Websites

PROVIDERS

Florida Medicare Contractor

www.floridamedicare.com

Centers for Medicare & Medicaid

Services

www.cms.hhs.gov

BENEFICIARIES

Centers for Medicare & Medicaid

Services

www.medicare.gov

ORDER FORM

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

