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

Highlights In This Issue…

Features

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

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 _____

_____

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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Vol. 4, No. 2
Second Quarter 2006

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

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

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

A PHYSICIAN'S FOCUS

Medicare Part B Coverage of Drugs and Biologicals – Special Focus on the Unlabeled Use of Anti-Cancer Drugs

Medicare Part B covers medically reasonable and necessary outpatient drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. With few exceptions, Medicare Part B does generally not reimburse for drugs that can be self-administered, such as those in pill form, or are used for self-injection. This is not to be confused with the new Medicare Part D benefit.

The "incident to" provision requires that the drug or biologic must be of a form that is not usually self-administered, must be furnished by a physician, and must be administered by the physician, or by auxiliary personnel employed by the physician or by the same entity by which the physician is employed and under the physician's personal supervision. CMS has provided instructions how to establish whether a drug is usually self-administered by the patient. Based on these, this contractor posts a "List of Excluded Self-Administered Injectable Drugs Incident to a Physician's Service" that are usually self-administered and thus not covered under Medicare Part B (*http://www.floridamedicare.com/partb_sad_FLB%20-%20List%20of%20Excluded%20Injectable%20Drugs.pdf*).

In order to be covered under Medicare, use of a drug or biological must be safe and effective and otherwise reasonable and medically necessary. Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for approved indications as specified on the labeling. Medical necessity is, however, determined by the carrier at the local level. Unless stated otherwise in a national (NCD) or local coverage determination (LCD), drugs and biologicals would be generally covered for their FDA-approved (labeled) indications.

An unlabeled use of a drug is a use that is not included as an indication on the drug's label as approved by the FDA. Under certain circumstances, FDA approved drugs used for indications other than listed on the official label may be covered under Medicare. In the case of the coverage of unlabeled drugs used in an anti-cancer chemotherapeutic regimen, CMS has established certain evidentiary criteria that are essentially based on support in accepted compendia, high phase clinical trials, and supportive evidence in reputable peer reviewed literature. The resulting payment decisions would be made on a case-by-case basis.

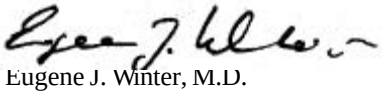
Until now, it was reasonable to assume that an FDA approved anti-cancer drug was covered only for its FDA-approved indications and the unlabeled indications as specifically listed in a NCD or LCD. Conversely, an assumption of noncoverage should have been made for any unlabeled indication not supported in an LCD or NCD. Such local and national positive coverage statements may not be readily available, especially in the case of newer agents. The publishing of new policies may take many months.

In the absence of a LCD or NCD, services are evaluated individually. This may lead to many pre- and/or post-payment reviews and numerous appeals without certainty of payment. Any time there is uncertainty whether Medicare's medical reasonableness and necessity criteria would be met; an advance beneficiary notice (ABN) is required. Furthermore, the individual review process is time consuming and is associated with possibly delayed access to care, paper work, and cash flow issues. This is magnified by the fact that the unlabeled use of anti-cancer drugs is not an uncommon practice.

After careful review of Medicare's rules and regulations, First Coast Service Options, Inc. (FCSO) is piloting a process that we hope will alleviate the above problems and reduce the bureaucratic and other burdens on all parties involved.

Effective March 1, 2006, an anti-cancer drug that meets all general program requirements may be considered medically reasonable and necessary for its FDA-approved indications and its "off-label" indications, as supported by the CMS approved compendia, unless there is a national or local statement to the contrary. This approach, in essence, accepts the endorsement of the editorial panels of the approved compendia as expert opinion and as a proxy for the review of clinical research that appears in peer-reviewed medical literature. It will result in the automated payment of most claims for unlabeled indications of FDA-approved anti-cancer drugs, as long as these indications are supported in the compendia approved by CMS and as long as there is no local or national statement to the contrary. An article outlining the details of this provision has been posted on our website *http://www.connecticutmedicare.com/1partb_articles_Medicare%20Coverage%20of%20Anti-Cancer%20Drugs.asp.* This applies only to the labeled and unlabeled uses of anti-cancer drugs for the treatment of malignant neoplastic conditions. Other drugs and biologicals and/or the use of anti-cancer drugs for non-cancerous conditions are outside the scope of this publication.

This is a local project without claiming any validity on the national level and without an attempt to set a precedent. We hope that it will create a win-win situation for the patients, providers, and the Medicare program in our jurisdiction.



Eugene J. Winter, M.D.
FCSO Medical Director

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

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

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

Who Receives the *Update?*

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

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

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

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

Clear Identification of State-Specific Content

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

Publication Format

The *Update!* is arranged into distinct sections.

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

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

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

An **Index** to the year's previous issues of the *Update!* and a Part B Materials order form are included in the back of the publication.

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

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

Advance Beneficiary Notices (ABNs)

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

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

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

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

New Patient Liability Notice

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

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

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

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

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

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

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

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

OR

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

CLAIMS

Bonus Payments for Services in Health Professional Shortage Areas

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: This article was revised on January 18, 2006, to reflect web addresses corresponding to the new CMS website.

Provider Types Affected

Critical Access Hospitals (CAHs) and psychiatrists

Provider Action Needed

This instruction clarifies MM3108 by adding Critical Access Hospital (CAHs) as eligible for the mental health HPSA bonus payment. This bonus is designed for psychiatric services rendered in an eligible CAH.

To be eligible, the CAH must receive payment under the Optional Method (Method II) payment rules and is located in a mental health area.

Background

If a CAH, which has elected the Optional Method (Method II), is located within a mental health HPSA, psychiatrists providing (outpatient) professional services in the CAH are eligible for the Mental Health HPSA bonus payments. When billing for this service, the CAH must bill using Revenue Code 961 plus the applicable HCPCS.

This Mental Health HPSA bonus will be paid to the CAH on a quarterly basis by their Medicare fiscal intermediary (FI). Also, the CAH should note that if their area is designated as both a mental health HPSA and a primary medical care HPSA, only one 10% bonus payment will be paid for the service.

Additional Information

This change will be implemented by your FI on July 6, 2004 and will apply to services rendered on or after July 1, 2004. To view the actual instruction issued to your FI, go to *http://www.cms.hhs.gov/Transmittals/downloads/R203CP.pdf* on the CMS website.

Also, please see the related article, MM3108, at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3108.pdf* on the CMS website.

Medlearn Matters Number: MM3336
Related Change Request (CR) #: 3336
Related CR Release Date: June 10, 2004
Effective Date: July 1, 2004
Related CR Transmittal #: R203CP
Implementation Date: July 6, 2004

Implementation of Change Request 3622

An article titled "Re-review of Previously Denied Claims Prohibited—CR3622" published in the Fourth Quarter 2005 Medicare Part B Update! (page 15) and the First Quarter 2006 Medicare Part B Update! (page 15).

The Center for Medicaid and Medicare Services (CMS) has delayed the implementation for change request 3622 until further notice. Providers should disregard information pertaining to change request 3622 until an implementation date is established and published.

First Coast Service Options, Inc. (FCSO) apologizes for any inconvenience this may have caused.

Source: CMS Joint Signature Memorandum (JSM) 05550, dated September 27, 2005

Correct Coding Initiative Issues

If you have concerns regarding specific CCI edits, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

Attention: Niles R. Rosen, M.D., Medical Director and Linda S. Dietz, RHIA, CCS, CCS-P, Coding Specialist

Fax #: 317-571-1745

If you are interested in purchasing The CCI Edits Manual from the National Technical Information Service (NTIS), visit the website at *http://www.ntis.gov/products/families/cci/* or contact by phone at 1-800-363-2068 or 703-605-6060.

Source: National Correct Coding Initiatives Edits page of the CMS website *http://www.cms.hhs.gov/NationalCorrectCodInitEd/*

Revision to the Medicare Claims Processing Manual Regarding Accessing Information on Use of the "AQ" Modifier

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians and providers billing Medicare carriers for services provided in a Health Professional Shortage Area (HPSA)

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4182, which revises the *Medicare Claims Processing Manual* (Chapter 12, Sections 90.4.1.1 and 90.4.2).

CAUTION – What You Need to Know

CR4182 instructs carriers and providers to visit the Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs) bonus payments web pages on the Centers for Medicare & Medicaid Services (CMS) website for instructions on determining a census tract when self designating through the use of the "AQ" modifier.

GO – What You Need to Do

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

Background

CMS is removing instructions on how to determine census tracts when self designating through the use of the "AQ" modifier (physician providing a service in a HPSA) from the *Medicare Claims Processing Manual* (Pub. 100-04) and placing the instructions on the HPSAs and PSAs specialty Web pages. This is being done as a result of recent inquiries CMS has received and because of the volatility of data on other government web sites that CMS depends upon to determine census tract information.

Beginning with 2005, an automated file of designations is updated on an annual basis and will be effective for services rendered with dates of service on or after January 1 of each calendar year beginning January 1, 2005, through December 31, 2005.

Physicians are allowed to self-designate throughout the year for newly designated HPSAs and HPSAs not included in the automated file based on the date of the data run used to create the file. To determine whether an "AQ" modifier is needed, physicians must review the information (referred to as "Instructions on Using the HPSA/PSA Specialty Page") provided on the CMS website for HPSA designations to determine if the location where they render services is, indeed, within a HPSA bonus area. The specific CMS website for this information is at *http://new.cms.hhs.gov/HPSAPSAPhysicianBonuses*.

Implementation

The implementation date for this instruction is February 6, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier *http://www.cms.hhs.gov/Transmittals/downloads/R807CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4182
Related Change Request (CR) #: 4182
Related CR Release Date: January 6, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R807CP
Implementation Date: February 6, 2006

Processing All Diagnosis Codes Reported on Claims Submitted to Carriers

The following sections of the Internet Only Manual are being revised or added to reflect processing of all diagnosis codes reported on a claim.

New Section

80.6 – Processing All Diagnosis Codes Reported on Claims Submitted to Carriers
(Rev.735, Issued: 10-31-05, Effective: 04-01-06, Implementation: 04-03-06)

Carrier standard systems shall capture and process all diagnosis codes reported on a claim (both paper and electronic) up to the maximum permitted under the format. The CWF shall process and maintain all diagnosis codes reported to CWF on a carrier processed claim.

Revised Section

Only item 21 was revised as a result of this change.

10.4 - Items 14-33 - Provider of Service or Supplier Information
(Rev.735, Issued: 10-31-05, Effective: 04-01-06, Implementation: 04-03-06)

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM |DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Item 15 - Leave blank. Not required by Medicare.

Item 16 - If the patient is employed and is unable to work *in his/her* current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders nonphysician services for the patient. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.
The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name and Unique Physician Identification Number (UPIN). This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services; and
- Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list shall also show the ordering/referring physician's name and UPIN (the NPI will be used when implemented). For example, a surgeon shall complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned UPIN (the NPI will be used when implemented) appear in items 17 and 17a.
When a service is incident to the service of a physician or non-physician practitioner, the name and assigned UPIN (the NPI shall be used when implemented) of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in items 17 and 17a.
All physicians who order or refer Medicare beneficiaries or services shall obtain a UPIN (the NPI will be used when implemented) even though they may never bill Medicare directly. A physician who has not been assigned a UPIN shall contact the Medicare carrier.
When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN (the NPI will be used when implemented) of the physician supervising the limited licensed practitioner shall appear in items 17 and 17a.
When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service.
Enter the original ordering/referring physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the first claim form.
Enter the ordering (performing) physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service).
Surrogate UPINs - If the ordering/referring physician has not been assigned a UPIN (the NPI will be used when implemented), one of the surrogate UPINs listed below shall be used in item 17a. The surrogate UPIN used depends on the circumstances and is used only until the physician is assigned a UPIN. Enter the physician's name in item 17 and the surrogate UPIN in item 17a.
All surrogate UPINs, with the exception of retired physicians (RET00000), are temporary and may be used only until a UPIN is assigned. The carrier shall monitor claims with surrogate UPINs.
The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;
2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;
3. A doctor of podiatric medicine for purposes of §§(k),

Processing All Diagnosis Codes Reported on Claims Submitted to Carriers, continued

(m), (p)(1), and (s) and Section 1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

4. A doctor of optometry, but only with respect to the provision of items or services described in Section 1861(s) of the Act which he/she is legally authorized to perform as a doctor f optometry by the State in which he/she performs them; or
5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of Section 1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of Section 1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in Section 1862(a)(4) of the Act) are furnished.

Item 17a - Enter the CMS assigned UPIN (the NPI will be used when implemented) of the referring/ordering physician listed in item 17.
When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.
Contractors use the following surrogate UPINs for physicians who have not been assigned individual UPINs. Claims received with surrogate numbers will be tracked and possibly audited.

- Residents who are issued a UPIN in conjunction with activities outside of their residency status use that UPIN. For interns and residents without UPINs, use the 8-character surrogate UPIN RES00000;
- Retired physicians who were not issued a UPIN may use the surrogate RET00000;
- Physicians serving in the Department of Veterans Affairs or the U.S. Armed Services may use VAD00000;
- Physicians serving in the Public Health or Indian Health Services may use PHS00000;
- When the ordering/referring physician has not been assigned a UPIN and does not meet the criteria for using one of the surrogate UPINs, the biller may use the surrogate UPIN "OTH00000" until an individual UPIN is assigned.
- The UPIN must be entered in item 17a for hepatitis B claims.

NOTE: This field is required when a service was ordered or referred by a physician.

Item 18 - Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19 – Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when an independent physical or occupational therapist submits claims or a physician providing routine foot care submits claims. For physical or occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file.
Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.
Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.
Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.
Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.
Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)
Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.
Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.
When dental examinations are billed, enter the specific surgery for which the exam is being performed.
Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.
Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.
Enter demonstration ID number "30" for all national emphysema treatment trial claims.
Enter the pin (or UPIN when effective) of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, chapter 1, section 30.2.9.1 for additional information.)
Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

Processing All Diagnosis Codes Reported on Claims Submitted to Carriers, continued

Item 20 - Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test.
A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1. **NOTE:** This is a required field when billing for diagnostic tests subject to purchase price limitations.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.
Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.
For physicians performing care plan oversight services, enter the 6-digit Medicare provider number of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.
Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.
When a physician provides services to a beneficiary residing in a SNF and the services were rendered to a SNF beneficiary outside of the SNF, the physician shall enter the Medicare facility provider number of the SNF in item 23.

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate Form CMS-1500.

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than one day and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the location, using a place of service code, for each item used or service performed. This is a required field.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

Item 24C - Medicare providers are not required to complete this item.

Item 24D - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code.
Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.
Return as unprocessable if an "unlisted procedure code" or an NOC code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item 24E - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field. If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

Item 24F- Enter the charge for each listed service.

Item 24G - Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.
Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.
For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.
For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.

NOTE: This field should contain at least 1day or unit. The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable.

Item 24H - Leave blank. Not required by Medicare.

Item 24I - Leave blank. Not required by Medicare.

Item 24J - Leave blank. Not required by Medicare.

Item 24K - Enter the PIN (the NPI will be used when implemented) of the performing provider of service/supplier if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, show the individual PIN (or NPI when implemented) in the corresponding line item. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN (or NPI when implemented) of the supervisor in item 24k.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security

Processing All Diagnosis Codes Reported on Claims Submitted to Carriers, continued

Number. The participating provider of service or supplier Federal Tax ID number is required for a mandated Medigap transfer.

Item 26 - Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

Item 27 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.
The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 - Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 - Enter the total amount the patient paid on the covered services only.

Item 30 - Leave blank. Not required by Medicare.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.
In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or nonphysician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 - Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.

Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12.
Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.
Providers of service (namely physicians) shall identify the supplier 's name, address, ZIP code and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.
For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.
For durable medical, orthotic, and prosthetic claims, the name address, or PIN of the location where the order was accepted must be entered (DMERC only).
This field is required. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.
This item is completed whether the supplier 's personnel performs the work at the physician's office or at another location.
If a QB or QU modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered shall be entered if other than home.
If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.
Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed, and the PIN.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.
Enter the PIN (or NPI when implemented), for the performing provider of service/supplier who is **not** a member of a group practice.
Enter the group PIN (or NPI when implemented), for the performing provider of service/supplier who is a member of a group practice.
Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item.
Enter the group UPIN, including the 2-digit location identifier, for the performing practitioner/supplier who is a member of a group practice.

Source: Pub 100-04, Transmittal 735, Change Request 4097

AMBULANCE SERVICES

Ambulance Fee Schedule – Medical Conditions List and Instructions

The Medical Conditions List is intended primarily as an educational guideline. It will help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list information does not guarantee payment of the claim or payment for a certain level of service. Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, and miles traveled, all of which must be available in the event the claim is selected for medical review (MR) by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage. The Healthcare Common Procedure Coding System (HCPCS) code or the medical conditions list information by themselves is not sufficient to justify coverage. All current Medicare ambulance policies remain in place.

The CMS issued the Medical Conditions List as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. While the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are not precluded from use on ambulance claims, they are currently not required (per Health Insurance Portability and Accountability Act (HIPAA)) on most ambulance claims, and these codes generally do not trigger a payment or a denial of a claim. Some carriers and fiscal intermediaries have Local Coverage Determinations (LCD) in place that cite ICD-9-CM that can be added to the claim to assist in documenting that the services are reasonable and necessary, but this is not common. Since ICD-9-CM codes are not required and are not consistently used, not all carriers or fiscal intermediaries edit on this field, and it is not possible to edit on the narrative field. The ICD-9-CM codes are generally not part of the edit process, although the Medical Conditions List is available for those who do find it helpful in justifying that services are reasonable and necessary.

The Medical Conditions List is set up with an initial column of primary ICD-9-CM codes, followed by an alternative column of ICD-9-CM codes. The primary ICD-9-CM code column contains general ICD-9-CM codes that fit the transport conditions as described in the subsequent columns. Ambulance crew or billing staff with limited knowledge of ICD-9-CM coding would be expected to choose the one or one of the two ICD-9-CM codes listed in this column to describe the appropriate ambulance transport and then place the ICD-9-CM code in the space on the claim form designated for an ICD-9-CM code. The option to include other information in the narrative field always exists and can be used whenever an ambulance provider or supplier believes that the information may be useful for claims processing purposes. If an ambulance crew or billing staff member has more comprehensive clinical knowledge, then that person may select an ICD-9-CM code from the alternative ICD-9-CM code column. These ICD-9-CM codes are more specific and detailed. An ICD-9-CM code does not need to be selected from both the primary column and the alternative column. However, in several instances in the alternative ICD-9-CM code column, there is a selection of codes and the word "PLUS." In these instances, the ambulance provider or supplier would select an ICD-9-CM code from the first part of the alternative listing (before the word "PLUS") and at least one other ICD-9-CM code from the second part of the alternative listing (after the word "PLUS"). The ambulance claim form does provide space for the use of multiple ICD-9-CM codes. Please see the example below:

The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 (from the alternative column on the Medical Conditions List)). In addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 (fits the "PLUS any other code" requirement when using the alternative list for this condition (abnormal vital signs)). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other Abnormal Clinical Findings) would work just as well. None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.

While the medical conditions/ICD-9-CM code list is intended to be comprehensive, there may be unusual circumstances that warrant the need for ambulance services using ICD-9-CM codes not on this list. During the medical review process contractors may accept other relevant information from the providers or suppliers that will build the appropriate case that justifies the need for ambulance transport for a patient condition not found on the list.

Because it is critical to accurately communicate the condition of the patient during the ambulance transport, most claims will contain only the ICD-9-CM code that most closely informs the Medicare contractor why the patient required the ambulance transport. This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side. For example, if an Advanced Life Support (ALS) ambulance responds to a condition on the medical conditions list that warrants an ALS-level response and the patient's condition on-scene also corresponds to an ALS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport. (All claims are required to have HCPCS codes on them, and may have modifiers as well.) Similarly, if a Basic Life Support (BLS) ambulance responds to a condition on the medical conditions list that warrants a BLS-level response and the patient's condition on-scene also corresponds to a BLS-level condition, the submitted claim need only include the code that most accurately reflects the on scene condition of the patient as the reason for transport.

When a request for service is received by ambulance dispatch personnel for a condition that necessitates the skilled assessment of an advanced life support paramedic based upon the medical conditions list, an ALS-level

ambulance would be appropriately sent to the scene. If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the on-scene condition of the patient. Because in this example, this code corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level. In these cases, when MR is performed, the Medicare contractor will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

Contractors may have (or may develop) individual local policies that indicate that some codes are not appropriate for payment in some circumstances. These continue to remain in effect.

Information on appropriate use of transportation indicators:

When a claim is submitted for payment, an ICD-9-CM code from the medical conditions list that best describes the patient's condition and the medical necessity for the transport may be chosen. In addition to this code, one of the transportation indicators below may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim.

Air and Ground

- **Transportation Indicator "C1":** Transportation indicator "C1" indicates an inter-facility transport (to a higher level of care) determined necessary by the originating facility based upon EMTALA regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list.
- **Transportation Indicator "C2":** Transportation indicator "C2" indicates a patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.
- **Transportation Indicator "C3":** Transportation indicator "C3" may be included on claims as a secondary code where a response was made to a major incident or mechanism of injury. All such responses – regardless of the type of patient or patients found once on scene – are appropriately Advanced Level Service responses. A code that describes the patient's condition found on scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified. Some examples of these types of responses would include patient(s) trapped in machinery, explosions, a building fire with persons reported inside, major incidents involving aircraft, buses, subways, trains, watercraft and victims entrapped in vehicles.
- **Transportation Indicator "C4":** Transportation indicator "C4" indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appear to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.

Ground Only

- **Transportation Indicator "C5"**: Transportation indicator "C5" has been added for situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter for any number of reasons, but the ambulance service is informing you that although the patient transported had an ALS-level condition, the actual service rendered was through a BLS-level ambulance in a situation where an ALS-level ambulance was not available. For example, a BLS ambulance is dispatched at the emergency level to pick up a 76-year-old beneficiary who has undergone cataract surgery at the Eye Surgery Center. The patient is weak and dizzy with a history of high blood pressure, myocardial infarction, and insulin-dependent diabetes melitus. Therefore, the on-scene ICD-9-CM equivalent of the medical condition is 780.02 (unconscious, fainting, syncope, near syncope, weakness, or dizziness – ALS Emergency). In this case, the ICD-9-CM code 780.02 would be entered on the ambulance claim form as well as transportation indicator C5 to provide the further information that the BLS ambulance transported a patient with an ALS-level condition, but there was no intervention by an ALS service. This claim would be paid at the BLS level.

- **Transportation Indicator "C6"**: Transportation indicator "C6" has been added for situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. If once on scene, the crew determines that the patient requiring transport has a BLS-level condition, this transportation indicator should be included on the claim to indicate why the ALS-level response was indicated based upon the information obtained in the operation's dispatch center. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.

- **Transportation Indicator C7-** Transportation indicator "C7" is for those circumstances where IV medications were required en route. C7 is appropriately used for patients requiring ALS level transport in a nonemergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to selfadministered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.

Air Only

All "transportation indicators" imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.

- D1 Long Distance - patient's condition requires rapid transportation over a long distance.
- D2 Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.
- D3 Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits to the patient.
- D4 Pick up point not accessible by ground transportation.

You can find more information about the Ambulance Fee Schedule – Medical Conditions List by going to: *http://www.cms.hhs.gov/transmittals/Downloads/R395CP.pdf*

Source: Pub 100-04, Transmittal 789, Change Request 4221

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
Emergency Conditions - Non-Traumatic						
535.50	458.9, 780.2, 787.01, 787.02, 787.03, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60 through 789.69, or 789.40 through 789.49 PLUS any other code from 780 through 799 except 793, 794, and 795.	Severe abdominal pain	With other signs or symptoms	ALS	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	A0427/A0433
789.00	726.2, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, or 789.09.	Abdominal pain	Without other signs or symptoms	BLS		A0429
427.9	426.0, 426.3, 426.4, 426.6, 426.11, 426.13, 426.50, 426.53, 427.0, 427.1, 427.2, 427.31, 427.32, 427.41, 427.42, 427.5, 427.60, 427.61, 427.69, 427.81, 427.89, 785.0, 785.50, 785.51, 785.52, or 785.59.	Abnormal cardiac rhythm/Cardiac dysrythmia.	Potentially life-threatening	ALS	Bradycardia, junctional and ventricular blocks,non-sinus tachycardias, PVC's >6, bi and trigeminy, ventricular tachycardia , ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED Fired	A0427/A0433
780.8	782.5 or 782.6	Abnormal skin signs		ALS	Diaphorhesis, cyanosis, delayed cap refill, poor turgor, mottled.	A0427/A0433
796.4	458.9, 780.6, 785.9, 796.2, or 796.3 PLUS any other code from 780 through 799.	Abnormal vital signs (includes abnormal pulse oximetry).	With or without symptoms.	ALS		A0427/A0433

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
995.0	995.1, 995.2, 995.3, 995.4, 995.60, 995.61, 995.62, 995.63, 995.64, 995.65, 995.66, 995.67, 995.68, 995.69 or 995.7.	Allergic reaction	Potentially life-threatening	ALS	Other emergency conditions, rapid progression of symptoms, prior hx. Of anaphylaxis, wheezing, difficulty swallowing.	A0427/A0433
692.9	692.0, 692.1, 692.2, 692.3, 692.4, 692.5, 692.6, 692.70, 692.71, 692.72, 692.73, 692.74, 692.75, 692.76, 692.77, 692.79, 692.81, 692.82, 692.83, 692.89, 692.9, 693.0, 693.1, 693.8, 693.9, 695.9, 698.9, 708.9, 782.1.	Allergic reaction	Other	BLS	Hives, itching, rash, slow onset, local swelling, redness, erythema.	A0429
790.21	790.22, 250.02, or 250.03.	Blood glucose	Abnormal <80 or >250, with symptoms.	ALS	Altered mental status, vomiting, signs of dehydration.	A0427/A0433
799.1	786.02, 786.03, 786.04, or 786.09.	Respiratory arrest		ALS	Apnea, hypoventilation requiring ventilatory assistance and airway management.	A0427/A0433
786.05		Difficulty breathing		ALS		A0427/A0433
427.5		Cardiac arrest—Resuscitation in progress		ALS		A0427/A0433

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
786.50	786.51, 786.52, or 786.59.	Chest pain (non-traumatic)		ALS	Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC.	A0427/A0433
784.9	933.0 or 933.1.	Choking episode	Airway obstructed or partially obstructed	ALS		A0427/A0433
991.6		Cold exposure	Potentially life or limb threatening	ALS	Temperature< 95F, deep frost bite, other emergency conditions.	A0427/A0433
991.9	991.0, 991.1, 991.2, 991.3, or 991.4.	Cold exposure	With symptoms	BLS	Shivering, superficial frost bite, and other emergency conditions.	A0429
780.01	780.02, 780.03, or 780.09.	Altered level of consciousness (nontraumatic)		ALS	Acute condition with Glascow Coma Scale<15.	A0427/A0433
780.39	345.00, 345.01, 345.2, 345.3, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.80, 345.81, 345.90, 345.91, or 780.31.	Convulsions, Seizures	Seizing, immediate post-seizure, postictal, or at risk of seizure & requires medical monitoring/observation.	ALS		A0427/A0433
379.90	368.11, 368.12, or 379.91.	Eye symptoms, non-traumatic	Acute vision loss and/or severe pain	BLS		A0429

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
437.9	784.0 PLUS 781.0, 781.1, 781.2, 781.3, 781.4, or 781.8.	Non traumatic headache	With neurologic distress conditions or sudden severe onset	ALS		A0427/A0433
785.1		Cardiac Symptoms other than chest pain.	Palpitations, skipped beats	ALS		A0427/A0433
536.2	787.01, 787.02, 787.03, 780.79, 786.8, or 786.52.	Cardiac symptoms other than chest pain.	Atypical pain or other symptoms	ALS	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions.	A0427/A0433
992.5	992.0, 992.1, 992.3, 992.4, or 992.5.	Heat Exposure	Potentially life-threatening	ALS	Hot and dry skin, Temp>105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.	A0427/A0433
992.2	992.6, 992.7, 992.8, or 992.9.	Heat exposure	With symptoms	BLS	Muscle cramps, profuse sweating, fatigue.	A0429
459.0	569.3, 578.0, 578.1, 578.9, 596.7, 596.8, 623.8, 626.9, 637.1, 634.1, 666.00, 666.02, 666.04, 666.10, 666.12, 666.14, 666.20, 666.22, 666.24, 674.30, 674.32, 674.34, 786.3, 784.7, or 998.11.	Hemorrhage	Severe (quantity) and potentially life-threatening	ALS	Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis, hemoptysis, epistaxis, active post-surgical bleeding.	A0427/A0433

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
038.9	136.9, any other condition in the 001 through 139 code range which would require isolation.	Infectious diseases requiring isolation procedures / public health risk.		BLS		A0429
987.9	981, 982.0, 982.1, 982.2, 982.3, 982.4, 982.8, 983.0, 983.1, 983.2, 983.9, 984.0, 984.1, 984.8, 984.9, 985.0, 985.1, 985.2, 985.3, 985.4, 985.5, 985.6, 985.8, 985.9, 986, 987.0, 987.1, 987.2, 987.3, 987.4, 987.5, 987.6, 987.7, 987.8, 989.1, 989.2, 989.3, 989.4, 989.6, 989.7, 989.9, or 990.	Hazmat Exposure		ALS	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.	A0427/A0433
996.00	996.01, 996.02, 996.04, 996.09, 996.1, or 996.2.	Medical Device Failure	Life or limb threatening malfunction, failure, or complication.	ALS	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device.	A0427/A0433
996.30	996.31, 996.40, 996.41, 996.42, 996.43, 996.44, 996.45, 996.46, 996.47, 996.49, or 996.59.	Medical Device Failure	Health maintenance device failures that cannot be resolved on location.	BLS	Oxygen System supply malfunction, orthopedic device failure.	A0429
436	291.3, 293.82, 298.9, 344.9, 368.16, 369.9, 780.09, 780.4, 781.0, 781.2, 781.94, 781.99, 782.0, 784.3, 784.5, or 787.2.	Neurologic Distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait/ balance; slurred speech, unable to speak	ALS		A0427/A0433

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
780.99		Pain, severe not otherwise specified in this list.	Acute onset, unable to ambulate or sit due to intensity of pain.	ALS	Pain is the reason for the transport. Use severity scale (7–10 for severe pain) or patient receiving pharmalogic intervention	A0427/A0433
724.5	724.2 or 785.9.	Back pain—non-traumatic (T and/or LS).	Suspect cardiac or vascular etiology	ALS	Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain.	A0427/A0433
724.9	724.2, 724.5, 847.1, or 847.2.	Back pain—non-traumatic (T and/or LS).	Sudden onset of new neurologic symptoms	ALS	Neurologic distress list.	A0427/A0433
977.9	Any code from 960 through 979.	Poisons, ingested, injected, inhaled, absorbed.	Adverse drug reaction, poison exposure by inhalation, injection or absorption.	ALS		A0427/A0433
305.0	303.00, 303.01, 303.02, 303.03, or any code from 960 through 979.	Alcohol intoxication or drug overdose (suspected).	Unable to care for self and unable to ambulate. No airway compromise.	BLS		A0429
977.3		Severe alcohol intoxication.	Airway may or may not be at risk. Pharmacological intervention or cardiac monitoring may be needed. Decreased level of consciousness resulting or potentially resulting in airway compromise.	ALS		A0427/A0433
998.9	674.10, 674.12, 674.14, 674.20, 674.22, 674.24, 997.69, 998.31, 998.32, or 998.83.	Post—operative procedure complications.	Major wound dehiscence, evisceration, or requires special handling for transport.	BLS	Non-life threatening.	A0429
650	Any code from 660 through 669 or from 630 through 767.	Pregnancy complication/ Childbirth/Labor		ALS		A0427/A0433
292.9	291.0, 291.3, 291.81, 292.0, 292.81, 292.82, 292.83, 292.84, or 292.89.	Psychiatric/Behavioral	Abnormal mental status; drug withdrawal.	ALS	Disoriented, DT's, withdrawal symptoms	A0427/A0433

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
298.9	300.9	Psychiatric/Behavioral	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior	BLS	Suicidal, homicidal, or violent.	A0429
036.9	780.6 PLUS either 784.0 or 723.5.	Sick Person - Fever	Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes.	BLS	Suspected spinal meningitis.	A0429
787.01	787.02, 787.03, or 787.91.	Severe dehydration	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration.	ALS		A0427/A0433
780.02	780.2 or 780.4	Unconscious, fainting, syncope, near syncope, weakness, or dizziness.	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	ALS		A0427/A0433
Emergency Conditions—Trauma						
959.8	800.00 through 804.99, 807.4, 807.6, 808.8, 808.9, 812.00 through 812.59, 813.00 through 813.93, 813.93, 820.00 through 821.39, 823.00 through 823.92, 851.00 through 866.13, 870.0 through 879.9, 880.00 through 887.7, or 890.0 through 897.7.	Major trauma	As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: Glascow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20'', 20'' deformity in vehicle or 12'' deformity of patient compartment, auto pedestrian/ bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.	ALS	See "Condition Specific" Column	A0427/A0433
518.5		Other trauma	Need to monitor or maintain airway	ALS	Decreased LOC, bleeding into airway, trauma to head, face or neck.	A0427/A0433
958.2	870.0 through 879.9, 880.00 through 887.7, 890.0 through 897.7, or 900.00 through 904.9.	Other trauma	Major bleeding	ALS	Uncontrolled or significant bleeding.	A0427/A0433
829.0	805.00, 810.00 through 819.1, or 820.00 through 829.1.	Other trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport.	BLS	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee, and ankle, deformity of bone or joint.	A0429

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
880.00	880.00 through 887.7 or 890.0 through 897.7.	Other trauma	Penetrating extremity injuries	BLS	Isolated with bleeding stopped and good CSM.	A0429
886.0 or 895.0	886.1 or 895.1.	Other trauma	Amputation—digits	BLS		A0429
887.4 or 897.4	887.0, 887.1, 887.2, 887.3, 887.6, 887.7, 897.0, 897.1, 897.2, 897.3, 897.5, 897.6, or 897.7.	Other trauma	Amputation—all other	ALS		A0427/A0433
869.0 or 869.1	511.8, 512.8, 860.2, 860.3, 860.4, 860.5, 873.8, 873.9, or 959.01.	Other trauma	Suspected internal, head, chest, or abdominal injuries.	ALS	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration.	A0427/A0433
949.3	941.30 through 941.39, 942.30 through 942.39, 943.30 through 943.39, 944.30 through 944.38, 945.30 through 945.39, or 949.3.	Burns	Major—per American Burn Association (ABA)	ALS	Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma	A0427/A0433

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
949.2	941.20 through 941.29, 942.20 through 942.29, 943.20 through 943.29, 944.20 through 944.28, 945.20 through 945.29, or 949.2.	Burns	Minor—per ABA	BLS	Other burns than listed above.	A0429
989.5		Animal bites, stings, envenomation	Potentially life or limb-threatening	ALS	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.	A0427/A0433
879.8	Any code from 870.0 through 897.7.	Animal bites/sting/envenomation	Other	BLS	Local pain and swelling or special handling considerations (not related to obesity) and patient monitoring required.	A0429
994.0		Lightning		ALS		A0427/A0433
994.8		Electrocution		ALS		A0427/A0433
994.1		Near Drowning	Airway compromised during near drowning	ALS		A0427/A0433
921.9	870.0 through 870.9, 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, or 921.0 through 921.9.	Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	BLS		A0429
995.83	995.53 or V71.5 PLUS any code from 925.1 through 929.9, 930.0 through 939.9, 958.0 through 958.8, or 959.01 through 959.9.	Sexual assault	With major injuries	ALS	Reference Codes 959.8, 958.2, 869.0/869.1	A0427/A0433

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples (not all-inclusive)	HCPCS Crosswalk
995.80	995.53 or V71.5 PLUS any code from 910.0 through 919.9, 920 through 924.9, or 959.01 through 959.9.	Sexual assault	With minor or no injuries	BLS		A0429
Non-Emergency						
428.9		Cardiac/hemodynamic monitoring required en route.		ALS	Expectation monitoring is needed before and after transport.	A0426
518.81 or 518.89	V46.11 or V46.12.	Advanced airway management.		ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.	A0426, A0434
293.0		Chemical restraint.		ALS		A0426
496	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Suctioning required en route, need for titrated O2 therapy or IV fluid management.		BLS	Per transfer instructions.	A0428
786.09		Airway control/positioning required en route.		BLS	Per transfer instructions.	A0428
492.8	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route.		BLS	Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assistance.	A0428

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples (not all-inclusive)	HCPCS Crosswalk
298.9	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - in restraints.		BLS	Refer to definition in 42 C.F.R Sec. 482.13(e).	A0428
293.1		Patient Safety: Danger to self or others - monitoring.		BLS	Behavioral or cognitive risk such that patient requires monitoring for safety.	A0428
298.8	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others - seclusion (flight risk).		BLS	Behavorial or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 C.F.R. Sec. 482.13(f)(2) for definition	A0428
781.3	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity).		BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.	A0428

Ambulance Fee Schedule - Medical Conditions List

ICD9 Primary Code		Condition (General)	Condition (Specific)	Service Level	Comments and examples (not all-inclusive)	HCPCS Crosswalk
041.9		Special handling en route - isolation.		BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.	A0428
907.2		Special handling en route to reduce pain - orthopedic device.		BLS	Backboard, halotraction, use of pins and traction, etc. Pain may be present.	A0428
719.45 or 719.49	718.40, 718.45, 718.49, or 907.2.	Special handling en route - positioning requires specialized handling.		BLS	Requires special handling to avoid further injury (such as with >grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of <1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures —post-op hip as an example	A0428

Ambulance Fee Schedule - Medical Conditions List

Transportation Indicators

Transportation Indicators Air and Ground*	Transport Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C1	Interfacility Transport	EMTALA-certified inter-facility transfer to a higher level of care.	Beneficiary requires higher level of care.	BLS, ALS, SCT, FW, RW	Excludes patient-requested EMTALA transfer.	A0428, A0429, A0426, A0427, A0433, A0434
C2	Interfacility Transport	Service not available at originating facility, and must meet one or more emergency or non-emergency conditions.		BLS, ALS, SCT, FW, RW		A0428, A0429, A0426, A0427, A0433, A0434
C3	Emergency Trauma Dispatch Condition Code	Major Incident or Mechanism of Injury	**Major Incident-This transportation indicator is to be used ONLY as a secondary code when the on-scene encounter is a BLS-level patient.**	ALS	Trapped in machinery, close proximity to explosion, building fire with persons reported inside, major incident involving aircraft, bus, subway, metro, train and watercraft. Victim entrapped in vehicle.	A0427/A0433
C4	Medically necessary transport but not to the nearest facility.	BLS or ALS Response	Indicates to Carrier/Intermediary that an ambulance provided a medically necessary transport, but that the number of miles on the Medicare claim form may be excessive.	BLS/ALS	This should occur if the facility is on divert status or the particular service is not available at the time of transport only. In these instances the ambulance units should clearly document why the beneficiary was not transported to the nearest facility.	Based on transport level.
C5	BLS Transport of ALS-level Patient	ALS-Level Condition treated and transport by a BLS-level ambulance	**This transportation indicator is used for ALL situations where a BLS-level ambulance treats and transports a patient that presents an ALS-level condition. No ALS-level assessment or intervention occurs at all during the patient encounter.**	BLS		A0429

Ambulance Fee Schedule - Medical Conditions List

Transport Description Modifiers Air and Ground*	Transport Category	Transportation Indicator Description		Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
C6	ALS-level Response to BLS level Patient	ALS Response Required based upon appropriate Dispatch Protocols - BLS-level patient transport	**Indicates to Carrier/Intermediary that an ALS-level ambulance responded appropriately based upon the information received at the time the call was received in dispatch and after a clinically appropriate ALS-assessment was performed on scene, it was determined that the condition of the patient was at a BLS level. These claims, properly documented, should be reimbursed at an ALS-1 level based upon coverage guidelines under the Medicare Ambulance Fee Schedule.**	ALS		A0427
C7		IV meds required en route.	This transportation indicator is used for patients that require an ALS level transport in a non-emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.	ALS	Does not apply to self-administered IV medications.	A0426

Air Ambulance Transportation Indicators

Air Ambulance Transportation Indicators		Transportation Indicator Description	Service Level	Comments and Examples (not all-inclusive)	HCPCS Crosswalk
D1		Long Distance-patient's condition requires rapid transportation over a long distance	FW, RW	If the patient's condition warrants only.	A0430, A0431
D2		Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.	FW, RW		A0430, A0431
D3		Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits for the patient.	FW, RW		A0430, A0431
D4		Pick-up point not accessible by ground ambulance	FW, RW		A0430, A0431

Note: HCPCS Crosswalk to ALS1E (A0427) and ALS2 (A0433) would ultimately be determined by the number and type of ALS level services provided during transport. All medical condition codes can be crosswalked to fixed wing and rotor wing HCPCS provided the air ambulance service has documented the medical necessity for air ambulance service versus ground or water ambulance. As a result, codes A0430 (Fixed Wing) and A0431 (Rotor Wing) can be included in Column 7 for each condition listed.

DURABLE MEDICAL EQUIPMENT

October Quarterly Update for 2004 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the First Quarter 2005 Medicare B Update! page 33.

Note: This article was revised on January 20, 2006, to reflect Web addresses that conform to the new CMS website.

Provider Types Affected

Physicians, providers, and suppliers

Provider Action Needed

This instruction provides information for updating and implementing the October Quarterly 2004 fee schedule amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). It implements fee schedule amounts for new codes and revises any fee schedule amounts for existing codes that were calculated in error.

Background

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings (Social Security Act, Sections 1834(a), (h), and (i)). In addition, payment on a fee schedule basis is required for Parenteral and Enteral Nutrition (PEN) by regulations contained in 42 CFR 414.102.

This instruction implements fee schedule amounts for new codes, deletes certain codes, and revises any fee schedule amounts for existing codes that were calculated in error in prior updates. Specifically, the changes for this update are as follows:

- Codes A4363, E1400 thru E1404, K0137 thru K0139, K0168 thru K0181, K0190 thru K0192, K0277 thru K0279, K0284, K0400, K0417, K0419 thru K0439, and K0530 were deleted from the Healthcare Common Procedure Coding System (HCPCS) effective 12/31/1999. These codes were inadvertently included in the 2004 fee schedule file, and they are being removed with this update.
- Codes E1019 and E1021 are also being removed as they are not valid 2004 HCPCS codes.
- The 2004 Puerto Rico schedule amounts for codes A4351 and A4352 were based on incorrect pricing information. The durable medical equipment regional carriers (DMERCs) must revise the base fee schedule amounts for these codes as part of the October quarterly update.
- Codes K0630 thru K0649, representing Lumbar Sacral Orthosis products were added to the HCPCS effective April 1, 2004 and their fee schedule amounts were implemented on July 1, 2004.
- However, the Centers for Medicare & Medicaid Services (CMS) has determined that the fee schedule amounts for codes K0630, K0631, K0632, K0634, K0635, K0636, K0637, K0639, K0640, K0642, K0644, K0645, and K0646 were based on incorrect pricing information and has recalculated those fee schedule amounts. The revised amounts will be implemented on October 4, 2004 as part of this update.
- Codes K0650 thru K0669 were added to the HCPCS effective July 1, 2004. Because data is not yet available, implementation of the fee schedule amounts for these items will be delayed until the January 2005 update.

Implementation

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

Additional Information

To view the official instruction issued to your DMERC or intermediary on this issue, please see *http://www.cms.hhs.gov/Transmittals/downloads/R272CP.pdf* on the CMS website.

Also, the quarterly update process for the DMEPOS fee schedule is located in Section 60 of Chapter 23 of the *Medicare Claims Processing Manual*, which may be found at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

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

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

Medlearn Matters Number: MM3377 *Revised*
Related Change Request (CR) #: 3377
Related CR Release Date: August 10, 2004
Effective Date: January 1, 2004 for revised 2004 fee schedule
Related CR Transmittal #:272
Implementation Date: October 4, 2004

DRUGS AND BIOLOGICALS

Payment for HCPCS G0332

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

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

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

MMA Pricing File Clarifications

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the Third Quarter 2004 Medicare B Update! pages 30-31.

Note: This article was revised on January 17, 2006, to use the new web addresses resulting from the new CMS web site.

Providers Affected

All providers who bill Medicare carriers and fiscal intermediaries (FIs) for Part B services

Provider Action Needed

STOP – Impact to You

Providers who previously accessed drugs and biologicals pricing files at the CMS web site should be aware that corrected files have been issued.

CAUTION – What You Need to Know

Providers should be aware that this instruction provides corrections to the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 pricing files that were provided with Pub.100-04, Revision 54, issued on December 24, 2003.

GO – What You Need to Do

If you are using the files from the CMS website (listed below), be sure you have the most current version.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 changed the basis for payment of drugs and biologicals not paid on a cost or prospective payment basis, and furnished on or after January 1, 2004, through December 31, 2004. This instruction provides:

- Corrections to the MMA pricing files that were provided with Pub.100-04, Revision 54, issued on December 24, 2003; and
- Directions to replace the MMA pricing files provided with Pub.100-04, Revision 54, with the new files available at *http://www.cms.hhs.gov/HistPartBDrugPricingFiles/02_MMA_Drug_Price.asp#TopOfPage* on the CMS website. (MMA Drug Payment Limits Pricing Files For Dates of Service 1/1/2004 and After – Revised)**.** These files are for claims for drugs and biologicals not paid on a cost or prospective payment basis with dates of service on or after January 1, 2004.

Beginning January 1, 2004, MMA provides that the payment limits for most drugs and biologicals not paid on a cost or prospective payment basis are based on 85 percent of the April 1, 2003 Average Wholesale Price (AWP) for those drugs and biologicals furnished on and after January 1, 2004.

Exceptions

The exceptions to this general rule and Medicare payment limits for drugs and biologicals not paid on a cost or prospective payment basis and furnished on or after January 1, 2004 through December 31, 2004, are described below:

- The payment limits for blood clotting factors are 95 percent of the AWP reflected in the published compendia as of September 1, 2003.
- The payment limits for new drugs or biologicals are 95 percent of the AWP reflected in the published compendia as of September 1, 2003. The payment limits for new drugs or biologicals without AWP listings in the published compendia as of September 1, 2003, are based on 95 percent of the AWP reflected in the published compendia as of the first of the month the payment limit for the drug or biological is determined.

For the purposes of this instruction, a new drug is an unlisted drug (not currently covered by a specific HCPCS code; i.e., a HCPCS code other than a NOC code such as J3490, J9999, etc.) that was approved by the Food and Drugs Administration (FDA) subsequent to April 1, 2003. A drug is not considered to be a new drug if:

- The brand or manufacturer of the drug changes;
- A new vial size is developed; or
- The drug receives a new indication.
- The payment limits for influenza, pneumococcal, and hepatitis B vaccines are 95 percent of the AWP reflected in the published compendia as of September 1, 2003.
- The payment limits for certain drugs studied by the OIG and GAO are based on the percentages of the AWP reflected in the published compendia as of April 1, 2003 specified in Table 1 in §20 of Chapter 17 of the Medicare Claims Processing Manual, Pub. 100-04.
- The payment limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2004 is 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted.
- The payment limits for drugs and biologicals furnished in connection with dialysis and billed by independent dialysis facilities are based on 95 percent of the AWP reflected in the published compendia as of September 1, 2003.

Drugs and biologicals not described above are paid at 85 percent of the AWP as reflected in the published compendia as of April 1, 2003.

The Medicare payment limit for drugs and biologicals not paid on a cost or prospective payment basis and furnished prior to January 1, 2004 is 95 percent of AWP.

Payment limits determined under this instruction will not be updated during 2004. Note that the absence or presence of a HCPCS code and its associated payment limit in these files does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. These determinations will be made by the local Medicare contractor processing the claim.

For any drug or biological not listed in the attached pricing files, intermediaries and carriers will determine the payment allowance in accordance with the policies described in the transmittal (R75CP).

Implementation

The effective and implementation date of these changes was January 30, 2004.

Additional Information

As mentioned previously, this instruction provides corrections to and directs the replacement of MMA pricing files provided with Pub.100-04, Rev.54, issued on December 24, 2003 with new files available at: *http://www.cms.hhs.gov/HistPartBDrugPricingFiles/02_MMA_Drug_Price.asp#TopOfPage* (MMA Drug Payment Limits Pricing Files For Dates of Service 1/1/2004 and After – Revised).

The Centers for Medicare & Medicaid Services (CMS) web page furnishes drug related information to Medicare providers, physicians and other suppliers, Medicare beneficiaries and to the public.

The relevant files include the following:

- **HCPCS Drug Pricing File** - Microsoft Excel file,
- **FI Specific HCPCS Drug Pricing File** - Microsoft Excel file,
- **HCPCS Drug Pricing Background File** for Other than ESRD-Related or DME Infusion Drugs - Microsoft Excel file,
- **HCPCS Drug Pricing Background File** for ESRD Drugs - Microsoft Exce
- file,
- **HCPCS Drug Pricing Background File** for DME Infusion Drugs – Microsoft Excel file, and
- **NOC Drug Pricing** - Microsoft Excel file.

Affected providers should note that Medicare carriers and FIs have been instructed to apply these changes to new claims received and they are not automatically adjusting claims previously paid.

However, these Medicare contractors have been instructed to adjust claims that are brought to their attention by the provider. Thus, if you have been paid an incorrect amount on a previously paid claim, you can submit an adjustment to your Medicare contractor and it will be processed.

To view CR3105, go to *http://www.cms.hhs.gov/Transmittals/downloads/R75CP.pdf* on the CMS website.

Medlearn Matters Number: MM3105	Related Change Request (CR) #: 3105
Related CR Release Date: January 30, 2004	Effective Date: January 30, 2004
Related CR Transmittal #: R75CP	Implementation Date: January 30, 2004

Drugs Paid by Average Selling Price Beginning January 1, 2005

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the January 2006 Medicare B Update! Special Issue pages 59-60.

Note: This article was revised on January 13, 2006, to reflect revised web addresses resulting from the new CMS website.

Provider Types Affected

Physicians, suppliers, and providers

Provider Action Needed

Physicians, suppliers, and providers should note that beginning January 1, 2005, the payment limit for Part B drugs and biologicals, not paid on a cost or prospective payment basis, will be paid based on the average sales price (ASP) plus six (6) percent. Drugs will be paid based on date of service and the lower of:

1) The submitted charge; **or**
2) The ASP plus six (6) percent.

Background

According to the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA), beginning January 1, 2004 through December 31, 2004, drugs and biologicals not paid on a cost or prospective payment basis are paid based on various standards specified in the statute, although the default payment limit standard is 85 percent of Average Wholesale Price (AWP).

MM3232 notifies contractors (Part B Local Carriers and Durable Medical Equipment Carriers (DMERCs)) that the MMA mandates that drugs and biologicals not paid on a cost or prospective payment basis are to be paid based on the ASP beginning January 1, 2005.

Therefore, beginning January 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will:

- Supply contractors with a drug payment limit file for drugs and biologicals; and
- Send quarterly updates of this file to contractors.

Payment will be based on:

- The lower of the submitted charge or the payment limit on this file; and
- The date-of-service.

Finally, contractors will:

- Develop payment limits when CMS does not supply a payment limit for the drug on the file;
- Continue to determine the payment limit for compounded drugs; and
- Continue to determine the payment limit for new drugs.

Implementation

The implementation date for the instruction is January 3, 2005.

Related Instructions

The *Medicare Internet Only Manual* (IOM) has been edited with revised and new sections to reflect changes implemented with this instruction. These revised and new sections include the following:

The Medicare Claims Processing Manual (Pub. 100-4), Chapter 17 (Drugs and Biologicals):

- Section 10 (Payment Rules for Drugs and Biologicals) – **revised**
- Section 20 (Payment Allowance Limit for Drugs and Biologicals Not Paid on a Cost or Prospective Payment Basis) – **revised**
- Subsection 20.1 (MMA Drugs) – **new**

These revised and new sections of the Medicare Claims Processing Manual are included in the actual instruction (CR 3232) issued to your carrier or DMERC.

Additional Information

The official instruction issued to your carrier/DMERC regarding this change may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R397CP.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.

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

Related Change Request (CR) #: 3232
Medlearn Matters Number: MM3232
Related CR Release Date: December 16, 2004 *Revised*
Related CR Transmittal #: 397
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

January 2005 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective January 1, 2005

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the January 2005 HCPCS/MPFSDB Medicare B Special Update! page 10.

Note: This article was revised on January 13, 2006, to provide a new web addresses to coincide with the new CMS website.

Provider Types Affected

All providers

Provider Action Needed

No provider action is necessary. This article is informational only and explains how Medicare pays for certain drugs that are not paid on a cost or prospective payment basis, effective January 1, 2005.

Background

According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005 drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the average sales price (ASP) plus six (6) percent. The Centers for Medicare & Medicaid Services (CMS) will supply its carriers/intermediaries with the ASP drug pricing file for Medicare Part B drugs. The ASP is based on quarterly drug information supplied to CMS by drug manufacturers.

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

Exceptions

There are exceptions to this general rule, as summarized below:

1. The payment allowance limits for blood and blood products, with certain exceptions such as blood clotting factors, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.

2. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005 will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted. The payment allowance limits will not be updated in 2005.
3. The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
4. The payment allowance limits for drugs not included in the ASP Medicare Part B Drug Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing.

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

Implementation

The implementation date is January 3, 2005.

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R348CP.pdf* on the CMS website.

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

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

Related Change Request (CR) #:3539
Medlearn Matters Number: MM3539
Related CR Release Date: October 29, 2004 *Revised*
Related CR Transmittal #: 348
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

END STAGE RENAL DISEASE

Identifying ESRD Composite Rate Procedures

Change request 3890 allows separate payment for AMCC tests if more than 50 percent of all Medicare-covered AMCC tests furnished to an ESRD patient on a particular date of service are tests that are not included in the composite payment rate.

The following list will assist with identifying which tests are included within the ESRD facility composite rate payment. Refer to *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3890.pdf* for more information.

Composite rate procedures	Non-composite rate procedures
82040	84460
84075	82247
84450	82248
82310	82465
82374	82550
82565	82977
83615	82947
84100	84295
84132	84478
84155	84550
84295	

A non-composite payment rate test is defined as any test separately reimbursable outside of the composite payment rate or beyond the normal frequency covered under the composite payment rate that is reasonable and necessary.

Source: Pub. 100-04, Transmittal: 598, Change Request 3890

EVALUATION AND MANAGEMENT SERVICES

Consultation Services Current Procedural Terminology (CPT) Codes 99241 – 99255

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians and qualified non-physician practitioners (NPPs) billing Medicare carriers for Part B services.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4215, which revises the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 12, Section 30.6.10) with the correct new CPT codes for 2006 to use for follow-up visits and second opinion evaluations beginning January 2006.

CAUTION – What You Need to Know

CR4215 addresses the Centers for Medicare & Medicaid Services (CMS) consultation policy clarifications regarding the definition, documentation requirements, when and by whom a consultation may be performed/reported, a split/shared evaluation and management service, and nonphysician practitioners. It also includes revised and updated consultation examples. Note also that CPT codes 99261 - 99263 (hospital inpatient follow-up consultations) and CPT codes 99271 - 99275 (confirmatory consultations) are deleted effective January 1, 2006.

GO – What You Need to Do

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

Background

Change Request (CR) 4215 revises the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 12, Section 30.6.10) with policy clarifications and identifies the new 2006 coding changes made by the American Medical Association (AMA) Current Procedural Terminology (CPT) for physicians and qualified non-physician practitioners (NPPs). Physicians and qualified NPPs need these new codes for reporting follow-up visits to a consultation service and for second opinion evaluations beginning January 1, 2006.

CR4215 explains how to report evaluation and management (E/M) services following a consultation service and also second opinion evaluations.

In addition, it clarifies:

- The definition of a consultation - when and by whom it may be reported;
- A split/shared visit may not be performed or reported as a consultation service; and
- Qualified NPPs can perform consultations when requirements are met; and

It updates:

- Documentation requirements for the requesting physician/qualified NPP and the consultant, and consultation examples.

Based on the new CPT 2006 coding changes, follow-up visits to a consultation service will be reported with the following Subsequent Hospital Care codes **in the hospital inpatient setting** and with the new Subsequent Nursing Facility (NF) Care codes **in the NF setting**:

Description	CPT Codes
Subsequent Hospital Care codes	99231 – 99233
Subsequent Nursing Facility (NF) Care codes	99307 – 99310

Beginning January 1, 2006, the following AMA CPT NF codes (99311 – 99313) are deleted and not valid for subsequent nursing facility visits.

Follow-up visits to **a consultation service in the office or other outpatient settings** will be reported with the following Office or Other Outpatient Established Patient codes.

Description	CPT Codes
Office or Other Outpatient Established Patient codes	99212 – 99215

Beginning January 1, 2006, **in a facility setting** a second opinion consultation arranged through the attending physician will be reported by a physician/qualified NPP using an appropriate Initial Inpatient Consultation code when the consultation requirements are met.

When consultation requirements are not met the Subsequent Hospital Care codes (99231-99233) in the hospital setting and the Subsequent NF Care codes (99307-99310) in the NF setting will be reported.

In the Office or Other Outpatient setting for a second opinion evaluation, a physician/qualified NPP will use new patient codes (99201 – 99205) for new patients and established patient codes (99212 – 99215) for an established patient, as appropriate.

Policy Clarifications/Reminders

Physicians and qualified NPPs should be aware that:

- A consultation service requires a request from an appropriate source, the consultation evaluation service, and a written report;
- Diagnostic and/or therapeutic services may be initiated at the initial consultation service or follow-up visits;
- A consultation service may be based on time when the counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician or qualified NPP and the patient;
- An NPP may request and/or perform a consultation service within the scope of practice and licensure requirements for the NPP in the State where he/she practices and the requirements for physician collaboration and physician supervision are met;
- A consultation will not be performed as a split/shared E/M visit;
- Ongoing management following the initial consultation service must be reported using the subsequent care visit codes depending on the setting and type of service; and
- In a transfer of care situation a new patient or established patient visit code must be reported.

In addition, CR4215 instructs physicians and qualified NPPs to report:

- Initial Inpatient Consultation codes (99251 – 99255) for an initial consultation in the inpatient hospital setting and the SNF/NF setting; and
- Appropriate Office or Other Outpatient Consultation codes (99241 – 99245) for an initial consultation in the office/ outpatient setting.

Following the physician's and qualified NPP's initial consultation service, the follow-up visits should be reported using the:

- Subsequent Hospital Care codes (99231 – 99233) for the inpatient hospital setting; and
- Subsequent NF Care codes (99307 – 99310) in the NF setting; and
- Office or Other Outpatient Established Patient codes (99212 – 99215) should be reported for the office/outpatient setting.

Also, physicians and qualified NPPs need to be aware that:

- Medicare does not recognize CPT code 99211, a minimal service, for a consultation service as it would not meet the consultation criteria;
- An initial inpatient consultation will be reported only once per consultant per patient per facility admission;
- In an office or outpatient setting, if an additional request for a consultation, regarding the same or a new problem with the same patient, is received from the same or another physician or qualified NPP and documented in the medical record, the Office or Other Outpatient Consultation codes may be used again;
- If the consultant continues to care for the patient for the original condition following the initial consultation, repeat consultation services will not be reported by this physician or qualified NPP during his/her ongoing management of this condition;
- For a second opinion evaluation (patient and/or family requested) in the facility setting arranged through the attending physician, the evaluation is reported as an Initial Inpatient Consultation service if the consultation requirements are met;
- If the second opinion evaluation does not meet the consultation requirements, the Subsequent Hospital Care codes for the inpatient setting and Subsequent NF Care codes for the NF setting are reported;
- For a second opinion evaluation, report the Office or Other Outpatient codes (new or established patient as appropriate) for the office/outpatient settings;
- A written report is not required by Medicare to be sent to a physician or qualified NPP when a second opinion evaluation visit has been requested by the patient and/or family;
- The CPT Modifier - 32 (mandated services) is not recognized as a payment modifier in Medicare;
- A second opinion evaluation service to satisfy a requirement for a third party payer is not a covered service in Medicare;
- Medicare will pay for a consultation if a physician or qualified NPP in a group practice requests a consultation from another physician or qualified NPP in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting professional's knowledge;
- A consultation service will not be reported on every patient as a routine practice between physicians and qualified NPPs within a group practice setting;
- Include a written request for a consultation in the requesting physician or qualified NPP's plan of care;
- A consultation request may be verbal; however, the verbal interaction identifying the request and reason for a consult must be documented in the patient's medical record by the requesting physician or qualified NPP and also by the consultant physician or qualified NPP in the patient's medical record;
- A consultation request by the requestor may be written on a physician order form in a shared medical record;
- The reason for the consultation service must be documented by the consultant in the patient's medical record;
- The consultant's written report may be part of a common medical record or in a separate letter to the requesting physician or qualified NPP and readily available;

- A preoperative consultation at the request of a surgeon is payable if the service is medically necessary and not routine screening;
- Following a preoperative consultation, if the same physician or qualified NPP assumes responsibility for management of all or part of the patient's care postoperatively, the appropriate subsequent inpatient hospital care codes, subsequent SNF/NF codes or established office/clinic codes should be used and not the consultation codes; and
- Physicians or qualified NPPs who had been treating the patient preoperatively or who had not seen the patient for a pre-operative consultation and are asked to assume management of an aspect of the patient's care postoperatively, must report subsequent hospital care codes for the inpatient hospital setting, subsequent NF care codes in the SNF/NF setting or the appropriate office or other outpatient visit codes in these settings. The surgeon is not asking the physician or qualified NPP for their advice or opinion on the surgeon's care of the patient.

Implementation

The implementation date for the instruction is January 17, 2006.

Additional Information

The revised portions of the *Medicare Claims Processing Manual* are attached to CR4215. These revisions include examples of situations that meet the consultation services criteria as well as some examples that do not meet the criteria. CR4215 may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R788CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4215
Related CR Release Date: December 20, 2005
Related CR Transmittal #: R788
Related Change Request (CR) #: 4215
Effective Date: January 1, 2006
Implementation Date: January 17, 2006

Nursing Facility Services (Codes 99304 - 99318)

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians and non-physician practitioners (NPPs) and physicians

Provider Action Needed

STOP – Impact to You

In both the skilled nursing facility (SNF) and nursing facility (NF) settings, qualified non-physician practitioners (NPP), i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS), may provide certain defined beneficiary visits prior to, and after, the physician performs the initial visit. In addition, in the NF setting, when certain requirements are met, an NPP not employed by the NF may also perform the initial visit itself.

In addition, effective January 1, 2006, Current Procedural Terminology (CPT) codes (99301 - 99303) for reporting the initial nursing facility care and subsequent nursing facility care (99311-99313) are deleted, and are replaced by new codes (see below).

CAUTION – What You Need to Know

CR4246, from which this article is taken, conveys that, in both the SNF and NF settings, a qualified NPP may provide covered medically necessary visits prior to and after the physician performs the initial visit. Qualified NPPs may provide federally mandated visits (after the initial visit by the physician and as permitted under the Long Term Care Regulations). Further, it provides that, when specific requirements are met in the NF setting, an NPP who is not employed by the NF and who is permitted by State law may perform the beneficiary's initial visit.

It also clarifies the distinction between required (i.e., federally mandated) and medically necessary visits, "incident to" services, prolonged services, split/shared E/M services, gang visits, and the SNF/NF discharge day management services.

The CR revises the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.13, with new CPT codes for reporting visits in the skilled nursing facility (SNF) or nursing facility (NF)settings: Initial Nursing Facility Care (codes 99304 – 99306); Subsequent Nursing Facility Care (codes 99307 – 99310 and Other Nursing Facility Services (CPT code 99318 for an annual assessment).

GO – What You Need to Do

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

Background

To begin this discussion, remember that the Medicare Statute is the basis for distinguishing between delegation of physician visits and tasks in skilled nursing facilities (SNF — Place of Service Code 31, for patients in a Part A SNF stay), and nursing facilities (NF — Place of Service Code 32, for patients who do not have Part A SNF benefits, patients who are in a Nursing Facility or in a non-covered SNF stay).

To the point, Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs. (For further information, refer to Medlearn Matters article number SE0418 at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0418.pdf* on the CMS website.

Payment Policy for E/M Visits

CR4246 clarifies payment policy (effective January 1, 2006) for evaluation and management (E/M) visits by physicians and qualified NPPs (i.e., nurse practitioners [NP], physician assistants [PA], or clinical nurse specialists [CNS]) in SNF and NF settings:

Delegation of the Initial Visit

First, CR4246 clarifies the policy for the delegation of the initial visit in the NF setting. Remember that the initial visit in both SNFs and NFs is defined (per the Survey and Certification memorandum (S&C-04-08), dated November 13, 2003) as the initial comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the nursing facility resident.

It must occur no later than 30 days after admission. In the SNF setting, the physician must perform this initial visit. In the NF setting, a qualified NPP, not employed by the NF, may perform the initial visit when permitted by state law, and when (as in all Evaluation & Management visits) the NPP meets all Medicare and physician collaboration and supervision requirements, and the service falls within the scope of practice and licensure for the state where the service occurs.

(Physician assistants, additionally, must meet the general physician supervision requirement as well as employer billing requirements.)

After the Initial Visit

In the SNF setting, after the initial visit by the physician, physicians may delegate alternating federally mandated physician visits to qualified NPPs (whether they are employed or not by the SNF).

Qualified NPPs in the NF setting, who are not employed by the NF, may, at the option of the state, perform federally mandated physician visits including the initial visit.

Physician Delegation of Medically Necessary Visits to Qualified NPPs

Also, CR4246 clarifies physician delegation of medically necessary visits to qualified NPPs in the SNF and NF settings. In both of these settings, if all the requirements for collaboration, physician supervision, licensure, and billing are met, qualified NPPs may perform medically necessary E/M visits (those visits necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member) prior to, and after, the physician's initial visit.

General physician supervision and employer billing requirements shall be met for PA services. The PA must also meet the state scope of practice and licensure requirements where the E/M visit is performed.

Medically Necessary E/M Visits

Medically necessary E/M visits are payable under the physician fee schedule under Medicare Part B.

Note: The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The physician or qualified NPP shall report only one E/M visit.

New Code Changes to Medicare Claims Processing Manual

CR4246 also revises the *Medicare Claims Processing Manual*, Pub.100-04, Chapter 12, Section 30.6.13, with new code changes made by the American Medical Association (AMA) Current Procedural Terminology (CPT) 2006 for services reported in a nursing facility.

Beginning January 1, 2006, CPT codes for reporting the initial nursing facility care and subsequent nursing facility care are deleted and replaced by new ones.

The new codes that physicians and qualified NPPs should use for SNF and NF visits are as follows:

CPT Codes 99304-99306 – Initial Nursing Facility Care

As of January 1, 2006, CPT codes 99304-99306 (Initial Nursing Facility Care, per day) shall be used to report the initial visit. CPT codes 99301 – 99303 are deleted after 12/31/05.

Only a physician may report 99304-99306 for an initial visit performed in an SNF or NF except for (as explained above) those performed by a qualified NPP in the NF setting who is not employed by the facility and when state law permits.

A readmission to a SNF or NF has the same payment policy requirements as an initial admission in both settings.

Codes 99307-99310 – Subsequent Nursing Facility Care

Codes 99307-99310 (Subsequent Nursing Facility Care, per day) shall be used to report federally mandated physician visits and other medically necessary visits. These codes are effective January 1, 2006, and replace codes 99311-99313 which are deleted after 12/31/05.

Medicare will pay for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. You shall also use these codes to report medically necessary E/M visits even if they are provided prior to the initial visit by the physician.

You shall also use these codes to report medically complex care in an SNF upon discharge from an acute care visit, again even if the visits are provided prior to the physician's initial visit.

Codes 99315-99316 – Discharge Day Management Service

Codes 99315-99316 (Discharge Day Management Service) shall be used to report the physician or NPP's face-to-face visit with the patient to meet the SNF/NF discharge day management service requirement. You shall report the visit as the actual date of the visit even if the patient is discharged from the facility on a different calendar date.

These codes may be used (depending on the code requirement) to report a death pronouncement of a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.

Code 99318 – Other Nursing Facility Service

Code 99318 (Other Nursing Facility Service) shall be used to report an annual nursing facility assessment visit on the required schedule of visits if an annual assessment is performed. For Medicare Part B payment policy, an annual assessment visit code shall substitute as meeting (but not be in addition to) one of the federally mandated physician visits if the code requirements for CPT code 99318 are fully met and in lieu of reporting a subsequent nursing facility care code (codes 99307 – 99310). This new code does not represent a new benefit service for Medicare Part B physician services.

Other Important Information to Remember

- Medicare will pay for E/M visits, prior to and after the initial physician visit, that are reasonable and medically necessary to meet the medical needs of the individual resident (unrelated to any state requirement or administrative purpose), but will not pay for additional visits that may be required by state law for an admission or for other additional visits to satisfy facility or other administrative purposes.
- A physician (or qualified NPP, where permitted, as discussed above) who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment, or may reassign payment for his/her professional service to the facility. However, a PA's employer must always report the visits that the PA performs.
- As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.
- The Prolonged Services (CPT codes 99354 – 99357) shall not be reported with Nursing Facility Services beginning January 1, 2006 until further notice. The new AMA CPT codes do not have typical/average time units established.
- E/M visits for counseling/coordination of care, for Nursing Facility Services, that are time-based must be billed based on the key components of an E/M service (history, exam and medical decision making) until the AMA CPT creates typical/average time units for the Nursing Facility Services.

Other Visit Information

- "Incident to" E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B. Where a physician establishes an office in a facility, the "Incident to" E/M visits and requirements are confined to this discrete part of a SNF/NF designated as his/her office. The place of service (POS) on the claim should be "office" (POS 11).
- Thus, visits performed outside the designated "office" area in the SNF/NF are subject to SNF/NF setting coverage and payment rules and shall not be reported using the CPT codes for office or other outpatient visits or use POS code 11.
- "Gang visits" (claims for an unreasonable number of daily E/M visits by the same physician to multiple residents at a facility within a 24-hour period) may result in medical review to determine medical necessity for the visits.
- The complexity level of an E/M visit and the CPT code billed must be a covered and medically necessary visit for each patient. The E/M visit (Nursing Facility Services) represents a "per day" service per patient as defined by the CPT code. The physician or qualified NPP who performed the E/M visit must personally document the service in the medical record, and the documentation should support the specific level of E/M visit to each individual patient.
- Split/shared E/M visits cannot be reported in the SNF/NF setting. A split/shared visit is defined as a medically necessary patient encounter in which the physician and a qualified NPP each personally perform a substantive portion of an E/M visit (all or some portion of the history, exam or medical decision making key components of an E/M service) face-to-face with the same patient on the same date of service.
- A split/shared E/M service applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non-facility clinic visits, and prolonged visits associated with these E/M visit codes).

Additional Information

For further reference on Survey and Certification issues applicable to the SNF/NF settings refer to Medlearn Matters article number SE0418 at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0418.pdf* on the CMS website.

To view the official instruction (CR4246) issued to your carrier or fiscal intermediary, please visit *http://www.cms.hhs.gov/Transmittals/downloads/R808CP.pdf* on the CMS website. You might also want to look at the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 12, Section 30.6.13 (Nursing Facility Services (Codes 99304 - 99318), which you can find as an attachment to CR4246.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

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

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

Medlearn Matters Number: MM4246	Related Change Request (CR) #: 4246
Related CR Release Date: January 6, 2006	Effective Date: January 1, 2006
Related CR Transmittal #: R808CP	Implementation Date: No later than January 23, 2006

LABORATORY/PATHOLOGY

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

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: **This article was re-issued on January 20, 2006, to reflect Web addresses that conform to the new CMS website. All other information remains the same.**

Provider Types Affected

All Medicare providers

Provider Action Needed

No action is necessary. This article is informational only. The Centers for Medicare & Medicaid Services (CMS) has determined, upon reconsideration of existing policy, that Autologous Blood-Derived Products for Chronic Non-Healing Cutaneous Wounds, both platelet-derived growth factor (PDGF) in platelet-poor plasma and platelet-rich plasma (PRP), will remain non-covered as CMS continues to believe that the clinical effectiveness of these autologous bloodderived products is not adequately proven in scientific literature.

Background

Patient-donated blood is centrifuged to produce an autologous gel for the treatment of chronic non-healing cutaneous wounds that persist for 30 days or longer and fail to complete the healing process properly. Autologous blood derived products for chronic non-healing wounds include both PDGF products, such as Procuren and more recent products, and PRP products.

PRP differs from previous products because it contains whole cells, including white cells, red cells, plasma, platelets, fibrinogen, stem cells, macrophages, and fibroblasts. PRP is used by physicians in clinical settings. PDGF does not contain cells and was marketed as a product to be used by patients at home.

In 1992 CMS issued a national Medicare non-coverage determination in relation to platelet-derived wound healing formulas containing growth factors in the treatment of non-healing wounds. The determination was based on a lack of sufficient published data to determine the safety and efficacy of such formulas, and a Public Health Service technology assessment.

Recently, CMS reconsidered that 1992 decision and concluded that the clinical effectiveness of autologous PDGF products continues to be inadequately proven in scientific literature, and it remains non-covered for treatment of chronic, nonhealing cutaneous wounds. Additionally, the clinical evidence does not support a benefit in the application of autologous PRP for the treatment of chronic, nonhealing wounds, and CMS has determined it is not reasonable and necessary and is nationally non-covered.

It will remain at the local carrier's discretion whether to pay for Becaplermin, a nonautologous growth factor product approved by the FDA for the treatment of chronic non-healing subcutaneous wounds. Also, the routine costs of autologous PRP products for the treatment of chronic non-healing wounds associated with Category B Investigational Device Exemption clinical trials are covered by Medicare in accordance with 42 CFR 405.201 – 405.215, 411.15, and 411.406 or section 310.1 of the National Coverage Determinations Manual.

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R19NCD.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM3384 *Revised*
Related Change Request (CR) #: 3384
Related CR Release Date: July 30, 2004
Effective Date: July 23, 2004
Related CR Transmittal #: R19NCD
Implementation Date: July 23, 2004

Clinical Diagnostic Laboratory Date of Service for Archived Specimens

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 4156, which is being issued to define the date of service (DOS) policy for laboratory tests on archived specimens, to clarify what is/or is not an archived specimen, and to revise the policy regarding a laboratory test that requires a specimen obtained from storage.

Background

The Centers for Medicare & Medicaid Services published a proposed rule on November 23, 2001 in the Federal Register (66 FR 58792, *http://www.access.gpo.gov/su_docs/fedreg/a011123c.html*) that clarified the date of service (DOS) for clinical diagnostic laboratory services, and CR 2383 (Transmittal AB-02-134, dated October 4, 2002) was issued but did not define archived specimens.

Note: CR 2383 (Transmittal AB-02-134, dated October 4, 2002, subject: Questions and Answers Related to Implementation of National Coverage Determinations (NCDs) for Clinical Diagnostic Laboratory Services) can be found at *http://www.cms.hhs.gov/Transmittals/downloads/AB02134.pdf* on the CMS website.

CMS has since developed a definition of an archived specimen through its rulemaking process and issued a revised DOS policy in the Federal Register notice dated February 25, 2005 (70 FR 9357, which can be viewed at *http://www.access.gpo.gov/su_docs/fedreg/a050225c.html*).

CR4156 implements this revised DOS policy for laboratory tests, and it clarifies what is/or is not an archived specimen. As a general rule, the DOS of a test is the date the specimen was collected, except as shown in the following table:

Specimen Description	Date of Service (DOS)
Specimen collected over a period spanning two calendar days (unless collected from archive).	Date the specimen collection ended.
Specimen stored for more than 30 calendar days before testing, (otherwise known as "an archived specimen").	Date the specimen was obtained from storage

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R800CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4156
Related CR Release Date: December 30, 2005
Related CR Transmittal #: R800CP
Related Change Request (CR) #: 4156
Effective Date: April 3, 2006
Implementation Date: April 3, 2006

Multiple Procedure Reduction of the Technical Component (TC) of Certain Diagnostic Imaging Procedures

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians and suppliers billing Medicare carriers for diagnostic imaging supplies and services

Provider Action Needed

STOP – Impact to You

This article provides details regarding the Centers for Medicare & Medicaid Services (CMS) revised policy for a multiple procedure reduction of the technical component (TC) of certain diagnostic imaging procedures.

CAUTION – What You Need to Know

CMS is phasing in a payment reduction of the technical component (TC) of selected multiple diagnostic imaging procedures with a 25 percent reduction in CY 2006 and a 50 percent reduction in CY 2007. The CMS review of its multiple imaging payment reduction policy will be ongoing.

GO – What You Need to Do

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

Background

Medicare prices diagnostic imaging procedures in the following three ways:

- The professional component (PC) represents the physician's interpretation (PC-only services are billed with the **26** modifier);
- The technical component (TC) represents practice expense (PE) and includes clinical staff, supplies, and equipment (TC-only services are billed with the TC modifier);
- The global service represents both PC and TC.

Effective January 1, 2006, CMS will implement a multiple procedure payment reduction on the technical component (TC) of certain diagnostic imaging procedures. The reduction applies to TC only services and the TC portion of global services for the procedures shown in Table 2 of this article. The reduction does not apply to professional component (PC) services. For 2006, CMS is making full payment for the highest priced procedure and payment at 75 percent for each additional procedure, when performed during the same session on the same day. For 2007, subsequent procedures will be paid at 50 percent.

The reduction applies only to contiguous body areas, i.e., within a family of codes, not across families, that are provided in one session. For example, the reduction would not apply to an MRI of the brain (CPT 70552) in code family 5 (of Table 2 of this article) when performed during the same (single) session, on the same day, as an MRI of the neck and spine (CPT 72142) in code family 6.

The 11 families of imaging procedures are included in Table 2 in the *Additional Information* section of this article, and are arranged by imaging modality:

- Ultrasound, CT, and computed tomographic angiography (CTA);
- MRI and magnetic resonance angiography (MRA); and
- Contiguous body area (for example, CT and CTA of Chest/Thorax/Abdomen/Pelvis).

CMS considers a single session to be one encounter where a patient could receive one or more radiological studies. If more than one of the imaging services in a single family is provided to the patient during one encounter, then this would constitute a single session and the lower-priced procedure(s) would be reduced.

On the other hand, if a patient has a separate encounter on the same day for a medically necessary reason and receives a second imaging service from the same family, then CMS considers these multiple studies in the same family on the same day to be provided in separate sessions.

In the latter case, CMS has established that the physician should **use modifier 59** to indicate multiple sessions, and that the multiple procedure reduction does not apply.

CMS responded to commenters in the Final Rule, which was published in the Federal Register on November 21, 2005 (*http://www.access.gpo.gov/su_docs/fedreg/a051121c.html*, Section J, page 70261).

An example of the current and CY 2006 payments is summarized in Table 1, and the revised lists of procedures subject to the reduction are included in Table 2 in the *Additional Information* section of this article.

Table 1. Example of Payments

	Procedure 1 (CPT 74183)	Procedure 2 (CPT 72196)	Current total payment	CY 2006 total payment CY 2006 payment calculation	Procedure 1 (CPT 74183)
PC	$117.00	$90.00	$207.00	$207.00	no reduction
TC	$978.00	$529.00	$1,507.00	$1,374.75	$978 + (.75 x $529)
Global	$1,095.00	$619.00	$1,714.00	$1,581.75	$207 + $978 + (0.75 x $529)

Implementation

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

Additional Information

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

The 11 families of imaging procedures covered by this change are contained in the following table:

Table 2. Revised Lists of Diagnostic Imaging Procedures Subject to Reduction

Diagnostic Imaging Services

Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical

76604 Us exam, chest, b-scan
76700 Us exam, abdom, complete
76705 Echo exam of abdomen
76770 Us exam abdo back wall, comp
76775 Us exam abdo back wall, lim
76778 Us exam kidney transplant
76831 Echo exam, uterus
76856 Us exam, pelvic, complete
76857 Us exam, pelvic, limited

Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)

71250 Ct thorax w/o dye
71260 Ct thorax w/ dye
71270 Ct thorax w/o & w/ dye
71275 Ct angiography, chest
72191 Ct angiography, pelv w/o & w/ dye
72192 Ct pelvis w/o dye
72193 Ct pelvis w/ dye
72194 Ct pelvis w/o & w/ dye
74150 Ct abdomen w/o dye
74160 Ct abdomen w/ dye
74170 Ct abdomen w/o & w/ dye
74175 Ct angiography, abdom w/o & w/ dye
75635 Ct angio abdominal arteries
0067T Ct colonography; dx

Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/ Neck)

70450 Ct head/brain w/o dye
70460 Ct head/brain w/ dye
70470 Ct head/brain w/o & w/ dye
70480 Ct orbit/ear/fossa w/o dye
70481 Ct orbit/ear/fossa w/ dye
70482 Ct orbit/ear/fossa w/o & w/ dye
70486 Ct maxillofacial w/o dye
70487 Ct maxillofacial w/ dye
70488 Ct maxillofacial w/o & w/ dye
70490 Ct soft tissue neck w/o dye
70491 Ct soft tissue neck w/ dye
70492 Ct soft tissue neck w/o & w/ dye
70496 Ct angiography, head
70498 Ct angiography, neck

Family 4 MRI and MRA (Chest/Abd/Pelvis)

71550 Mri chest w/o dye
71551 Mri chest w/ dye
71552 Mri chest w/o & w/ dye
71555 Mri angio chest w/ or w/o dye
72195 Mri pelvis w/o dye
72196 Mri pelvis w/ dye
72197 Mri pelvis w/o &w/ dye
72198 Mri angio pelvis w/ or w/o dye
74181 Mri abdomen w/o dye
74182 Mri abdomen w/ dye
74183 Mri abdomen w/o and w/ dye
74185 Mri angio, abdom w/ or w/o dye

Family 5 MRI and MRA (Head/Brain/Neck)

70540 Mri orbit/face/neck w/o dye
70542 Mri orbit/face/neck w/ dye
70543 Mri orbit/face/neck w/o & w/dye
70544 Mr angiography head w/o dye
70545 Mr angiography head w/dye
70546 Mr angiography head w/o & w/dye
70547 Mr angiography neck w/o dye
70548 Mr angiography neck w/dye
70549 Mr angiography neck w/o & w/dye
70551 Mri brain w/o dye
70552 Mri brain w/dye
70553 Mri brain w/o & w/dye

Family 6 MRI and MRA (spine)

72141 Mri neck spine w/o dye
72142 Mri neck spine w/dye
72146 Mri chest spine w/o dye
72147 Mri chest spine w/dye
72148 Mri lumbar spine w/o dye
72149 Mri lumbar spine w/dye
72156 Mri neck spine w/o & w/dye
72157 Mri chest spine w/o & w/dye
72158 Mri lumbar spine w/o & w/dye

Family 7 CT (spine)

72125 CT neck spine w/o dye
72126 Ct neck spine w/dye
72127 Ct neck spine w/o & w/dye
72128 Ct chest spine w/o dye
72129 Ct chest spine w/dye
72130 Ct chest spine w/o & w/dye
72131 Ct lumbar spine w/o dye
72132 Ct lumbar spine w/dye
72133 Ct lumbar spine w/o & w/dye

Family 8 MRI and MRA (lower extremities)

73718 Mri lower extremity w/o dye
73719 Mri lower extremity w/dye
73720 Mri lower ext w/ & w/o dye
73721 Mri joint of lwr extre w/o dye
73722 Mri joint of lwr extr w/dye
73723 Mri joint of lwr extr w/o & w/dye

Diagnostic Imaging Services

73725 – MRA Mr angio lower ext w or w/o dye

Family 9 CT and CTA (lower extremities)

73700 Ct lower extremity w/o dye
73701 Ct lower extremity w/dye
73702 Ct lower extremity w/o & w/dye
73706 Ct angio lower ext w/o & w/dye

Family 10 Mr and MRI (upper extremities and joints)

73218 Mri upper extr w/o dye
73219 Mri upper extr w/dye
73220 Mri upper extremity w/o & w/dye
73221 Mri joint upper extr w/o dye
73222 Mri joint upper extr w/dye
73223 Mri joint upper extr w/o & w/dye

Family 11 CT and CTA (upper extremities)

73200 Ct upper extremity w/o dye
73201 Ct upper extremity w/dye
73202 Ct upper extremity w/o & w/dye
73206 Ct angio upper extr w/o & w/dye

Medlearn Matters Number: SE0587
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2006
Related CR Transmittal #: N/A
Implementation Date: January 3, 2006

Positron Emission Tomography Scans for Dementia and Neurodegenerative Diseases

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the Second Quarter 2005 Medicare B Update! page 44.

Note: This article was revised on January 19, 2006, to reflect new Web addresses to conform to the new CMS website.

Provider Types Affected

Providers and suppliers who bill Medicare carriers and fiscal intermediaries for PET Scan services

Provider Action Needed

STOP – Impact to You

This article explains updates to the *Medicare Claims Processing Manual* related to 2-deoxy-2- [F-18] fluoro-D-glucose Positron Emission Tomography (FDG-PET) Scans.

CAUTION – What You Need to Know

Information for the payment method for all PET scans provided in critical access hospitals has also been added to the *Medicare Claims Processing Manual*.

GO – What You Need to Do

Use of the correct codes and understanding of the reimbursement methods will help Medicare make prompt and correct payments for PET Scan services.

Background

The Radiology Services and Other Diagnostic Procedures Chapter of the *Medicare Claims Processing Manual* has been updated in regard to billing requirements and coverage for 2-deoxy-2- [F-18] fluoro-D-glucose Positron Emission Tomography (FDG-PET) Scans for the differential diagnosis of Front- Temporal Dementia (FTD) and Alzheimer's Disease (AD).

There are three updates to the Medicare Claims Processing Manual related to FDG-PET Scans:

- The previous edit to allow HCPCS G0336 (PET imaging, brain imaging for the differential diagnosis of AD with aberrant features versus FTD) to be billed no more than once in a beneficiary's lifetime has been removed.
- Medicare carriers and fiscal intermediaries must ensure that an appropriate diagnosis code accompanies the claim with HCPCS G0336. When submitting a claim for a FDG-PET Scan, one of the following diagnosis codes must accompany the HCPCS G0336 code: 290.0, 290.10 – 290.13, 290.20 – 290.21, 290.3, 331.0, 331.11, 331.19, 331.2, 331.9, 780.93.

Line items with HCPCS code G0336 will be denied if one of the above diagnosis codes is not provided. Such denials will be reflected by claim adjustment reason code 11.

- The payment method for ALL PET Scan claims submitted for services provided in Critical Access Hospitals (CAHs) is as follows: CAHs under Method I have technical services paid at 101% of reasonable cost; CAHs under Method II have technical services paid at 101% of reasonable cost; and Professional services are paid at 115% of the MPFSDB.

Affected providers should issue an Advanced Beneficiary Notice to beneficiaries advising them of potential financial liability in the event that one of the appropriate diagnosis codes is not present on the claim.

All other billing requirements for PET Scans for dementia and neurodegenerative diseases remain the same.

Additional Information

The revised portion of Chapter 13, Section 60 of the *Medicare Claims Processing Manual* can be found as part of the official instruction issued to your carrier/intermediary regarding these changes. That instruction, CR3640, may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R428CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM3640 *Revised*
Related CR Release Date: January 14, 2005
Related CR Transmittal #: R428CP
Related Change Request (CR) #: 3640
Effective Date: September 15, 2004
Implementation Date: April 4, 2005

SURGERY

Cardiac Catheterization In Other Than A Hospital Setting

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians and/or providers who bill Medicare carriers for cardiac catheterizations performed in freestanding facilities

Important Points to Remember

Effective for services performed on or after January 12, 2006, the Centers for Medicare & Medicaid Services (CMS) is repealing section 20.25, titled Cardiac Catheterization In Other Than A Hospital Setting, of publication 100-03 *(National Coverage Determinations Manual)*.

Repeal of this section will result in determinations of coverage for cardiac catheterization when performed outside the hospital setting at the discretion of the local Medicare carrier through their local medical review policies.

Background

The original language from section 20.25 of publication 100-03 required that Medicare carriers, in consultation with the Peer Review Organizations (PROs), renamed Quality Improvement Organizations (QIOs), review freestanding cardiac catheterizations facilities to determine that procedures can be performed safely.

This function of the QIOs is no longer in their scope of work as their focus has shifted to include other functions. It will now be at the carrier's discretion through local medical review policies to make decisions regarding the coverage of cardiac catheterization in freestanding facilities.

Implementation

The implementation date for this instruction is February 27, 2006.

Additional Information

The official instructions issued to your carrier regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R46NCD.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4280
Related Change Request (CR) #: 4280
Related CR Release Date: January 27, 2006
Effective Date: January 12, 2006
Related CR Transmittal #: R46NCD
Implementation Date: February 27, 2006

HIPAA - The Health Insurance Portability and Accountability Act

Advantages of Submitting Electronic Claims

One obvious advantage of submitting claims to Medicare electronically is "It's the Law!!". The Administrative Simplification ComplianceAct (ASCA), effective October, 2003, mandates that all Medicare claims, unless they meet one of the exception criteria specified within the Act, be submitted in the approved HIPAA electronic format to Medicare.

Even if you meet one of the exception criteria (primarily small provider exception), you should consider obtaining the capability to transmit your claims electronically to Medicare for these additional advantages:

- Control over input of claims information – you enter the data.
- Eliminates mailing costs (paper, envelopes, stamps)
- Earlier payment of electronic claims improves cash flow (14 day payment floor), which saves time and money compared to (27-day payment floor) paper claims.
- The benefit of earlier detection of errors by an immediate 997 report verifying receipt of claim submission and next day availability of an electronic Batch Detail Control Listing showing acceptance into the Medicare processing system or identifying errors that need correcting
- The relative ease of EDI and help desk support available to assist in EDI transactions.
- Ability to submit/retrieve electronic transactions 24 hours a day, 7 days a week.
- Take advantage of other electronic applications such as Electronic Remittance Notification (ERN), Electronic Funds Transfer (EFT), and Electronic Claim Status (ECS).

No Electronic Capability??? - Free Medicare software (PC-ACE PRO32Ò) is available for your use in submitting claims.

Contact Medicare EDI today at (203) 639-3160 option 4, if you are interested in finding out more about electronic claims submission, or if you have any questions concerning any of the information above.

USE ELECTRONIC TRANSACTIONS TODAY!!

Correction of the Medicare Claims Processing Manual Regarding MSN/ ANSI X12 Denial Messages for Anti-Emetic Drugs

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Providers and suppliers billing Medicare carriers or durable medical equipment regional carriers (DMERCs) for anti-emetic drugs

Provider Action Needed

This article is provided for your information only.

Background

CR4001 corrects an error in the *Medicare Claims Processing Manual* (Pub. 100- 4), Chapter 17, Section 80.2.3 (MSN / ANSI X12N Denial Messages for Anti-Emetic Drugs).

The text incorrectly cites Medicare Summary Notice (MSN) 6.3 as a valid MSN denial message for anti-emetic drugs. In response to this correction, your carriers and DMERCs will not use *MSN 6.3: Payment cannot be made for oral drugs that do not have the same active ingredients as they would have if given by injection when an anti-emetic drug is denied.*

Rather, if the anti-emetic drug is denied because the Food and Drug Administration (FDA) did not approve it or because the drug is not being used as part of an anti-cancer chemotherapeutic regimen, carriers and DMERCs will use either:

- MSN 6.2: Drugs not specifically classified as effective by the Food and Drug Administration are not covered (ANSI X12 Adjustment Code 114); or
- MSN 6.4: Medicare does not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours after administration of a Medicare covered chemotherapy drug (ANSI X12 Group Code PR 96 with Remark Code M100).

Additional Information

You can find more information about Denial Messages for Anti-Emetic Drugs by going to *http://www.cms.hhs.gov/transmittals/downloads/R684CP.pdf* on the CMS website.

Finally, 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.

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: MM4001
Related CR Release Date: September 23, 2005
Related CR Transmittal #: 684
Related Change Request (CR) #: 4001
Effective Date: December 23, 2005
Implementation Date: December 23, 2005

Claim Status Category Code and Claim Status Code Update

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All providers submitting Health Care Claim Status Transactions to Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4256, which provides the April 2006 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHIs).

CAUTION – What You Need to Know

Medicare contractors are to use codes with the **"new as of 4/06"** designation and prior dates and inform affected providers of the new codes. CR 4256 applies to Chapter 31, Section 20.7, Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277.

GO – What You Need to Do

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

Background

Claim Status Category codes indicate the general category of a claim's status (accepted, rejected, additional information requested, etc.), which is then further detailed by the Claim Status Code(s). Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction.

The Health Care Code Maintenance Committee maintains the Claim Status Category and Claim Status codes, and as previously mentioned, the Committee meets at the beginning of each X12 trimester meeting and makes decisions about additions, modifications, and retirement of existing codes.

Note: The updated list is posted three times a year (after each X12 trimester meeting) at the Washington Publishing Company web site at *http://www.wpcedi.com/codes.* Once at the Washington Publishing Company web site, select "Claim Status Codes" or "Claim Status Category Codes" to access the updated code list. Included in the code lists are specific details, including the date when a code was added, changed or deleted. All code changes approved in February 2006 are to be listed at this above web site approximately thirty (30) days after the meeting concludes. For this update, Medicare will begin using the codes in place as of 4/06.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R814CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4256
Related Change Request (CR) #: 4256
Related CR Release Date: January 20, 2006
Effective Date: April 1, 2006
Related CR Transmittal #: R814CP
Implementation Date: April 3, 2006

Healthcare Provider Taxonomy Codes Update

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

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 Part A and Part B services.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4254 which informs Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs) and regional home health intermediaries (RHHIs)) to obtain the most recent Healthcare Provider Taxonomy Codes (HPTC) and use it to update their internal HPTC tables.

CAUTION – What You Need to Know

HIPAA requires that submitted data, which is part of a named code set, be valid data from that code set. Claims accepted with invalid data are non-compliant. Because health care provider taxonomy is a named code set in the 837 Institutional and Professional implementation guides, Medicare must validate the inbound taxonomy codes against their internal HPTC tables.

GO – What You Need to Do

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

Background

The Healthcare Provider Taxonomy Codes (HPTC) set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment (specifically within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care claim transaction).

HPTCs are scheduled for update twice per year (April and October). The HPTC list is available from the Washington Publishing Company at *http://www.wpcedi.com/codes/taxonomy* in two forms:

- A free Adobe PDF download of the HPTC list; and
- An electronic representation of the list (available for purchase) which facilitates the automatic loading of the code set.

Note: Claims received with invalid data are non-compliant with HIPAA and will not be processed by Medicare.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R815CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4254
Related Change Request (CR) #: 4254
Related CR Release Date: January 20, 2006
Effective Date: April 1, 2006
Related CR Transmittal #: R815CP
Implementation Date: April 3, 2006

Requirements for Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: This article was revised on November 21, 2005, to clarify language included regarding the crosswalk of legacy numbers and national provider identifier (NPI).

Provider Types Affected

Physicians, providers, and suppliers who submit claims for services to Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), to include regional home health intermediaries (RHHIs)

Provider Action Needed

The requirements for Stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are not based on the date of receipt of a transaction, unless otherwise stated in a business requirement.

Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the NPI in Stage 2 is October 1, 2006.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005.

Applications can be made by mail and also online at *https://nppes.cms.hhs.gov*.

NPI and Legacy Identifiers

The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. **Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers.**

Legacy provider identifiers include:

- Online Survey Certification and Reporting (OSCAR) system numbers;
- National Supplier Clearinghouse (NSC) numbers;
- Provider Identification Numbers (PINs); and
- Unique Physician Identification Numbers (UPINs) used by Medicare.

They **do not** include taxpayer identifier numbers (TINs) such as:

- Employer Identification Numbers (EINs); or
- Social Security Numbers (SSNs).

Primary and Secondary Providers

Providers are categorized as either "primary" or "secondary" providers:

- ***Primary providers*** include billing, pay-to, rendering, or performing providers. In the DMERCs, primary providers include ordering providers.
- ***Secondary providers*** include supervising physicians, operating physicians, referring providers, and so on.

Crosswalk

During Stage 2, Medicare will utilize a Crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. Key elements of this Crosswalk include the following:

- Each primary provider's NPI reported on an inbound claim or claim status query will be cross-walked to the Medicare legacy identifier that applies to the owner of that NPI.
- The Crosswalk will be able to do a two-directional search, from a Medicare legacy identifier to NPI, and from NPI to a legacy identifier.
- The Medicare Crosswalk will be updated daily to reflect new provider registrations.

NPI Transition Plans for Medicare FFS Providers

Medicare's implementation involving acceptance and processing of transactions with the NPI will occur in separate stages, as shown in the table below:

Stage	Medicare Implementation
May 23, 2005 - January 2, 2006:	Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.
January 3, 2006 - October 1, 2006:	Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.
October 2, 2006 - May 22, 2007: (*This is stage 2, the subject of CR4023)*	CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.* Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.
May 23, 2007 – Forward:	CMS systems will only accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007.

Claim Rejection

Claims will be rejected if:

- The NPI included in a claim or claim status request does not meet the content criteria requirements for a valid NPI; this affects:
- X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only);
- National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only);
- Claims submitted using Medicare's free billing software;
- Electronic claim status request received via X12 276 or DDE screen; and
- Non-X12 electronic claim status queries;
- An NPI reported cannot be located in Medicare files;
- The NPI is located, but a legacy identifier reported for the same provider in the transaction does not match the legacy identifier in the Medicare file for that NPI;
- Claims include the NPI but do not have a taxpayer identification number (TIN) reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare's free billing software.

Note: If only provider legacy identifiers are reported on an inbound transaction prior to May 23, 2007, pre-NPI provider legacy number edit rules will be applied to those legacy identifiers.

Additional Information

X12 837 Incoming Claims and COB

During Stage 2, an X12 837 claim may technically be submitted with only an NPI for a provider, **but you are strongly encouraged to also submit the corresponding Medicare legacy identifier for each NPI** in X12 837 Medicare claims.

Use of both numbers could facilitate investigation of errors if one identifier or the other cannot be located in the Medicare validation file. When an NPI is reported in a claim for a billing or pay-to provider, a TIN must also be submitted in addition to the provider's legacy identifier as required by the claim implementation guide.

National Council of Prescription Drug Plans (NCPDP) Claims

The NCPDP format was designed to permit a prescription drug claim to be submitted with either **an NPI or a legacy identifier, but not more than one identifier** for the same retail pharmacy or prescribing physician. The NCPDP did provide qualifiers, including one for NPIs, to be used to identify the type of provider identifier being reported.

- For Stage 1, retail pharmacies were directed to continue filing their NCPDP claims with their individual NSC number and to report the UPIN of the prescribing physician.
- During Stage 2, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have the prescribing physician's NPI) in their claims.

When an NPI is submitted in an NCPDP claim, it will be edited in the same way as an NPI submitted in an X12 837 version 4010A1 claim. The retail pharmacy will be considered the primary provider and the prescribing physician as the secondary provider for NPI editing purposes.

Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006 and end February 28, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

Pending the start of submission of the revised CMS-1500 and the UB-04, providers must continue to report legacy identifiers, and not NPIs, when submitting claims on the non-revised CMS-1500 and the UB-92 paper claim forms.

Provider identifiers reported on those claim forms are presumed to be legacy identifiers and will be edited accordingly. "Old" form paper claims, received through the end of the transition period that applies to each form, may be rejected if submitted with an NPI.

Or, if they are not rejected—since some legacy identifiers were also 10-digits in length—could be incorrectly processed, preventing payment to the provider that submitted that paper claim.

Standard Paper Remits (SPRs)

The SPR FI and carrier/DMERC formats are being revised to allow reporting of both a provider's NPI and legacy identifier when both are available in Medicare's files. If a provider's NPI is available in the data center provider file, it will be reported on the SPR, even if the NPI was not reported for the billing/pay-to, or rendering provider on each of the claims included in that SPR. The revised FI and carrier/DMERC SPR formats are attached to CR4023:

- CR 4023 Attachment 1: FI Standard Paper Remit (SPR) Amended Format for Stage 2; and
- CR 4023 Attachment 2: Carrier/DMERC SPRAmended Stage 2 Format.

Remit Print Software

The 835 PC-Print and Medicare Remit Easy Print software will be modified by October 2, 2006, to enable either the NPI or a Medicare legacy number, or both, if included in the 835, to be printed during Stage 2.

Free Billing Software

Medicare will ensure that this software is changed as needed by October 2, 2006, to enable reporting of both an NPI and a Medicare legacy identifier for each provider for which data is furnished in a claim, and to identify whether an entered identifier is an NPI or a legacy identifier.

In-Depth Information

Please refer to CR4023 for additional detailed NPI-related claim information about the following topics:

- Crosswalk
- X12 837 Incoming Claims and COB
- Non-HIPAA COB Claims
- NCPDP Claims
- DDE Screens
- Paper Claim Forms
- Free Billing Software
- X12 276/277 Claim Status Inquiry and Response Transactions
- 270/271 Eligibility Inquiry and Response Transactions
- 835 Payment and Remittance Advice Transactions
- Electronic Funds Transfer (EFT)
- Standard Paper Remits (SPRs)
- Remit Print Software
- Claims History
- Proprietary Error Reports
- Carrier, DMERC, and FI Local Provider Files, including EDI System Access Security Files
- Med A and Med B Translators
- Other Translators
- Stages 3 and 4

CR4023, the official instruction issued to your FI/ regional home health intermediary (RHHI) or carrier/durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to *http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp* on the CMS website. From that Web page, look for CR4023 in the CR NUM column on the right, and click on the file for that CR.

You may also wish to review *Medlearn Matters* article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition *Medlearn Matters* Articles on NPI-Related Activities," which is available at *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0555.pdf* on the CMS website. This article contains further details on the NPI and how to obtain one.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find their toll free phone number, go to *http://www.cms.hhs.gov/medlearn/tollnums.asp* 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: MM4023
Related CR Release Date: November 3, 2005
Related CR Transmittal #: 190
Related Change Request (CR) #: 4023
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Revision to Chapter 31 – Attestation Form for Conducting Real Time Eligibility Inquiries with Medicare

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Providers who access the 270/271 health care eligibility inquiry and response application in real time

Provider Action Needed

STOP – Impact to You

Beginning September 1, 2005, an on-line attestation form (*Trading Partner Agreement for Submission of 270s to Medicare on a Real-Time Basis)* must be completed by submitters authenticated by the Centers for Medicare & Medicaid Services (CMS) to conduct 270/271 transactions with CMS before providers may access the real-time 270/271 health care eligibility inquiry and response application.

CAUTION – What You Need to Know

Submitters requesting access to the Medicare beneficiary database must follow the procedure outlined in the *Additional Information* section below.

GO – What You Need to Do

Please be sure to fill out this new agreement form located at *http://www.cms.hhs.gov/it* so you can conduct 270/271 transactions with Medicare.

Background

The purpose of Change Request (CR) 4093 is to alert Medicare providers to the revision in the *Medicare Claims Processing Manual*, Chapter 31 (ANSI X12N Formats Other than Claims or Remittance).

This revision addresses the standards for Medicare beneficiary eligibility inquiries, and creates the database and infrastructure needed to provide a real-time, centralized Health Insurance Portability and Accountability Act (HIPAA) compliant Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

Additional Information

Access Process for Clearinghouses/Provider

Beginning September 1, 2005:

- The Medicare Eligibility Integration Contractor (MEIC) will e-mail the on-line attestation form outlining security and privacy procedures for submitters already submitting authenticated 270 transactions on a real time basis.
- Each Submitter should complete the form in its entirety and transmit it back via e-mail to *MCAREHD@emdeon.com.*

Beginning October 1, 2005:

- Submitters will be able to access the appropriate forms for the CMS 270/271 Medicare Eligibility transaction at: *http://www.cms.hhs.gov/AccessToDataApplication*
- The submitter must provide the information requested on the form electronically and click on the appropriate assurances. If the submitter does not consent to the terms of the agreement, by appropriately completing the form, the access process will be terminated.
- A copy of the appropriately completed form must be electronically submitted to CMS. Once CMS has the completed form, it will be authenticated, at which time the submitter will then be directed to complete an Medicare Data Communications Network (MDCN) connectivity form and submit it electronically in order to be connected to the 270/271 eligibility database.

CMS staff will make sure that all of the necessary information is provided on the form, and will ensure the complete connectivity to the 270/271 application.

A CMS contractor known as the Medicare Eligibility Integration Contractor (MEIC) will contact the submitter in order to authenticate the accessing entity's identity.

Once authentication has been completed, the MEIC will provide the Clearinghouses, Providers, and Trading Partners with a submitter identification (ID) that must be used on all 270/271 transactions.

The MDCN extranet application is suitable for many providers that can create, send, and receive complete X12 eligibility transactions. CMS will soon offer a second solution for providers that desire to conduct the transaction using the Direct Data Entry (DDE) version. The DDE version will allow all approved providers to conduct eligibility transactions over the public internet at no cost to the provider.

Please note that in order to access the MDCN, an entity must obtain the necessary telecommunication software from the AT&T reseller on its own. AT&T Resellers and contact cumbers include the following:

- IVANS: *http://www.ivans.com*; Telephone: 1-800-548-2675
- McKesson: *http://www.mckesson.com*; Telephone: 1-800-782-7426; Key option 5, then key option 8

MEIC Helpdesk Support

You may also contact the MEIC help desk for connectivity issues on Monday through Friday, 7:00 a.m. - 9:00 p.m. EST; Telephone: 1-866-324-7315; E-mail address: *MCARE@cms.hhs.gov*.

Related Links

The official instruction issued to your fiscal intermediary (FI), regional home health intermediary (RHHI), carrier, or durable medical equipment regional carrier (DMERC) regarding this change may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R700CP.pdf* on the CMS website.

Please refer to your local FI, RHHI, Carrier or DMERC for more information about this issue. To find the toll free phone number, go to *http://www.cms.hhs.gov/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: MM4093
Related Change Request (CR) #: 4093
Related CR Release Date: October 7, 2005
Effective Date: October 1, 2006
Related CR Transmittal #: 700
Implementation Date: November 7, 2005

Termination of the Medicare HIPAA Incoming Claim Contingency Plan, Addition of a Self-Assessable Unusual Circumstance, Modification of the OTAF Exception, and Modification of ASCA Exhibit Letters A, B and C

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Physicians, providers, and suppliers who submit claims to the Centers for Medicare & Medicaid Services (CMS) Medicare contractors (carriers, fiscal intermediaries (FIs), durable medical equipment regional carriers (DMERCs) or regional home health intermediaries (RHHIs))

Background

This article, based on CR4119, summarizes some of the key revisions to electronic data interchange (EDI) requirements contained in the *Medicare Claims Processing Manual*, Chapter 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims). Some of these changes have already been reported in earlier Medlearn Matters articles and are mentioned here only as reminders.

The EDI policy revisions are necessary for:

- HIPAA compliancy, including contingency plan termination, and free claim software changes;
- Administrative Simplification Compliance Act (ASCA) compliancy, including unusual circumstance, "Obligated to Accept as Payment in Full" (OTAF) modification, and modified ASCA letters.

Medicare providers must adhere to these electronic data interchange requirements. Electronic transactions that do not fully comply with the implementation guide requirements for these formats will be rejected.

Key Points

Medicare HIPAA Incoming Claim Contingency Plan

The Medicare HIPAA incoming claim contingency plan has been terminated. All electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the National Council for Prescription Drug Program (NCPDP) Telecommunication Standard requirements and the Batch Standard 5.1 (DMERCs only) will be rejected. Please refer to the *Additional Information* section of this article for more information.

Until the Medicare contingency plan for **HIPAA mandated transaction types other than claims sent to Medicare is terminated**, Medicare contractors **will support** the pre-HIPAA

electronic transaction formats listed in the *Medicare Claims Processing Manual*, Chapter 24, Section 40.2 (attached to CR 4119).

Please refer to the *Additional Information* section of this article for more information.

NCPDP Claims

NCPDP claims submitted to DMERCs may contain modifiers for compound drugs in the **narrative portion** in the prior authorization segment on the NCPDP standard since it does not currently support reporting modifiers in the compound segment. Please refer to the attachment to CR4119, *Medicare Claims Processing Manual*, Chapter 24, Section 40.2 – B, for further instructions and a list of the modifiers.

Currently Coordination of Benefits (COB) trading partners are not able to accept NCPDP format transmissions for **secondary payment**. CMS is working with the NCPDP to develop a "workaround" to resolve this problem, however, until then; NCPDP claims will not be crossed over to other payers. **Retail pharmacies will need to bill secondary payers directly to collect supplemental benefits that may be due for those claims.** Transmission of pre-HIPAA electronic format claims to other payers under a COB agreement will end when (the earliest of the date) a trading partner completes successful testing on the use of the X12 837 version 4010A1 and /or the HIPAA NCPDP format (as appropriate); or the Medicare HIPAA COB contingency plan ends.

Other Issues

Medicare secondary payer claims may be submitted **non-electronically** when a primary payer has made an "Obligated to Accept as Payment in Full" (OTAF) adjustment, **and there is more than one primary payer.** Providers have been directed to report OTAF adjustments in a CN1 segment of a claim, but it is not possible to either identify which primary payer owns a reported OTAF adjustment, or to report more than one OTAF adjustment in the event they apply to each primary payer.

The free billing software (from your Medicare contractor) should be able to **identify when Medicare is a secondary payer**. It should also be able to collect standard claim adjustment reason codes and adjustment amounts made by a primary payer when Medicare is the secondary payer. If it is not collecting this information, the software must be modified to enable this requirement.

Unusual Circumstances

Certain "unusual circumstances" are automatically waived from the electronic claim submission requirement for either the indicated claim type, or for the period when an "unusual situation" exists. CMS has added a circumstance to the self assessable Unusual Circumstance list in which **paper claim submission is permitted**. **Home oxygen therapy claims** for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO2 is more than 60 mmHg but a combination of factors necessitates use of oxygen. The X12 work group responsible for development of the version 4010A1 implementation guide recognizes that there is a deficiency in the guide pertaining to home oxygen therapy claims. This will be corrected in a later version of that implementation guide, but in the interim, covered entities are bound by the existing version 4010A1 requirements. As result, CMS will permit claims that meet this situation to be submitted on paper.

Modified examples of ASCA exhibit letters A, B, and C can be found in the manual attachment to CR4119 (*Medicare Claims Processing Manual*, Chapter 24, Exhibits of Form Letters). Your Medicare contractor will send these revised letters, as appropriate.

- Exhibit A—Response to a non- "unusual circumstance" waiver request
- **Exhibit B—Denial of an "unusual circumstance" waiver request**
- Exhibit C—Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper

Additional Information

Medicare HIPAA Incoming Claim Contingency Plan Termination

All electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the NCPDP requirements will be rejected. The Medicare contingency plan for the X12 835, 276/277 (version 4010 support will need to be terminated), 837 claims that Medicare sends to another payer as provided for in a trading partner agreement, and the 270/271 version 4010A1 transactions remain in effect pending further notice. CMS will issue advance notice to the health care industry when a decision is reached to terminate the remaining Medicare contingency plans.

HIPAA Mandated Transaction Types Other Than Claims Sent to Medicare

Until the Medicare contingency plan (mentioned above) is terminated, Medicare contractors will support the pre-HIPAA electronic transaction formats listed in the *Medicare Claims Processing Manual*, Chapter 24, Section 40.2. These include for claims submitted to:

- All Medicare contractors – UB – 92 version 6.0 claims for coordination of benefits (COB) sent to other payers under trading partner agreements; proprietary format for eligibility data responses using the CMS standard eligibility data set; and X12 276/277 version 4010.
- FIs – X12 837 institutional version 4010 and 3051; X12 835 versions 3030Ma, 3051.3A, and 3051.4A for remittance advice.
- Carriers and DMERCs – X12 837 professional version 4010 and 3051; National Standard Format (NSF) version 3.01; X12 835 IG versions 3030Mb, 3051.3B, and 3051.4B for remittance advice; and NSF version 3.01.
- Carriers only - X12 270/271 IG version 3051 for eligibility query and response.
- Please note - Specifications for each of these transactions can be found the Washington Publishing Company website at *http://www.wpcedi.com/HIPAA* for those X12 IGs (other than the NCPDP) adopted as national standards under HIPAA.

The official instruction, CR4119, issued to your FI/RHHI, or carrier/ DMERC, regarding this change may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R802CP.pdf.* Attached to CR4119, you will find the revised portions of the *Medicare Claims Processing Manual* referenced in this article.

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

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

Medlearn Matters Number: MM4119
Related Change Request (CR) #: 4119
Related CR Release Date: December 30, 2005
Effective Date: April 1, 2006
Related CR Transmittal #: R802CP
Implementation Date: April 3, 2006

FRAUD AND ABUSE

OIG Reports $35.4 Billion in Savings and Recoveries

The Department of Health & Human Services (HHS) Office of Inspector General (OIG) Semiannual Report to Congress reported total fiscal year (FY) 2005 savings and expected recoveries of nearly $35.4 billion, more than doubling savings and recoveries since FY 2000. Specifically, OIG's FY 2005 $35.4 billion in savings encompasses $32.6 billion in implemented recommendations to put funds to better use, $1.2 billion in audit receivables, and $1.6 billion in investigative receivables. Also for this reporting period, OIG reported exclusions of 3,806 individuals and entities for fraud or abuse of federal health care programs and/or their beneficiaries; 537 criminal actions against individuals or entities that engaged in crimes against departmental programs; and 262 civil actions, which include False Claims Act and unjust enrichment suits filed in district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters. OIG continues to be an aggressive force within HHS to improve the efficiency and effectiveness of the Department and to punish those who defraud its programs. OIG is dedicated to maintaining public credibility of HHS programs. OIG enforcement action in the second half of FY 2005 included the HealthSouth Corporation fraud settlement of $325 million plus interest paid to the U.S. Government. HealthSouth also entered into a five-year corporate integrity agreement with OIG. The settlement resolved allegations of Medicare Part A cost report fraud uncovered during the Government's investigation of the company's financial statements. The settlement also resolved allegations that the company submitted false claims to Medicare Part B for certain outpatient physical therapy services.

Also among OIG FY 2005 accomplishments were two audits of New York City's Medicaid claims for school-based services. One report found that 86 sampled claims for speech services did not comply with federal and state requirements. In the second report, none of the sampled claims for transportation services complied with all federal and state requirements. OIG recommended that the state refund $532 million to the federal government, resolve an additional $12 million in set-aside claims, and provide proper and timely guidance on federal Medicaid criteria to New York City. OIG testified before the Senate Finance Committee in late June regarding states' use of Medicaid financing mechanisms and pricing of Medicaid prescription drugs. Intergovernmental transfers (IGT), one such state financing mechanism, are transfers of non-federal public funds between local public Medicaid providers and state Medicaid agencies. Misuse of IGTs circumvents the federal/state Medicaid partnership and increases federal payments to states at the expense of the intended beneficiaries. One example of IGTs involves upper-payment-limit (UPL) funds, which are intended to reimburse Medicaid providers but are often retained by the states. OIG audits identified several nursing homes in which the quality of care was adversely affected because they were not allowed to retain enough UPL funds to provide adequate staffing. In addition, OIG, in a series of three evaluation reports, found that statutorily defined prices for prescription drugs in the Medicare and Medicaid programs based on actual sales were substantially lower than published prices (average wholesale price) and wholesale acquisition costs. The semiannual report describes OIG investigations and evaluation and audit reports finalized during the reporting period. This publication is a significant indicator of the progress OIG has made and the challenges the Department faces in achieving even greater economy and efficiency. To read more about OIG activities to identify fraud and abuse involving HHS programs, go to: *http://oig.hhs.gov/publications/docs/semiannual/2005/SemiannualFall05.pdf*.

Source: Office of Inspector General News, December 2, 2005

PRESCRIPTION DRUG COVERAGE

Medicare Prescription Drug Coverage: Essential Information and Resources for Prescribing Health Care Professionals

The Eleventh in the Medlearn Matters Series of Articles on the New Prescription Drug Plans

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All health care professionals who prescribe prescription medications for Medicare beneficiaries.

Impact on Providers

The new Medicare prescription drug coverage began on January 1st. Already, pharmacists have filled millions of prescriptions for people with Medicare. During this important transition period to the new prescription drug coverage, the Centers for Medicare & Medicaid Services (CMS) understands that there is much that prescribing health care professionals need to know about this new coverage in order to help their Medicare patients.

Essential Information for Prescribing Health Care Professionals

CMS has compiled a list of information, resources, and tools that will allow health care professionals and their support staff to help their Medicare patients during this transition period.

Finding formulary Information

CMS has a formulary finder that provides direct access to all plan websites at *http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp* on the Web. In addition, we have worked with Epocrates to provide free software which makes the formulary selection process very simple. You can load this program into your PDA or run the software on a desktop. This tool is available at *http://www.epocrates.com/* on the Web.

Coverage Determination

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, an enrollee can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

CMS does not have the authority to mandate a standard exception process for each Medicare drug plan or MA-PD; however, the Agency is working to simplify the exceptions process. Like typical commercial payers, health care professionals may occasionally need to help a patient file a prior authorization for a medication or appeal a medication's tier. CMS is working with medical specialty societies to address these issues.

A form has been created by a coalition of medical societies and advocacy groups that can be faxed to your office by a pharmacist when he or she is given a prescription that is either not on the formulary or on a higher tier.

This form streamlines communication between the pharmacist and the physician and reduces the need for time consuming telephone calls to the doctor's office.

The form is located at *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartDPharmacyFaxForm.pdf* on the CMS website, as well as at several medical society websites.

Expedited Review Process

There is an expedited review process that CMS has outlined to ensure that drug plans can move an appeal quickly, i.e., within a 24-hour turnaround time, to provide medicines to patients with an immediate need. Beyond this expedited review process, the standard appeals process to challenge a plan's coverage determination has five levels:

- Redetermination by the plan;
- Reconsideration by a Medicare drug coverage qualified independent contractor (QIC);
- An Administrative Law Judge (ALJ) hearing;
- Review by the Medicare Appeals Council; and
- Review by federal district court.

Visit *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp* for a list of plan contacts you can use to query your patient's plan should you need to pursue an appeal or require clarification on an issue.

Part B Drugs vs. Drugs Covered under Medicare Prescription Drug Coverage (Part D)

A previous Medlearn Matters article explains the difference between drugs covered under Part B versus those covered under Part D.

This article can be found at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0570.pdf* on the CMS website. Additionally, a chart explaining specific drugs can be found at *http://www.cms.hhs.gov/pharmacy/downloads/partsbdcoverageissues.pdf* on the CMS website.

Verifying Beneficiary Enrollment in a Medicare Drug Plan

Office staff can use the Medicare Prescription Drug Plan Finder, located at *http://www.medicare.gov*, to verify a beneficiary's enrollment in a Medicare drug plan. By entering all information provided on a beneficiary's Medicare card, the Plan Finder will identify the plan in which the beneficiary is enrolled.

Pharmacists have access to a new computer tool called "E1" that provides real time enrollment and eligibility information. This tool provides both eligibility and billing information at the point of sale and is constantly updated by CMS.

Obtaining Prior Authorizations

A prior authorization can only be obtained by calling the drug plan directly. 1-800-MEDICARE cannot process a prior authorization.

Ensuring Coverage for a Dual Eligible Beneficiary Who Needs to be Enrolled in a Plan

CMS has ensured that people with Medicare and full Medicaid benefits (full dual) will have drug coverage by enabling customer service representatives at 1-800-MEDICARE to enroll these beneficiaries in WellPoint, a national plan.

If these beneficiaries have **immediate prescription needs**, they should visit their local pharmacies. The pharmacist can enroll them in WellPoint at the pharmacy.

To find out more about what happens with Medicare prescription drug coverage in certain situations, visit *http://www.cms.hhs.gov/Pharmacy/Downloads/whatif.pdf* on the CMS website.

Providing a 30-day Supply of Transitional Prescription Medication

CMS has instructed all Medicare-approved plans to provide patients who are on stabilized drug regimens with at least a 30-day supply of their current medication, even if their particular drug is not on their plan's formulary. Plans have also been instructed to extend this temporary coverage on a case-by-case basis.

Important Contact Information to Report Problems with Medicare Prescription Drug Coverage

Health Care Professionals: E-mail *prit@cms.hhs.gov* with problems and issues encountered. Please take advantage of CMS' regular conference call at 2PM EST every Tuesday. This call gives health care professionals an opportunity to ask questions of CMS staff. Call 1-800-619-2457; Passcode: RBDML.

Pharmacists: Call 1-866-835-7595, a CMS dedicated line designed to help answer questions regarding billing and beneficiary enrollment information.

Additional Information

Health care professionals can visit *http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage* on the CMS website. The redesigned web page contains all the latest information on Medicare prescription drug coverage.

Medlearn Matters Number: SE0603
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

Clarification on Part D and Fee-For-Service Providers, New Web-based Educational Products, and the Latest Information on Medicare Prescription Drug Coverage

This information was previously published in the First Quarter 2006 Medicare B Update! pages 117-119.
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: This article was revised on January 27, 2006, to provide new web addresses that reflect changes in the new CMS web site. All other information remains the same.

Provider Types Affected

Physicians, providers, suppliers, and their staff who provide service to people with Medicare

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.
- It will cover brand name and generic drugs.
- This new drug coverage requires all people with Medicare to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Therefore, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients.
- You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.
- If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to *http://www.medicare.gov* for information and assistance.

Clarifying Information for Fee-For-Service (FFS) Medicare Providers

Billing for Drugs Covered Under Part D

There has been some confusion among FFS providers regarding their ability to bill drugs covered under Part D, commonly referred to as "Medicare Prescription Drug Coverage." In short, being an enrolled provider in the FFS program does not impart Part D-related billing privileges. Medicare Part B covers a limited number of prescription drugs and biologicals. Currently, covered Medicare drugs generally fall into three categories:

- Drugs furnished incident to a physician's service;
- Drugs furnished through a Medicare Part B covered item of durable medical equipment (DME); and
- Drugs specifically covered by statute (for example, oral immunosuppressive drugs).

These drugs continue to be covered and paid for under the FFS Medicare program (i.e., Part B) and FFS providers (e.g., physicians, hospitals, and pharmacies) will continue to bill their carriers, fiscal intermediaries, and durable medical equipment regional carriers (DMERCs) for these drugs.

This coverage under Part B continues after the January 1, 2006 effective date for Part D. (For a more detailed discussion of Medicare Part B covered drugs, see http://www.cms.hhs.gov/providers/drugs/ on the CMS website.)

How Medicare Prescription Drug Coverage Will be Administered

Medicare prescription drug coverage under Part D will be administered through Medicare Advantage Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs). For a person with Medicare who joins an MA or a PDP, their provider must have a contractual relationship with that MA-PD or PDP to bill and receive payment from the MA-PDP or PDP for that individual's covered prescription drugs. This is true regardless of whether or not the provider is enrolled in the FFS Medicare program and billing FFS Medicare for Medicare Part B covered drugs.

Example: Suppose a pharmacy is currently receiving payment under Medicare Part B for an individual's Medicare Part B covered drug, albuterol, delivered through a *nebulizer,* which is considered to be DME. The pharmacy would, as they do today, bill the local DMERC for this drug. The same individual has joined a PDP and has coverage of albuterol *delivered through a metered dose inhaler (*which is not considered DME under Part B). The pharmacy can only bill the MA-PD or PDP for covered albuterol delivered through a metered dose inhaler if the pharmacy has a contractual relationship with that MA-PD or PDP.

New Information on the Medicare Prescription Drug Coverage Information for Providers Web Page

The following new information can be found on the Medicare Prescription Drug Coverage Information for Providers web page at *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website.

Toolkit for Health Professionals: Medicare Prescription Drug Coverage

The Centers for Medicare & Medicaid Services (CMS) has released the Toolkit for Health Care Professionals: Medicare Prescription Drug Coverage, available as an Adobe PDF file (860Kb) at *http://www.cms.hhs.gov/medlearn/provtoolkit.pdf* on the CMS web site. This toolkit includes downloadable educational materials specifically for physicians and other health care professionals and their staff to learn the basics about Medicare Prescription Drug Coverage. It also includes materials that can be distributed to Medicare patients. The kit contains reproducible artwork, a letter from the CMS Administrator, a fact sheet (English and Spanish), a brochure, an article, and a list of other resources. You may add your logo and business information to these materials and copy freely.

Limited Income? SSA Can Help - Posters to Display in Health Care Settings

Flat wall posters directing people with Medicare who have limited income to a number they can call to find out if they are eligible for help with prescription drug costs are available now. Posters are suitable for display in a physician's, provider's or supplier's office, a pharmacy, or other health care setting where people with Medicare will see this information. Easel posters are no longer available. To order, visit the Medlearn Product Ordering Page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS website.

New Fact Sheets Available On the Medicare Website

The following Fact Sheets are now available at *http://www.medicare.gov*. These can help your patients better understand Medicare's new prescription drug coverage:

Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Have Coverage from an Employer or Union (Publication Number 11107)

Basic information about Medicare's new prescription drug coverage for people who have prescription coverage from an employer or union. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11107.pdf*.

Quick Facts about Medicare's New Coverage for Prescription Drugs for People with a Medicare approved Drug Discount Card (Publication Number 11104)

Basic information about Medicare's new prescription drug coverage for a person with a Medicare-approved drug discount card. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11104.pdf*.

New Medicare Prescription Drug Coverage—Who Can Help Me Apply and Enroll? (Publication Number 11125)

Explains who can help people with Medicare apply for extra help in paying for prescription drug costs and join a Medicare prescription drug plan. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11125.pdf*.

Quick Facts about Medicare's New Coverage for Prescription Drugs for People in a Medicare Health Plan with Drug Coverage (Publication Number 11135)

Basic information about Medicare's new prescription drug coverage for people with a Medicare health plan with prescription drug coverage. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11135.pdf*.

New Medicare Prescription Drug Coverage: A Message for People Who Care for Someone with Medicare (Publication Number 11126)

Explains Medicare's new prescription drug coverage to those who make health care decisions for people with Medicare. (4 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11126.pdf*.

Quick Facts about Medicare's New Coverage for Prescription Drugs for Alaskans with Limited Income and Resources (Publication Number 11105_AK)

Basic information about Medicare's new prescription drug coverage for a person with limited income and resources in Alaska. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11105_AK.pdf*.

Quick Facts about Medicare's New Coverage for Prescription Drugs for Hawaiians with Limited Income and Resources (Publication Number 11105_HI)

Basic information about Medicare's new prescription drug coverage for a person with limited income and resources in Hawaii. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11105_HI.pdf*.

Quick Facts About Medicare Prescription Drug Coverage and Protecting Your Personal Information (Publication Number 11147)

Information about how people with Medicare can protect their personal information when dealing with plans and others about Medicare prescription drug coverage. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11147.pdf*.

New Publications Available on the CMS Website

The following new publications are available by going to *http://www.cms.hhs.gov/medicarereform/factsheets.asp* on the CMS website and clicking on the appropriate links described below:

Basic Questions and Answers About Prescription Drug Coverage

We encourage you to use these basic questions and answers to respond to inquiries from people with Medicare: *http://www.cms.hhs.gov/partnerships/news/mma/qsandas.pdf*.

What Medicare Prescription Drug Coverage Means to You: A Guide to Getting Started

A new brochure available to explain the basics of prescription drug coverage:*http://www.cms.hhs.gov/medicarereform/91007_MedicareBrochure.pdf*.

Additional Information

More information on provider education and outreach regarding drug coverage can be found at *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website.

Detailed drug coverage information for CMS partners and advocates for people with Medicare can be found at http://www.cms.hhs.gov/partnerships/news/mma/default.asp on the CMS website.

You can also find additional information regarding prescription drug plans at *http://www.cms.hhs.gov/pdps* on the CMS website.

Further information on CMS implementation of the Medicare Modernization Act MMA can be found at *http://www.cms.hhs.gov/medicarereform/* on the CMS website.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0557
Related CR Release Date: N/A

Medicare Prescription Drug—More Web-based Educational Products Available

This information was previously published in the Fourth Quarter 2005 Medicare B Update! pages 91-92.
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

The Fifth article in a series of: Information for Providers, Physicians, Pharmacies and their Staff About Medicare Prescription Drug Coverage

Note: This article was revised on January 11, 2006 to provide new web addresses to reflect changes in the new CMS website. All other information remains the same.

Provider Types Affected

Physicians, providers, suppliers, and their staff providing service to people with Medicare

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.
- It will cover brand name and generic drugs.
- This new drug coverage requires all people with Medicare to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Because of this, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients.

- You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.
- If your Medicare patients ask you questions about the new coverage, for additional information and assistance you may refer them to 1-800-MEDICARE and to *http://www.medicare.gov*.

New Fact Sheets Available on *http://www.medicare.gov*

There are fact sheets now available that explain Medicare's new prescription drug coverage that can help your patients understand this new coverage:

- *Quick Facts about Medicare's New Coverage for Prescription Drugs - Publication Number 11102. This fact sheet provides basic information about Medicare's new prescription drug coverage. (2 pages)* *http://www.medicare.gov/Publications/Pubs/pdf/11102.pdf*
- Quick Facts about Medicare's New Coverage for Prescription Drugs for People with Limited Income and Resources – Publication Number 11105. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person with limited income and resources. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11105.pdf
  - *Quick Facts about Medicare's New Coverage for Prescription Drugs If You Applied for Extra Help* – Publication Number 11130. This fact sheet explains what you need to know after applying for extra help paying Medicare prescription drug coverage costs. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11130.pdf*
  - *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Get Supplemental Security Income* – Publication Number 11116. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person who gets Supplemental Security Income benefits or help from their state Medicaid program paying their Medicare premiums. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11116.pdf*.
  - *Quick Facts about Medicare's New Coverage for Prescription Drugs for People with Medicare and Medicaid* – Publication Number 11106. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person with full Medicaid benefits. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11106.pdf*
  - *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who are Nursing Home Residents* – Publication Number 11121. This fact sheet explains how the new Medicare prescription drug coverage works for nursing home residents. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11121.pdf*.
  - *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Get Help From Their State Pharmacy Program* – Publication Number 11108. This fact sheet explains what people who get help from their state pharmacy program to pay for their prescriptions need to know about the new Medicare prescription drug coverage. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11108.pdf*.
  - *Do You Have a Medigap Policy with Prescription Drug Coverage?* – Publication Number 11113. This fact sheet explains how the new Medicare prescription drug coverage works for people who have a Medigap policy with prescription drug coverage. (4 pages). *http://www.medicare.gov/Publications/Pubs/pdf/11113.pdf*.
  - *Medicare Covers America* – Publication Number 11141. This brochure provides basic information for people with Medicare about Medicare prescription drug coverage. This information includes how Medicare prescription drug coverage works, how to get coverage, and how to join a Medicare prescription drug plan. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11141.pdf*.
  - *Introducing Medicare Prescription Drug Coverage* – Publication Number 11142. This brochure provides basic information to people with Medicare about Medicare prescription drug coverage. This information includes who can join, when people can join, and when more information will be available. (2 pages) *http://www.medicare.gov/Publications/Pubs/pdf/11142.pdf*.

New Fact Sheets and Tip Sheets Available on the CMS website at *http://www.cms.hhs.gov/medicarereform/factsheets.asp*

- *The Facts about Medicare Prescription Drug Plans* – Publication Number 11065. This fact sheet provides basic introductory information about Medicare's new prescription drug coverage. (2 pages) *http://www.medicare.gov/Publications/pubs/pdf/11065.pdf*.
- *Quick Facts about Medicare's New Coverage for Prescription Drugs* (en Espanol) – Publication Number 11102-S. This fact sheet provides basic information about Medicare's new prescription drug coverage, in Spanish. *http://www.cms.hhs.gov/medicarereform/elnewcovprescdrug.pdf*.
- *Medicaid Spend Down – Tip Sheet* (3 pages) This tip sheet provides an example of the spend down requirement for patients who have Medicaid because of high medical expenses. This sheet shows the qualifications for patients to receive extra help. *http://www.cms.hhs.gov/partnerships/downloads/medicaidspenddown.pdf.*
- *Food Stamps – Tip Sheet* (3 pages) This tip sheet provides information on income limits, resource limits and qualifications for extra help for people who have Medicare and are also on food stamps. *http://www.cms.hhs.gov/partnerships/downloads/foodstamps.pdf*

- *Medicare Prescription Drug Coverage and other Federal Means – Tested Programs – Tip Sheet* (2 pages) This tip sheet is intended to help explain how Medicare prescription drug coverage will work with other federal means-tested programs such as food stamps, HUD housing assistance, Medicaid, low income home energy assistance, and supplemental security income *http://www.cms.hhs.gov/partnerships/downloads/LowIncome.pdf*

Other Publications/Products

- *Introducing Medicare's New Coverage for Prescription Drugs (bi-fold)* – This pamphlet provides general information about the New Medicare Prescription Drug Coverage, such as who can join, when, and the cost to join, as well as providing sources for additional information. This pamphlet is available at *http://www.medicare.gov/Publications/Pubs/pdf/11103.pdf*.
- V*ignettes/Bios/Case Studies*– These vignettes may be used to help explain how Medicare prescription drug coverage works with and affects other types of health care coverage. They may be used to supplement other outreach materials. (10 pages). These vignettes are available at *http://www.cms.hhs.gov/partnerships/downloads//vignettesfinal.pdf*.
- *Introducing Medicare's New Coverage for Prescription Drugs (Russian, Korean, Vietnamese, and Chinese)* – To access this product, go to *http://www.socialsecurity.gov/multilanguage/CMS/index.htm.*

At the middle of the Web page, select the language desired from the drop-down menu. This will reveal a link to the document in the desired language.

Outreach Toolkit

A new outreach toolkit is also available. This toolkit is designed to equip community-level organizations with the materials needed to provide clear, accurate information and assistance about Medicare prescription drug coverage for their clients.

The toolkit contains basic, straightforward information that may be easily conveyed to people with Medicare. You may view and download this kit online from the CMS web site, as well as order a copy to be shipped to your office, by visiting the CMS website: *http://www.cms.hhs.gov/NationalMedicareYouTrain/Downloads/MPDCToolkit.zip*.

Additional Information

More information on provider education and outreach regarding drug coverage can be found at: *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website.

Detailed drug coverage information for CMS partners and advocates for people with Medicare can be found at *http://www.cms.hhs.gov/Partnerships/05_PDPforPartners.asp#topofpage* on the CMS website.

You can also find additional information regarding prescription drug plans at *http://www.cms.hhs.gov/pdps* on the CMS website.

Further information on CMS implementation of the MMA can be found at *http://www.cms.hhs.gov/MMAUpdate/MMU/list.asp#TopOfPage* on the CMS website.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0541 *Revised*
Related CR Release Date: N/A

The Facts for Providers Regarding the Medicare Prescription Drug Plans That Will Become Available in 2006

The Second in a Series of Medlearn Matters Articles for Providers on Medicare's New Prescription Drug Coverage

This information was previously published in the Third Quarter 2005 Medicare B Update! pages 95-96.

Note: This article was revised on January 11, 2006, to provide new web addresses to reflect changes in the new CMS web site. All other information remains the same.

Provider Types Affected

All Medicare providers and any staff who have contact with Medicare beneficiaries

Provider Action Needed

This special edition article provides updated information regarding the Medicare Prescription Drug Plans that will be available to Medicare beneficiaries in 2006. This new benefit was established by the Medicare Modernization Act (MMA), which was enacted in 2003.

This new drug coverage requires **every** Medicare beneficiary to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage . Because of this, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients. Help can be as simple as referring them to CMS beneficiary educational resources such as 1-800-MEDICARE and *http://www.medicare.gov*. It is important to encourage your patients to learn more about the new coverage as it may save them money on prescription drug costs.

The Basic Plan

Beginning January 1, 2006, new Medicare prescription drug plans will be available to all people with Medicare. Insurance companies and other private companies will be working with Medicare to offer these drug plans and negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards that phase out by May 15, 2006, or

when a beneficiary's enrollment in a Medicare prescription drug plan takes effect, if earlier. The cards offered discounts, while the plans offer insurance coverage for prescription drugs.

Medicare prescription drug plans provide insurance coverage for prescription drugs, and like other insurance plans, participating beneficiaries will pay:

- A monthly premium (generally around $37 in 2006); and
- A share of the cost of their prescriptions (with costs varying depending on the drug plan chosen by the beneficiary).

In addition, drug plans can vary depending on the following:

- What prescription drugs are covered;
- How much the beneficiary pays; and
- Which pharmacies the beneficiary can use.

All drug plans will provide a standard level of coverage which Medicare will set. However, for a higher monthly premium, some plans might offer more coverage and additional medications.

When a Medicare beneficiary joins a drug plan, it is important that they choose one that meets their prescription drug needs. The following questions and answers provide key information that might be of interest to you, your staff, or your patient.

When can your patients enroll in this new plan?

If a beneficiary currently has Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance), the beneficiary can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. In general, a beneficiary can join or change plans once each year between November 15 and December 31. If they join a Medicare prescription drug plan:

- By December 31, 2005, their coverage will begin on January 1, 2006; and
- After December 31, 2005, their coverage will be effective the first day of the month after the month they join.

Even if a beneficiary does not use many prescription drugs now, they still should consider joining a plan. If they don't join a plan by May 15, 2006, and they don't have a drug plan that covers as much or more than a Medicare prescription drug plan, they will have to pay more each month to join later.

What if the Medicare beneficiary can not pay for a Medicare prescription drug plan?

Some people with an income at or below a set amount and with limited assets (including their savings and stocks, but not counting their home) will qualify for extra help.

The exact income amounts will be set in early 2005. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions.

The type of extra help received will be based on income and assets. In mid-2005, SSA will send people with certain incomes information about how to apply for extra help in paying for their prescription drug costs. If they think they may qualify for extra help, they can sign up with the Social Security Administration (SSA) or their local Medicaid office as early as the summer of 2005.

Will this new plan work with other Medicare coverage that your patients may have?

Yes, Medicare prescription drug plans work with all types of Medicare health plans, and there will be:

- Medicare prescription drug plans that add coverage to the Original Medicare Plan (these plans will be offered by insurance companies and other private companies); and
- Medicare prescription drug plans that are a part of Medicare Advantage Plans (like HMOs), in some areas.

What if a Medicare beneficiary has a Medigap policy with drug coverage or prescription drug coverage from an employer or union?

The Medicare beneficiary will get a detailed notice from their insurance company or the employer or union informing them whether or not their policy covers as much or more than a Medicare prescription drug plan.

This notice will explain their rights and choices.

If a Medicare beneficiary's employer or union plan covers as much as or more than a Medicare prescription drug plan, they can:

- Keep their current drug plan. If they join a Medicare prescription drug plan later, their monthly premium won't be higher;
  or
- Drop their current drug plan, and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

If a Medicare beneficiary's employer or union plan covers less than a Medicare prescription drug plan, they can:

- Keep their current drug plan, and join a Medicare prescription drug plan to give them more complete prescription drug coverage; or
- Keep their current drug plan. However, if they join a Medicare prescription drug plan later, they will have to pay more for the monthly premium; or
- Drop their current drug plan and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

Additional Information

More information on provider education and outreach regarding drug coverage can be found at *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website.

The information contained in this article is based on a fact sheet for beneficiaries. To obtain a copy of this fact sheet for your patients, visit*: http://www.medicare.gov/Publications/Pubs/pdf/11065.pdf.*

You can also find additional information regarding prescription drug plans at *http://www.cms.hhs.gov/pdps/* on the CMS website.

Further information on CMS implementation of the Medicare Modernization Act (MMA) can be found at *http://new.cms.hhs.gov/MMAUpdate* on the CMS website.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0502
Related CR Release Date: N/A *Revised*

Your Important Role—Medicare Prescription Drug Plan

This information was previously published in the Third Quarter 2005 Medicare B Update! pages 95-96.
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

#3: Information for Providers, Physicians, Pharmacists and Their Staffs About Medicare Prescription Drug Coverage

Note: This article was revised on January 11, 2006 to provide new web addresses to reflect changes in the new CMS web site. All other information remains the same.

Provider Types Affected

Medicare physicians, institutional providers, pharmacists, and any staff who have contact with Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

On January 1, 2006, a new benefit will be available to the 41 million Americans who receive health insurance coverage through the Medicare program. Medicare Prescription Drug Plans will help reduce the cost of prescription drugs. Your patients may ask you about this new benefit.

CAUTION – What You Need to Know

We need your help to make sure Medicare patients know about and understand this new benefit. Information is just a click away. Through Medlearn Matters articles, we will give you access to various levels of information. You decide the level of involvement you want to have in helping Medicare patients.

GO – What You Need to Do

Stay informed; visit: *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the Web. This website includes links to all articles in this series and information providers need about the new coverage. At a minimum, refer your Medicare patients to 1-800-MEDICARE and *http://www.medicare.gov* on the Web.

Background

You and your staff are trusted sources of information for your patients. You may be the first source of information that Medicare beneficiaries use to explain Medicare Prescription Drug Coverage. Please encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. **If a beneficiary fails to actively choose a prescription drug plan, they may miss out on cost savings for prescription drugs.**

Medicare Prescription Drug Coverage will:

- Help pay for prescriptions;
- Provide extra help for people with limited income and resources; and
- Cover brand name and generic drugs.

The Centers for Medicare & Medicaid Services (CMS) will include Medicare Prescription Drug Coverage details in the *2006 Medicare & You Handbook*, and send it to beneficiaries in October 2005.

Your Role and Involvement – You Choose

Your interest may range from wanting basic to detailed information on this coverage. For example, if you work in a rural locale, or in areas that serve a large population of beneficiaries with limited income and resources, you may have a greater interest in counseling your patients.

- **Basic** - You know that Medicare Prescription Drug Coverage exists and where to send people to learn about benefit details. You may display a poster (available later this spring) in your office or clinic, and make beneficiary-focused materials available in your office.

- **Intermediate** - You know more about Medicare Prescription Drug Coverage, such as:

- How beneficiaries can enroll;
- Co-payment amounts;
- Where to find additional help for people with limited income and resources;
- Where to find information on the following websites:
http://www.medicare.gov
http://www.cms.hhs.gov/medlearn/drugcoverage.asp
- How to answer the basic questions.

- **Advanced** - You know detailed information about Medicare Prescription Drug Coverage and the plans available in your area. You, or someone on your staff, can answer detailed questions about the drug benefit. In some cases, you or your staff may counsel beneficiaries on their particular situation and the options that will work best for them.

To Stay Updated on New Information and Educational Resources

- Pay attention to correspondence from your national professional associations—they are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their listservs and read their newsletters.
- Keep current with information from your Medicare fee-for-service claims processing contractor; bookmark their website, read their bulletins, and register to receive electronic listserv messages.
- Bookmark and visit the provider educational web page on Medicare Prescription Drug Coverage, *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website.
- Register to receive listserv email messages to alert you when new *Medlearn Matters* articles have been released on the new drug benefit (and other Medicare information); register at *http://new.cms.hhs.gov/apps/mailinglists/default.asp?audience=11* on the CMS website.
- Participate in CMS Open Door Forums, to hear from and ask questions of CMS leadership on topics of interest to your particular provider type; for information about these forums visit *http://new.cms.hhs.gov/OpenDoorForums/23_ODF_PNAHP.asp* on the CMS website.

Get Your Staff Involved

In addition, inform members of your staff who interact with Medicare patients every day about the information in this article:

- Physicians – supply this information to nursing and front office staff.
- Hospitals - supply this information to nursing, discharge planning, financial, and emergency room staff.
- Pharmacists - supply this information to your pharmacy technicians and front counter staff.

If you or your staff are willing to further advice and counsel people with Medicare, CMS will have tools to help you do this at *http://www.cms.hhs.gov/partnerships* on the CMS website.

CMS has released the Toolkit for Health Care Professionals: Medicare Prescription Drug Coverage, available as an Adobe PDF file (860Kb) at *http://www.cms.hhs.gov/MedlearnProducts/downloads/provtoolkit.pdf* on the CMS website.

Summary

CMS asks you to:

- Respond to questions from your patients in a way that encourages them to seek more information from the Medicare Program;
- Inform members of your staff who interact with Medicare patients about the information resources available to them, and where they may refer patients to learn more about Medicare Prescription Drug Coverage; and
- At a minimum, refer your Medicare patients who are looking for information on Medicare Prescription Drug Coverage to 1-800-MEDICARE or *http://www.medicare.gov* on the Web.

Related Change Request (CR) #: N/A
Medlearn Matters Number: SE0520
Related CR Release Date: N/A *Revised*

New Educational Products Available

This information was previously published in the Fourth Quarter 2005 Medicare B Update! page 90.
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

The Fourth in the Medlearn Matters Series of Articles on the Medicare Prescription Drug Coverage

Note: This article was revised on January 11, 2006 to provide new web addresses to reflect changes in the new CMS website. All other information remains the same.

Provider Types Affected

Physicians, providers, suppliers, and their staff providing service to people with Medicare

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.
- You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs.
- If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to *http://www.medicare.gov* for additional information and assistance.

This article announces new educational resources available to assist Medicare beneficiaries in their understanding of the new Medicare Prescription Drug Coverage.

Release of Notices to Medicare Beneficiaries Who Automatically Qualify for Extra Help

Starting at the end of May through June, the Centers for Medicare & Medicaid Services (CMS) is mailing notices to people who are automatically eligible for extra help paying for a Medicare prescription drug plan, including people with Medicare and Medicaid, Supplemental Security Income, and Medicare Savings Program coverage.

The notices will let these people know that Medicare prescription drug coverage is coming and that they will get extra help without needing to apply for it.

This summer, the Social Security Administration (SSA) will mail a different letter to other people who do not automatically qualify for the extra help but may be potentially eligible for it. The letter will include an application that people can fill out and return to find out if they qualify for extra help paying for a Medicare prescription drug plan.

This letter can viewed at *http://www.ssa.gov/organizations/medicareoutreach2* on the Social Security Administration website. Select "Application for Help with Medicare Prescription Drug Plan Costs."

Posters - Now Available for Display

Posters titled "Have Limited Income? Social Security Can Help with Prescription Costs" can be ordered free of charge on the CMS web site. The posters are suitable for display in a physician's, providers, or supplier's office; a pharmacy; or other health care setting where Medicare beneficiaries will see this information.

The posters direct Medicare beneficiaries with limited income and resources to a toll free number where they can find out if they are eligible for help with prescription drug costs.

To view and order the posters, go to the Medlearn Prescription Drug Coverage web page located at *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website. We need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

Information Tool Available on Web

The new prescription drug coverage informational tool, "Learn About Your Medicare Prescription Coverage Options" was recently released on *http://www.medicare.gov*. This awareness tool for people with Medicare provides information about what is coming and what actions they will need to take with regard to the new prescription drug coverage.

By answering two or three questions, the individual will be provided with information such as: eligibility for extra help for people with limited income and resources, customized information based on the individual's current coverage, as well as educational resources and links to publications about the new drug coverage.

Summary

CMS understands the pressure on your clinical time with patients, which is why we ask that you inform your Medicare patients that this new prescription drug coverage could be valuable to them and worth exploring. In addition to the products discussed in this article, CMS plans to provide you with access to information you could make available to your patients in your offices.

Additional Information

More information on provider education and outreach regarding drug coverage can be found at: *http://www.cms.hhs.gov/medlearn/drugcoverage.asp* on the CMS website.

Detailed drug coverage information for CMS partners and advocates for people with Medicare can be found at *http://www.cms.hhs.gov/Partnerships/05_PDPforPartners.asp#TopOfPage* on the CMS website.

You can also find additional information regarding prescription drug plans at *http://www.cms.hhs.gov/pdps/* on the CMS website.

Further information on CMS implementation of the Medicare Modernization Act (MMA) can be found at *http://new.cms.hhs.gov/MMAUpdate* on the CMS website.

Medlearn Matters Number: SE0537 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

GENERAL INFORMATION

Consolidation of the Claims Crossover Process: Additional Common Working File (CWF) Functionality

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the Third Quarter 2004 Medicare B Update! pages 49-50.

Note: This article was reissued on January 17, 2006, to reflect new Web addresses for the new CMS website.

Provider Types Affected

All Medicare providers

Provider Action Needed

Medicare physicians, suppliers, and providers should note that this instruction communicates changes to the existing Medicare claims crossover process. CMS is implementing a new initiative known as the "Coordination of Benefits Agreement (COBA) consolidated crossover process." This article provides guidance on the new COBA crossover strategy, including a new claim-based Medigap and Medicaid crossover process to be implemented by Medicare carriers and DMERCs on October 4, 2004. It is especially important to understand that the new claim-based COBA IDs being issued by CMS to Medigap insurers and State Medicaid Agencies must be submitted on incoming claims in certain defined instances, as explained later in this article.

Background

The Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits (COB) program identifies the health benefits available to a Medicare beneficiary and coordinates the payment process to ensure appropriate payment of Medicare benefits. The program offers an automatic crossover service to other insurers, or trading partners, that may pay benefits after the Medicare claim has been processed. The trading partner is charged a fee-per-claim that is crossed by Medicare. COB trading partners include:

- Medicare supplemental insurers (i.e., non-Medigap plans);
- Title XIX State Medicaid Agencies; and
- Medigap insurers

To better service its customers, CMS is streamlining the claims crossover process and is consolidating the claims crossover function under one contractor, the Medicare Coordination of Benefits Contractor (COBC).

As part of this streamlined process, COB trading partners, who are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability, will no longer have to sign separate agreements with individual Medicare carriers and intermediaries. Instead, each COB trading partner will:

- Enter into one national Coordination of Benefits Agreement (COBA) with the CMS consolidated claims crossover contractor (COBC); and
- No longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers, or receive numerous crossover files. They will instead submit one eligibility file periodically and will regularly receive a consolidated file of claims data for those eligibles.

These changes are the result of input from affected stakeholders in the health insurance industry and will result in a more effective implementation of the COBA process and more effective processes for Medicare providers to receive claim payments that are secondary to Medicare benefits. In addition, the revised COBA process will ensure that CMS fulfills the requirements imposed by the HIPAA ANSI-X12 835 (Electronic Remittance Advice (ERA)) Implementation Guide with respect to communication of crossover information to its Medicare providers and suppliers.

Eligibility-Based Crossover Process

As previously mentioned, national COBAs will now be executed with the COBC by the trading partners and trading partners will send COB eligibility files to the COBC. Trading partners that provide eligibility files will be assigned COBA IDs to facilitate the crossover process.

For an eligibility file-based crossover, the COBA ID of the trading partner, along with all other eligibility file data elements associated to an individual beneficiary, will be stored in Medicare's Common Working File (CWF) in the recently established Beneficiary Other Insurance (BOI) auxiliary record. CWF will also house the COBA Insurance file that will contain specific information associated to the trading partner that is identified on the BOI auxiliary record. As Medicare claims are processed, CWF will be equipped to apply each COB trading partner's claims selection criteria against the Medicare claims and provide information to the Medicare carrier or intermediary to enable those entities to place appropriate crossover claims information on the HIPAA ANSI X12N 835 Electronic Remittance Advice sent to providers and suppliers.

Claim-Based Crossover Process

For those Medigap and Medicaid insurers that do not provide COB eligibility files identifying beneficiaries that are insured by their plans, a claim-based crossover process will be implemented by October 4, 2004. Unique five-digit COBA IDs will be assigned by the COBC to Medigap and Medicaid insurers that do not provide eligibility files to the COBC. Medicare providers and suppliers will receive a listing of all Medigap and Medicaid insurers that have been assigned unique claim-based COBA IDs and will be responsible for entering the unique claim-based COBA Ids on each claim submitted to Medicare to initiate the crossing over of claims to the Medigap or Medicaid insurer for supplemental payment to the provider or supplier.

Through this instruction, Medicare claims processing systems will also be modified to house Medigap and Medicaid claim-based COBA IDs and the associated Medigap or Medicaid information necessary for the Medicare carrier or DMERC to prepare an ERA and send the claim to the COBC to cross to the Medigap or Medicaid insurer. The Part B or DME provider or supplier is required to include a claim-based COBA ID on incoming Medicare claims where:

- The beneficiary presents (or has presented) some evidence of his/her coverage under a Medigap plan or eligibility for Medicaid benefits and a corresponding COBA ID for the identified Medigap insurer or State Medicaid Agency can be located on CMS' COBA claim-based ID listing;
- The provider or supplier participates in the Medicare Program. Note that this condition applies both to Medigap and Medicaid claim-based crossover; and
- The beneficiary assigns (or has assigned) his/her Medigap benefits to the provider or supplier.

Implementation

The implementation date for this instruction is July 6, 2004

Because of this instruction's impact on providers and suppliers, carriers and DMERCs will not be required to implement the COBA claim-based crossover requirements described in this instruction until October 4, 2004. Effective October 4, 2004, all participating Part B and DME providers and suppliers will cease including the carrier or DMERC-issued Medigap or Medicaid ID on incoming claims. Instead, they will begin to include the claim-based COBA ID, which will be assigned by Medicare's Coordination of Benefits Contractor (COBC), on incoming claims. When Part B or DME providers or suppliers check the claim-based COBA ID listing and locate the beneficiary's identified Medigap plan, they will include the Medigap claim-based COBA ID on the incoming claim if the provider or supplier participates in the Medicare Program, and the beneficiary assigns (or has assigned) his/her rights to benefits to the provider or supplier. When Part B or DME providers or suppliers that participate in the Medicare Program check the claim-based COBA ID listing and locate the State Medicaid Agency that pays benefits for the beneficiary, they will include the Medicaid claim-based COBA ID on the incoming claim.

As of October 4, 2004, CMS will require participating Part B and DME providers and suppliers to include the CMS-issued Medigap or Medicaid claim-based COBA ID on their submitted claims to Medicare if they wish to have their patients' Medicare claims crossed over to the Medigap or Medicaid insurer that does not supply an eligibility file for their insureds. (Section 70.6 of Chapter 28 of the *Medicare Claims Processing Manual* (Pub 100-04) has complete details concerning this requirement as well as other coordination of benefits procedures.)

Additional Information

You can find the CMS Program Manuals Index at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Medlearn Matters Number: MM3109
Related Change Request (CR) #: 3109
Related CR Release Date: February 6, 2004
Effective Date: July 1, 2004
Related CR Transmittal #: R98CP
Implementation Date: July 6, 2004*

*Carriers and durable medical equipment regional carriers (DMERCs) must complete the Coordination of Benefits Agreement (COBA) claim based crossover system changes described in this instruction by July 6, 2004. However, because of this instruction's impact on Part B providers and suppliers, the COBA claim-based crossover process will not be operational until October 4, 2004.

Appeals of Claims and Appeal Decisions for Medicare Part B

Effective January 1, 2006 the Medicare claim appeals process was amended. The reconsideration process has been added as the new second level of appeal. In addition, it is no longer necessary to appeal a claim if a minor error or omission was made which caused the claim to deny. In these cases, the provider can request that the claim be reopened and the error or omission corrected.

Definitions

Levels of Appeal	Definition	Time Limit from Determination	Address
1st - Redetermination	The first appeal level after the initial determination. A redetermination must be submitted to the carrier in writing.	120 days from initial or revised initial determination	**Connecticut** Medicare Part B Appeals First Coast Service Options, Inc. P.O. Box 45041 Jacksonville, FL 32232-5041 **Florida** Medicare Part B Claims Review P.O Box 2360 Jacksonville, FL32231-2100
2nd - Hearings	The second level of appeal for redeterminations made prior to **01/01/06**. These appeals should be submitted to the **carrier** as instructed in your redetermination notice.	Six months from the redetermination	**Connecticut** Medicare Part B Hearings First Coast Service Options, Inc. P.O. Box 45041 Jacksonville, FL 32232-5041 **Florida** Medicare Hearings Post Office Box 45156 Jacksonville FL 32232-5156
New 2nd - Reconsideration	The new second level of appeal for redeterminations made on or after 01/**01/06**. These appeals should be submitted to the **Qualified Independent Contractor** (QIC) as instructed in your redetermination notice.	180 days from redetermination	**Connecticut/Florida** Q2 Administrators, LLC Part B QIC East Operations P.O. Box 183092 Columbus, Ohio 43218-3092 Attn: Administration Manager

Appeal Process

If you are dissatisfied with the determination made on your case you should file an appeal with the appropriate entity. The appropriate entity depends on the level of appeal and the completion date of the determination you are appealing. The name and address for the next level of appeal will appear on your decision notice. Providers, physicians, and other suppliers are responsible for submitting all required documentation with the appeal request.

REMINDER: Unprocessable claims (CO16 denial code) result when the provider submits an incomplete or invalid Medicare claim (EMC or paper). Claims denied as unprocessable because information is incomplete, missing, invalid or non-linked (diagnosis code reference number) cannot be corrected over the telephone or via written appeal. The provider must determine what information is missing or incomplete, correct the billing error and file a new claim to the carrier. Example: A claim submitted with an invalid modifier.

Telephone Reopenings

If you feel your office has made a minor clerical error or omission, (that did not deny as unprocessable) you may request that we reopen the claim to correct the error.

Florida Contact Provider Customer Service - Monday – Friday at 1-866-454-9007 (8:00 a.m. – 4:30 p.m., in Eastern and Central time zones).

Connecticut Contact Telephone Reopening - Monday – Friday at 1-866-535-6790 (9:00 a.m. – 4:00 p.m.)

Continue to contact Provider Services at 1-866-419-9455 Monday – Friday between 8:00a.m. and 4:30p.m. if you feel that Medicare has processed your claim incorrectly.

The provider must be able to provide the beneficiary's:

- Date of Birth;
- Name;
- Medicare HICN

When you call, please have your Remittance Advice and any other documentation on hand. We will only be able to handle three different claims during each call. The following information will be verified during the call:

- Callers Name
- Callers Phone Number
- Provider's Name
- Date(s) of Service
- Item(s) or Service(s) at issue

Examples of minor omissions or clerical errors are as follows:

- Diagnosis code changes
- Number of Services changes
- Place of Service change
- Submitted charge correction
- Date of Service correction
- Add, Change or Delete modifiers excluding 22, 24, 25, 52, 53, 58, 59, 62, 66, 78 and 79
- Procedure code changes excluding codes requiring documentation on the initial submission or codes now being upcoded.

Telephone reopenings are generally inappropriate for the following issues:

- Limitation of liability;
- Medical necessity denials and reductions, or
- Denials requiring manual review of medical documentation

A written redetermination must be requested for the type of denials above.

Redetermination Request

Redetermination requests should be submitted on the Redetermination form with documentation attached to support the service(s) rendered. The redetermination forms are located at:

Connecticut - *http://www.connecticutmedicare.com*

Florida - *http://www.floridamedicare.com*.

Reconsideration Request

Reconsideration requests should be submitted on the reconsideration form attached to your redetermination notice.

Source: CMS Pub 100-4, Chapter 29, Section 310

Centralized Billing for Flu and Pneumococcal Vaccination Claims

Centralized billing is a process in which a provider, who provides mass immunization services for influenza and pneumococcal (PPV) immunizations, can send all claims to a single carrier for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the flu and PPV vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in centralized billing must contact CMS central office (CO), in writing, at the following address by June 1 of the year they wish to begin centrally billing.

Center for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop C4-12-18
Baltimore, Maryland 21244

CRITERIA FOR CENTRALIZED BILLING

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

- To qualify for centralized billing, an individual or entity providing mass immunization services for flu and pneumonia must provide these services in at least three payment localities for which there are at least three different carriers processing claims.
- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.
- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the flu and PPV benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. This practice is unacceptable.
- The carrier assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned carrier for this year is TrailBlazer Health Enterprises.

- The payment rates for the administration of the vaccinations are based on the Medicare physician fee schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.
- The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.
- Centralized billers must submit their claims on roster bills in an **approved** electronic media claims standard format. Paper claims will not be accepted.
- Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. TrailBlazer Health Enterprises must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare health insurance claim number) as the carrier will not be able to process incomplete or incorrect claims.
- Centralized billers must obtain an address for each beneficiary so that a Medicare summary notice (MSN) can be sent to the beneficiary by the carrier. Beneficiaries are sometimes confused when they receive an MSN from a carrier other than the carrier that normally processes their claims which results in unnecessary beneficiary inquiries to the Medicare carrier. Therefore, centralized billers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the processing carrier. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.
- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. TrailBlazer Health Enterprises will provide this information.
- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from TrailBlazer Health Enterprises. This is done by completing the Form CMS-855 (Provider Enrollment Application), which may be obtained from TrailBlazer Health Enterprises.
- If an individual or entity's request for centralized billing is approved, the approval is limited to the 12 month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. TrailBlazer Health Enterprises will not process claims for any centralized biller without permission from CMS CO.
- Each year the centralized biller must contact TrailBlazer Health Enterprises to verify understanding of the coverage policy for the administration of the PPV vaccine, and for a copy of the warning language that is required on the roster bill.
- The centralized biller is responsible for providing the beneficiary with a record of the PPV vaccination. The information in items 1 through 6 below must be included with the individual or entity's annual request to participate in centralized billing:
    1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations
    2. Estimates for the number of beneficiaries who will receive PPV vaccinations
    3. The approximate dates for when the vaccinations will be given
    4. A list of the states in which flu and PPV clinics will be held
    5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse); and
    6. Whether the nurses who will administer the flu and PPV vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering flu and PPV vaccinations.

Source: CMS Internet Only Manual, Chapter 18, Section 10.3.1.1

Explanation of Systems Used by Medicare to Process Your Claims

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

All physicians, providers, and suppliers who submit claims to Medicare

Introduction

This Special Edition article provides a high-level overview of the software systems Medicare uses to process your claims. Frequently, *Medlearn Matters* articles reference Medicare systems and this article will help explain briefly what those systems are.

Sometimes, you may see documents from the Centers for Medicare & Medicaid Services (CMS) that reference the "Shared Systems," or system acronyms, such as FISS, MCS, or CWF. The purpose of this Special Edition article is to provide you with some understanding of these systems and how they are used to process your claims.

Overview

When a beneficiary visits a physician, hospital, or other supplier of health care services, a claim is sent by the provider of the service to a Medicare fiscal intermediary (FI) or carrier, including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs). Collectively, the carriers and FIs, DMERCs, and RHHIs are referred to as Medicare contractors.

Using certain systems, known within CMS as "Shared Systems," the Medicare contractors perform traditional claims processing services, and send claims to another Medicare system, known as the Common Working File (CWF) System for verification, validation, and payment authorization.

Responses are returned from the CWF concerning payments to the FI, RHHI, DMERC, or carrier, who subsequently pays for the service, if appropriate. Only CMS and the Medicare contractors have direct communication with the CWF System. CWF provides an interface between CMS and its contractors.

The Medicare Claims Flow Diagram on the last page of this article illustrates the claims processing flow. In brief, the various systems that process Medicare claims are described as follows:

Shared Systems

There are three "Shared Systems" that process Medicare claims:

- One processes Medicare claims submitted to FIs and RHHIs;
- Another processes claims submitted to carriers; and
- The third processes claims submitted to DMERCs.

All three of the "Shared Systems" interface with the CWF, which is addressed below. These systems apply certain edits to claims received. Claims that do not pass those edits are returned to the provider (RTP) and are often referred to as RTP claims. Examples of claims that may be RTP'ed include those where an invalid health insurance claim number (HICN) or an invalid provider number is supplied on the initial claim.

Fiscal Intermediary Standard System (FISS)

FISS is a mainframe system that FIs and RHHIs use to process Medicare Part A claims nationwide, including outpatient claims submitted under Part B. Within FISS, claims are entered, corrected, adjusted, or canceled. Inquiries for status of claims**,** for additional development requests, or for eligibility and various codes are processed.

Multi-Carrier System (MCS)

MCS is a mainframe system that Medicare Part B carriers use to process Medicare Part B Claims nationwide. It processes claims for physician care, durable medical equipment, and other outpatient services. Like its Part A counterpart, claims are entered, corrected, adjusted, or canceled. Inquiries for status of claims**,** for additional development requests, or for eligibility and various codes are processed.

VMS Shared System

This system has some of the same characteristics as the MCS, but processes claims submitted by suppliers to the Medicare DMERCs.

CMS-Supplied Modules and Pricing/Coding Files

In addition to the "Shared Systems," CMS supplies other uniform modules to FIs, RHHIs, DMERCs, and carriers, and these modules are used by the shared systems in processing Medicare claims. By and large, these modules establish rates (or prices) and processing logic according to type of service.

These modules or programs include the following:

- Those referred to as the PRICERs (there are several PRICERs, such as an inpatient PRICER, an outpatient PRICER, and so on);
- OCE (Outpatient Code Editor);
- MCE (Inpatient Code Editor); and
- GROUPER, which translates variables such as age, diagnosis, and surgical codes into a diagnosis related group (DRG).

In addition, fee schedules and codes are supplied by CMS in the form of downloadable files which are used by the shared systems in processing Medicare claims.

Some of these files include: MPFSDB (Medicare Physician Fee Schedule) and its various forms; DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Schedule); Ambulance Fee Schedule; and HCPCS (Health Care Common Procedure Codes).

Common Working File (CWF)

The CWF contains information about all Medicare beneficiaries. The shared systems interface with the CWF to verify beneficiaries' entitlement to Medicare, deductible status, and benefits available, such as lifetime reserve days. The CWF actually approves payment of each claim. Under CWF, Part A and Part B data for each beneficiary is combined into a single, common working file.

Medlearn Matters Number: SE0605
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

NOTE: Unable to download graphic attached to this special edition article. That graphic may be viewed by going to *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0605.pdf* located on the CMS website.

Medicare Secondary Payer Application to Former Spouses and Certain Family Members with Coverage Under the Federal Employees Health Benefits Program

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.
This information was previously published in the First Quarter 2005 Medicare B Update! pages 72-73.

Note: This article was re-issued on January 17, 2006, to reflect the new address of CR3120 as it appears on the new CMS website.

Provider Types Affected

All Medicare providers

Provider Action Needed

This is an informational article to alert providers that former spouses of certain federal employees, former employees, or annuitants, may qualify to enroll in a health benefits plan under the Federal Employees Health Benefit Plan (FEHB) and the correct order of payment.

A determination has been made that Medicare will be the primary payer for such former spouses, once they are entitled to Medicare based on age or disability.

Background

Certain former spouses of people who have Federal Employees Health Benefits are entitled to coverage under the Spouse Equity Act because their divorce decree gives them the right to a portion of a future retirement annuity and/or to a survivor annuity, and because their former spouse is either an active worker, someone who is entitled to a future annuity, or is an annuitant.

The Medicare law in Section 1862 (b)(1)(A) of the Social Security Act, states that Medicare is secondary payer for individuals age 65 or over who have group health coverage by virtue of their own or a spouse's current employment status. The question was raised as to whether FEHB coverage provided to former spouses under the Spouse Equity Act is secondary to Medicare under this provision. Also, the question has been raised as to whether FEHB coverage provided to the spouse and family members under the Spouse Equity Act is secondary to Medicare under the disability provision.

Under the Spouse Equity Act, the individual is no longer on the former spouse's policy. The coverage is considered to be a separate, self-only policy, i.e., not dependent coverage but a policy separate from the former spouse. The employer makes no contributions to the coverage.

Since the language in the Spouse Equity Act gives the former spouse the right to enroll in FEHB whether or not the spouse himself or herself is enrolled, the FEHB former spouse coverage is not considered employment based. Consequently, Medicare is the primary payer for the former spouse, once they are entitled to Medicare under the working aged provision. Under the Medicare secondary for the disabled provision, Medicare would be primary for the former spouse as well as any covered family members since the coverage is not considered employment based.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R18MSP.pdf* on the CMS website.

Related Change Request (CR) #: 3120	Medlearn Matters Number: MM3120 *Revised*
Related CR Release Date: August 27, 2004	Related CR Transmittal #: R18MSP
Effective Date: November 29, 2004	Implementation Date: November 29, 2004

New Requirements for Low Vision Rehabilitation Demonstration Billing

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

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 which 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 of 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.

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

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 which 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 of 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.

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 Medicare Physician Fee Schedule (MPFS) with jurisdictional pricing; vision services covered under the demonstration provided in a hospital outpatient setting will not be paid under the OPPS 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:

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 5 degrees or less.
Total visual impairment (total blindness)	No light perception

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnostic codes included in the following table will be used to support medical necessity for coverage under the demonstration.

ICD-9-CM	Description
368.41	Scotoma involving central area
368.45	Generalized contraction or constriction
368.46	Homonymous Bilateral Field Defect
368.47	Heteronymous Bilateral Field Defect
369.01	Better Eye: Total Vision Impairment Lesser Eye: Total Vision Impairment
369.03	Better Eye: Near-Total Vision Impairment Lesser Eye: Total Vision Impairment
369.04	Better Eye: Near-Total Vision Impairment Lesser Eye: Near-Total Vision Impairment
369.06	Better Eye: Profound Vision Impairment Lesser Eye: Total Vision Impairment
369.07	Better Eye: Profound Vision Impairment Lesser Eye: Near-Total Vision Impairment
369.08	Better Eye: Profound Vision Impairment Lesser Eye: Profound Vision Impairment
369.12	Better Eye: Severe Vision Impairment Lesser Eye: Total Vision Impairment
369.13	Better Eye: Severe Vision Impairment Lesser Eye: Near-Total Vision Impairment
369.14	Better Eye: Severe Vision Impairment Lesser Eye: Profound Vision Impairment
369.16	Better Eye: Moderate Vision Impairment Lesser Eye: Total Vision Impairment
369.17	Better Eye: Moderate Vision Impairment Lesser Eye: Near-Total Vision Impairment
369.18	Better Eye: Moderate Vision Impairment Lesser Eye: Profound Vision Impairment
369.22	Better Eye: Severe Vision Impairment Lesser Eye: Severe Vision Impairment
369.24	Better Eye: Moderate Vision Impairment Lesser Eye: Severe Vision Impairment
369.25	Better Eye: Moderate Vision Impairment Lesser Eye: Moderate 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 1-2 times per week, and not less frequently than once every two weeks. The sessions are generally 30-60 minutes in duration.

Periodic follow-up and evaluation should be documented by the physician 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, CR3816, 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 CR3816 and CR 4294, and click on the files for those CRs. **Example "G" codes** include:

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

Payable Places Of Service (POS) for Part B claims include:

- Office (11);
- Home (12);
- Assisted living facility (13);
- Group home (14);
- Custodial care facility (33); and
- 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 HCFA 1500. Facilities will use occurrence code 17 for 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), 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 this instruction is April 3, 2006.

Additional Information

As previously 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 in 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/apps/contacts/* on the CMS website.

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

Medlearn Matters Number: 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

Physician Voluntary Reporting Program

The Centers for Medicare & Medicaid Services (CMS) issued revised instructions on the Physician Voluntary Reporting Program on December 23, 2005. These instructions (Pub 100-19, transmittal 35) may be viewed on the CMS website at the following link: *http://www.cms.hhs.gov/Transmittals/Downloads/R35DEMO.pdf*. A revised Medlearn Matters article (MM 4183) titled "Physician Voluntary Reporting Program (PVRP) Using Quality G-Codes" is also available on the website at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4183.pdf*.

Source: Provider Education Resources Listserv, Message 200601-10

Physician Voluntary Reporting Program Using Quality G-Codes

This information was previously published in the January 2006 Medicare B Update! Special Issue pages 77-89.
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: This article was revised on December 29, 2005 since the Centers for Medicare & Medicaid Services revised the related CR4183. The number of measures that will initially be used in the PVRP has been changed to 16 measures. The transmittal number and related CR release date were also changed.

Provider Types Affected

Physicians and other health care providers who bill Medicare

Provider Action Needed

This article provides information about the Centers for Medicare & Medicaid Services' (CMS) Physician Voluntary Reporting Program (PVRP). It will assist physicians in understanding this new voluntary reporting program and the use of G-codes to report data about the quality of care provided to Medicare beneficiaries.

Background

As part of its overall quality improvement efforts, CMS is launching the Physician Voluntary Reporting Program (PVRP). This new program builds on Medicare's comprehensive efforts to substantially improve the health and function of our beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered.

Under the voluntary reporting program, physicians who choose to participate will help capture data about the quality of care provided to Medicare beneficiaries, in order to identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care.

Voluntary reporting of quality data through the PVRP will begin in January 2006.

National Consensus Measures and Indicators

To this end, CMS has begun the process of developing a comprehensive set of national consensus measures and indicators that will allow physicians to more efficiently report quality information on the health services provided to Medicare beneficiaries.

CMS has identified 36 evidence-based clinically valid measures that have been part of the guidelines endorsed by physicians and the medical specialty societies and are the result of extensive input and feedback from physicians and other quality care experts.

However, after announcing the PVRP on October 28, 2005, suggestions have been made by several physician organizations to identify a starter set in order to lessen the potential reporting burden for physicians and better align the PVRP with other quality measurement activities affecting physicians.

CMS has decided to adopt the suggestion of a smaller core starter set of PVRP measures. The core set consists of 16 measures, which will significantly reduce the number of measures applicable to any individual physician practice specialty.

Additionally, we have selected primary care measures based on measures that are National Quality Forum (NQF) endorsed, part of the Ambulatory Care Quality Alliance (AQA) starter set, and that will be used by the Quality Improvement Organization (QIO) programs for physician quality improvement in its eighth Scope of Work (8th SOW). Despite the smaller starter set of 16 measures, the PVRP maintains its same scope of coverage for physician specialties.

Confidential reports available to physicians will be limited to the 16-core starter set. Physicians may report clinical data on the remaining 20 measures, but will not receive summarizing reports.

Moreover, CMS is developing the underlying infrastructure so that the reporting of these measures on existing physician claims could begin as soon as January 1, 2006.

Data Collection through the Administrative Claims System

The usual source of the clinical data for quality measures is retrospective chart abstraction, but data collection through chart abstraction can be quite burdensome. Additionally, while electronic health records may ultimately greatly facilitate clinical data reporting, they do not, at present, provide a widespread means for physicians to report clinical data.

Therefore, to avoid the necessity for chart abstraction, CMS will start the process of collecting quality information on services provided to the Medicare population by using the administrative claims system.

G-Codes

Specifically, CMS has defined a set of HCPCS codes (termed G-codes) to report data for the calculation of the quality measures. These new codes will supplement the usual claims data with clinical data that can be used to measure the quality of services rendered to beneficiaries.

CMS currently has 16 sets of specialty measures. Additional measures to cover a broader set of specialties will be developed over the next few payment cycles.

Each measure has a defined numerator (the appropriate G-code) and a denominator (specifically defined according to the appropriate services or condition). The reporting rate is calculated as a percentage for each of the 16 measures.

You can use G-codes when all of the following circumstances are met:

- The G-code reported on the claim relates to a covered diagnosis, covered treatment(s), or covered preventive service(s) that are applicable to the beneficiary.
- The G-code is directly relevant to the specific service(s) provided to the beneficiary by the practitioner reported on the claim.
- The G-code represents medically necessary and appropriate medical practice under the circumstances.
- The basis for the G-code is documented in the beneficiary medical record.

Important Points for Physicians

- When applicable, the G-code should be reported **in addition to** CPT and ICD-9 codes required for appropriate claims coding.
- They do **not** substitute for CPT and ICD-9 codes requirements for payment.
- They are not associated with a separate fee, and will **not** be individually compensated.
- G-codes are always billed in conjunction with a service and are never billed independently.
- The G-codes should be reported with a submitted charge of zero ($0.00). (G-codes will not appear on the Medicare Physician Fee Schedule Data Base (MPFSDB) because there are no relative value units (RVUs) or amounts for these codes.)
- **They are not specialty specific**. Therefore, a medical specialty may report G-codes classified under other specialties. However, it is anticipated that the reporting of certain G-codes will be predominated by certain specialties.
- The failure to provide a G-code will **not** result in denial of a claim that would otherwise be approved, and thus **submission of a G-code is voluntary.**

Although reporting is voluntary, CMS is encouraging physicians to submit G-codes when applicable. The PVRP's objective is to provide CMS with data that it can use to calculate quality measures. Therefore, CMS will calculate the reporting rate for physicians who participate in the program, and will provide them with feedback information in an effort to assist them in improving their data accuracy and reporting rate.

Additional Information

The specific quality measures related to the G-codes in this initial program launch are reflected in the table at the end of this article.

You can find more information about the physician voluntary reporting program and quality G-Codes by going to *http://www.cms.hhs.gov/Transmittals/downloads/R35DEMO.pdf* on the CMS website.

Appendices accompanying CR4183 contain the specific G-Codes and their descriptors as they relate to the developed quality measures reflected in the above table. The transmittal will list both the 36 proposed measures and the 16 measures which will be used initially in the PVRP.

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

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

Physician Voluntary Reporting Program
G-Codes and Descriptions for Clinical Measures

Measure: Aspirin at arrival for acute myocardial infarction

Numerator:

G8006: Acute myocardial infarction: patient documented to have received aspirin at arrival
G8007: Acute myocardial infarction: patient not documented to have received aspirin at arrival
G8008: Clinician documented that acute myocardial infarction patient was not an eligible candidate to receive aspirin at arrival measure

Denominator:

ICD-9: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, and 410.91

and

CPT 99281-99285, 99221-99223, 99218-99220, 99234-99236, or 99291- 99292

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with acute myocardial infarction. It is anticipated that the patient would receive aspirin therapy upon initial arrival if clinically appropriate.

However, the timeframe for this measure includes the entire 24 hour period before presentation and the 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction who present to the emergency department or the hospital setting.

Measure: Beta blocker at time of arrival for acute myocardial infarction

Numerator:

G8009: Acute myocardial infarction: patient documented to have received beta-blocker at arrival
G8010: Acute myocardial infarction: patient not documented to have received beta-blocker at arrival
G8011: Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure

Denominator:

Patients with ICD-9: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, and 410.91

and

CPT 99281-99285, 99221-99223, 99218-99220, 99234-99236, or 99291- 99292

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with acute myocardial infarction who presents to the hospital emergency department or other hospital setting. It is anticipated that the patient would receive beta-blocker therapy upon initial arrival if clinically appropriate. However, the timeframe for this measure includes the entire 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction in the emergency department or hospital setting.

Measure: Antibiotic administration timing for patient hospitalized for pneumonia

Numerator:

G8012: Pneumonia: patient documented to have received antibiotic within 4 hours of presentation
G8013: Pneumonia: patient not documented to have received antibiotic within 4 hours of presentation
G8014: Clinician documented that pneumonia patient was not an eligible candidate for antibiotic within 4 hours of presentation measure

Denominator:

ICD-9 480.1, 480.2, 480.3, 480.8, 480.9, 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0

and

CPT 99281-99285; 99221-99223, 99218-99220, or 99291-99292

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 is used with the listed CPT services for a patient with pneumonia. This measure should reflect the quality of services for the initial management of a patient with pneumonia presenting to the emergency department and admitted to hospital or a hospital setting. Patients transferred to an emergency department should not be considered an eligible candidate and the clinician should use the appropriate quality G-code indicator to indicate that such a patient is not a candidate for this measure.

Measure: Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus

Numerator:

G8016: Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as less than or equal to 9%
G8015: Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as greater than 9%
G8017: Clinician documented that diabetic patient was not eligible candidate for hemoglobin A1c measure
G8018: Clinician has not provided care for the diabetic patient for the required time for hemoglobin A1c measure (6 months)

Denominator:

ICD-9 250.0-250.9, 357.2, 362.0, 366.41, or 648.0

and

CPT 99201-99205, 99211-99215, 99341-99350, 99304-99310, 99324-99328, 99334-99337, or G0344

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus. It is not anticipated that clinicians would use this indicator if the clinician is not providing services for the primary management of diabetes mellitus.

Measure: Low-density lipoprotein control in patient with Type I or Type II diabetes mellitus

Numerator:

G8020: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as less than 100 mg/dl
G8019: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as greater than or equal to 100 mg/dl
G8021: Clinician documented that diabetic patient was not eligible candidate for low-density lipoprotein measure
G8022: Clinician has not provided care for the diabetic patient for the required time for low-density lipoprotein measure (12 months)

Denominator:

ICD-9 250.0-250.9 , 357.2, 362.0, 366.41, or 648.0

and

CPT 99201-99205, 99211-99215, 99341-99350, 99304-99310, 99324-99328, or 99334-99337

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus. It is not anticipated that clinicians would use this indicator if the clinician is not providing services for the primary management of diabetes mellitus.

Measure: High blood pressure control in patient with Type I or Type II diabetes mellitus

Numerator:

G8024: Diabetic patient with most recent blood pressure (within the last 6 months) documented less than 140 systolic and less than 80 diastolic
G8023: Diabetic patient with most recent blood pressure (within the last 6 months) documented as equal to or greater than 140 systolic or equal to or greater than 80 mmHg diastolic

G8025: Clinician documented that the diabetic patient was not eligible candidate for blood pressure measure
G8026: Clinician has not provided care for the diabetic patient for the required time for blood measure (within the last 6 months)

Denominator:

ICD-9 250.0-250.9, 357.2, 362.0, 366.41, or 648.0

and

CPT 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99304-99306, 99307-99310, 99324-99328, 99334-99337, or G0344

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus.

Measure: Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction

Numerator:

G8027: Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy
G8028: Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy
G8029: Clinician documented that heart failure patient was not an eligible candidate for either angiotensinconverting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy measure

Denominator:

ICD-9 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, or 428.9

and

Patients who had documentation of an ejection fraction < 40% (use most recent value) or moderately or severely depressed left ventricular systolic function

and

CPT 99201-99205, 99211-99215, 99341-99350, 99304-99306, 99307-99310, 99324-99328, or 99334-99337

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services visit are provided to patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment would be an echocardiogram that provides a numerical value of left ventricular systolic dysfunction or that uses descriptive terms such moderate or severely depressed left ventricular dysfunction. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure.

Measure: Beta-blocker therapy for patient with prior myocardial infarction

Numerator:

G8033: Prior myocardial infarction - coronary artery disease patient documented to be on beta-blocker therapy
G8034: Prior myocardial infarction - coronary artery disease patient not documented to be on beta –blocker therapy
G8035: Clinician documented that prior myocardial infarction - coronary artery disease patient was not eligible candidate for beta - blocker therapy measure

Denominator:

ICD-9 414.00-414.07, 414.8, 414.9, 410.00-410.92, 412, 411.0-411.89, 413.0-413.9, V45.81, or V45.82

and

CPT 99201-99205, 99211-99215, 99341-99350, 99304-99306, 99307-99310, 99324-99328, or 99334-99337

and

Patients with prior MI: 410.00-410.92, 412

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients with documented coronary artery disease and prior myocardial infarction. This measure is intended to reflect the quality of services provided for the primary management of patients with coronary artery disease.

Measure: Assessment of elderly patients for falls

Numerator:

G8055: Patient documented for the assessment for falls within last 12 months
G8054: Patient not documented for the assessment for falls within last 12 months
G8056: Clinician documented that patient was not an eligible candidate for the falls assessment measure within the last 12 months

Denominator:

CPT 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99304-99306, 99307-99310, or G0344

and

Patients 75 years of age or older

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to geriatric patients. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. It is anticipated that the clinical assessment would include annual review of the patient's fall history as part of a medically necessary visit.

Measure: Dialysis dose in end stage renal disease patient

Numerator:

G8075: End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2)
G8076: End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2)
G8077: Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure

Denominator:

CPT: G0308-G0327, 90945, 90947

or

ICD-9 585.6

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services or ICD-9 are provided and the listed hemodialysis CPT services are provided to patients with end stage renal disease. This measure is anticipated to reflect the services provided for the primary management of end stage renal disease. It is not anticipated that this measure would be applicable for services not related to the primary management of end stage renal disease.

Measure: Hematocrit level in end stage renal disease patient

Numerator:

G8078: End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11)
G8079: End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11)
G8080: Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure

Denominator:

CPT G0308-G0327, 90945, or 90947

or

ICD-9 585.6

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 is used or the listed CPT services or ICD-9 are provided to patients with end stage renal disease on hemodialysis.

This measure is anticipated to reflect the services provided for the primary management of end stage renal disease. It is not anticipated that this measure would be applicable for services not related to the primary management of end stage renal disease.

Measure: Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis

Numerator:

G8081: End-stage renal disease patient requiring hemodialysis vascular access documented to have received autogenous AV fistula
G8082: End-stage renal disease patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula

Denominator:

CPT: G0308-G0327, 90945, 90947, 36818-36821, or 36825

or

ICD-9 585.6

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are used and the listed CPT services are provided to patients with end stage renal disease on hemodialysis. It is anticipated that the clinician providing vascular access for the patient's hemodialysis and the clinician primarily managing hemodialysis therapy would both submit this measure for their patients. It is anticipated that clinicians will still make clinical determinations at the individual level regarding whether a patient is an appropriate candidate for arteriovenous fistula placement.

Measure: Antidepressant medication during acute phase for patient diagnosed with new episode of major depression

Numerator:

G8126: Patient documented as being treated with antidepressant medication during the entire 12 week acute treatment phase
G8127: Patient not documented as being treated with antidepressant medication during the entire 12 weeks acute treatment phase
G8128: Clinician documented that patient was not an eligible candidate for antidepressant medication during the entire 12 week acute treatment phase measure

Denominator:

Patients 18 years and older diagnosed with a New Episode of MDD (major depression) and treated with antidepressant medication: CPT 99201-99205, 99211-99215, 90801, or 90804-90809

and

ICD-9 296.2, 296.3, 300.4, 309.1, or 311

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the patient is placed on prescription therapy for the treatment of a new episode of major depression disorder. It is anticipated that the clinician that provides the primary management of depression for the patient would submit this measure.

Measure: Antibiotic prophylaxis in surgical patient

Numerator:

G8152: Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
G8153: Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)
G8154: Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure

Denominator:

Patients with selected surgical procedures as listed:

Musculoskeletal: 27130, 27125, 27138, 27437, 27445, 27446

Cardiovascular System: 33300 33305 33400 33401 33403 33404 33405 33406 33410 33411 33412 33413 33414 33415 33416 33417 33420 33422 33425 33426 33427 33430 33460 33463 33464 33465 33468 33470 33471 33472 33474 33475 33476 33478 33496 33510 33511 33512 33513 33514 33516 33517 33518 33519 33521 33522 33523 33530 33533 33534 33535 33536 33545 33560 33600 33602 33608 33610 33611 33612 33615 33617 33619 33641 33645 33647 33660 33665 33670 33681 33684 33688 33692 33694 33697 33702 33710 33720 33722 33730 33732 33735 33736 33737 33770 33771 33774 33775 33776 33777 33778 33779 33780 33781 33786 33813 33814 33875 33877 33918 33919 33920 33924 33999 34520 34830 34831 34832 35081 35082 35091 35092 35102 35103 35111 35112 35121 35122 35131 35132 35141 35142 35151 35152 35256 35286 35331 35341 35351 35355 35361 35363 35371 35372 35381 35516 35518 35521 35522 35525 35531 35533 35536 35541 35546 35548 35549 35551 35556 35558 35563 35565 35566 35571 35583 35585 35587 35600 35616 35621 35623 35631 35636 35641 35646 35647 35650 35651 35654 35656 35661 35665 35666 35671 35686 35879 35881 35903 35907 37500 37700 37720 37730 37735 37760 37765 37766 37780 37785 37788 37791 92992 92993 93580 93581

Hemic and Lymphatic Systems: 38082 38103

Digestive System: 44025 44110 44111 44120 44121 44125 44130 44139 44140 44141 44143 44144 44145 44146 44147 44150 44151 44152 44153 44155 44156 44160 44204 44205 44206 44207 44208 44210 44211 44212 44300 44320 44322 44604 44605 44615 44625 44626 44660 44661 44799 45110 45111 45112 45113 45114 45116 45119 45120 45121 45123 45126 45130 45135 45550 45562 45563 45800 45805 45820 45825 45999

Urinary System: 51597 51925

Female Genital System: 57307 58150 58152 58180 58200 58210 58240 58260 58262 58263 58285 58550 58552 58553 58554 58951 58953 59135 59136 59140 59525

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing surgery that typically requires the administration of prophylactic antibiotics. It is anticipated that this measure should reflect the management of the surgical patient to reduce complications from infections. Thus, it is anticipated that it may be appropriate for both the clinician performing the surgery and the clinician providing anesthesia services may submit this measure for a patient.

Measure: Thromboembolism prophylaxis in surgical patient

Numerator:

G8155: Patient with documented receipt of thromboemoblism prophylaxis
G8156: Patient without documented receipt of thromboemoblism prophylaxis
G8157: Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure

Denominator:

Patients with selected surgical procedures as listed:

Integumentary System: 13160

Musculoskeletal System: 20102 22554 22556 22558 22585 22590 22600 22612 22614 22800 22802 22804 22808 22810 22812 22840 22851 27120 27125 27130 27132 27134 27137 27138 27236 27437 27445 27446 27447 27486 27487

Respiratory System: 32140 32141 32220 32225 32310 32320 32440 32442 32445 32480 32482 32484 32486 32488 32520 32522 32525 32651 32652 32655 32656 32663 32800 32850

Cardiovascular System: 33930 35840 35870 37799

Hemic and Lymphatic Systems: 38100 38101 38102 38120

Mediastinum and Diaphragm: 39501 39502 39503 39520 39530 39531 39540 39541 39545 39560 39561 39599

Digestive System: 42953 43020 43045 43107 43108 43112 43113 43116 43117 43118 43121 43122 43123 43124 43228 43240 43250 43251 43258 43267 43268 43269 43271 43272 43280 43289 43300 43305 43310 43312 43313 43314 43316 43320 43324 43325 43326 43340 43341 43350 43351 43352 43360 43361 43401 43405 43410 43415 43420 43425 43496 43499 43500 43501 43502 43510 43620 43621 43622 43631 43632 43633 43634 43635 43638 43639 43640 43641 43652 43761 43800 43810 43820 43825 43840 43842 43843 43845 43846 43847 43848 43850 43855 43860 43865 43870 43880 43999 44005 44010 44015 44020 44021 44025 44050 44055 44110 44111 44120 44121 44125 44126 44127 44128 44130 44132 44133 44139 44140 44141 44143 44144 44145 44146 44147 44150 44151 44152 44153 44155 44156 44160 44201 44202 44203 44204 44205 44206 44207 44208 44210 44211 44212 44300 44310 44316 44320 44322 44340 44345 44346 44351 44370 44379 44383 44397 44602 44603 44604 44605 44615 44620 44625 44626 44640 44650 44660 44661 44680 44700 44799 44800 44820 44850 45000 45005 45020 45110 45111 45112 45113 45114 45116 45119 45120 45121 45123 45126 45130 45135 45136 45160 45170 45321 45327 45345 45387 45500 45505 45540 45541 45550 45562 45563 45800 45805 45820 45825 45999 46730 46735 46744 46746 46748 47010 47011 47120 47122 47125 47130 47133 47300 47315 47350 47360 47361 47362 47370 47371 47380 47381 47382 47399 47400 47420 47425 47460 47510 47511 47564 47570 47579 47610 47612 47620 47716 47720 47721 47740 47741 47760 47765 47780 47785 47800 47802 47900 47999 48000 48001 48005 48020 48120 48140 48145 48146 48148 48150 48151 48152 48153 48154 48155 48160 48180 48500 48510 48511 48520 48540 48545 48547 48550 48554 48556 48662 48999 49002 49020 49021 49040 49041 49060 49061 49080 49081 49085 49201 49210 49215 49220 49255 49420 49421 49425 49426 49605 49606 49610 49611 49900 49904 49906 49999 96445

Urinary System: 50020 50021 50220 50223 50225 50230 50234 50236 50240 50300 50320 50340 50360 50365 50370 50380 50543 50545 50546 50547 50548 50562 50715 50722 50725 50727 50728 50760 50770 50780 50782 50783 50785 50800 50810 50815 50820 50947 50948 51314 51550 51555 51565 51570 51575 51580 51585 51590 51595 51596 51597 51800 51820 51860 51865 51880 51900 51920 51925 51940 51960 52355 53899

Male Genital System: 54380 54385 54390 54595 55810 55812 55815 55821 55831 55840 55842 55845 55866

Female Genital System: 57307 57330 57531 58150 58152 58180 58200 58210 58240 58260 58262 58263 58285 58291 58292 58550 58552 58553 58554 58661 58662 58679 58700 58720 58823 58920 58925 58940 58943 58950 58951 58952 58953 58954 58960 58999 59120 59121 59135 59136 59140 59150 59151 59154 59525

Endocrine System: 60540 60545

Nervous System: 61105 61107 61108 61120 61150 61151 61154 61156 61210 61250 61253 61304 61305 61312 61313 61314 61315 61320 61321 61322 61323 61330 61332 61333 61340 61345 61437 61440 61470 61480 61490 61510 61512 61514 61516 61518 61519 61520 61521 61522 61524 61526 61530 61534 61536 61537 61538 61539 61540 61541 61542 61543 61545 61556 61557 61570 61571 61575 61576 61580 61581 61582 61583 61584 61585 61586 61590 61591 61592 61595 61598 61600 61601 61605 61606 61607 61608 61615 61616 61720 61735 61770 61800 62000 62005 62010 62161 62162 62163 62164 64752 64755 64760 64999

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services codes are provided to a surgical patient. This measure should reflect the quality of the services provided for surgical patients to prevent the complications of thromboembolism. It is anticipated that the clinician providing primary management of the surgical patient would submit this measure. It is anticipated that thromboembolism prophylaxis includes low-dose unfractionated heparin, low molecular weight heparin, graduated compression stockings, intermittent pneumatic compression devices, factor Xa inhibitor and warfarin. The appropriate use of thromboembolism prophylaxis will vary according to the surgical procedure.

Measure: Use of internal mammary artery in coronary artery bypass graft surgery

Numerator:

G8158: Patient documented to have received coronary artery bypass graft with use of internal mammary artery
G8159: Patient documented to have received coronary artery bypass graft without use of internal mammary artery
G8160: Clinician documented that patient was not an eligible candidate for coronary artery bypass graft with use of internal mammary artery measure

Denominator:

Patients with coronary artery bypass graft using internal mammary artery: CPT: 33533, 33534, 33535, 33536

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. This measure is intended to reflect the quality of the surgical services provided for CABG patients.

Medlearn Matters Number: MM4183 *Revised*
Related CR Release Date: December 23, 2005
Related CR Transmittal #: R35DEMO
Related Change Request (CR) #: 4183
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Smoking and Tobacco-Use Cessation Counseling Services: Common Working File (CWF) Inquiry for Providers

This information was previously published in the First Quarter 2006 Medicare B Update! page 45.
CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Note: This article was revised on January 25, 2006, to reflect changes made to CR4104. The CR was changed to show that this inquiry is only available to providers who bill intermediaries.

Provider Affected

Providers billing Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for smoking and tobacco-use cessation counseling

Provider Action Needed

CR4104 announces the implementation of the capability for providers to access the CWF (part of Medicare's claims processing systems) for viewing the number of smoking and tobacco-use cessation counseling sessions a beneficiary has received.

Background

CR3929, issued July 15, 2005, implements a frequency-of-service limitation edit in the CWF for smoking and tobacco-use cessation counseling, for dates of service on or after October 1, 2005. The implementation date for this CWF edit is October 3, 2005.

Effective April, 1, 2006, Medicare providers will be given the capability to view the number of smoking and tobacco-use cessation counseling sessions provided to a beneficiary. Providers will be able to access this file through the CWF, by entering the beneficiary's health insurance claim number (HICN).

Ultimately, the capability to view the number of smoking and tobacco-use cessation counseling sessions provided to a beneficiary gives providers the ability to determine a beneficiary's available coverage for this service.

Additional Information

For complete details, please see the official instruction issued to your FI/RHHI regarding this change. That instruction may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R818CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4104 *Revised*
Related Change Request (CR) #: 4104
Related CR Release Date: January 24, 2006
Effective Date: April 1, 2006
Related CR Transmittal #: R818CP
Implementation Date: April 3, 2006

Redesigned CMS Web Page Dedicated to NPI Information

Announcing the redesigned CMS Web page dedicated to providing all the latest NPI news for health care providers! Visit http://www.cms.hhs.gov/NationalProvIdentStand/ on the Web. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A new fact sheet with answers to questions that health care providers may have regarding the NPI is now available on the web page; 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* on the Web.

Source: CMS Joint Signature Memorandum (JSM) 06184, January 23, 2006
Provider Education Resources Listserv, Message 200601-07

The National Provider Identifier Final Rule

The National Provider Identifier (NPI) Final Rule requires health care providers who are organizations and who are covered entities under HIPAA to determine if they have "subparts" that should be assigned NPIs. The NPI Final Rule provides guidance to those health care providers in making those determinations.

The Centers for Medicare and Medicaid Services (CMS) has communicated to the Provider Enrollment staff at the carriers and fiscal intermediaries the Medicare program's expectations concerning the determination of subparts for NPI assignment purposes. CMS has posted a document describing the subpart concept and its relationship to the way in which Medicare enrolls its organization providers at *http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp#TopOfPage*.

This document will be helpful to providers in understanding the issue of subparts and how subpart determination could be done in a way that helps to promote smoother and more efficient Medicare claims processing during the implementation of the NPI in the Medicare program.

The health care industry in general has expressed an interest in being informed of this type of information. CMS is making this information available on the CMS website so that it is easily available to interested parties.

Source: Provider Education Resources Listserv, Message 200601-11

Surrogate Unique Physician Identification Numbers Reported on Independent Diagnostic Testing Facilities Claims

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Independent Diagnostic Testing Facilities (IDTFs) billing Medicare carriers for services

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4096, which directs Medicare carriers to reject IDTF claims submitted with Surrogate Unique Physician Identification Number (UPIN) "OTH000," effective for claims with dates of service on or after January 3, 2006.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) will no longer accept the Surrogate UPINs (e.g., OTH000, RES000, VAD000, PHS000, and RET000) on claims submitted by a supplier enrolled as an IDTF.

GO – What You Need to Do

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

Background

IDTFs have been allowed to bill for diagnostic services with the use of Surrogate UPINs. To help ensure future program integrity, CMS will no longer accept the Surrogate UPINs on IDTF claims.

In addition, effective for dates of service of January 3, 2006, and later:

- IDTFs must submit the UPIN assigned to the ordering physician; and
- Carriers shall return as unprocessable all IDTF claims submitted with Surrogate UPINs.

Implementation

The implementation date for CR4096 is January 3, 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/R769CP.pdf* on the CMS website.

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

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

Medlearn Matters Number: MM4096
Related Change Request (CR) #: 4096
Related CR Release Date: December 2, 2005
Effective Date: January 3, 2006
Related CR Transmittal #: 769
Implementation Date: January 3, 2006

2006 Oncology Demonstration Project

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article.

Provider Types Affected

Hematologists and oncologists who bill Medicare for the care of cancer patients

Provider Action Needed

This article provides information on the oncology demonstration project for 2006. Additional information and guidance is available in *Medlearn Matters* article SE0588, which is available at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0588.pdf* on the Centers for Medicare & Medicaid Services' (CMS) website.

Background

The Social Security Act Amendments of 1967 (Pub. L. 90-248, Sections 402(a) (1) (B) and 402(b)), give the Secretary of Health and Human Services the authority to develop and implement experiments and demonstration projects to:

- Provide incentives for economy, while
- Maintaining or improving quality in health services delivery. In this context, CR4219, upon which this article is based, announces the implementation of the Medicare oncology demonstration project for 2006. This one-year demonstration project's purpose is to identify and assess, in office-based oncology practices, certain oncology services that positively affect outcomes in the Medicare population.

This 2006 oncology demonstration project replaces the 2005 chemotherapy demonstration project, and substantially changes the reporting emphasis. In the 2006 project, your reporting will no longer be specific to chemotherapy administration services, but, instead, will be associated with physician evaluation and management (E & M) visits for established patients with cancer.

The project builds on the use of G-codes (temporary national codes for items or services requiring uniform national coding between one year's update and the next) to gather more specific information about patients with particular types of cancer (noted below), including information about the primary focus of the visit and the spectrum of care that you provide.

It will emphasize practice guidelines as the source for standards of care, permitting CMS to monitor and encourage quality care to cancer patients, and to identify and promote best cancer care practices that should lead to improved patient outcomes.

This purpose is facilitated by the elimination of some G-codes and the adoption of new ones. Calendar year 2005 G-codes (G0921 to G0932), specific to the assessment of patient symptoms, have been eliminated, effective December 31, 2005.

G-Codes Address Three Reporting Categories

To facilitate the collection of the oncology demonstration information, CMS has established 81 new G-codes that address three reporting categories:

1) The primary focus of the evaluation and management visit;
2) Whether current management adheres to clinical guidelines; and
3) The current disease state.

Capturing these variables will form the building blocks of efficiency-oriented demonstrations in the future. You can find these new G-codes in the table at the end of this article.

Diagnostic Categories

Office-based hematologists and oncologists can participate in this demonstration, for services they furnish in 2006, when they provide an evaluation & management (E & M) service of level 2, 3, 4, or 5 to an established patient (American Medical Association's Current Procedural Terminology (CPT) codes 99212, 99213, 99214 and 99215) with a primary diagnosis of cancer belonging to one of the following 13 major diagnostic categories:

1.) Head and neck cancer (140.0 –149.9, 161.0-161.9)
2.) Esophageal cancer (150.0-150.9)
3.) Gastric cancer (151.0-151.9)
4.) Colon cancer (153.0-153.9)
5.) Rectal cancer (154.0, 154.1)
6.) Pancreatic cancer (157.0, 157.1, 157.2, 157.3, 157.8, 157.9)
7.) Lung cancer (both non-small cell and small cell) (162.2-162.9)
8.) Female breast cancer (invasive) (174.0-174.9)
9.) Ovarian cancer (183.0)
10.) Prostate cancer (185)
11.) Non-Hodgkin's lymphoma (202.00-202.08, 202.80-202.98)
12.) Multiple myeloma (203.00, 203.01)
13.) Chronic myelogenous leukemia (205.10, 205.11)

To Qualify for the Payment

To qualify for the payment associated with this demonstration payment, you must submit one G-code from each of the three categories mentioned above when you bill for an E & M of level 2, 3, 4, or 5 for established patients. Practices reporting data on all three categories will qualify for an additional oncology demonstration payment of $23 in addition to the E & M visit.

Important Details

The following are some important details that you should be aware of:

Participation is Voluntary

Participation in this demonstration is voluntary and the physician participates by filing a claim for services (i.e., a level 2, 3, 4, or 5 established office visit with three separate G codes, one from each category) with the Medicare carrier.

Qualifying Specialties

The physician specialties that qualify for this 2006 oncology demonstration are hematology (specialty code 82), medical oncology (specialty 83), and hematology/oncology (specialty 90).

Midlevel practitioners, such as nurse practitioners or others who may bill independently for Medicare services, are not eligible to participate in the demonstration. Medicare carriers will deny claims for the 2006 oncology demonstration submitted by other than a qualifying specialty. Such claims will be denied with remittance advice code N95 and claim adjustment reason code 185.

Other Cancer Types Not Included

E & M services that you furnish for patients with cancer types as the principal diagnosis, other than these mentioned in this CR, will not be included in the demonstration. If you report claims with these demonstration G codes that are not related to the 13 specific cancer types, those G codes will be denied.

Applies to Beneficiaries Not Enrolled in Medicare Advantage Plan

The project applies only to Medicare beneficiaries who are not enrolled in a Medicare Advantage plan, and is effective only for services provided on or after January 1, 2006, and before January 1, 2007. Medicare carriers will return/reject, as not able to process, oncology demonstration G-codes that are billed for dates of service not within CY 2006, using Remittance Advice reason code B18 and remark code N56 and Medicare Summary Notice (MSN) message 16.13.

Chemotherapy

While chemotherapy may be provided to the patient on the same day as the E & M visit, it is only the latter that is linked to the demonstration project. In this instance, therefore, you should attach modifier 25 to the E & M service. This denotes that you have performed a significant, separately identifiable evaluation and management service on the same day of a procedure (the chemotherapy administration service). Further, you should appropriately document the patient's record to support the level of the E & M service billed.

Billing Codes

You must bill a code from each of the three categories mentioned above. If you bill one or more (but not one from all three categories) of the demonstration codes on a single claim, carriers will return/reject the claim as not able to process and use Remittance Advice reason code 16 and remark code MA130.

Conversely, if you bill more than one G-code from the same category for the same date of service on the same claim (for instance, you submit a claim for more than two G-codes from the category of "primary focus of the visit"), carriers will also reject the claim as not able to process, and use remittance advice reason code 125 and remittance advice remark code MA130.

Note: Some Medicare carriers may choose to manually split the claim and only return the not able to process portion (i.e., the portion related to submitting data for the oncology demonstration). However, CMS will not require carriers to do this.

Claims Must Be Assigned

Your claims must be assigned. If a participating provider submits a non-assigned claim for the oncology demonstration G codes, carriers will process the claim as assigned and generate Remittance Advice remark code MA09.

If a nonparticipating provider submits a non-assigned claim for the G-codes and related E & M service, carriers will process the claim for coverage and payment of those services that do not require assignment (e.g., the evaluation and management service) and deny the G-codes using Remittance Advice reason code 111, remark code N149, and MSN message 16.6.

Resubmitting G-Codes

Providers may resubmit oncology demonstration G-codes that were denied for not accepting assignment and, in such instances, the G-codes will be approved if the related E & M codes were approved. However, if there is no approved E & M code for the same service date and place of service as the G-codes on the claim or in the history, carriers will deny the G-codes using Remittance Advice reason code 107 and MSM code 16.26.

Place of Service

The place of service reported for codes must be "office" (place of service code 11). If the place of service reported is other than "office," carriers will return/reject the claim as not able to process using Remittance Advice reason code 5 and MSN code 16.2.

Payment Allowances

Carriers will establish the following payment allowances for the demonstration codes and determine payment based on the lesser of 80% of the actual charge or on the allowance by code:

- G9050 to G9055 - $7.67
- G9056 to G9062 - $7.67
- G9063 to G9130 - $7.66

These amounts apply in all localities, and the usual Part B coinsurance and deductible apply.

SNF Consolidated Billing

During the demonstration, the oncology G-codes will bypass SNF consolidated billing for beneficiaries in a Part A stay.

Additional Information

The new 2006 oncology G codes and their descriptors can be viewed beginning on the next page of this article.

In addition, a special edition *Medlearn Matters* article is available to provide additional coding guidance. That article is available at *http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0588.pdf* on the CMS website.

To view the actual instruction, CR4219, issued to your carrier, visit *http://www.cms.hhs.gov/Transmittals/downloads/R36DEMO.pdf* on the CMS website.

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

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

Oncology Demonstration Project G-codes (in Numerical Order by Code)

Category/ G-code	Description
Primary focus of the visit	
G9050	ONCOLOGY; PRIMARY FOCUS OF VISIT; WORK-UP, EVALUATION, OR STAGING AT THE TIME OF CANCER DIAGNOSIS OR RECURRENCE (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)
G9051	ONCOLOGY; PRIMARY FOCUS OF VISIT; TREATMENT DECISION-MAKING AFTER DISEASE IS STAGED OR RESTAGED, DISCUSSION OF TREATMENT OPTIONS, SUPERVISING/COORDINATING ACTIVE CANCER DIRECTED THERAPY OR MANAGING CONSEQUENCES OF CANCER DIRECTED THERAPY
G9052	ONCOLOGY; PRIMARY FOCUS OF VISIT; SURVEILLANCE FOR DISEASE RECURRENCE FOR PATIENT WHO HAS COMPLETED DEFINITIVE CANCER-DIRECTED THERAPY AND CURRENTLY LACKS EVIDENCE OF RECURRENT DISEASE; CANCER DIRECTED THERAPY MIGHT BE CONSIDERED IN THE FUTURE
G9053	ONCOLOGY; PRIMARY FOCUS OF VISIT; EXPECTANT MANAGEMENT OF PATIENT WITH EVIDENCE OF CANCER FOR WHOM NO CANCER DIRECTED THERAPY IS BEING ADMINISTERED OR ARRANGED AT PRESENT; CANCER DIRECTED THERAPY MIGHT BE CONSIDERED IN THE FUTURE
G9054	ONCOLOGY; PRIMARY FOCUS OF VISIT; SUPERVISING, COORDINATING OR MANAGING CARE OF PATIENT WITH TERMINAL CANCER OR FOR WHOM OTHER MEDICAL ILLNESS PREVENTS FURTHER CANCER TREATMENT; INCLUDES SYMPTOM MANAGEMENT, END-OF-LIFE CARE PLANNING, MANAGEMENT OF PALLIATIVE THERAPIES
G9055	ONCOLOGY; PRIMARY FOCUS OF VISIT; OTHER, UNSPECIFIED SERVICE NOT OTHERWISE LISTED
Guideline Adherence Codes	
G9056	ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT ADHERES TO GUIDELINES
G9057	ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT DIFFERS FROM GUIDELINES AS A RESULT OF PATIENT ENROLLMENT IN AN INSTITUTIONAL REVIEW BOARD APPROVED CLINICAL TRIAL
G9058	ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT DIFFERS FROM GUIDELINES BECAUSE THE TREATING PHYSICIAN DISAGREES WITH GUIDELINE RECOMMENDATIONS
G9059	ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT DIFFERS FROM GUIDELINES BECAUSE THE PATIENT, AFTER BEING OFFERED TREATMENT CONSISTENT WITH GUIDELINES, HAS OPTED FOR ALTERNATIVE TREATMENT OR MANAGEMENT, INCLUDING NO TREATMENT
G9060	ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT DIFFERS FROM GUIDELINES FOR REASON(S) ASSOCIATED WITH PATIENT COMORBID ILLNESS OR PERFORMANCE STATUS NOT FACTORED INTO GUIDELINES
G9061	ONCOLOGY; PRACTICE GUIDELINES; PATIENT'S CONDITION NOT ADDRESSED BY AVAILABLE GUIDELINES
G9062	ONCOLOGY; PRACTICE GUIDELINES; MANAGEMENT DIFFERS FROM GUIDELINES FOR OTHER REASON(S) NOT LISTED

2006 Oncology Demonstration Project, continued

Category/ G-code	Description
Disease Status Codes	
Lung cancer, Non-small cell, small cell lung cancer (162.2-162.9)	
G9063	ONCOLOGY; DISEASE STATUS; LIMITED TO NON-SMALL CELL LUNG CANCER; EXTENT OF DISEASE INITIALLY ESTABLISHED AS STAGE I (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9064	ONCOLOGY; DISEASE STATUS; LIMITED TO NON-SMALL CELL LUNG CANCER; EXTENT OF DISEASE INITIALLY ESTABLISHED AS STAGE II (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9065	ONCOLOGY; DISEASE STATUS; LIMITED TO NON-SMALL CELL LUNG CANCER; EXTENT OF DISEASE INITIALLY ESTABLISHED AS STAGE III A (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9066	ONCOLOGY; DISEASE STATUS; LIMITED TO NON-SMALL CELL LUNG CANCER; STAGE III B- IV AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE
G9067	ONCOLOGY; DISEASE STATUS; LIMITED TO NON-SMALL CELL LUNG CANCER; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT YET DETERMINED, OR NOT LISTED
G9068	ONCOLOGY; DISEASE STATUS; LIMITED TO SMALL CELL AND COMBINED SMALL CELL/NON-SMALL CELL; EXTENT OF DISEASE INITIALLY ESTABLISHED AS LIMITED WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9069	ONCOLOGY; DISEASE STATUS; SMALL CELL LUNG CANCER, LIMITED TO SMALL CELL AND COMBINED SMALL CELL/NON-SMALL CELL; EXTENSIVE STAGE AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE
G9070	ONCOLOGY; DISEASE STATUS; SMALL CELL LUNG CANCER, LIMITED TO SMALL CELL AND COMBINED SMALL CELL/NON-SMALL; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, PRE-SURGICAL, OR NOT LISTED
Female breast cancer (174.0-174.9)	
G9071	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE I OR STAGE IIA-IIB; OR T3, N1, M0; AND ER AND/OR PR POSITIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9072	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE I, OR STAGE IIA-IIB; OR T3, N1, M0; AND ER AND PR NEGATIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9073	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE IIIA-IIIB; AND NOT T3, N1, M0; AND ER AND/OR PR POSITIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9074	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; STAGE IIIA-IIIB; AND NOT T3, N1, M0; AND ER AND PR NEGATIVE; WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES

2006 Oncology Demonstration Project, continued

Category/ G-code	Description
Disease Status Codes	
Lung cancer, Non-small cell, small cell lung cancer (162.2-162.9)	
G9075	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE
G9076	ONCOLOGY; DISEASE STATUS; INVASIVE FEMALE BREAST CANCER (DOES NOT INCLUDE DUCTAL CARCINOMA IN SITU); ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, PRE-SURGICAL OR NOT LISTED
Prostate cancer (185)	
G9077	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; T1-T2C AND GLEASON 2-7 AND PSA < OR EQUAL TO 20 AT DIAGNOSIS WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9078	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; T2 *OR T3A+* GLEASON 8-10 OR PSA > 20 AT DIAGNOSIS WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9079	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; T3B-T4, ANY N; ANY T, N1 AT DIAGNOSIS WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9080	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; AFTER INITIAL TREATMENT WITH RISING PSA OR FAILURE OF PSA DECLINE
G9081	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; NON-CASTRATE, INCOMPLETELY CASTRATE; CLINICAL METASTASES OR M1 AT DIAGNOSIS
G9082	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; CASTRATE; CLINICAL METASTASES OR M1 AT DIAGNOSIS
G9083	ONCOLOGY; DISEASE STATUS; PROSTATE CANCER, LIMITED TO ADENOCARCINOMA; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION OR NOT LISTED
Colon cancer (153.0-153.9)	
G9084	ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-3, N0, M0 WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9085	ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T4, N0, M0 WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9086	ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-4, N1-2, M0 WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9087	ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE WITH CURRENT CLINICAL, RADIOLOGIC, OR BIOCHEMICAL EVIDENCE OF DISEASE
G9088	ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE

2006 Oncology Demonstration Project, continued

Category/ G-code	Description
Disease Status Codes	
Lung cancer, Non-small cell, small cell lung cancer (162.2-162.9)	
G9089	ONCOLOGY; DISEASE STATUS; COLON CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, NOT YET DETERMINED, UNDER EVALUATION, PRE-SURGICAL, OR NOT LISTED
Rectal cancer (154.0, 154.1)	
G9090	ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-2, N0, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9091	ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T3, N0, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9092	ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-3, N1-2, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE OR METASTASES
G9093	ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T4, ANY N, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9094	ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE
G9095	ONCOLOGY; DISEASE STATUS; RECTAL CANCER, LIMITED TO INVASIVE CANCER, ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, NOT YET DETERMINED, UNDER EVALUATION, PRE-SURGICAL, OR NOT LISTED
Esophageal cancer (150.0-150.9)	
G9096	ONCOLOGY; DISEASE STATUS; ESOPHAGEAL CANCER, LIMITED TO ADENOCARCINOMA OR SQUAMOUS CELL CARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-T3, N0-N1 OR NX (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9097	ONCOLOGY; DISEASE STATUS; ESOPHAGEAL CANCER, LIMITED TO ADENOCARCINOMA OR SQUAMOUS CELL CARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T4, ANY N, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9098	ONCOLOGY; DISEASE STATUS; ESOPHAGEAL CANCER, LIMITED TO ADENOCARCINOMA OR SQUAMOUS CELL CARCINOMA AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE
G9099	ONCOLOGY; DISEASE STATUS; ESOPHAGEAL CANCER, LIMITED TO ADENOCARCINOMA OR SQUAMOUS CELL CARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, NOT YET DETERMINED, UNDER EVALUATION, PRE-SURGICAL, OR NOT LISTED

2006 Oncology Demonstration Project, continued

Category/ G-code	Description
Gastric cancer (151.0-151.9)	
G9100	ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; POST R0 RESECTION (WITH OR WITHOUT NEOADJUVANT THERAPY) WITH NO EVIDENCE OF DISEASE RECURRENCE, PROGRESSION, OR METASTASES
G9101	ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; POST R1 OR R2 RESECTION (WITH OR WITHOUT NEOADJUVANT THERAPY) WITH NO EVIDENCE OF DISEASE PROGRESSION, OR METASTASES
G9102	ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; CLINICAL OR PATHOLOGIC M0, UNRESECTABLE WITH NO EVIDENCE OF DISEASE PROGRESSION, OR METASTASES
G9103	ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; CLINICAL OR PATHOLOGIC M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE
G9104	ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT YET DETERMINED, PRESURGICAL, OR NOT LISTED
Pancreatic cancer (157.0-157.3, 157.8, 157.9)	
G9105	ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; POST R0 RESECTION WITHOUT EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9106	ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA; POST R1 OR R2 RESECTION WITH NO EVIDENCE OF DISEASE PROGRESSION, OR METASTASES
G9107	ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA; UNRESECTABLE AT DIAGNOSIS, M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE
G9108	ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT YET DETERMINED, PRE-SURGICAL, OR NOT LISTED
Head and neck cancer (140.0-149.9, 161.0-161.9)	
G9109	ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-T2 AND N0, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9110	ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T3-4 AND/OR N1-3, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9111	ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE
G9112	ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, NOT YET

2006 Oncology Demonstration Project, continued

Category/ G-code	Description
Gastric cancer (151.0-151.9)	
G9100	ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; POST R0 RESECTION (WITH OR WITHOUT NEOADJUVANT THERAPY) WITH NO EVIDENCE OF DISEASE RECURRENCE, PROGRESSION, OR METASTASES
G9101	ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; POST R1 OR R2 RESECTION (WITH OR WITHOUT NEOADJUVANT THERAPY) WITH NO EVIDENCE OF DISEASE PROGRESSION, OR METASTASES
G9102	ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; CLINICAL OR PATHOLOGIC M0, UNRESECTABLE WITH NO EVIDENCE OF DISEASE PROGRESSION, OR METASTASES
G9103	ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; CLINICAL OR PATHOLOGIC M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE
G9104	ONCOLOGY; DISEASE STATUS; GASTRIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT YET DETERMINED, PRESURGICAL, OR NOT LISTED
Pancreatic cancer (157.0-157.3, 157.8, 157.9)	
G9105	ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA AS PREDOMINANT CELL TYPE; POST R0 RESECTION WITHOUT EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9106	ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA; POST R1 OR R2 RESECTION WITH NO EVIDENCE OF DISEASE PROGRESSION, OR METASTASES
G9107	ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA; UNRESECTABLE AT DIAGNOSIS, M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE
G9108	ONCOLOGY; DISEASE STATUS; PANCREATIC CANCER, LIMITED TO ADENOCARCINOMA; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT YET DETERMINED, PRE-SURGICAL, OR NOT LISTED
Head and neck cancer (140.0-149.9, 161.0-161.9)	
G9109	ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T1-T2 AND N0, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9110	ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE INITIALLY ESTABLISHED AS T3-4 AND/OR N1-3, M0 (PRIOR TO NEO-ADJUVANT THERAPY, IF ANY) WITH NO EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9111	ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; M1 AT DIAGNOSIS, METASTATIC, LOCALLY RECURRENT, OR PROGRESSIVE

2006 Oncology Demonstration Project, continued

Category/ G-code	Description
G9112	ONCOLOGY; DISEASE STATUS; HEAD AND NECK CANCER, LIMITED TO CANCERS OF ORAL CAVITY, PHARYNX AND LARYNX WITH SQUAMOUS CELL AS PREDOMINANT CELL TYPE; EXTENT OF DISEASE UNKNOWN, NOT YET DETERMINED, PRE-SURGICAL, OR NOT LISTED
Ovarian cancer (183.0)	
G9113	ONCOLOGY; DISEASE STATUS; OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER; PATHOLOGIC STAGE IA-B (GRADE 1) WITHOUT EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)
G9114	ONCOLOGY; DISEASE STATUS; OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER; PATHOLOGIC STAGE IA-B (GRADE 2-3); OR STAGE IC (ALL GRADES); OR STAGE II; WITHOUT EVIDENCE OF DISEASE PROGRESSION, RECURRENCE, OR METASTASES
G9115	ONCOLOGY; DISEASE STATUS; OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER; PATHOLOGIC STAGE III-IV; WITHOUT EVIDENCE OF PROGRESSION, RECURRENCE
G9116	ONCOLOGY; DISEASE STATUS; OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER; EVIDENCE OF DISEASE PROGRESSION, OR RECURRENCE, AND/OR PLATINUM RESISTANCE
G9117	ONCOLOGY; DISEASE STATUS; OVARIAN CANCER, LIMITED TO EPITHELIAL CANCER; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, INCOMPLETE SURGICAL STAGING, PRE-SURGICAL STAGING, OR NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT)
Non-Hodgkin's lymphoma (202.00-202.08, 202.80-202.98)	
G9118	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; STAGE I, II AT DIAGNOSIS, NOT RELAPSED, NOT REFRACTORY
G9119	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; STAGE III, IV NOT RELAPSED, NOT REFRACTORY (FOR USE IN A MEDICARE – APPROVED DEMONSTRATION PROJECT)
G9120	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, TRANSFORMED FROM FOLLICULAR LYMPHOMA TO DIFFUSE LARGE B-CELL LYMPHOMA G9121 ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; RELAPSED/ REFRACTORY
G9122	ONCOLOGY; DISEASE STATUS; NON-HODGKIN'S LYMPHOMA, LIMITED TO FOLLICULAR LYMPHOMA, MANTLE CELL LYMPHOMA, DIFFUSE LARGE B-CELL LYMPHOMA, SMALL LYMPHOCYTIC LYMPHOMA; DIAGNOSTIC EVALUATION, STAGE NOT DETERMINED, EVALUATION OF POSSIBLE RELAPSE OR NONRESPONSE TO THERAPY, OR NOT LISTED
Chronic Myelogenous leukemia (205.10, 205.11)	
G9123	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND/OR BCR-ABL POSITIVE; CHRONIC PHASE NOT IN HEMATOLOGIC, CYTOGENETIC, OR MOLECULAR REMISSION

2006 Oncology Demonstration Project, continued

Category/ G-code	Description
Primary focus of the visit	
G9124	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND /OR BCR-ABL POSITIVE; ACCELERATED PHASE NOT IN HEMATOLOGIC CYTOGENETIC, OR MOLECULAR REMISSION
G9125	ONCOLOGY; DISEASE STATUS; CHRONIC MYLOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND /OR BCR-ABL POSITIVE; *BLAST PHASE NOT*† IN HEMATOLOGIC, CYTOGENETIC, OR MOLECULAR REMISSION
G9126	ONCOLOGY; DISEASE STATUS; CHRONIC MYELOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND /OR BCR-ABL POSITIVE; IN HEMATOLOGIC, CYTOGENETIC, OR MOLECULAR REMISSION
G9127	ONCOLOGY; DISEASE STATUS; CHRONIC MEYLOGENOUS LEUKEMIA, LIMITED TO PHILADELPHIA CHROMOSOME POSITIVE AND /OR BCR-ABL POSITIVE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, NOT LISTED (FOR USE IN A MEDICARE-APPROVED DEMONSTRATION PROJECT
Multiple Myeloma (203.00, 203.01)	
G9128	ONCOLOGY; DISEASE STATUS; LIMITED TO MULTIPLE MYELOMA, SYSTEMIC DISEASE; SMOLDERING, STAGE I
G9129	ONCOLOGY; DISEASE STATUS; LIMITED TO MULTIPLE MYELOMA, SYSTEMIC DISEASE; STAGE II OR HIGHER
G9130	ONCOLOGY; DISEASE STATUS; LIMITED TO MULTIPLE MYELOMA, SYSTEMIC DISEASE; EXTENT OF DISEASE UNKNOWN, UNDER EVALUATION, OR NOT LISTED

Medlearn Matters Number: MM4219
Related Change Request (CR) #: N/A
Related CR Release Date: December 30, 2005
Effective Date: January 1, 2006
Related CR Transmittal #: R36DEMO
Implementation Date: January 17, 2006

GENERAL MEDICAL REVIEW

Articles in this section apply to both Florida and Connecticut.

Medicare Coverage of Anti-Cancer Drugs

This article is based on Medicare law, rules, and regulations. It defines the criteria that must be met for the payment for anti-cancer drugs upon initial claim submission. Claims not meeting these standards will be denied. Currently, Medicare does not provide pre-authorization for drugs and biologicals. Denials may be appealed by means of the prescribed process.

Indications – Labeled and Unlabeled

An anti-cancer drug that meets all general program requirements may be considered medically reasonable and necessary for its FDA (Food and Drug Administration) approved indications and its "off-label" indications, as supported by the Centers for Medicare & Medicaid Services (CMS) approved compendia, unless there is a national or local statement to the contrary.

Regulatory Background and Rationale:

FDA approval is one of the standards for Medicare coverage. The CMS Manual System, Pub 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.5 (*http://www.cms.hhs.gov/manuals/*) refers to the unlabeled use for anti-cancer drugs. An important criterion is support by one or more citations in at least one of the two drug compendia listed below, and the use is not listed as "not indicated" in any of the two compendia: American Hospital Formulary Service (AHFS) Drug Information, and United States Pharmacopoeia Drug Information (USPDI).

The CMS Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.5 D states that the "compendium process for making decisions concerning unlabeled uses is very thorough and continuously updated." To avoid undue bureaucratic burden, First Coast Service Options (FCSO) will accept the endorsement of the editorial panels of these compendia as expert opinion and as a proxy for the review of clinical research that appears in peer reviewed medical literature.

This contractor has local coverage determinations (LCDs) on specific anti-cancer drugs. There are national coverage determinations (NCDs) on certain anti-cancer drugs.

An anti-cancer drug that meets all program requirements for coverage of items as incident to a physician's services will be considered reasonable and necessary for the treatment of the illness or injury for which it is administered if:

1. It is FDA approved.
2. It is FDA approved for the treatment of the illness or injury for which it is administered.
3. Its use is supported by one or more citations in at least one of the two drug compendia listed above, and the use is not listed as "not indicated" in any of the two compendia.
4. A NCD has established its medical reasonableness and necessity for the indication used.
5. A LCD has established its medical reasonableness and necessity for the indication used.

Note: Contractor LCDs are developed based on the strongest evidence available as instructed in the CMS Manual System, Pub. 100-8, Medicare Program Integrity Manual, Chapter 13, Section 7.1, specifically published authoritative evidence derived from definitive randomized clinical trials or other definitive studies.

Unless stated otherwise by CMS or this contractor, a presumption of coverage may be made if condition #1 and one of the conditions #2 through #5 apply. All other claims not meeting these criteria will be denied.

This article is subordinate to any NCD or LCD of this carrier. For example, even if an agent is supported in the compendia for a given indication but an NCD or one of this carrier's LCDs restricts or does not allow its use for that indication, the statement in the NCD or LCD supersedes.

Under the above provisions, this contractor will consider an unlabeled indication beginning with 45 days after receipt of a copy of its official publication in the CMS authorized compendium. Claims for such services rendered on preceding dates will continue to be denied and may be reviewed individually by means of the appeal process.

In this article, the statements about labeled and unlabeled uses of anti-cancer drugs are limited to the treatment of malignant neoplastic conditions. Other drugs and biologicals and/or the use of anti-cancer drugs for non-cancerous conditions are outside the scope of this publication.

Dosage and Frequency

Doses that exceed the accepted standard of recommended dosage and/or frequency, as described in the package insert are not reimbursable, as they represent an unapproved unlabeled use.

Regulatory Background and Rationale:

The CMS Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.1 addresses medical reasonableness and necessity based on the FDA approval and labeling: "Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling." The labeling spells out the safe and effective, i.e. medically reasonable and necessary dosage and frequency.

The dosage for a compendia supported unlabeled indication can at times be different than the dosage in the package insert. This may be considered based on the studies that were submitted to the respective compendium and accepted in support of the unlabeled indication.

Medicare Coverage of Anti-Cancer Drugs, continued

Wastage

Payment for wastage may only be made when single-use vials have to be utilized. No reimbursement will be made for wastage in the case of multi-use vials.

Regulatory Background and Rationale:

This is based on the CMS Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 17, Section 40, Discarded Drugs and Biologicals that addresses wastage: "CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered. NOTE: The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drug."

Route of Administration

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

Regulatory Background and Rationale:

The CMS Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.1 addresses medical reasonableness and necessity based on the FDA approval and labeling: "Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling." This statement extends to the mode of administration that is considered safe and effective, i.e., medically reasonable and necessary by Medicare's criteria.

The CMS Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.2 K - Reasonable and Necessary, stipulates that "Carriers and fiscal intermediaries will make the determination of reasonable and necessary with respect to the medical appropriateness of a drug to treat the patient's condition. Contractors will continue to make the determination of whether the intravenous or injection form of a drug is appropriate as opposed to the oral form."

Coding

Please place the applicable HCPCS code in Item 24D and the ICD-9-CM diagnosis code that supports medical necessity in Item 24E of CMS Form-1500 or the respective equivalent electronic fields. The number of units should be inserted in Item 24G or its electronic equivalent.

Note: The number of units may not be equal to the dose administered. For example, if a HCPCS code descriptor were for 100 mg of a given agent, the number of units for 1000 mg administered would be 10 and not 1000.

FDA approved antineoplastic drugs that do not have a designated HCPCS code must be billed with HCPCS code J9999 (not otherwise classified, antineoplastic drugs).

ICD-9-CM code listings may cover a range and include truncated codes. It is the provider's responsibility to avoid truncated codes by selecting a code(s) carried out to the highest level of specificity and selected from the ICD-9-CM book appropriate to the year in which the service was performed. It is not enough to link a HCPCS code to a correct, payable ICD-9-CM code. The diagnosis must be present for the procedure to be paid.

This notification becomes effective for services rendered on or after March 1, 2006. Claims for dates of service prior to March 1, 2006 cannot be filed retrospectively and paid under these provisions, even if an agent might have had compendia support for an unlabeled indication prior to this date.

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

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

Early observations indicate that bevacizumab may be useful in the treatment of age-related macular degeneration (AMD). Some providers have used it as an intravitreal injection.

Currently, publications in peer-reviewed literature are not sufficient to support medical reasonableness and necessity by Medicare's criteria. Even though the intravitreal administration looks promising and may be cost effective, there are still a number of concerns, specifically about safety.

Until appropriately designed and powered studies are published and evaluated, bevacizumab for the treatment of age-related macular degeneration (AMD) is considered investigational. Services that lead up to or are associated with non-covered services are not covered, as well. Thus, a medical necessity denial for bevacizumab would be associated with a denial for the intravitreal injection. HCPCS code J9035 (Injection, bevacizumab, 10 mg) does not apply to the intravitreal administration, as a pharmacist has processed the agent.

Providers billing for intravitreal bevacizumab should use CPT code 67028 for the intravitreal injection and HCPCS code J3490 (unclassified drugs) for the bevacizumab. Please enter "Intravitreal bevacizumab" in Item 19 of CMS Form 1500 or its electronic equivalent. Providers should not submit any additional documentation with the claim. First Coast Service Options, Inc. will request this information separately by means of an additional documentation request (ADR) letter.

The beneficiary should be thoroughly educated about the benefits and risks of this modality. An advance beneficiary notice (ABN) should be provided and the modifier GA should be appended to the codes for these services. This will give the patient the opportunity to purchase the intravitreal injection and the bevacizumab.

CONNECTICUT MEDICAL REVIEW

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

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

Effective and Notice Dates

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

Electronic Notification

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

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

More Information

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

Attention: Medical Policy
First Coast Service Options, Inc.
P.O. Box 9000
Meriden, CT 06450-9000

Phone: 1-866-419-9455

Medical Review Table of Contents

Advance Notice Statement

Advance beneficiary notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

NEW LCDs

86141: High Sensitivity C-Reactive Protein—LCD Addition

A high sensitivity C-reactive protein (hsCRP) assay measures low levels of CRP, which allows for measurement of conditions indicative of chronic, lo-grade inflammation. The stimulus for the rise in serum CRP in CAD remains undetermined, although it may result from local inflammation within atheromatous plaques, from a systemic or local inflammation or infection elsewhere in the body that contributes to atherogenesis, or to unrelated conditions. Increased CRP may reflect plaque instability and an increased risk for a CAD event.

The hsCRP results, along with The Framingham Heart Study Risk Assessment (a tool which considers gender, age, total cholesterol, systolic blood pressure, antihypertensive medications, family history and smoking risks) provides cardiac prognostic information. However, hsCRP and LDL cholesterol levels are minimally correlated.

Currently, First Coast Service Options (FCSO) will consider high-sensitivity C-reactive protein (hsCRP) testing medically reasonable and necessary for the assessment of CAD risk when ALL of the following criteria are met:

- When the hsCRP would add substantial incremental information in the decision making process to optimize/maximize current lipid lowering pharmacologic therapy in a patient who has been identified as being at intermediate risk for CAD (10- year risk of coronary heart disease between 10-20% per the ATP III Guidelines). This is to be used for a one time decision point and is not intended to monitor therapy.
- The test is performed in patients considered to be metabolically stable and without obvious inflammatory or infectious conditions.
- The ICD-9-CM codes that support Medical Necessity for hsCRP include:

- 272.0 - Pure hypercholesterolemia
- 272.1 - Pure hyperglyceridemia
- 272.2 - Mixed hyperlipidemia
- 272.3 - Hyperchylomicronemia
- 272.4 - Other and unspecified hyperlipidemia

If high sensitivity C-reactive protein (hsCRP) testing is performed for cardiovascular risk assessment, in the absence of signs or symptoms of illness or injury, then the service will be denied as not reasonable or medically necessary.

A local coverage determination (LCD) was developed for both Florida and Connecticut to provide access to care, define the indication, limitations and documentation requirements for these services.

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

90801: Psychiatric Diagnostic Interview Exam—LCD Addition

A psychiatric diagnostic interview examination consists of elicitation of a complete medical history (to include past, family and social); psychiatric history, a complete mental status exam, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. Information may be obtained from the patient, other physicians, other clinicians or community providers, and/or family members. There may be overlapping of the medical and psychiatric history depending upon the problem(s).

A local coverage determination (LCD) has been developed to define the indications and limitations of coverage, documentation requirements and medical necessity for psychiatric diagnostic interview examinations.

This LCD was presented to the carrier advisory committee October 11, 2005. It will be effective for services rendered on or after April 11, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

96150: Health and Behavior Assessment/Intervention—LCD Addition

Health and Behavior Assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus is not on mental health, but on the biopsychosocial factors important to physical health problems and treatments.

Effective, January 1, 2002, the CPT codes for health and behavior assessment and intervention services (*96150-96154*) apply to behavioral, social, and psychosocial procedures for the prevention, treatment, or management of physical health problems. Until then, almost all intervention codes used by psychologists involved psychotherapy and required a mental health diagnosis. In contrast, health and behavior assessment and intervention services focus on patients whose primary diagnosis is physical in nature.

Therefore, a local coverage determination (LCD) was developed for both Florida and Connecticut to provide access to care, define the indication, limitations and documentation requirements for these services.

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

REVISIONS TO LMRPS/LCDS

64415: Sympathetic Blocks—LCD Revision

This LCD was last revised effective August 9, 2005. Since that time, this LCD has been revised to reflect that the diagnosis range has been changed from 200.00-208.9 to 200.00-208.91. This ICD-9–CM range has been updated to fifth digit specificity.

This revision is effective for claims processed on or after November 29, 2005 for services rendered on or after September 29, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

71250: Computed Tomography of the Thorax—LCD Revision

This local coverage determination (LCD) was last revised effective June 7, 2005. Since that time, the "Indication and Limitations of Coverage" and "Documentation Requirements" sections have been revised.
In addition, the Florida and Connecticut LCD's have been combined.

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

76070: Bone Mineral Density Studies—LCD Revision

The last revision for local coverage determination (LCD) Bone Mineral Density Studies was effective June 7, 2005. Since that time, this LCD has been revised to indicate additional medical circumstances where Medicare may cover a bone mass measurement for a patient more frequently than every 2 years, if medically necessary. These revisions include:

- Monitoring a patient to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy if the result is being used to determine the need for continued treatment of osteoporosis. Agents approved by the FDA for osteoporosis prevention and/or treatment include:
  - Estrogen therapy (for purposes of this policy, the estrogen must be specifically used for treatment of osteoporosis)
  - Alendronate (Fosamax)
  - Calcitonin-salmon (Miacalcin-nasal spray or injection)
  - Raloxifene (Evista)
  - Risedronate (Actonel)
  - Teriparatide (Forteo) injection
  - Ibandronate (Boniva)
- To determine a patient's response to pharmacologic therapy when the therapy has been changed to another family of therapeutic agents.

Revisions have been made in the "Indications and Limitations of Coverage and/or Medical Necessity" and "Utilization Guidelines" sections accordingly. These revisions were effective for services rendered on or after November 21, 2005.

In addition, this LCD has been revised in the "Indications and Limitations of Coverage and/or Medical Necessity",

"ICD-9 Codes that Support Medical Necessity" and "Documentation Requirements" sections. These revisions include updating the NCD language, providing clarification for rendering this service for a woman who has been determined by the physician or a qualified non-physician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings and the addition of ICD-9-CM code 627.4 in the "ICD-9 Codes that Support Medical Necessity" section. These revisions will be effective for services rendered on or after April 11, 2006.

The full-text of this local coverage determination may be viewed on the provider education website *http://www.connecticutmedicare.com* when it becomes available.

90804: Individual Psychotherapy—LCD Revision

This local coverage determination (LCD) was last updated on November 1, 2005. Since that time, the LCD has been updated for clarification and revised in the following sections:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Do Not Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision
- ICD-9 Codes that Support Medical Necessity

Revisions include the removal of ICD-9-CM code 318.2 from the "ICD-9 Codes that Do Not Support Medical Necessity" section, and adding it to the "ICD-9 Codes that Support Medical Necessity" section. Also, additional documentation requirements were added.

This LCD was presented to the carrier advisory committee October 11, 2005. It will be effective for services rendered on or after April 11, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

90853: Group Psychotherapy—LCD Revision

This local coverage determination (LCD) was last updated on November 8, 2005. Since that time the LCD has been updated for clarification and revised in the following sections:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Do Not Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision
- ICD-9 Codes that Support Medical Necessity

Revisions include the removal of ICD-9-CM code 318.2 from the "ICD-9 Codes that Do Not Support Medical Necessity" section and adding it to the "ICD-9 Codes that Support Medical Necessity" section. Also, additional documentation requirements were added.

This LCD was presented to the carrier advisory committee October 11, 2005. It will be effective for services rendered on or after April 11, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

92225: Ophthalmoscopy—LCD Revision

The last revision for local coverage determination (LCD) Ophthalmoscopy was effective October 1, 2005. Since that time, this LCD has been updated and revised in the following sections:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision

Revisions include the removal of ICD-9-CM codes 250.50, 250.51, and 282.60 and the addition of ICD-9-CM codes 362.03, 362.05, and 362.06 in the "ICD-9 Codes that Support Medical Necessity" section, as other diagnosis codes in the policy should be used in order to provide greater specificity.

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

93922: Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries—LCD Revision

The last revision for local coverage determination (LCD) Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries was effective November 8, 2005. Since that time, the following sections of the LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines

Revisions include the provision of credentialing requirements.

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

99183: Hyperbaric Oxygen Therapy (HBO Therapy)—LCD Revision

The last revision for local coverage determination (LCD) hyperbaric oxygen therapy (HBO Therapy) was effective August 17, 2004. Since that time, the following sections of the LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision
- Coding Guidelines

Revisions include dual diagnosis requirements when billing HBO for the treatment of diabetic wounds of the lower extremities and clarification when billing evaluation and management (E/M) services and procedures on the same date of HBO therapy.

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

J1950: Leuprolide Acetate—Coding Guideline Revision

The coding guideline attachment for this local coverage determination (LCD) was developed on April 11, 2005. Since that time this coding guideline has been revised.

First Coast Service Options, Inc (FCSO) implements the least costly alternative (LCA) policy for Leuprolide Acetate. Medical literature indicates there is no demonstrable difference in clinical efficacy between J9217 leuprolide acetate (for depot suspension) and J9202 goserelin acetate implant (Zoladex) in the treatment of malignant neoplasm of the prostate (ICD-9-CM code 185) and malignant neoplasm of female breast (ICD-9-CM codes 174.0-174.9). If there are medical indications that require the use of J9217 instead of J9202, Medicare will consider payment at the higher rate if documentation to support the medical necessity of the use of the more costly agent accompany the claim.

The coding guideline attachment of this LCD has been revised to include instructions for those providers who submit electronic claims and want to provide documentation to support reimbursment at the higher rate (J9217). These instructions state that those providers who bill electronically and have documentation that supports reimbursement of the more costly agent, can populate field 19 or the electronic equivelent with the following statement: **Supporting documentation available for J9217.** By doing this, providers will receive a development letter with instructions to submit the claim for review. Providers are not mandated or required to populate block 19 or its electronic equivalent for claim development. FCSO recommends that providers who wish to have claims reviewed for reimbursment for the use of the more costly agent, implement these instructions for those claims.

These revisions are effective for claims processed on or after January 24, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

J2820: Sargramostim (GM-CSF, Leukine®)—LCD Revision

This local coverage determination (LCD) was last updated on October 01, 2005. Since that time, the following ICD-9-CM codes were added under the "ICD-9 Codes that Support Medical Necessity" section:

- 205.00-205.91 – Myeloid leukemia
- 996.85 – Complications of transplanted organ, bone marrow
- V42.81 – Organ or tissue replaced by transplant, bone marrow
- V42.82 – Organ or tissue replaced by transplant, peripheral stem cells
- V59.02 – Doners blood, stem cells
- V59.3 – Doners, bone marrow

It was also noted that ICD-9-CM codes *V42.81 and *V42.82 are secondary diagnosis codes and should not be billed as the primary diagnosis.

Standard verbiage was added to the following sections:

- Diagnoses that Support Medical Necessity
- ICD-9 Codes that DO NOT Support Medical Necessity
- Diagnoses that DO NOT Support Medical Necessity

In addition, the "Sources of Information and Basis for Decision" section was updated, and the above ICD-9-CM diagnosis codes were also added under the "Coding Guidelines" section.

These revisions are effective for services rendered on or after December 14, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

J9000: Antineoplastic Drugs—LCD Revision

The local coverage determination (LCD) for Antineoplastic Drugs was last updated on October 11, 2005. Since that time, a revision to this LCD was made to add the following additional off-label indication for Oxaliplatin (J9263) under the "Indications and Limitations of Coverage and/or Medical Necessity" section:

- Oxaliplatin is allowed for colon cancer, stage II, adjuvant treatment in combination with 5-Fluorouracil/leucovorin

This revision is effective for services rendered on or after August 1, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

EPO: Epoetin alfa—LCD Revision

The local coverage determination (LCD) for epoetin alfa was last updated on January 1, 2006. Since that time, the "ICD-9 Codes that Support Medical Necessity" section for HCPCS code J0885 was revised to remove the benign neoplasm ICD-9-CM diagnosis codes 210.0-229.9. These ICD-9-CM diagnosis codes are not supported as medically necessary in the indication and limitation section of this LCD. In addition, under EPO indication #6 – neoplastic disease was revised to read malignant neoplastic disease. The coding guideline for this LCD was revised accordingly.

This revision is effective for services rendered on or after January 13, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services (NCSVCS) was previously revised on January 1, 2006. Since that time, the LCD has been revised. Based on Change Request 4268 (Emergency Update to the 2006 Medicare Physician Fee Schedule Database), procedure codes 0141T, 0142T, and 0143T have been removed from the Local Noncoverage Decisions section of the LCD, as they are not valid for Medicare purposes.

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

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

The local coverage determination (LCD) for darbepoetin alfa (Aranesp®)(novel erythropoiesis stimulating protein [NESP]) was last updated on October 1, 2005. Since that time, the "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add diagnosis 585.4 (Chronic kidney desease, Stage IV [severe]) for HCPCS codes J0880 and Q0137.

This revision is effective for services rendered October 1, 2005 through December 31, 2005 (**Note**: Effective for services rendered on or after January 1, 2006, HCPCS codes J0880 and Q0137 were deleted and replaced with HCPCS code J0881). The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

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

The local coverage determination (LCD) for darbepoetin alfa (Aranesp®)(novel erythropoiesis stimulating protein [NESP]) was last updated on January 1, 2006. Since that time, the "ICD-9 Codes that Support Medical Necessity" section for HCPCS code J0881 was revised to remove the benign neoplasm ICD-9-CM diagnosis codes 210.0-229.9. These codes are not supported as medically necessary in the indication and limitation section of the LCD. The coding guideline for this LCD was revised accordingly.

This revision is effective for services rendered on or after January 13, 2006. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

VISCO: Viscosupplementation Therapy for Knee—LCD Revision

This local coverage determination (LCD) was last updated January 1, 2005. Since that time, a revision was made to the "Utilization Guideline" section of this LCD. The medication table was revised to show the weekly dosage/injections per week for each medication and to show the total dosage for a course of treatment. The total dosage for Orthovisc was revised to read 90-120mg. The duration of treatment for Hyalgan was revised to read 5 weeks.

This revision is effective for services rendered on or after November 15, 2005. The full-text of this LCD is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

RETIREMENT OF EXISTING LMRPS

D0120: Dental Services—Policy Retired

The local medical review policy (LMRP) for dental services – D0120 was previously revised on January 1, 2005. Since that time, the LMRP has been retired based on National Coverage guidelines (Pub 100-2, Chapters 15 and 16, Pub 100-3, Section 260.6), data analysis, and local practice patterns for dental services. This retirement is effective for services rendered on or after December 5, 2005. The full-text of this LMRP is available on our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

Multiple Policies Being Retired

The following local medical review policies (LMRPs) were retired. The decision to retire these policies was based on data analysis and standards of local practice. This retirement is effective for services rendered on or after January 1, 2006.

Policy Number	Policy Name
77280	Therapeutic Radiology Simulation-Aided Field Setting
77300	Basic Radiation Dosimetry Calculation
77332	Treatment Devices, Design, and Construction
77336	Radiation Physics Consultation

For coding and/or billing guidance, please refer to the Connecticut Medicare website at *http://www.connecticutmedicare.com* under education manuals for the Medicare Guidelines for Radiation Oncology manual.

ADDITIONAL INFORMATION ON LCDS

LCD Changes Related to the 2006 HCPCS Update

Connecticut Medicare has revised local coverage determinations (LCDs) impacted by the 2006 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

Policy Title	Changes
15822 Upper Eyelid and Brow Surgical Procedures	• Descriptor change for procedure codes *67901* and *67902*
22899 Kyphoplasty	• Removed procedure code *22899* • Removed procedure code *76499* **(Not related to 2006 HCPCS)** • Added procedure codes *22523*, *22524*, and *22525* • Added procedure codes *76012* and *76013* **(Not related to 2006 HCPCS)** • Changed LCD Number from *22899* to *22523*
97001 Physical Medicine and Rehabilitation	• Deleted procedure codes *97020*, *97504*, *97520*, and *97703* • Added procedure codes *97760*, *97761*, and *97762* • Descriptor change for procedure codes *97024*, and *97542* • Updated wheelchair management section with guidelines for assessment and fitting • Added heading of "Unlisted Modalities" to the Documentation Requirements section to clarify that the requirements are specific to the unlisted modalities **(Not related to 2006 HCPCS)**
ALEFACEPT Alefacept (**Coding Guidelines only)**	• Deleted procedure code *90782* to the Coding Guideline attachment • Added *CPT 90772* and related information to the Coding Guideline attachment
BEXXAR Tositumomab and Iodine I 131 Tositumomab (Bexxar®) Therapy	• Deleted procedure codes A9533 and A9534 • Added procedure codes A9544 and A9545 • Updated "CMS National Coverage Policy" section of the policy **(Not related to 2006 HCPCS)**
BOTULINUM TOXINS Botulinum Toxins (**Coding Guidelines only**)	• Added procedure codes *95865*, *95873*, and *95874* to the Coding Guideline attachment

LCD Changes Related to the 2006 HCPCS Update, continued

Policy Title	Changes
EPO Epoetin alfa	• Deleted procedure codes Q0136 and Q4055 • Added procedure codes J0885 and J0886
Macugen Macugen (pegaptanib sodium injection)	• Removed procedure code J3490 • Added procedure code J2503 • Changed LCD Number from Macugen to J2503
NCSVCS The List of Medicare Noncovered Services	• Deleted procedure code *0020T*, *97020*, G0279, and G0280 from the Local Noncoverage Decisions section of the LCD • Deleted procedure code G0235 as it is non-covered per national coverage guidelines (N-status indicator) **(Not related to 2006 HCPCS)** • Added procedure codes *0019T**, *0089T** through *0111T**, *0115T** through *0117T**, *0120T**, *0123T**, *0124T**, *0126T**, *0130T**, *0133T**, *0135T**, *0140T** through *0144T**, 0153T*, *0154T**, *28890**, *43770**, *43771**, *43772** *43773**, *43774**, *43886**, *43887**, *43888** and *90649* to the Local Noncoverage Decisions section of the LCD (* investigational) • Descriptor change for procedure codes *90680* and *90724* in the Local Noncoverage Decisions section of the LCD
NESP Darbepoetin alfa (Aranesp®) (novel erythopoiesis stimulating protein [NESP])	• Deleted procedure codes J0880, Q0137 and Q4054 • Added procedure codes J0881 and J0882
Q9941 Intravenous Immune Globulin	• Deleted procedure codes Q9941, Q9942, Q9943, and Q9944 • Added procedure codes J1566 and J1567 • Change LCD Number from Q9941 to J1566
SKINSUB Skin Substitutes	• Deleted procedure codes *15342* and *15343* and replaced them with generic skin substitute/skin replacement verbiage • Descriptor change for procedure codes J7340, J7342, J7343, and J7344
ZEVALIN Ibritumomab Tiuxetan (Zevalin™) Therapy	• Deleted procedure codes A9522 and A9523 • Added procedure codes A9542 and A9543

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

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

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

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

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

Attention: Correspondence

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

Attention: Financial Services

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

Attention: Fraud and Abuse

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

Attention: Freedom of Information (FOIA)

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

Attention: Medical Review

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

Attention: MSP

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

Attention: Pricing/ Provider Maintenance

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

Attention: Resolutions

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

MAILING ADDRESS EXCEPTIONS

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

Redeterminations/Appeals

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

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

Hearings

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

Post Office Box for Appeals/Hearings:

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

Electronic Media Claims/EDI

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

Post Office Box for EDI:

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

Claims

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

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

CONNECTICUT MEDICARE PHONE NUMBERS

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

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

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

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

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

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

Electronic Funds Transfer Information
1-203-639-3219

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

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

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

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

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

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

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

Health Insurance Counseling Program
1-800-994-9422

Area Agency on Aging
1-800-994-9422

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

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

MEDICARE WEBSITES

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

BENEFICIARIES
Centers for Medicare & Medicaid Services
www.medicare.gov

FLORIDA MEDICAL REVIEW

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

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

Effective and Notice Dates

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

Electronic Notification

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

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

More Information

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

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

1-904-791-8465

Medical Review Table of Contents

Advance Notice Statement

Advance beneficiary notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity. See page 5 for details concerning ABNs.

NEW LCDS

64640: Destruction by neurolytic agent; interdigital nerve of the foot—Morton's Neuroma—LCD Addition

Destruction by neurolytic agent is preformed to treat chronic pain by destroying specific sites along a nerve. The interdigital spaces of the foot are common sites for the development of neuromas (e.g. Morton's neuroma). These occur most often between the third and fourth digits of the foot where the medial and lateral plantar nerves combine, usually from repetitive stress. Pain occurs when the metatarsal heads of the foot are squeezed together. Neurolysis (or destruction of a nerve) can be accomplished by chemical or thermal means. .

This local coverage determination (LCD) was developed based on data analysis for procedure code *64640*. Indications and limitations along with frequency guidelines were incorporated into this LCD. ICD-9-CM codes that do and do not support medical necessity were included in this LCD.

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

86141: High Sensitivity C-Reactive Protein (hsCRP)—LCD Addition

A high sensitivity C-reactive protein (hsCRP) assay measures low levels of CRP, which allows for measurement of conditions indicative of chronic, lo-grade inflammation. The stimulus for the rise in serum CRP in CAD remains undetermined, although it may result from local inflammation within atheromatous plaques, from a systemic or local inflammation or infection elsewhere in the body that contributes to atherogenesis, or to unrelated conditions. Increased CRP may reflect plaque instability and an increased risk for a CAD event.

The hsCRP results, along with The Framingham Heart Study Risk Assessment (a tool which considers gender, age, total cholesterol, systolic blood pressure, antihypertensive medications, family history and smoking risks) provides cardiac prognostic information. However, hsCRP and LDL cholesterol levels are minimally correlated.

Currently, First Coast Service Options (FCSO) will consider high-sensitivity C-reactive protein (hsCRP) testing medically reasonable and necessary for the assessment of CAD risk when ALL of the following criteria are met:

- When the hsCRP would add substantial incremental information in the decision making process to optimize/maximize current lipid lowering pharmacologic therapy in a patient who has been identified as being at intermediate risk for CAD (10- year risk of coronary heart disease between 10-20% per the ATPIII Guidelines). This is to be used for a one time decision point and is not intended to monitor therapy.
- The test is performed in patients considered to be metabolically stable and without obvious inflammatory or infectious conditions.
- The ICD-9-CM codes that support Medical Necessity for hsCRP include:

    - 272.0 - Pure hypercholesterolemia
    - 272.1 - Pure hyperglyceridemia
    - 272.2 - Mixed hyperlipidemia
    - 272.3 - Hyperchylomicronemia
    - 272.4 - Other and unspecified hyperlipidemia

If high sensitivity C-reactive protein (hsCRP) testing is performed for cardiovascular risk assessment, in the absence of signs or symptoms of illness or injury, then the service will be denied as not reasonable or medically necessary.

This service is currently non-covered for Florida and will be removed from The List of Medicare Noncovered Services local coverage determination (LCD) effective April 11, 2006. Therefore, a LCD was developed for both Florida and Connecticut to provide access to care, define the indication, limitations and documentation requirements for these services.

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

90853: Group Psychotherapy—LCD Addition

Psychotherapy is the treatment of mental illness and behavior disturbances in which the provider establishes a professional contact with the patient and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development or accept losses, especially related to aging and coping with such. Group Psychotherapy is a form of treatment administered in a group setting with a trained group leader in charge of several patients. Since it involves psychotherapy it must be led by a person, authorized by state statute to perform this service.

A local coverage determination (LCD) has been developed to define the indications and limitations of coverage, documentation requirements and medical necessity for group psychotherapy.

This LCD was presented to the carrier advisory committee November 12, 2005. It will be effective for services rendered on or after April 11, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

96150: Health and Behavior Assessment/Intervention—LCD Addition

Health and Behavior Assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus is not on mental health, but on the biopsychosocial factors important to physical health problems and treatments.

Effective, January 1, 2002, the CPT codes for health and behavior assessment and intervention services (*96150-96154*) apply to behavioral, social, and psychosocial procedures for the prevention, treatment, or management of physical health problems. Until then, almost all intervention codes used by psychologists involved psychotherapy and required a mental health diagnosis. In contrast, health and behavior assessment and intervention services focus on patients whose primary diagnosis is physical in nature. These services are currently non-covered for Florida and will be removed from The List of Medicare Noncovered Services local coverage determination (LCD) effective April 11, 2006.

Therefore, a LCD was developed for both Florida and Connecticut to provide access to care, define the indication, limitations and documentation requirements for these services.

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

REVISIONS TO LMRPS/LCDS

11000: Debridement Services—LCD Revision

The local coverage determination (LCD) for debridement services (11000) was previously revised on January 1, 2006. Since that time, the following ICD-9-CM code ranges have been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD for procedure codes *97597* and *97598* only:

941.20 - 941.29	943.20 - 943.29	945.20 - 945.29
941.30 - 941.39	943.30 - 943.39	945.30 - 945.39
941.40 - 941.49	943.40 - 943.49	945.40 - 945.49
942.20 - 942.29	944.20 - 944.28	946.20 - 946.29
942.30 - 942.39	944.30 - 944.38	946.30 - 946.39
942.40 - 942.49	944.40 - 944.48	946.40 - 946.49

This revision is effective for claims processed on or after January 30, 2006 for services rendered on or after January 1, 2005. The full-text of the LCD is available on the provider education website at *http://www.floridamedicare.com*.

No Action Required by Providers

Providers who have claims for dates of service on or after January 1, 2005 which were denied for these diagnoses do not need to take any action. Adjustments will be done on all the affected claims soon after the changes are complete.

We apologize for any inconvenience this may have caused.

70370: Dysphagia/Swallowing Diagnosis and Therapy – Policy Revision

The local medical review policy (LMRP) for dysphagia/swallowing diagnosis and therapy (*70370*) was previously revised on April 7, 2003. Since that time, the LMRP was revised to remove the following statement based on Change Request 3648.

"Modified Barium Swallow studies (*70370*, *70371*, and *74230*) are not covered when performed on a mobile basis."

This revision is effective for services rendered on or after June 6, 2005.

In addition, the LMRP has been converted to a local coverage determination (LCD) format. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

70450: Computed Tomography Scans—LCD Revision

This local coverage determination (LCD) was last updated effective September 20, 2005. Since that time, this LCD has been revised and the title of the LCD has been changed to Computed Tomography Scans of the Head or Brain.

This revision included changes to the "Indication and Limitations of Coverage" and "Documentation Requirements" sections of the LCD.

This revision also included the following changes:

- Procedure codes *70480-70492*, *72125-72133*, *73200-73202* and *73700-73702* were removed from the LCD.
- Since the ICD-9-CM codes associated with the many indications of the CT of the Head or Brain can be numerous and the ability to identify every appropriate diagnosis code for this service would result in an extensive diagnosis list, the ICD-9-CM codes were removed from the LCD.

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

71250: Computed Tomography of the Thorax—LCD Revision

This local coverage determination (LCD) was last revised effective October 11, 2005. Since that time, the "Indication and Limitations of Coverage" and "Documentation Requirements" sections have been revised. In addition, the Florida and Connecticut LCD's have been combined.

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

76070: Bone Mineral Density Studies—LCD Revision

The last revision for local coverage determination (LCD) Bone Mineral Density Studies was effective June 7, 2005. Since that time, this LCD has been revised to indicate additional medical circumstances where Medicare may cover a bone mass measurement for a patient more frequently than every 2 years, if medically necessary. These revisions include:

- Monitoring a patient to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy if the result is being used to determine the need for continued treatment of osteoporosis. Agents approved by the FDA for osteoporosis prevention and/or treatment include:
  - Estrogen therapy (for purposes of this policy, the estrogen must be specifically used for treatment of osteoporosis)
  - Alendronate (Fosamax)
  - Calcitonin-salmon (Miacalcin-nasal spray or injection)
  - Raloxifene (Evista)
  - Risedronate (Actonel)
  - Teriparatide (Forteo) injection
  - Ibandronate (Boniva)
- To determine a patient's response to pharmacologic therapy when the therapy has been changed to another family of therapeutic agents.

Revisions have been made in the "Indications and Limitations of Coverage and/or Medical Necessity" and "Utilization Guidelines" sections accordingly.

These revisions are effective for services rendered on or after November 21, 2005.

In addition, this LCD has been revised in the "Indications and Limitations of Coverage and/or Medical Necessity", "ICD-9 Codes that Support Medical Necessity" and "Documentation Requirements" sections. These revisions include updating the NCD language, providing clarification for rendering this service for a woman who has been determined by the physician or a qualified non-physician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings and the addition of ICD-9-CM code 627.4 in the "ICD-9 Codes that Support Medical Necessity" section. These revisions will be effective for services rendered on or after April 11, 2006.

The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

90801: Psychiatric Diagnostic Interview Examination—LCD Revision

This local coverage determination (LCD) was last updated on October 1, 2005. Since that time the LCD has been updated for clarification and revised in the following sections:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision

This major revision includes removal of all ICD-9-CM codes, updates and clarifies the indications and limitations section and documentation guidelines.

This LCD was presented to the carrier advisory committee November 12, 2005. It will be effective for services rendered on or after April 11, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

90804: Individual Psychotherapy—LCD Revision

This local coverage determination (LCD) was last updated on October 18, 2005. Since that time the LCD has been updated for clarification and revised in the following sections:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Do Not Support Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision

Revisions include the removal of ICD-9-CM code 318.2 from the "ICD-9 Codes that Do Not Support Medical Necessity" section and adding it to the "ICD-9 Codes that Support Medical Necessity" section. Also, additional documentation requirements were added.

This LCD was presented to the carrier advisory committee November 12, 2005. It will be effective for services rendered on or after April 11, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

92225: Ophthalmoscopy—LCD Revision

The last revision for local coverage determination (LCD) Ophthalmoscopy was effective October 1, 2005. Since that time, this LCD has been updated and revised as the result of a widespread probe performed for this service. The following sections of the LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision

Revisions include the addition of ICD-9-CM codes 361.89, 362.03, 362.05, 362.06 and 998.82 in the "ICD-9 Codes that Support Medical Necessity" section.

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

93922: Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries—LCD Revision

The last revision for local coverage determination (LCD) Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries was effective November 8, 2005. Since that time, the following sections of the LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Coding Guidelines

Revisions include the provision of credentialing requirements and utilization parameters and the addition of ICD-9-CM code 447.5 in the "ICD-9 Codes that Support Medical Necessity" section.

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

93925: Duplex Scan of Lower Extremity Arteries—LCD Revision

The last revision for local coverage determination (LCD) Duplex Scan of Lower Extremity Arteries was effective November 8, 2005. Since that time, the following sections of the LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Coding Guidelines

Revisions include the provision of credentialing requirements and utilization parameters and the removal of ICD-9-CM codes 782.61, V67.00 and V67.09 and the addition of ICD-9-CM code V58.49 in the "ICD-9 Codes that Support Medical Necessity" section.

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

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

The last revision for local coverage determination (LCD) Non-Invasive Evaluation of Extremity Veins was effective November 8, 2005. Since that time, the following sections of the LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Coding Guidelines

Revisions include the provision of credentialing requirements and utilization parameters, the removal of ICD-9-CM code 454.9 and the addition of ICD-9-CM code V67.09 in the "ICD-9 Codes that Support Medical Necessity" section.

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

99183: Hyperbaric Oxygen Therapy (HBO Therapy)—LCD Revision

The last revision for local coverage determination (LCD) Hyperbaric Oxygen Therapy (HBO Therapy) was effective August 17, 2004. Since that time, the following sections of the LCD have been revised:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision
- Coding Guidelines

Revisions include dual diagnosis requirements when billing HBO for the treatment of diabetic wounds of the lower extremities and clarification when billing evaluation and management (E/M) services and procedures on the same date of HBO therapy.

This revision will be effective for services rendered on or after April 11, 2006. The full-text of this LCD may be viewed on the provider education website *http://www.floridamedicare.com* on or after this effective date.

J1950: Leuprolide Acetate—Coding Guideline Revision

The coding guideline attachment for this local coverage determination (LCD) was last revised on January 14, 2005. Since that time this coding guideline has been revised.

First Coast Service Options, Inc (FCSO) implements the least costly alternative (LCA) policy for leuprolide acetate. Medical literature indicates there is no demonstrable difference in clinical efficacy between J9217 leuprolide acetate (for depot suspension) and J9202 goserelin acetate implant (zoladex) in the treatment of malignant neoplasm of the prostate (ICD-9-CM code 185) and malignant neoplasm of female breast (ICD-9-CM codes 174.0-174.9). If there are medical indications that require the use of J9217 instead of J9202, Medicare will consider payment at the higher rate if documentation to support the medical necessity of the use of the more costly agent accompany the claim.

The coding guideline attachment of this LCD has been revised to include instructions for those providers who submit electronic claims and want to provide documentation to support reimbursment at the higher rate (J9217). These instructions state that those providers who bill electronically and have documentation that supports reimbursement of the more costly agent, can populate field 19 or the electronic equivelent with the following statement: **Supporting documentation available for J9217.** By doing this, providers will receive a development letter with instructions to submit the claim for review. Providers are not mandated or required to populate block 19 or its electronic equivalent for claim development. FCSO recommends that providers who wish to have claims reviewed for reimbursment for the use of the more costly agent, implement these instructions for those claims.

These revisions are effective for claims processed on or after December 30, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J2355: Oprelvekin (Neumega®)—Policy Revision

The local medical review policy (LMRP) for Oprelvekin (Neumega®) was last updated on August 25, 2003. Since that time the policy has been revised. The LMRP was converted to local coverage determination (LCD) format. In addition to conversion, a request was received to add additional ICD-9-CM codes 203.00-203.81 (Multiple Myeloma) and 204.00-204.91(Lymphoid Leukemia) to the "ICD-9 codes that support medical necessity" section of the LCD. A review of literature supported this request and this section was revised accordingly. The following statement, "All other diagnosis codes not listed as covered in the "ICD-9 codes that support medical necessity" section of this LCD" was added to the "ICD-9 codes that do not support medical necessity" section of this LCD.

This revision is effective for services rendered on or after November 28, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J2820: Sargramostim (GM-CSF, Leukine®)—LCD Revision

This local coverage determination (LCD) was last updated on October 01, 2005. Since that time, the following ICD-9-CM codes were added under the "ICD-9 Codes that Support Medical Necessity" section:

205.00-205.91	*Myeloid leukemia*
996.85	*Complications of transplanted organ, bone marrow*
V42.81	*Organ or tissue replaced by transplant, bone marrow*
V42.82	*Organ or tissue replaced by transplant, peripheral stem cells*
V59.02	*Doners blood, stem cells*
V59.3	*Doners, bone marrow*

It was also noted that ICD-9-CM codes *V42.81 and *V42.82 are secondary diagnosis codes and should not be billed as the primary diagnosis.
Standard verbiage was added to the following sections:

- Diagnoses that Support Medical Necessity
- ICD-9 Codes that DO NOT Support Medical Necessity
- Diagnoses that DO NOT Support Medical Necessity

In addition, the "Sources of Information and Basis for Decision" section was updated, and the above listed ICD-9-CM diagnosis codes were also added under the "Coding Guidelines" section.

These revisions are effective for services rendered on or after December 14, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J9000: Antineoplastic Drugs—LCD Revision

The local coverage determination (LCD) for Antineoplastic Drugs was last updated on October 11, 2005. Since that time, a revision to this LCD was made to add the following additional off-label indication for Oxaliplatin (J9263) under the "Indications and Limitations of Coverage and/or Medical Necessity" section:

- Oxaliplatin is allowed for colon cancer, stage II, adjuvant treatment in combination with 5-Fluorouracil/leucovorin

This revision is effective for services rendered on or after August 1, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

EPO: Epoetin alfa—LCD Revision

The local coverage determination (LCD) for epoetin alfa was last updated on January 1, 2006. Since that time, the "ICD-9 Codes that Support Medical Necessity" section for HCPCS code J0885 was revised to remove the benign neoplasm ICD-9-CM diagnosis codes 210.0-229.9. These ICD-9-CM diagnosis codes are not supported as medically necessary in the indication and limitation section of this LCD. In addition, under EPO indication #6 – neoplastic disease was revised to read malignant neoplastic disease. The coding guideline for this LCD was revised accordingly.

This revision is effective for services rendered on or after January 13, 2006**.** The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services (NCSVCS) was previously revised on January 1, 2006. Since that time, the LCD has been revised. Based on Change Request 4268 (Emergency Update to the 2006 Medicare Physician Fee Schedule Database), procedure codes *0141T*, *0142T*, and *0143T* have been removed from the "Local Noncoverage Decisions" section of the LCD, as they are not valid for Medicare purposes.

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

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

This local coverage determination (LCD) was last updated on January 1, 2006. Since that time, this LCD has been revised. LCDs have been developed for Health and Behavior Asessment/Intervention services (*96150-96154*) and High Sensitivity C-Reactive Protein (hsCRP) *86141* for Florida and Connecticut.

These services are currently locally noncovered in Florida. Therefore, the List of Medicare Noncovered Services LCD is being revised to remove procedure codes *96150-96154* and *86141*. This revision is effective for services rendered on or after April 11, 2006. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

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

The local coverage determination (LCD) for darbepoetin alfa (Aranesp®)(novel erythropoiesis stimulating protein [NESP]) was last updated on October 1, 2005. Since that time, the "ICD 9 Codes that Support Medical Necessity" section of the LCD has been revised to add ICD-9-CM 585.4 (Chronic kidney desease, Stage IV [severe]) for HCPCS codes J0880 and Q0137.

This revision is effective for services rendered October 1, 2005 through December 31, 2005 (**Note**: Effective for services rendered on or after January 1, 2006, HCPCS codes J0880 and Q0137 were deleted and replaced with HCPCS code J0881). The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

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

The local coverage determination (LCD) for darbepoetin alfa (Aranesp®)(novel erythropoiesis stimulating protein [NESP]) was last updated on January 1, 2006. Since that time, the "ICD 9 Codes that Support Medical Necessity" section for HCPCS code J0881 was revised to remove the benign neoplasm ICD-9-CM diagnosis codes 210.0-229.9. These codes are not supported as medically necessary in the indication and limitation section of the LCD. The coding guideline for this LCD was revised accordingly.

This revision is effective for services rendered on or after January 13, 2006 The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

VISCO: Viscosupplementation Therapy for Knee—LCD Revision

This local coverage determination (LCD) was last updated January 1, 2005. Since that time, a revision was made to the "Utilization Guidelines" section of this LCD. The medication table was revised to show the weekly dosage/injections per week for each medication and to show the total dosage for a course of treatment. The total dosage for Orthovisc was revised to read 90-120mg. The duration of treatment for Hyalgan was revised to read 5 weeks.

This revision will be effective for services rendered on or after November 15, 2005. The full-text of this LCD is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

RETIREMENT OF EXISTING LMRPS

A4300: Implantable Vascular Access—Policy Retired

The local medical review policy (LMRP) for implantable vascular access – A4300 was previously revised on January 1, 2003. Since that time, the LMRP has been retired based on data analysis and local standards of practice.

This retirement is effective for services rendered on or after November 15, 2005. The full-text of this LMRP is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

D0120: Dental Services—Policy Retired

The local medical review policy (LMRP) for dental service – D0120 was previously revised on January 1, 2005. Since that time, the LMRP has been retired based on National Coverage guidelines (Pub 100-2, Chapters 15 and 16, Pub 100-3, Section 260.6), data analysis, and local practice patterns for dental services.

This retirement is effective for services rendered on or after December 5, 2005. The full-text of this LMRP is available on our provider education website at *http://www.floridamedicare.com* on or after this effective date.

Multiple Policies Being Retired

The following local medical review policies (LMRPs) were retired. The decision to retire these policies was based on data analysis and standards of local practice. This retirement is effective for services rendered on or after January 1, 2006.

Policy Number	Policy Name
77280	Therapeutic Radiology Simulation-Aided Field Setting
77300	Basic Radiation Dosimetry Calculation
77305	Teletherapy Isodose Plan
77321	Special Teletherapy Port Plan
77326	Brachytherapy Isodose Calculation
77331	Special Dosimetry
77332	Treatment Devices, Design and Construction
77336	Radiation Physics Consultation
77401	Radiation Treatment Delivery
77427	Weekly Radiation Therapy Management
77470	Radiation Special Treatment Procedures

For coding and/or billing guidance, please refer to the Florida Medicare website at *http://www.floridamedicare.com* under education manuals for the Medicare Guidelines for Radiation Oncology manual.

WIDESPREAD MEDICAL REVIEW PROBES

82550: Widespread Probe Review Results

Overview

Procedure code 82550 was chosen for Focused Medical Review for FY2004 based on the January through June 2003 data revealing a carrier to nation ratio of allowed dollars of 1.82* with a maximum potential savings of $239,765.00. Based on the conclusions of the findings, the performance of the services was considered a widespread problem; therefore, a recommendation to perform a widespread probe and possibly develop a local coverage determination was made. A widespread probe of ninety-five (95) claims from nineteen (19) providers for the time period from January 1, 2004 to March 31, 2004 was performed. The purpose of the review was to determine if the services billed to Medicare were documented as having been performed and determine the medical conditions for which the service was being performed.

***Note:** Florida Carrier to nation ratio refers to Florida allowed dollars/1000 enrollees divided by the national average allowed dollars/1000 enrollees. To further assist in interpreting the data: 0.5 is 50% below the national average, 1.0 is average, 1.5 is 50% above the national average, 2.0 is 100% above the national average, 2.5 is 150% above the national average and etc.

Summary

The summary of findings is as follows:

- Fifty-eight (58) out of ninety-five (95) claims reviewed supported the medical necessity as outlined in current medical literature for performing a CK lab test. Twenty-five (25) services were allowed, although the documentation supports routine testing. A notable finding was documented that current medical literature supports that routine laboratory monitoring of CK is of little value in the absence of clinical signs and symptoms. One would expect CK testing to be done as a baseline for the initiation and the titration of a statin medication in the absence of clinical signs and symptoms.
- Twelve (12) of ninety-five (95) services were denied as follows;
- Seven (7) services were denied as no additional documentation was received to support medical necessity as outlined in current medical literature. The services were reviewed based on the submitted laboratory requisitions and laboratory results without medical records from the referring provider.
- Five (5) services were denied, as the documentation did not support that the patients were on a newly initiated statin medication and/or statin therapy which is a standard of practice outline in current medical literature.

Conclusion

Creatine kinase (CK) is an enzyme that catalyst the creatine-creatinine pathway in muscle and brain tissue. The CK test is used in the diagnosis of myocardial infarction and as a reliable measure of skeletal and inflammatory muscle disease. Current literature supports doing a CK test for the following conditions:

- Conditions in which a CK test may be medically reasonable and necessary, but is not limited to, acute myocardial infarction, acute cerebrovascular disease, cardioversion and/or defibrillation, cardiac surgery, myocarditis, central nervous system trauma, hypothyroidisms, malignant hyperthermia syndrome, hypokalemia, convulsions, rhabdomylosis, delirium tremors and chronic alcoholism.
- CK testing may be medically necessary when done as a baseline for the initiation and the titration of a statin medication in the absence of clinical signs and symptoms. Patients beginning to receive statin medications should be instructed to report muscle discomfort, weakness, or brown urine immediately, which should then prompt a CK measurement.
- Conditions, which are associated with decreased CK levels, include, but are not limited to, decreased muscle mass and/or prolonged bed rest.

Even though a patient has a condition stated above, it is not expected that a CK test be performed frequently for stable chronic symptoms that are associated with that disease. Current literature supports that routine laboratory monitoring of CK is of little value in the absence of clinical signs and symptoms.

Based on these widespread probe findings, an educational article is being done to clarify when a CK test should be performed according to current medical literature. In addition, First Coast Service Options will perform additional analysis to determine if a local coverage determination (LCD) needs to be developed to further define the indications and limitations of coverage and/or medical necessity.

ADDITIONAL INFORMATION ON LMRPS/LCDS

Intravenous Vitamin Therapy - HCPCS codes J3411 (thiamine HCl, 100mg) and J3415 (pyridoxine HCl, 100 mg)

Thiamine (Vitamin B1) and Pyridoxine (Vitamin B6) are water-soluble nutrients found in many foods and over-the-counter preparations. For therapeutic use, they are available parenterally and orally. Data analysis reveals an extraordinary high and rising intravenous utilization of these vitamins in Florida.

There are certain vitamin deficiency states in which rapid intravenous replenishment in high doses, such as 1,000 mg daily for several days, may be needed. It is almost never medically necessary to administer vitamins B1 and B6 parenterally in the long term. There is some evidence that vitamins may slow the progression of HIV disease. Studies in support of this contention have been largely conducted with oral preparations.

In summary, unless a severe deficiency state exists that requires immediate intravenous correction; there is no added benefit in administering vitamins B1 and B6 parenterally. If an agent is available in both oral and injectable forms and both forms are equally effective, the oral preparation shall be used, unless there is a medical reason not to do so. If a provider elects to use the intravenous route, nevertheless, the vitamins are not reimbursable by Medicare. Because services that lead up to or are associated with non-covered services are not covered as well, also the intravenous administration is not payable.

LCD Changes Related to the 2006 HCPCS Update

Florida Medicare has revised local coverage determinations (LCDs) impacted by the 2006 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

Policy Title	Changes
11000 Debridement Services	• Deleted procedure codes *15350* and *15351* • Added procedure code range *15300-15336* • Updated "CMS National Coverage Policy" section of the policy (**Not related to 2006 HCPCS**)
15822 Upper Eyelid and Brow Surgical Procedures	• Descriptor change for procedure codes *67901* and *67902*
22520 Percutaneous Vertebroplasty	• Descriptor change for procedure code *76012*
22899 Kyphoplasty	• Removed procedure code *22899* • Removed procedure code *76499* (**Not related to 2006 HCPCS**) • Added procedure codes *22523*, *22524*, and *22525* • Added procedure codes *76012* and *76013* (**Not related to 2006 HCPCS**) • Changed LCD Number from *22899* to *22523*
43644 Surgical Management of Morbid Obesity	• Added procedure codes *43770*, *43771*, *43772*, *43773*, *43774*, *43886*, *43887*, and *43888* (These procedures are associated with the surgical techniques that are considered investigational and non-covered when performed for severe obesity. Therefore, they are also considered investigational and non-covered.) • Added procedure code *43659* as noncovered when billed for the removal and replacement of both gastric band and subcutaneous port components **(Not related to 2006 HCPCS)** • Descriptor change for procedure code *43848*
64561 Sacral Neuromodulation (**Coding Guidelines only**)	• Deleted procedure codes E0752 and E0756 from the Coding Guideline attachment • Added procedure codes L8680, L8685, L8686, L8687, L8688, and L8689 to the Coding Guideline attachment
78459 Myocardial Imaging, Positron Emission Tomography (PET) Scan	• Removed procedure code A4641 • Added procedure code A9555 • Descriptor change for procedure code A9526 • Coding Guideline attachment retired as it is no longer applicable

LCD Changes Related to the 2006 HCPCS Update, continued

Policy Title	Changes
78460 Myocardial Perfusion Imaging (**Coding Guidelines only**)	• Descriptor change for procedure code A4641 in the Coding Guideline attachment • Corrected typographical error in the Coding Guideline attachment – 7878 was changed to *78478* (**Not related to 2006 HCPCS**)
95250 Continuous Glucose Monitoring System (CGMS)	• Added procedure code *95251* • Descriptor change for procedure code *95250*
96000 Comprehensive Motion Analysis Studies (**Coding Guidelines only**)	• Changed the code range from *95860 – 95875* to *95860-95864*, *95867-95872*, and *95875* in the Coding Guideline attachment. New 2006 HCPCS codes *95865*, *95866*, *95873*, and *95874* are not being added, as they are not applicable. Therefore, the procedure code range in the "Coding Guidelines" has been updated to not include those codes.
A9600 Metastron C Strontium–89 Chloride	• Descriptor change for procedure code A9600 • Corrected typographical error in the Coding Guideline attachment – A96000 was changed to A9600 (**Not related to 2006 HCPCS**)
ALEFACEPT Alefacept (**Coding Guidelines only**)	• Deleted procedure code *90782* to the Coding Guideline attachment • Added procedure code *90772* and related information to the Coding Guideline attachment
BEXXAR Tositumomab and Iodine I 131 Tositumomab (Bexxar®) Therapy	• Deleted procedure codes A9533 and A9534 • Added procedure codes A9544 and A9545 • Updated "CMS National Coverage Policy" section of the policy (**Not related to 2006 HCPCS**)
BOTULINUM TOXINS Botulinum Toxins (**Coding Guidelines only**)	• Added procedure codes *95865*, *95873*, and *95874* to the Coding Guideline attachment
EPO Epoetin alfa	• Deleted procedure codes Q0136 and Q4055 • Added procedure codes J0885 and J0886
J3487 Zoledronic Acid (Zometa®) (**Coding Guidelines only**)	• Deleted procedure code G0347 and related billing instructions from the Coding Guideline attachment
J7190 Hemophilia Clotting Factors	• Deleted procedure codes Q0187 and Q2022 • Added procedure codes J7188 and J7189 • Changed LCD Number from J7190 to J7188
Macugen Macugen (pegaptanib sodium injection)	• Removed procedure code J3490 • Added procedure code J2503 • Changed LCD Number from Macugen to J2503
NCSVCS The List of Medicare Noncovered Services	• Deleted procedure code *0020T*, *97020*, G0279, and G0280 from the Local Noncoverage Decisions section of the LCD • Deleted procedure code G0235 as it is non-covered per national coverage guidelines (N-status indicator) (**Not related to 2006 HCPCS**) • Added procedure codes 0019T*, 0089T* through *0111T**, *0115T** through *0117T**, *0120T**, *0123T**, *0124T**, *0126T**, *0130T**, *0133T**, *0135T**, *0140T** through *0144T**, *0153T**, *0154T**, *28890**, and *90649* to the Local Noncoverage Decisions section of the LCD (* investigational) • Descriptor change for procedure codes *90680* and *90724* in the Local Noncoverage Decisions section of the LCD
NESP Darbepoetin alfa (Aranesp®) (novel erythopoiesis stimulating protein [NESP])	• Deleted procedure codes J0880, Q0137 and Q4054 • Added procedure codes J0881 and J0882
OOS Outpatient Observation Services	• Deleted procedure codes G0244, G0263, and G0264 • Added procedure codes G0378 and G0379

LCD Changes Related to the 2006 HCPCS Update, continued

Policy Title	Changes
PHPPROG Psychiatric Partial Hospitalization Program	• Deleted procedure codes *96100*, *96115*, and *96117* • Added procedure codes *96101*, *96116*, and *96118*
Q9941 Intravenous Immune Globulin	• Deleted procedure codes Q9941, Q9942, Q9943, and Q9944 • Added procedure codes J1566 and J1567 • Change LCD Number from Q9941 to J1566
SKINSUB Skin Substitutes	• Deleted procedure codes *15342* and *15343* and replaced them with generic skin substitute/skin replacement verbiage • Descriptor change for procedure codes J7340, J7342, J7343, and J7344
THERSVCS Therapy and Rehabilitation Services	• Deleted procedure codes *96115*, *97020*, *97504*, *97520*, and *97703* • Added procedure codes *92626*, *92627*, *92630*, *92633*, *96116*, *97760*, *97761*, and *97762* • Descriptor change for procedure codes *92506*, *92507*, *97024*, and *97542* • Updated wheelchair management section with guidelines for assessment and fitting
ZEVALIN Ibritumomab Tiuxetan (Zevalin™) Therapy	• Deleted procedure codes A9522 and A9523 • Added procedure codes A9542 and A9543

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

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MEDICARE B UPDATE!

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P.O. BOX 2078 JACKSONVILLE, FL 32231-0048 (FLORIDA)
P.O. BOX 44234 JACKSONVILLE, FL 32231-4234 (CONNECTICUT)

*** ATTENTION BILLING MANAGER ***