

Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

2006 Healthcare Common Procedure Coding System and Medicare Physician Fee Schedule Database Update

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

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

Routing Suggestions:

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

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Medicare B Update!

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ANNUAL HCPCS UPDATE

Effective for Services Rendered on or After January 1, 2006

The Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) is used to administer the Medicare Part B program for all carriers. The HCPCS is updated annually to reflect changes in the practice of medicine and provisions of healthcare. When filing claims for dates of service beginning January 1, 2006, refer to the coding changes in this publication. For dates of service in 2005, continue to use 2005 procedure codes.

The purpose of this section is to provide an overview of changes to the HCPCS coding structure for 2006. This publication only covers specific coding changes. Related billing and reimbursement changes will be posted to our provider education websites at <http://www.connecticutmedicare.com> and <http://www.floridamedicare.com>, and in future issues of the *Medicare B Update!* This information will also be shared with the Connecticut Medical Association, the Florida Medical Association, all county medical societies, and all active specialty associations. Stay in contact with these organizations and read their bulletins for additional HCPCS information.

Description of HCPCS Coding Levels

Procedure code additions, deletions and revisions are being made to all three levels of the HCPCS coding structure for 2005. The three levels of procedure codes are:

Level I -Numeric Codes (CPT)

Level I codes and modifiers include five-digit numeric codes (for example, procedure code 71010). These codes describe various physician and laboratory procedures and are contained in the American Medical Association's *Current Procedural Terminology (CPT)*.

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Level II -Alpha Numeric (CMS-Assigned)

Level II codes and modifiers include alphanumeric codes (for example, procedure code A6255) assigned by CMS. These codes describe various nonphysician and a relatively few number of physician services. These procedure codes begin with a letter in the A-V range and are used for durable medical equipment (DME), ambulance services, prosthetics, orthotics, ostomy supplies, etc.

The 2006 HCPCS Update

Additions

The procedure/modifier codes listed under "Modifiers/Procedure Codes Added for 2006" (pages 5-6) are newly identified codes and should be used only for services rendered on or after January 1, 2006.

Revisions

The procedure/modifier codes listed under "Modifiers/Procedure Codes Revised for 2006" (pages 6-7) include codes in which the descriptor or administrative instructions have changed from 2005. When using these codes, please be sure to refer to the 2006 HCPCS or *CPT* to ensure you are using the accurate procedure code for the service performed.

Discontinued Procedures

The procedure/modifier codes listed under "Modifiers/Procedure Codes Discontinued for 2006" (page 7) should not be used for service dates after December 31, 2005. However, FCSO Medicare will continue to accept claims for certain discontinued procedure codes with 2005 service dates received prior to April 1, 2006.

Effective for claims received on or after April 1, 2006, services performed in 2006 that are billed using discontinued codes will be denied payment when submitted to Medicare Part B. In these instances, providers will be notified that a discontinued procedure code was submitted and a valid procedure code must be used.

When billing for services listed in the discontinued code section, the procedure code(s) indicated in the "Codes to Report" column must be used. If more than one replacement code or no replacement code exists, refer to the appropriate coding book for additional guidelines.

A Word About Coverage

Procedure codes that are noncovered by Medicare due to statute are not represented on these lists. However, inclusion of a code on the lists does not necessarily constitute Medicare coverage. For example, a code may be noncovered based on local coverage determination (LCD). Diagnostic tests that are noncovered due to LCD are noncovered whether purchased or personally performed.

Carrier Jurisdiction

The lists of procedures that are added, revised, or discontinued for 2006 are complete with no regard to carrier jurisdiction. The majority of procedure codes in HCPCS are processed by the local Medicare Part B carrier, FCSO. However, some procedure codes listed represent services that should be billed to the Durable Medical Equipment Regional Carrier (DMERC), not the local carrier. The DMERC that serves Connecticut is HealthNow (<http://www.healthnow.org>); for Florida, it is Palmetto Government Benefits Administrators (<http://www.palmettogba.com>). It is the responsibility of the billing provider to submit claims to the appropriate carrier.

Use of Unlisted Procedure Codes

If you are unable to find a procedure code which most closely relates to the service rendered, then an “unlisted or not otherwise classified” procedure code may be submitted with a complete narrative description of the service rendered and supporting documentation. To ensure accurate processing in these instances, the following documentation should be provided:

Type of Service Performed	Clarification/Documentation Needed
Surgery, surgical assistant	Operative report or office records (if anesthesia performed in an office setting)
Orthotic/prosthetic device	Physician’s orders
Laboratory/pathology	Laboratory/pathology report
Radiology	Radiology report

Every effort should be made to locate a specific replacement code, since the use of unlisted procedure codes will result in delays in claims processing.

Reminder for Electronic Media Claim (EMC) Billers

Unlisted and not otherwise classified procedure codes may be submitted in two ways:

- If the unlisted or not otherwise classified procedure code can be submitted with a brief descriptor, the required information may be indicated in the appropriate narrative record. If you are unsure if your system has this capability, contact your vendor.
- If the unlisted or not otherwise classified procedure code requires documentation (e. g., pathology or operative reports), the service must be submitted on a paper Form CMS-1500.

Questions or Concerns?

Providers are encouraged to refer to all available resource materials for specific procedure coding instructions and claims filing information. Medicare’s reference materials include the *Medicare B Update!* and special bulletins.

If you have any questions about these coding changes, contact our provider customer service department toll-free at.

Connecticut: (866) 419-9455
 Florida: (866) 454-9007

Acquiring the 2006 Coding Books

Because of the many changes to the HCPCS coding structure, providers are strongly encouraged to purchase the 2006 *CPT* (Level I) book and/or the 2006 HCPCS (Level II) coding book. The 2006 edition of *CPT* may be purchased from the American Medical Association online at <http://www.ama-assn.org/catalog>, by calling 1-800-621-8335, or by writing:

American Medical Association
 P. O. Box 109050
 Chicago, IL 60610-0946

The 2006 HCPCS Alpha-Numeric Hardcopy

Additionally the 2005 alpha-numeric hardcopy, titled *2006 Alpha-Numeric Healthcare Common Procedure Coding System*, may be secured from:

Superintendent of Documents
 U. S. Government Printing Office
 Washington D. C. 20402
 Telephone:(202) 512-1800

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Modifiers and Procedure Codes Added for 2006

Modifiers	0143T	2004F	46712	90765	99318
27	0144T	22010	50250	90766	99324
63	0145T	22015	50382	90767	99325
AQ	0146T	22523	50384	90768	99326
BL	0147T	22524	50387	90772	99327
CR	0148T	22525	50389	90773	99328
FB	0149T	28890	50592	90774	99334
GR	0150T	3000F	51999	90775	99335
GS	0151T	3002F	57295	90779	99336
J1	0152T	32503	58110	91022	99337
J2	0153T	32504	61630	92626	99339
J3	0154T	33507	61635	92627	99340
P1	01965	33548	61640	92630	
P2	01966	33768	61641	92633	
P3	1003F	33880	61642	95251	
P4	1004F	33881	64650	95865	
P5	1005F	33883	64653	95866	
P6	1006F	33884	75956	95873	
QR	1007F	33886	75957	95874	
	1008F	33889	75958	96101	
	15040	33891	75959	96102	
CPT-4 Codes	15110	33925	76376	96103	
0089T	15111	33926	76377	96116	
0090T	15115	36598	77421	96118	
0091T	15116	37184	77422	96119	
0092T	15130	37185	77423	96120	
0093T	15131	37186	80195	96401	
0094T	15135	37187	82271	96402	
0095T	15136	37188	82272	96409	
0096T	15150	37718	83037	96411	
0097T	15151	37722	83631	96413	
0098T	15152	4003F	83695	96415	
0099T	15155	4012F	83700	96416	
0100T	15156	4014F	83701	96417	
0101T	15157	4015F	83704	96521	
0102T	15170	4016F	83900	96522	
0103T	15171	4017F	83907	96523	
0104T	15175	4018F	83908	97760	
0105T	15176	43770	83909	97761	
0106T	15300	43771	83914	97762	
0107T	15301	43772	86200	98960	
0108T	15320	43773	86355	98961	
0109T	15321	43774	86357	98962	
0110T	15330	43886	86367	99051	
0111T	15331	43887	86480	99053	
0112T	15335	43888	86923	99060	
0115T	15336	44180	86960	99143	
0116T	15340	44186	87209	99144	
0117T	15341	44187	87900	99145	
0120T	15360	44188	88333	99148	
0123T	15361	44213	88334	99149	
0124T	15365	44227	88384	99150	
0126T	15366	45395	88385	99300	
0130T	15420	45397	88386	99304	
0133T	15421	45400	89049	99305	
0135T	15430	45402	90649	99306	
0137T	15431	45499	90714	99307	
0140T	2001F	45990	90736	99308	
0141T	2002F	46505	90760	99309	
0142T	2003F	46710	90761	99310	
					CMS Assigned Codes
					A0998
					A4218
					A4233
					A4234
					A4235
					A4236
					A4363
					A4411
					A4412
					A4604
					A5120
					A5512
					A5513
					A6457
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					A6530
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					A6532
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					A6549
					A9275
					A9281
					A9282
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					A9539
					A9540
					A9541
					A9542
					A9543
					A9544

A9545	E2209	J1640	L0631	L7404	Q4079
A9546	E2210	J1675	L0632	L7405	Q4080
A9547	E2211	J1751	L0633	L7600	Q9945
A9548	E2212	J1752	L0634	L8609	Q9946
A9549	E2213	J1945	L0635	L8623	Q9947
A9550	E2214	J2278	L0636	L8624	Q9948
A9551	E2215	J2325	L0637	L8680	Q9949
A9552	E2216	J2425	L0638	L8681	Q9950
A9553	E2217	J2503	L0639	L8682	Q9951
A9554	E2218	J2504	L0640	L8683	Q9952
A9555	E2219	J2513	L0859	L8684	Q9953
A9556	E2220	J2805	L2034	L8685	Q9954
A9557	E2221	J2850	L2387	L8686	Q9955
A9558	E2222	J3285	L3671	L8687	Q9956
A9559	E2223	J3355	L3672	L8688	Q9957
A9560	E2224	J3471	L3673	L8689	Q9958
A9561	E2225	J3472	L3702	Q0480	Q9959
A9562	E2226	J7188	L3763	Q0481	Q9960
A9563	E2371	J7189	L3764	Q0482	Q9961
A9564	E2372	J7306	L3765	Q0483	Q9962
A9565	G0235	J7318	L3766	Q0484	Q9963
A9566	G0372	J7341	L3905	Q0485	Q9964
A9567	G0375	J7620	L3913	Q0486	S0133
A9698	G0376	J7627	L3919	Q0487	S0142
B4185	G0378	J7640	L3921	Q0488	S0143
C2637	G0379	J8498	L3933	Q0489	S0145
C9224	G9033	J8515	L3935	Q0490	S0146
C9225	G9041	J8540	L3961	Q0491	S0197
C9723	G9042	J8597	L3967	Q0492	S0198
C9724	G9043	J9025	L3971	Q0493	S0265
C9725	G9044	J9027	L3973	Q0494	S0595
E0170	J0132	J9175	L3975	Q0495	S0613
E0171	J0133	J9225	L3976	Q0496	S0625
E0172	J0278	J9264	L3977	Q0497	S2068
E0485	J0365	K0730	L3978	Q0498	S2075
E0486	J0480	L0491	L5703	Q0499	S2076
E0641	J0795	L0492	L5858	Q0500	S2077
E0642	J0881	L0621	L5971	Q0501	S2078
E0705	J0882	L0622	L6621	Q0502	S2079
E0762	J0885	L0623	L6677	Q0503	S2114
E0764	J0886	L0624	L6883	Q0504	S2117
E0911	J1162	L0625	L6884	Q0505	S2900
E0912	J1265	L0626	L6885	Q0510	S3005
E1392	J1430	L0627	L7400	Q0511	S3626
E1812	J1451	L0628	L7401	Q0512	S3854
E2207	J1566	L0629	L7402	Q0513	S8270
E2208	J1567	L0630	L7403	Q0514	S8940
				Q0515	V2788

Modifiers and Procedure Codes Revised for 2006

Modifiers	15121	2000F	31536	37209	50688
TS	15200	30130	31540	4006F	52647
	15201	30140	31541	4009F	52648
	15220	30801	31561	4011F	57421
CPT-4 Codes	15240	30930	31560	43848	61864
0078T	15260	31520	31570	44202	64613
15000	15400	31525	31571	44310	67901
15100	15401	31526	33502	44320	67902
15001	16020	31530	34833	45119	75900
15101	16025	31531	34834	45540	76012
15120	16030	31535	36415	45550	77412

Modifiers and Procedure Codes Revised for 2006, continued

78491	96423	A5501	C1719	E0638	J1564
78492	96420	A5503	C1720	E0761	J2324
78608	96422	A5504	C2616	E0935	J7340
78609	97024	A5505	C2633	E0951	J7342
78811	97542	A5506	C2634	E0952	J7343
78812	97811	A5507	C2635	E0955	J7344
78813	97813	A5508	C8918	E0956	J7350
78814	97814	A5509	C8919	E0957	J7626
78815	99050	A5510	C8920	E0967	K0669
78816	99056	A5511	C9211	E0971	L1820
82270	99058	A6025	D0350	E0978	L1832
83036	99298	A6412	D0415	E0986	L1843
83630	99299	A6550	D0480	E1010	L1844
83898		A7032	D2710	E1038	L1845
83901	CMS	A7033	D2910	E1039	L1846
84238	Assigned	A9500	D3332	E1011	L2035
86022	Codes	A9502	D4210	E1014	L2036
86023	A4215	A9503	D4211	E1025	L2037
86920	A4216	A9504	D4240	E1026	L2038
86921	A4222	A9505	D4241	E1027	L2039
86922	A4244	A9507	D4260	E1038	L2320
87534	A4245	A9508	D4261	E1225	L2330
87535	A4246	A9510	D4273	E1226	L2405
87536	A4247	A9512	D4276	G0173	L2755
87537	A4281	A9516	D4341	G0237	L2800
87538	A4282	A9517	D4381	G0238	L3031
87539	A4283	A9521	D6056	G0239	L3170
87901	A4284	A9524	D6057	G0244	L3215
87902	A4285	A9525	D7111	G0260	L3216
87903	A4286	A9526	D7286	G0295	L3217
87904	A4305	A9528	D7287	G0308	L3219
88175	A4306	A9529	D7490	G0309	L3221
90680	A4332	A9530	D7955	G0310	L3222
90713	A4372	A9531	E0116	G0311	L3230
90715	A4409	A9532	E0118	G0312	L3906
90870	A4410	A9534	E0203	G0313	L3923
90940	A4414	A9600	E0221	G0314	L4040
91020	A4415	A9605	E0240	G0315	L4045
92506	A4421	A9699	E0450	G0316	L4050
92507	A4458	B4100	E0461	G0317	L4055
92520	A4554	B4149	E0463	G0318	L6890
92568	A4630	B4150	E0464	G0319	L6895
92569	A4632	B4152	E0550	G0320	L7180
95250	A4641	B4153	E0560	G0321	L8010
90657	A4642	B4154	E0616	G0322	Q3001
90658	A4932	B4155	E0625	G0323	Q3031
96405	A5119	C1716	E0935	J0150	S2150
96406	A5500	C1717	E0637	J0152	T2005
		C1718	E0638	J0880	V2745

Procedure Codes Reinstated for 2006

CPT-4 Codes

0019T

Modifiers and Procedure Codes Discontinued for 2006

Modifiers

QB
 QQ
 QU

CPT-4 Codes

0010T	To report, use 86480	86587	To report, use 86367
0020T	To report, use 28890	90780	To report, see 90760, 90761, 90765-90768
0023T	To report, use 87900	90781	To report, see 90760, 90761, 90765-90768
0033T	To report, use 33880	90782	To report, use 90772
0034T	To report, use 33881	90783	To report, use 90773
0035T	To report, use 33883	90784	To report, use 90774
0036T	To report, use 33884	90788	To report, use 90772
0037T	To report, use 33889	90799	To report, use 90779
0038T	To report, use 75956	90871	
0039T	To report, use 75957	90939	To report, use 90940
0040T	To report, use 75958, 75959	92330	
01964	To report, use 01965, 01966	92335	
15342	To report, see 15170, 15175, 15340, 15360, 15365	92390	
15343	To report, see 15171, 15176, 15341, 15361, 15366	92391	
15350	To report, see 15300, 15320, 15330, 15335	92392	
15351	To report, see 15301, 15321, 15331, 15336	92393	
15810		92395	
15811		92396	
16010	To report, see 16020-16030	92510	
16015	To report, see 16020-16030	95858	
21493		96100	To report, see 96101, 96102, 96103
21494		96115	To report, use 96116
31585		96117	To report, see 96118, 96119, 96120
31586		96400	To report, see 96401, 96402
32520		96408	To report, use 96409
32522		96410	To report, use 96413
32525		96412	To report, use 96415
33918	To report, see 33925, 33926	96414	To report, use 96416
33919	To report, see 33925, 33926	96520	To report, use 96520
37720		96530	To report, use 96522
37730	To report, use 37722, 37718	96545	
42325		97020	To report, use 97024
42326		97504	To report, use 97760
43638		97520	To report, use 97761
43639		97703	To report, use 97762
44200	To report, use 44180	99052	
44201	To report, use 44186	99054	
44239	To report, use 45499	99141	To report, see 99143-99145
69410		99142	To report, see 99143-99145
76375		99261	
78160		99262	
78162		99263	
78170		99271	
78172		99272	
78455		99273	
82273	To report, use 82271	99274	
83715	To report, use 83700, 83701	99275	
83716	To report, use 83700, 83701	99301	
86064	To report, use 86355	99302	
86379	To report, use 86357	99303	
86585	To report, use 86580	99311	
		99312	
		99313	
		99321	
		99322	
		99323	
		99331	
		99332	
		99333	

Modifiers and Procedure Codes Discontinued for 2006, continued

CMS Assigned Codes

A4254		C9206	See code J7343
A4260	See code J7306	C9211	See code J0215
A4643		C9212	See code J0215
A4644		C9218	See code J9025
A4645		C9223	See code J0150, J0152
A4646		C9226	See code J2278
A4647		C9400	See code A9505
A4656		C9401	See code A9600
A5119		C9402	See code A9517
A5509		C9403	See code A9528
A5511		C9404	See code A9529
A6551		C9405	See code A9530
A9511		C9410	See code J1190
A9513		C9411	See code J2430
A9514		C9413	See code J7317
A9515		C9414	See code J8560
A9519		C9415	See code J9000
A9520		C9417	See code J9040
A9522		C9418	See code J9060
A9523		C9419	See code J9065
A9525		C9420	See code J9070
A9533		C9421	See code J9093
A9534		C9422	See code J9100
B4184		C9423	See code J9130
B4186		C9424	See code J9150
C1079	See code A9546	C9425	See code J9181
C1080	See code A9544	C9426	See code J9200
C1081	See code A9545	C9427	See code J9208
C1082	See code A9542	C9428	See code J9209
C1083	See code A9543	C9429	See code J9211
C1091	See code A9547	C9430	See code J9218
C1092	See code A9548	C9431	See code J9265
C1093	See code A9566	C9432	See code J9280
C1122	See code A9549	C9433	See code J9340
C1200		C9435	See code J1620
C1201	See code A9551	C9436	See code J7501
C1305	See code J7340	C9437	See code J9050
C1775	See code A9552	C9438	See code J7502
C9000	See code A9553	C9439	See code J9165
C9007	See code J0476	C9440	See code J9390
C9008	See code J0475	C9704	See code 0133T
C9009	See code J0475	C9713	See code 52648
C9013		C9718	See code 22523
C9102	See code A9553	C9719	See code 22525
C9103	See code A9554	C9720	See code 0102T
C9105	See code 90371	C9721	See code 28890
C9112	See code Q9957	C9722	See code 77421
C9123		E0169	
C9126	See code Q4079	E0752	See code L8680
C9127	See code J9264	E0754	See code L8681
C9128	See code J2503	E0756	
C9129	See code J9027	E0757	See code L8682
C9200	See code J7340	E0758	See code L8683
C9201	See code J7342	E0759	See code L8684
C9202	See code Q9956	E0953	See code E2211
C9203	See code Q9955	E0954	See code E2219
C9205	See code J9263	E0972	
		E0996	See code E2220
		E1000	See code E2214
		E1001	See code E2224

Modifiers and Procedure Codes Discontinued for 2006, continued

E1019		G0242	
E1021		G0244	
E1025		G0252	
E1026		G0253	
E1027		G0254	
E1210		G0258	
E1211		G0263	
E1212	See code K0010	G0264	
E1213	See code K0010	G0279	
E1239		G0280	
G0030		G0296	
G0031		G0336	
G0032		G0338	
G0033		G0345	
G0034		G0346	
G0035		G0347	
G0036		G0348	
G0037		G0349	
G0038		G0350	
G0039		G0351	
G0040		G0353	
G0041		G0354	
G0042		G0355	
G0043		G0356	
G0044		G0357	
G0045		G0358	
G0046		G0359	
G0047		G0360	
G0110		G0361	
G0111		G0362	
G0112		G0363	
G0113		G0369	See code Q0510
G0114		G0370	See code Q0511, Q0512
G0115		G0371	See code Q0513
G0116		G0374	See code Q0514
G0125		J0880	
G0210		J1563	
G0211		J1564	
G0212		J1750	
G0213		J2324	
G0214		J7051	
G0215		J7317	
G0216		J7320	
G0217		J7616	
G0218		J7617	
G0220		K0064	See code E2213
G0221		K0066	See code E2220
G0222		K0067	See code E2211
G0223		K0068	See code E2212
G0224		K0074	See code E2214
G0225		K0075	See code E2219
G0226		K0076	See code E2221
G0227		K0078	See code E2215
G0228		K0102	See code E2207
G0229		K0104	See code E2208
G0230		K0106	See code E2209
G0231		K0415	
G0232		K0416	
G0233		K0452	See code E2210
G0234		K0600	See code E0762

Modifiers and Procedure Codes Discontinued for 2006, continued

K0618	See code L0491	Q2001	
K0619	See code L0492	Q2002	See code J9175
K0620	See code A6457	Q2003	See code J0365
K0628	See code A5512	Q2005	
K0629	See code A5513	Q2006	See code J1162
K0630	See code L0621	Q2007	See code J1430
K0631	See code L0622	Q2008	See code J1451
K0632	See code L0623	Q2011	See code J1640
K0633	See code L0624	Q2012	See code J2504
K0634	See code L0625	Q2013	See code J2513
K0635	See code L0626	Q2014	
K0636	See code L0627	Q2018	See code J3355
K0637	See code L0628	Q2019	See code J0480
K0638	See code L0629	Q2020	See code J1675
K0639	See code L0630	Q2021	See code J1945
K0640	See code L0631	Q2022	See code J7188
K0641	See code L0632	Q3000	
K0642	See code L0633	Q3002	
K0643	See code L0634	Q3003	
K0644	See code L0635	Q3004	
K0645	See code L0636	Q3005	
K0646	See code L0637	Q3006	
K0647	See code L0638	Q3007	
K0648	See code L0639	Q3008	
K0649	See code L0640	Q3009	
K0670	See code E1392	Q3010	
K0671	See code E1392	Q3011	
K0731	See code L8623	Q3012	
K0732	See code L8624	Q4054	See code J0882
L0860	See code L0859	Q4055	See code J0886
L1750	See code A4565	Q4075	See code J0133
L2039		Q4076	See code J1265
L3963		Q4077	See code J3285
L8100	See code A6530	Q9941	
L8110	See code A6531	Q9942	
L8120	See code A6532	Q9943	
L8130	See code A6533	Q9944	
L8140	See code A6534	S0016	See code S0072
L8150	See code A6535	S0071	
L8160	See code A6536	S0072	
L8170	See code A6537	S0107	See code J2357
L8180	See code A6538	S0114	
L8190	See code A6539	S0118	
L8195	See code A6540	S0158	See code J1931
L8200	See code A6541	S0159	See code J0180
L8210	See code A6542	S0168	
L8220	See code A6543	S0173	
L8230	See code A6544	S2082	
L8239	See code A6549	S2090	
L8620		S2091	
Q0136	See code J0885	S2215	
Q0137	See code J0881	S8004	See code 78804
Q0187	See code J7189	S8095	
Q1001		S8434	
Q1002		T2006	See code A0998

MEDICARE PHYSICIAN FEE SCHEDULE

Emergency Update to the 2006 Medicare Physician Fee Schedule

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services paid under the MPFS and provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4268, which amends payment files issued to Medicare carriers based upon the November 21, 2005, MPFS Final Rule.

CAUTION – What You Need to Know

CR4268 includes a new G-code for intravenous infusion of immunoglobulin (G0332), new G-codes for the 2006 Oncology Demonstration Project, and changes to CPT code status indicators, global periods, and relative value units.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) issued payment files to carriers based upon the MPFS Final Rule published in the November 21, 2005, Federal Register (http://www.access.gpo.gov/su_docs/fedreg/a051121c.html), and the Social Security Act (Section 1848(c)(4)) (http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) authorizes CMS to establish ancillary policies necessary to implement relative values for physicians' services.

CR4268 amends the November 21, 2005, MPFS Final Rule payment files and includes a new G-code (G0332 - Intravenous Infusion of Immunoglobulin) and additional new G-codes for the 2006 Oncology Demonstration Project. There are corrected descriptors for codes G0332, G9050-G9130, 0137T, 0001F, 0005F, and J7640. The coverage indicator on the HCPCS files should be a "C" for Category III codes 0144T-0154T. In addition, CR4268 includes changes to several Current Procedural Terminology (CPT) codes with respect to:

- Status indicators;
- Global periods; and
- Relative value units.

See Attachment 1 of CR4268 for the complete list of changes to G-codes and CPT codes included in this Emergency Update to the 2006 MPFS Database.

Implementation

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

Additional Information

For complete details, please see CR4268, the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R798CP.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: MM4268
 Related Change Request (CR) #: 4268
 Related CR Release Date: December 30, 2005
 Effective Date: January 1, 2006
 Related CR Transmittal #: R798CP
 Implementation Date: January 3, 2006

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

2006 FEE SCHEDULES

2006 Fee Schedules

The 2006 Fee Schedules are pending a future publication.

AMBULATORY SURGICAL CENTER

Update of Healthcare Common Procedure Coding System Codes, File Names, Descriptions and Instructions for Retrieving the 2006 Ambulatory Surgical Center HCPCS Additions, Deletions, and Master Listing

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

Provider Types Affected

ASCs providing services to Medicare beneficiaries and billing Medicare carriers or fiscal intermediaries (FIs) for those services

Provider Action Needed

Be aware of the ASC Healthcare Common Procedure Coding System Codes (HCPCS) codes that are being added to and deleted from the ASC list, effective January 1, 2006.

Background

The Centers for Medicare & Medicaid Services (CMS) is updating the ASC HCPCS codes list as a result of changes in the American Medical Association (AMA) Physician's Current Procedural Terminology (CPT) for 2006.

Note: These code changes will not be published until after the AMA's 2005 CPT-4 codes are published, which usually occurs by November 1, 2005.

Implementation Date

The implementation date is January 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/FI regarding this change. Attachment A of that instruction (CR4082) is included below and it contains the ASC list of both HCPCS deletions and additions, effective January 1, 2006.

CR4082 may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that Web page, look for CR4082 in the CR NUM column on the right, and click on the file for that CR.

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

Attachment A from CR4082

The following is the ASC List of Approved Procedures HCPCS Code Changes (deletions/additions) for January 1, 2006, effective for services performed on or after January 1, 2006:

Deletions

HCPCS CODE	Short Descriptor	ASC Payment Group	Payment Amount
15350	Skin homograft	2	446.00
15351	Skin homograft add on	2	446.00
16015	Treatment of burn(s)	2	446.00
21493	Treat hyoid bone fracture	3	510.00
21494	Treat hyoid bone fracture	4	630.00
31585	Treat larynx fracture	1	333.00
31586	Treat larynx fracture	2	446.00
37720	Removal leg vein	3	510.00
37730	Removal leg veins	3	510.00
42325	Create salivary cyst drain	2	446.00

2006 ASC HCPCS Additions, Deletions, and Master listing, continued

Additions

HCPCS CODE	Short Descriptor	ASC Payment Group	Payment Amount
15040	Harvest cultured skin graft	2	446.00
15110	Epidrm autogrft trnk/arm/leg	2	446.00
15111	Epidrm autogrft t/a/l add-on	1	333.00
15115	Epidrm a-grft face/nck/hf/g	2	446.00
15116	Epidrm a-grft f/n/hf/g addl	1	333.00
15130	Derm autograft, trnk/arm/leg	2	446.00
15131	Derm autograft t/a/l add-on	1	333.00
15135	Derm autograft face/nck/hf/g	2	446.00
15136	Derm autograft, f/n/hf/g add	1	333.00
15150	Cult epiderm grft t/arm/leg	2	446.00
15151	Cult epiderm grft t/a/l addl	1	333.00
15152	Cult epiderm graft t/a/l +%	1	333.00
15155	Cult epiderm graft, f/n/hf/g	2	446.00
15156	Cult epiderm grft f/n/hfg add	1	333.00
15157	Cult epiderm grft f/n/hfg +%	1	333.00
15300	Apply skinallogrft, t/arm/leg	2	446.00
15301	Apply sknallogrft t/a/l addl	1	333.00
15320	Apply skin allogrft f/n/hf/g	2	446.00
15321	Aply sknallogrft f/n/hfg add	1	333.00
15330	Aply acell alogrft t/arm/leg	2	446.00
15331	Aply acell grft t/a/l add-on	1	333.00
15335	Apply acell graft, f/n/hf/g	2	446.00
15336	Aply acell grft f/n/hf/g add	1	333.00
15420	Apply skin xgrft, f/n/hf/g	2	446.00
15421	Apply skn xgrft f/n/hf/g add	1	333.00
15430	Apply acellular xenograft	2	446.00
15431	Apply acellular xgrft add	1	333.00
16025	Dress/debrid p-thick burn, m	2	446.00
16030	Dress/debrid p-thick burn,	2	446.00
37718	Ligate/strip short leg vein	3	510.00
37722	Ligate/strip long leg vein	3	510.00
45990	Surg dx exam, anorectal	2	446.00

Related Change Request (CR) #: 4082

Medlearn Matters Number: MM4082

Related CR Release Date: October 21, 2005

Related CR Transmittal #: 720

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

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2006 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD is available on the Connecticut and Florida Medicare Part B websites at:

Connecticut: http://www.connecticutmedicare.com/common_shared_medpard_medpard.asp#TopOfPage

Florida: http://www.floridamedicare.com/common_shared_medpard_medpard.asp#TopOfPage

Source: Pub 100-04, Transmittal 730, Change Request 4051

CLAIMS

Health Professional Shortage Areas

Physicians are eligible for a 10% bonus when they render service(s) in certain medically underserved areas. These areas, known as Health Professional Shortage Areas (HPSAs), may cover an entire county or a portion of a county or city, and are designated as either rural or urban HPSAs. HPSA designations are made by the Division of Shortage Designation (DSD) of the Public Health Service (PHS) and can be accessed queried at:

<http://belize.hrsa.gov/newhpsa/newhpsa.cfm>.

The incentive payments are based on 10% of the paid amount for both assigned and nonassigned claims for services performed by the physician. The incentive payment is not made on a claim-by-claim basis; rather, payments are issued quarterly.

Eligibility

A physician is eligible for the HPSA incentive payment *when services are furnished in an area designated as a HPSA*, regardless of where the physician's office is located. For example, a physician's office may be located in an area not designated as a HPSA; however, the physician may treat a patient in a nursing facility located in a HPSA. In this instance, the physician would be eligible for the HPSA incentive payment. Likewise, the physician's office may be in a HPSA; however, the physician may treat a patient in his/her home that is not located in a HPSA. In this case, the physician is *not* eligible for the HPSA incentive payment.

Only physicians are eligible for the HPSA incentive payments. The following degrees/credentials are considered physicians eligible for the incentive payments: M.D., D.O., D.C., D.P.M., D.D.S., and O.D.

Claims Filing Requirements

To report services furnished in a HPSA, one of the following procedure code modifiers should be reported with the service:

AQ	Physician providing a service in a HPSA (dates of service on or after January 1, 2006)
QB	Physician service rendered in a rural HPSA (dates of service prior to January 1, 2006)
QU	Physician service rendered in an urban HPSA (dates of service prior to January 1, 2006)

In addition, item 32 of Form CMS-1500 (or electronic equivalent) must be completed when either the AQ, QB or QU modifiers is billed. The physical location where the service was furnished must be indicated, if it is other than the patient's home.

Appeal of HPSA Incentive Payments

The incentive payments do not include remittance advice notices; only a list of the claims to which the incentive payment applies is provided with the payment. As a result, physicians have not been provided with an opportunity to challenge the amounts of their HPSA incentive payments on nonassigned claims or to challenge nonassigned claims where incentive has not been paid.

CMS has provided clarification of these issues:

- In cases where a physician is not satisfied with the amount of the incentive payment on either assigned or nonassigned claims, he or she may request a review of the incentive payment. The review request must be made within 60 days of the date when the incentive payment was issued.
- In cases where an incentive payment was not made on a claim (assigned or nonassigned), but the physician believes that one should have been made, he or she may request a reopening of that particular claim. The request must be within one year of the claim payment.

Note: If the physician is unsure of the date a nonassigned claim was *processed*, the request for reopening may be made within one year of the date the claim was *submitted*, to ensure the request for the reopening is made within the one-year time limit.

Geographic HPSA Designations

The following are counties/area names/parts designated as geographic HPSAs (and therefore eligible for the HPSA bonus payment) for the state of Connecticut, as of November 21, 2005. **Note:** There have been no changes to the Connecticut HPSA designations.

Connecticut – Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Fairfield/Southwest Bridgeport	0702.00, 0703.00, 0704.00, 0705.00, 0706.00, 0707.00, 0708.00, 0709.00, 0710.00, 0711.00, 0712.00	Urban
Fairfield/Central/East Bridgeport	0713.00, 0714.00, 0715.00, 0716.00, 0717.00, 0735.00, 0736.00,	

Connecticut – Primary Care, continued

County/Area Name	Census Tracts (C.T.)	Type
Fairfield/Central Norwalk	0738.00, 0739.00, 0740.00, 0741.00, 0742.00, 0743.00, 0744.00 0440.00, 0441.00, 0444.00, 0445.00	Urban Urban
Hartford/North Central Hartford	5005.00, 5008.00, 5009.00, 5010.00, 5011.00, 5012.00, 5013.00, 5014.00, 5015.00, 5016.00, 5017.00, 5018.00, 5020.00, 5021.00, 5022.00, 5031.00, 5032.00, 5033.00, 5034.00, 5035.00, 5036.00, 5037.00, 5038.00, 5039.00, 5040.00, 5041.00, 5042.00, 5044.00	Urban
Hartford/Charter Oak Terrace/Rice Heights	5001.00, 5002.00, 5003.00, 5004.00, 5019.00, 5027.00, 5028.00, 5029.00, 5030.00, 5043.00, 5045.00, 5046.00, 5049.00	Urban
New Haven/ Fair Haven	1421.00, 1422.00, 1423.00, 1424.00, 1425.00, 1426.01, 1426.02	Urban
New London/ Central Groton	7022.00, 7023.00, 7025.00, 7027.00, 7028.00	Urban

The following are counties/area names/parts designated as geographic HPSAs (and therefore eligible for the HPSA bonus payment) for the state of Florida, as of November 21, 2005.

Florida – Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Bradford (Terminated September 1, 2004)		Rural
Clay/Keystone Heights division		Urban
Dixie		Rural
Escambia	0038.00, 0039.00, 0040.00	Rural
Gadsden		Urban
Glades		Rural
Hardee		Rural
Hendry/Labelle	9604.00, 9603.00	Rural
Holmes		Rural
Lafayette		Rural
Liberty		Rural
Madison		Rural
Martin/Indiantown/Indiantown division		Urban
Sumter		Rural
Suwannee		Rural
Wakulla		Rural
Walton		Rural
Washington (terminated 9/27/05)		Rural

The following are counties (all census tracts) designated as geographic HPSAs (and therefore eligible for the HPSA bonus payment) for Mental Health for the state of Florida, as of November 21, 2005.

Florida – Mental Health

County	Type	County	Type
Bradford	Rural	Lafayette	Rural
Columbia	Rural	Martin/Indiantown/Indiantown division (effective 9/27/05)	
Dixie	Rural	Monroe	Rural
Gilchrist	Rural	Putnam	Rural
Hamilton	Rural	St Johns	Urban
Hillsborough/Ruskin/Wimauma-Lithia (effective 11/21/05)		Suwannee	Rural
Holmes	Rural	Union	Rural
Jackson	Rural	Walton	Rural
		Washington	Rural

Florida Only

The following counties/areas have been **added** to the HPSA designation (Mental Health) with an effective date of 11/03/05:

Hillsborough
SE Hillsborough
Ruskin CCD
Wimauma-Lithia CCD
Martin (effective 09/27/05)
Indiantown Service Area
Indiantown CCD

The following county/area has been **removed** from the HPSA designation (Primary Care) with an effective date of 11/03/05:

Washington

Note: There have been no changes to the Connecticut HPSA designations.

Quarterly Update to Correct Coding Initiative Edits, Version 12.0, Effective January 1, 2006

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

Provider Types Affected

Physicians billing Medicare carriers

Provider Action Needed

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

Physicians may view the current CCI edits and the current mutually exclusive code (MEC) edits at <http://www.cms.hhs.gov/physicians/cciedits> on the Centers for Medicare & Medicaid (CMS) website. The website will be updated with the Version 12.0 edits as soon as they are effective.

Background

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on:

- Coding conventions defined in the American Medical Association’s Current Procedural Terminology (CPT) manual;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practice; and
- Review of current coding practice.

The latest package of CCI edits, Version 12.0, is effective on January 1, 2006.

This version will include all previous versions and updates from January 1, 1996, to the present and will be organized in two tables: *Column 1/Column 2 Correct Coding Edits* table and *MEC Edits* table.

Additional Information

The CCI and MEC files will maintain the file formats in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 20.9, which can be found at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS website.

Medlearn Matters Number: MM4168
Related Change Request (CR) #: 4168
Related CR Release Date: November 4, 2005
Effective Date: January 1, 2006
Related CR Transmittal #: 742
Implementation Date: January 3, 2006

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

COVERAGE/REIMBURSEMENT

AMBULANCE

Ambulance Inflation Factor for CY 2006

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

Provider Types Affected

Providers and suppliers of ambulance services billing Medicare carriers and fiscal intermediaries (FIs) for those services.

Provider Action Needed

None. This article is for your information only. It provides the Ambulance Inflation Factor (AIF) for calendar year (CY) 2006. The AIF for CY 2006 is 2.5 percent.

Background

Section 1834(l)(3)(B) of the Social Security Act (SSA) provides the basis for updating the payment limits that carriers and FIs use to determine how much to pay you for the claims that you submit for ambulance services. The national fee schedule for ambulance services has been phased in over a five-year transition period beginning April 1, 2002. The ambulance inflation factor (AIF) updates payments annually and is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year.

The AIF for CY 2006 will be 2.5 percent. This follows the CY 2005 AIF of 3.3 percent, the CY 2004 AIF of 2.1 percent, and the CY 2003 AIF of 1.1 percent.

Additionally, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established that the ground ambulance base rate (for services furnished during the period July 1, 2004 through December 31, 2009) will have a baseline “floor” amount.

Payment will not be less than this “floor,” which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule to calculate a regional conversion factor and a regional mileage payment.

Some key issues related to the AIF are discussed below:

Payments Based on Blended Methodology

During this five-year transition period, your payments are based on a blended methodology. Before January 1, 2006, for each ambulance provider or supplier, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional) and to the reasonable cost/charge portion. Then, these two amounts were added together to determine each provider or supplier’s total payment amount.

As of January 1, 2006, the total payment amount for ground ambulance providers and suppliers will be based on either 100 percent of the national ambulance fee schedule, or 60 percent of the national ambulance fee schedule added to 40 percent of the regional ambulance fee schedule. *The total payment amount for air ambulance providers and suppliers will be based on 100 percent of the national ambulance fee schedule.*

National or Regional Fee Schedules

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate.

Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division’s fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate. For CY 2006, this blend will be 40 percent regional ground base rate and 60 percent national ground base rate.

Part B Coinsurance and Deductible Requirements

Part B coinsurance and deductible requirements apply.

Additional Information

More information about the CY 2006 ambulance inflation factor is available at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that Web page, look for CR4061 in the CR NUM column on the right, and click on the file for that CR.

Also useful is the *Medicare Claims Processing Manual*, 100.04, Chapter 15, Section 20.6 (Update Charges), Subsection 20.6.1 (Ambulance Inflation Factor – AIF), which is included as an attachment to CR4061. 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/medlearn/tolnums.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).

Related Change Request (CR) #: 4061

Medlearn Matters Number: MM4061

Related CR Release Date: November 25, 2005

Related CR Transmittal #: 762

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

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Reminder Notice of the Implementation of the Ambulance Transition Schedule

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

Provider Types Affected

Ambulance providers and suppliers

Provider Action Needed

STOP – Impact to You

During the current calendar year (CY) 2005, year four of a five-year transition to the ambulance fee schedule implementation, payment for ambulance services is based on a blend of 80 percent of the fee schedule amount plus 20 percent of the provider’s reasonable cost or the supplier’s reasonable charge for the service. As of **January 1, 2006**, the Medicare **allowed amount is based solely on the ambulance fee schedule (100%)** for ambulance services furnished and mileage incurred on or after January 1, 2006.

CAUTION – What You Need to Know

The fee schedule applies to **ALL** ambulance services furnished as a benefit under Medicare Part B. Ambulance providers and suppliers are required to accept assignment and must accept Medicare allowed charges as payment in full. They may not bill or collect from the beneficiary any amount other than an unmet Part B deductible and the Part B coinsurance amounts.

GO – What You Need to Do

Be aware that the next phase of the fee schedule payment process goes into effect on January 1, 2006 and adjust accounts receivable processes as necessary.

Background

Section 4531 (b) (2) of the Balanced Budget Act (BBA) of 1997 added a new section 1834 (l) to the Social Security Act, which mandates implementation of the national fee schedule for ambulance services furnished as a benefit under Medicare Part B. The fee schedule applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers, i.e., hospitals, critical access hospitals and skilled nursing facilities. Section 1834 (l) also requires mandatory assignment for all ambulance services. Ambulance providers and suppliers must accept the Medicare allowed charge as payment in full and not bill or collect from the beneficiary any amount other than any unmet Part B deductible and the Part B coinsurance amounts. Effective January 1, 2006, the full fee schedule comprises the entire Medicare allowed amount and no portion of the provider’s reasonable cost or the supplier’s reasonable charge will be considered.

Providers and suppliers are reminded that the ambulance fee schedule was implemented on a five-year transition period and that transition period is complete as of January 1, 2006.

Year Fee Schedule	Percentage	Cost/Charge Percentage
Year 1 (4/1/02 – 12/31/02)	20%	80%
Year 2 (CY 2003)	40%	60%
Year 3 (CY 2004)	60%	40%
Year 4 (CY 2005)	80%	20%
Year 5 (CY 2006 and thereafter)	100%	0%

Note also that temporary Q codes (Q3019 (ALS Vehicle Used, Emergency Transport, No ALS Services Furnished) and Q0320 (ALS Vehicle Used, Non-Emergency Transport, NO ALS Level Services Furnished)) and HCPCS code A0800 (Ambulance Night Differential Charges) may no longer be used for claims with dates of service on or after January 1, 2006. These codes were only for use during the transition period for the fee schedule.

Implementation

The implementation date for this change is January 3, 2006

Additional Information

Suppliers should also note that Medicare carriers and intermediaries will deny claims for separately billed supplies and ancillary services furnished during an ambulance transport on or after January 1, 2006. Supplies and ancillary services are considered part of the fee schedule base rate and are not separately billable after December 31, 2005.

The official instruction issued to your carrier/intermediary regarding this change may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R799CP.pdf> on the CMS website.

For additional information relating to this issue, please refer to your local carrier/intermediary. To find that 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: MM4217
 Related CR Release Date: December 30, 2005
 Related CR Transmittal #: R799CP

Related Change Request (CR) #: 4217
 Effective Date: January 1, 2006
 Implementation Date: January 3, 2006

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Important Reminder for Ambulance Suppliers

Section 1834(l) of the Social Security Act provided a 5-year transition period for full implementation of the Medicare Ambulance Fee Schedule. During this transition period Medicare ambulance suppliers were reimbursed using a blended payment reimbursement. The blended fee reimbursement included specific percentages of the ambulance fee schedule and the supplier's reasonable cost or reasonable charge amounts. The 5-year transition period was effective for claims with dates of service on or after April 1, 2002, ending December 31, 2005.

This is a reminder to all Medicare ambulance suppliers that effective January 1, 2006, it is no longer necessary to figure a blended fee reimbursement. On December 19, 2005, First Coast Service Options, Inc., posted the 2006 Medicare Ambulance Fee Schedule amounts calculated by CMS on our websites. These fee schedule amounts represent your full Medicare allowance based on your specific locality and whether the services were performed in an urban or rural area. Additionally, with the implementation of the full Medicare Ambulance Fee Schedule, Medicare contractors are no longer required to mail ambulance disclosure statements.

Additional information relating to this change may be found by going to: <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4061.pdf>.

Terminating Ambulance HCPCS A0800, Q3019, and Q3020

Effective January 1, 2006 with implementation of the full ambulance fee schedule, temporary HCPCS A0800, Q3019, and Q3020 have been terminated. Ambulance suppliers that were previously permitted to bill separately for these services furnished incident to the ambulance transport could continue to do so until the full implementation of the ambulance fee schedule.

These codes will appear as valid on the HCPCS file, but will be updated to reflect this change in a future release.

Source: Publication 100-4, Transmittal 806, Change Request 4251

AUDIOLOGY

Auditory Osseointegrated and Auditory Brainstem Devices

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

Provider Types Affected

Physicians and providers billing Medicare carriers or fiscal intermediaries (FIs) for auditory osseointegrated and auditory brainstem devices.

Provider Action Needed

STOP – Impact to You

The definition of "hearing aids" in the Medicare Claims Processing Manual was modified to exclude certain implanted devices from the category of hearing aid.

CAUTION – What You Need to Know

Medicare contractors will not pay for any part A or part B expenses incurred for items or services related to "hearing aids or examination for the purpose of prescribing, fitting, or changing hearing aids." (42 CFR 411.15(d)) These items and services are excluded from coverage. However, the definition of hearing aids now indicates that **auditory osseointegrated (code L8699) devices and auditory brainstem (code L8614) devices are prosthetic devices that are eligible for Medicare payment.**

GO – What You Need to Do

Be aware that Medicare contractors **will pay** for osseointegrated auditory and brainstem auditory devices as prosthetic devices but only when indicated: where hearing aids are medically inappropriate or cannot be used due to congenital malformations, chronic disease, severe sensorineural hearing loss, or surgery.

Background

Medicare now defines hearing aids as follows:

Hearing aids are amplifying devices that compensate for impaired hearing. Hearing aids include air conduction devices that provide acoustic energy to the cochlea via stimulation of the tympanic membrane with amplified sound. They also include bone conduction devices that provide mechanical energy to the cochlea via stimulation of the scalp with amplified mechanical vibration or by direct contact with the tympanic membrane or middle ear ossicles.

Certain devices that produce perception of sound by replacing the function of the middle ear, cochlea, or auditory nerve are payable by Medicare as prosthetic devices. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformations, chronic disease, severe sensorineural hearing loss, or surgery.

The following are prosthetic devices:

- Cochlear implants and auditory brainstem implants; that is, devices that replace the function of cochlear structures or auditory nerves and provide electrical

energy to auditory nerve fibers and other neural tissue via implanted electrode arrays.

- Osseointegrated implants; that is, devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer.

Hospital outpatient departments and physicians should bill related implantation services using the current codes for osseointegrated implantation (such as 69714, 69715, 69717, and 69718) for device code L8699. In addition, physicians should bill the appropriate services for implantation of the auditory brainstem device (code L8614), using the codes for tumor resection (61520, 61530, 61598), if indicated, and also a code for cranial neurostimulators (61875).

Additional Information

Additional information about coverage for cochlear implantation can be found in CR3796 and the accompanying Medlearn Matters article, MM3796. The *Additional Information* section of MM3796 also outlines the policy guidelines for cochlear implantation coverage, and a listing of Healthcare Common Procedural Coding System (HCPCS) codes associated with cochlear implantation.

To view CR3796, Transmittal #601: Cochlear Implantation, go to http://www.cms.hhs.gov/manuals/pm_trans/R601CP.pdf on the CMS website. To view the associated Medlearn Matters article, MM3796, on Cochlear Implantation, go to <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3796.pdf> on the CMS website.

The official instruction issued to your carrier/intermediary 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 CR4038 in the CR NUM column on the right, and click on the file for that CR.

For additional information relating to this issue, please refer to your local carrier or FI. To find the toll free phone number for your local carrier or FI, 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).

Related Change Request (CR) #: 4038

Medlearn Matters Number: MM4038

Related CR Release Date: November 10, 2005

Related CR Transmittal #: 39

Effective Date: November 10, 2005

Implementation Date: December 12, 2005

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CONSOLIDATED BILLING

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

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

Provider Types Affected

All Medicare providers billing carriers, including durable medical equipment regional carriers (DMERCs), regional home health intermediaries (RHHIs), or fiscal intermediaries (FIs), for medical supply or therapy services.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2006. Affected providers should be aware of these changes.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA.) As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes.

Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physicians;
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare periodically publishes Routine Update Notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

Additional Information

CR4114 provides the annual HH consolidated billing update effective January 1, 2006. The following table describes the HCPCS codes and the specific changes to each that this notification is implementing on January 3, 2006:

Code	Description of Code	Type Change	Replacement Code or Code Being Replaced
Non-Routine Supplies			
A4656	Needle, any size each	Delete	Replacement code: A4215 with revised definition (code A4215 is already on HH CB list.)
A5119	Skin barrier wipes box pr	Delete	Replacement code: A5120
A6025	Gel sheet for dermal or epidermal application (e.g., silicone, hydrogel, other)	Delete	
A6457	Tubular dressing with or without elastic, any width, per linear yard	Add	
A4412	Ostomy pouch, drainable, high output, for use on a barrier with flange (two-piece system), without filter, each	Add	
A5120	Skin barrier, wipes or swabs, each	Add	Replaces code A5119
A4363	Ostomy clamp, any type, replacement only, each	Add	
A4411	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each	Add	
Therapies – No Update			

The last update to the HH consolidated billing was issued under Transmittal 340, CR3525. The related *Medlearn Matters* article, MM3525, may be found at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3525.pdf> on the CMS website.

For complete details, please see the official instruction issued to your carrier/DMERC/RHHI/intermediary regarding this change. That instruction may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_disc.asp on the CMS website. From that Web page, look for CR4114 in the CR NUM column on the right, and click on the file for that CR.

A complete historical listing of codes subject to HH consolidated billing can be found at <http://www.cms.hhs.gov/providers/hhapps/> on the CMS web site. The last bullet on this page contains a link to download the list.

If you have any questions, please contact your carrier/DMERC/RHHI/intermediary at their toll-free number, which may be found at <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: MM4114
 Related Change Request (CR) #: 4114
 Related CR Release Date: October 14, 2005
 Effective Date: January 1, 2006
 Related CR Transmittal #: 710
 Implementation Date: January 3, 2006

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DMEPOS

Fee Schedule Update for 2006 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

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 services paid under the DMEPOS Fee Schedule

Provider Action Needed

This article is based on Change Request (CR) 4194, and it provides specific information regarding the annual update for the 2006 DMEPOS Fee Schedule.

Background

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

- Implement fee schedule amounts for new codes; and
- Revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for:

- Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)); and
- Parenteral and Enteral Nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

Note: DMERCs will use the 2006 PEN fee schedule payment amounts to pay claims for items furnished from January 1, 2006 through December 31, 2006. The 2006 DMEPOS Fee Schedule Update factors for Health Care Common Procedure Codes (HCPCS) items furnished from January 1, 2006, through December 31, 2006, and are as follows:

HCPCS Codes	Notes
A5120	Modifier "AV" is added for billing items furnished for facial prosthetics. Modifier "AU" is added for billing items furnished for urological supplies.
L2005	Is being revised effective January 1, 2006, to ensure that the code's allowable amount is representative of a full knee, ankle, foot orthoses (KAFO), including the joint component.

HCPSC Codes	Notes
L8609 and L8685 through L8689	Describe items that are subject to the fee schedule for prosthetics and orthotics (PO) and are being added to the HCPSC effective January 1, 2006. These codes fall under the jurisdiction of the local carriers rather than the DMERCs. The Centers for Medicare & Medicaid Services (CMS) will be calculating the fee schedule amounts for these items using the standard gapfilling process. The description for these codes can be obtained from the 2006 HCPSC file as soon as it becomes available at http://www.cms.hhs.gov/HCPSCReleaseCodeSets/ANHCPC S/list.asp#TopOfPage on the CMS website.

The following codes are being **deleted** from the HCPSC, effective January 1, 2006, and are therefore being removed from the DMEPOS and PEN fee schedule files:

A4254	E0996	K0075	K0670	L8140
A4643 thru A4647	E1000	K0076	K0671	L8150
A5119	E1001	K0078	K0731	L8160
A5509	E1019	K0102	K0732	L8170
A5511	E1021	K0104	L0860	L8180
B4184	E1025 thru E1027	K0106	L1750	L8190
B4186	E1210 thru E1213	K0415	L3963	L8195
E0169	E1239	K0416	L8100	L8200
E0752	K0064	K0452	L8110	L8230
E0754 thru E0759	K0066	K0600	L8120	L8239
E0953	K0067	K0618 thru K0620	L8130	L8620
E0954	K0068	K0628 thru K0649		
E0972	K0074			

The HCPSC codes listed below are being **added to the HCPSC on January 1, 2006**:

A4218	B4185	E2212 thru E2226	L3961
A4233 thru A4236	E0170 thru E0172	E2371	L3967
A4363	E0485	E2372	L3971
A4411	E0486	L0491	L3973
A4412	E0641	L0492	L3975 thru L3978
A4604	E0642	L0621 thru L0640	L5703
A5120	E0705	L0859	L5858
A5512	E0762	L2034	L5971
A5513	E0764	L2387	L6621
A6457	E0911	L3671 thru L3673	L6677
A6513	E0912	L3702	L6883 thru L6885
A6530	E1392	L3763 thru L3766	L7400 thru L7405
A6531	E1812	L3905	L7600
A6532	E2207 thru E2210	L3913	L8609
A6533 thru A6544	E2211	L3919	L8623
A6549	E2211	L3921	L8624
A9275	E2212	L3933	L8680 thru L8689
A9281		L3935	
A9282			

The Medicare DMERCs will gap-fill base fee schedule amounts for each state in their region for the following new HCPCS codes that will be subject to the DMEPOS fee schedules in 2006:

HCPCS Codes	Notes
A4363, A4411, A4412	Ostomy, Tracheostomy, or Urological Supplies (OS)
A4233, A4234, A4235, A4236, A4604, E0485, E0486, E2216, E2217, E2218, E2222, E2223, E2225, E2226, E2371, E2372	Inexpensive or Routinely Purchased DME (IN)
E0170, E0171, E0911, E0912, E1812	Capped Rental DME (CR)
L0624, L0629, L0632, L0634, L2034, L2387, L3671, L3672, L3673, L3702, L3763, L3764, L3765, L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975, L3976, L3977, L3978, L5703, L5971, L6621, L6677, L6883, L6884, L6885, L7400, L7401, L7402, L7403, L7404, L7405	Prosthetics and Orthotics (PO)
A6513	Surgical Dressings (SD)

Suppliers should remember to add HCPCS modifier **AV** when billing code A5120 for facial prosthetic items only when furnished in conjunction with a facial prosthesis. Also, add modifier **AU** when billing code A5120 for urological items only when furnished in conjunction with urological supplies.

Implementation

The implementation date for the instruction is January 3, 2006

Additional Information

The official instruction issued to your carrier, intermediary, or DMERC regarding this change, can be found at <http://new.cms.hhs.gov/transmittals/downloads/R770CP.pdf> on the CMS website.

If you have questions regarding this issue, you may also contact your carrier, FI, or DMERC at their toll free number, which may be found at: <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: MM4194

Related Change Request (CR) #: 4194

Related CR Release Date: December 2, 2005

Effective Date: January 1, 2006

Related CR Transmittal #: 770

Implementation Date: January 3, 2006

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Reasonable Charge Update for 2006 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Ocular Lenses

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) for services/supplies related to splints, casts, dialysis supplies and equipment, and certain intraocular lenses

Provider Action Needed

This article is based on Change Request (CR) 4131, which provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year (CY) 2006. The 2006 payment limits for splints and casts will be based on the 2005 limits, increased by 2.5 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2005.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses in CY 2006 as required by regulations contained in 42 CFR 405.501, which can be reviewed at http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr405_02.html.

For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. The CPT codes should be used as indicated in the CPT section “Application of Casts and Strapping” for the specified CPT procedure codes in the 29XXX series.

For dialysis supplies, Healthcare Common Procedure Coding System (HCPCS) codes A4215, A6216, and A6402 have been added to the dialysis supplies that require an AX modifier for payment. Therefore, suppliers must attach the AX modifier to these codes when they are used to bill for dialysis supplies. HCPCS codes A6216 and A6402, when billed with the HCPCS modifier AX, should be reported as type of service (TOS) “L.” HCPCS codes A4215, A6216, and A6402, when billed without the HCPCS modifier AX, should be reported as TOS “S.”

HCPCS Code/Modifier	Description
Code A4215	Needle, sterile, any size, each
Code A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border
Code A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border
Modifier AX	Item furnished in conjunction with home dialysis services

For intraocular lenses, dialysis supplies, and dialysis equipment, the 2006 customary and prevailing charges will be computed using actual charge data from July 1, 2004, through June 30, 2005.

Remember that for intraocular lenses, payment is made only on a reasonable charge basis for lenses implanted while the patient is in a physician’s office.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website.

From that Web page, look for CR4131 in the CR NUM column on the right, and click on the file for that CR.

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/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: MM4131
 Related Change Request (CR) #: 4131
 Related CR Release Date: November 8, 2005
 Effective Date: January 1, 2006
 Related CR Transmittal #: 749
 Implementation Date: January 3, 2006

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EVALUATION AND MANAGEMENT SERVICES

Payment for Office/Outpatient E/M Visits (Codes 99201-99215)

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

Provider Types Affected

Physicians billing Medicare carriers for drug administration and for evaluation and management (E/M) services

Provider Action Needed

Physicians should note that this article clarifies and corrects the definition of "new patient" and "physician in a group practice" for billing evaluation and management (E/M) services and updates the policy on billing E/M services with drug administration codes in the *Medicare Claims Processing Manual*. Previously, Change Request (CR) 3631 instructed carriers **not to allow payment for Current Procedural Coding Terminology (CPT) code 99211 if billed with a drug administration service, such as chemotherapy or non-chemotherapy drug infusion code. In the Medicare Physician Fee Schedule Final Rule published on November 15, 2004, this policy was expanded to include therapeutic and diagnostic injection codes.**

The Medicare Claims Processing Manual (Chapter 12, Section 30.6.7) **is updated** stating that Medicare will pay for medically necessary office/outpatient visits billed on the same day as a drug administration service with **modifier -25 when the modifier indicates that a separately identifiable evaluation and management (E/M) service was performed** that meets a higher complexity level of care than a service represented by CPT code 99211.

The same section of the manual defines "new patient" for the E/M visit code and reads as follows. (The *italicized/bold words* are new.)

Interpret the phrase "new patient" to mean a patient who has not received any professional services, *i.e., evaluation and management (E/M) service or other face-to-face service (e.g., surgical procedure)* from the physician or *physician group practice (same physician specialty)* within the previous three years. For example, if a professional component of a previous procedure is billed in a 3-year time-period, e.g., a lab interpretation is billed and no *E/M service or other face-to-face service with the patient* is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an *E/M service or other face-to-face service with the patient* does not affect the designation of a new patient.

Paragraph B of Chapter 12, Section 30.6.7, clarifies "physician in a group practice" for office/outpatient E/M Visits provided on the same day for unrelated problems as follows:

As for all other E/M services except where specifically noted, carriers may not pay two E/M office visits billed by

a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office or outpatient setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

Paragraph D of the same section describes drug administration services and E/M visits billed on the same day of service as follows:

Carriers must advise physicians that CPT code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or non-chemotherapy drug infusion service (effective January 1, 2004). This drug administration policy was expanded in the Physician Fee Schedule Final Rule, November 14, 2004, to also include a therapeutic or diagnostic injection code (effective January 1, 2005).

Therefore, when a medically necessary, significant, and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of these drug administration services, the appropriate E/M CPT code should be reported with modifier -25. Documentation should support the level of E/M service billed. For an E/M service provided on the same day, a different diagnosis is not required

Implementation

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

Additional Information

To see the official instruction issued to your carrier regarding this change, go to

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website.

From that Web page, look for CR 4032 in the CR NUM column on the right, and click on the file for that CR.

The revised section of the *Medicare Claims Processing Manual* is attached to CR4032. If you have any questions, please contact your carrier at their toll-free number, which may be found at:

<http://www.cms.hhs.gov/medlearn/tollnums.asp> on the CMS website.

For more information regarding the revised Payment for Office/Outpatient E/M Visits (Codes 99201-99215) see the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.7, at http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf on the CMS website.

Related Change Request (CR) #: 4032
 Related CR Release Date: October 28, 2005
 Effective Date: January 1, 2004, for chemotherapy and non-chemotherapy drug infusion codes and January 1, 2005, for therapeutic and diagnostic injection codes.
 Implementation Date: January 3, 2006

Medlearn Matters Number: MM4032
 Related CR Transmittal #: 731

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New G Code for Power Mobility Devices

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article. This information was previously published in the First Quarter 2006 Medicare B Update! pages 31-32.

Note: This article was revised on November 6, 2005, to reflect a revision made to CR4121. That CR was revised to show that the changes impact physician services only and do not impact claims billed to Medicare fiscal intermediaries (FIs).

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers for services related to power mobility devices (PMDs).

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4121, which announces that a new G Code (G0372) has been established to recognize the additional physician service and resources required to establish and document the need for PMDs.

CAUTION – What You Need to Know

The new G code is only payable if all of the information necessary to document the PMD prescription is included in the medical record after a face-to-face examination of the beneficiary, and the prescription is received by the PMD supplier within 30 days after the face-to-face examination.

GO – What You Need to Do

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

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 302(a)(2)(E)(iv)) details the revised conditions for Medicare payment of PMDs. It states that payment for motorized or power wheelchairs may not be made unless a face-to-face examination of the beneficiary has been conducted, and a written prescription (order) for the PMD has been provided by a:

- Physician (as defined in Section 1861(r)(1) of the Social Security Act);
- Physician assistant;
- Nurse practitioner; or
- Clinical nurse specialist (as those terms are defined in Section 1861(aa)(5) of the Social Security Act).

Note: Payment for the history and physical examination will be made through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient.

New G Code

Due to the MMA requirement that the physician or treating practitioner create a written prescription and a regulatory requirement that the physician or treating practitioner prepare pertinent parts of the medical record for submission to the durable medical equipment supplier, the Centers for Medicare & Medicaid Services (CMS) has established the new G Code (G0372) to recognize additional physician services and resources required to establish and document the need for a PMD.

CMS believes that the typical amount of additional physician services and resources involved is equivalent to the physician fee schedule relative values established for a level 1 office visit for an established patient (Current Procedural Terminology (CPT) code 99211).

The payment amount for such a visit is \$21.60; therefore, the payment amount for G0372 for 2005 will be \$21.60, adjusted by the geographic area where the services is provided, and based on the physician fee schedule values for a level 1 established patient office visit (CPT 99211).

Code G0372 indicates that:

- All of the information necessary to document the PMD prescription is included in the medical record; and
- The prescription, along with the supporting documentation, has been received by the PMD supplier within 30 days after the face-to-face examination.

Effective October 25, 2005, G0372, will be used to recognize additional physician services and resources required to establish and document the need for the PMD, and it will be added to the Medicare physician fee schedule.

G Code & Payment Information	Short Descriptor	Long Descriptor
G0372 WRVU = 0.17 Non-Facility PE RVU = 0.39 Facility PE RVU = 0.06 Malpractice RVU = 0.01 PC/TC = 0 Site of Service = 1 Global Surgery = XXX Multiple Procedure Indicator = 0 Bilateral Procedure Indicator = 0 Assistant at Surgery Indicator = 0 Co-Surgery Indicator = 0 Team Surgery Indicator = 0 Diagnostic Supervision = 0 Type of Service = 1	MD service required for PMD	Physician service required to establish and document the need for a power Procedure Status = A mobility device

Implementation

The implementation date for the instruction is October 25, 2005.

Additional Information

For full details regarding wheelchair coverage, visit the CMS page for wheelchairs at <https://www.cms.hhs.gov/coverage/wheelchairs.asp> on the CMS website.

For complete details on the new G code, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that Web page, look for CR4121 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier at their toll-free number, which may be found at <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: MM4121 *Revised*
 Related CR Release Date: November 4, 2005
 Related CR Transmittal #: 748

Related Change Request (CR) #: 4121
 Effective Date: October 25, 2005
 Implementation Date: October 25, 2005

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

Home Care and Domiciliary Care Visits - Current Procedural Terminology Codes 99324 - 99350

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

Provider Types Affected

Physicians and 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) 4212, which provides CPT coding updates to CR3922. CR3922 is being implemented on December 5, 2005. New code changes by the American Medical Association's (AMA) Current Procedural Terminology (CPT) 2006 identify the correct Evaluation and Management (E/M) visit codes to report beginning January 2006.

CAUTION – What You Need to Know

The AMA CPT 2006 has created new codes to be used beginning January 2006, for visits provided in a domiciliary, rest home (e.g., boarding home), or custodial care setting and new codes to be used for visits in the skilled nursing facility (SNF) or nursing facility (NF) settings. A new code for an annual NF assessment has been added. The new domiciliary codes have typical/average times associated with them and therefore, reasonable and medically necessary, face-to-face prolonged services may be reported with the appropriate companion E/M visit code. **Note:** The CPT codes 99321 – 99333 for Domiciliary, Rest Home (e.g., boarding home), or Custodial Care Services are deleted after December 31, 2005. The CPT codes 99301 – 99303 for Initial Nursing Facility Care Services and codes 99311 – 99313 for Subsequent Nursing Facility Care Services are deleted after December 31, 2005.

GO – What You Need to Do

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

Background

These revisions are included in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 12, Section 30.6.14. Change Request (CR) 3922 (Transmittal 667, dated September 2, 2005, implementation date December 5, 2005) identifies the correct places of service and associated CPT codes to report for services through December 31, 2005, in the:

- Patient’s private residence;
- A domiciliary (or rest home, boarding home); and
- Nursing facility (both skilled and nursing facility).

CR4212 updates the previous instruction with the new AMA CPT 2006 codes to use beginning January 2006.

Evaluation and Management (E/M) Services

Beginning January 2006, physicians and qualified NPPs are to report medically necessary E/M services to residents residing in a facility that provides room, board, and other personal assistance services, generally on a long-term basis using the following new CPT codes:

Description	CPT Codes
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services	99324 – 99328 (new patient visit) and 99334 – 99337 (established patient visit)

Private Residence

To report E/M services provided in a private residence of the patient, use the following CPT Codes:

Description	CPT Codes
Home Services	99341 – 99350

Note: The Home Services codes will not be used for Place of Service (POS) code 13 (assisted living) and POS code 14 (group home).

Skilled Nursing Facility or Nursing Facility

Beginning January 2006, physicians and qualified NPPs will report covered, medically necessary E/M services to residents residing in a Skilled Nursing Facility (SNF) or a Nursing Facility (NF) using the following new CPT Initial Nursing Facility Care codes for the initial visit and Subsequent Nursing Facility Care codes for a subsequent visit:

Description	CPT Codes
Initial Nursing Facility Care	99304 – 99306
Subsequent Nursing Facility Care	99307 – 99310

Annual Nursing Facility Assessment

Physicians and qualified NPPs will use the following CPT code to report an annual nursing facility assessment, beginning January 2006:

Description	CPT Codes
Other Nursing Facility Services	99318

Note: The correct POS codes to use with the Nursing Facility Services CPT codes are POS 31 (SNF) and POS 32 (NF), POS 54 (Intermediate Care Facility/Mentally Retarded) and POS 56 (Psychiatric Residential Treatment Center. See CR3922 (transmittal 667, <http://new.cms.hhs.gov/transmittals/downloads/R667CP.pdf> or its corresponding Medlearn Matters article at <http://new.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3922.pdf> on the CMS website.

Prolonged Services

Beginning January 2006, the new CPT codes for Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services have typical/average times associated with them. Therefore, beginning January 2006, physicians and qualified NPPs may report reasonable and medically necessary and direct (face– to-face) prolonged services represented by CPT codes 99354 – 99355 with the appropriate CPT Domiciliary companion E/M code. All the requirements for prolonged services must be met.

Description	CPT Codes
Reasonable, Medically Necessary, and Direct (face– to-face) Prolonged Services	99354 – 99355

Note: Prolonged service performed and reported with the Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service visit code must meet the requirements for a prolonged service as defined in the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 12, and Section 30.6.15.1)

Implementation

The implementation date for the instruction 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://new.cms.hhs.gov/transmittals/downloads/R775CP.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/medlearn/tollnums.asp> on the CMS website.

Medlearn Matters Number: MM4212

Related Change Request (CR) #: 4212

Related CR Release Date: December 2, 2005

Effective Date: January 1, 2006

Related CR Transmittal #: 775

Implementation Date: January 3, 2006

INDEPENDENT DIAGNOSTIC TREATMENT FACILITY**IDTF Approved Procedure Codes**

As a reminder, Medicare may reimburse Independent Diagnostic Testing Facilities (IDTFs) only for procedure codes for which they are approved, based on equipment and personnel requirements. IDTFs are required to submit to Medicare Enrollment a list of all procedure codes performed by the facility. The codes and equipment should be listed on Attachment 2, Section 1 of Enrollment Application Form CMS-855B.

There are indications that some IDTFs may have billed for procedures that have not been reviewed and approved by Medicare Enrollment. The Medicare carrier may deny these services, even if the IDTF has the appropriate equipment and personnel. It is the responsibility of the IDTF to provide any changes to its list of procedures on an updated Form CMS-855B (with Attachment 2) to each Medicare contractor with which it does business.

Source: CMS Publication 100-8, Transmittal 41, Change Request 2595

INJECTABLE DRUGS**Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment Is Based on 95 Percent of the Average Wholesale Price**

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

Provider Types Affected

Physicians, non-physician practitioners, providers, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for these vaccines

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

Effective September 1, 2005, when payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for the influenza virus vaccines are as follows: CPT 90655 is \$14.678; 90656 is \$15.818; 90657 is \$6.028; 90658 is \$12.056. Payment for the pneumococcal vaccine (CPT 90732) is \$24.57 (when payment is based on 95 percent of the AWP).

CAUTION – What You Need to Know

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. Also, remember that all physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination or the pneumococcal vaccination must take assignment on the claim for that vaccine.

GO – What You Need to Do

Please take note of this pricing information to ensure accurate claims processing. Your carrier or FI will not search their files to adjust claims that were processed prior

to the November 21, 2005, implementation date unless you bring such claims to their attention.

Additional Information

The official instructions issued to your carrier/intermediary regarding this change can be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR4109. Click on the link to open and view the files for the CR.

If you have questions regarding this issue you may also contact your carrier or FI at their toll free number, which may be found at

<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: MM4109

Related Change Request (CR) #: 4109

Related CR Release Date: October 21, 2005

Effective Date: September 1, 2005

Related CR Transmittal #: 185

Implementation Date: November 21, 2005

January 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective January 1, 2006, and Revisions to January 2005, April 2005, July 2005, and October 2005 Quarterly ASP Medicare Part B Drug Pricing Files

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

Provider Types Affected

All Medicare providers who bill Medicare for Part B drugs

Provider Action Needed

STOP – Impact to You

CR4140 provides notice of the updated payment allowance limits in the January 2006, January 2005, April 2005, July 2005, and October 2005 drug pricing files.

CAUTION – What You Need to Know

Be aware that certain Medicare Part B drug payment limits have been revised and that CMS updates the payment allowance on a quarterly basis. The revised payment limits included in the revised ASP and not otherwise classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to this document.

GO – What You Need to Do

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

Background

According to Section 303 (c) of the Medicare Modernization Act of 2003 (MMA), the Centers for Medicare & Medicaid Services (CMS) will update the payment allowances for Medicare Part B drugs on a quarterly basis. Beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the average sales price (ASP).

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter, CMS will update your carrier/FI payment allowance limits with the ASP files. On or after December 19, 2005, revised January 2005, April 2005, July 2005, and October 2005 ASP and NOC payment files and the January 2006 ASP and NOC files will be available for download.

- The revised January 2005 payment allowance limits apply to dates of service January 1, 2005 through March 31, 2005.
- The revised April 2005 payment allowance limits apply to dates of service April 1, 2005 through June 30, 2005.

- The revised July 2005 payment allowance limits apply to dates of service July 1, 2005 through September 30, 2005.
- The revised October 2005 payment allowance limits apply to dates of service October 1, 2005 through December 31, 2005.
- The January 2006 payment allowance limits apply to dates of service January 1, 2006 through March 31, 2006.

Exceptions

There are, however, exceptions to the general rule and they were summarized in MM3846, effective July 1, 2005, and may be viewed at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3783.pdf> on the CMS website.

Implementation

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

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that Web page, look for CR4140 in the CR NUM column on the right and click on the file for that CR.

CMS will also update the Microsoft Excel files on the CMS website to reflect these revised payment limits. Those files can be found at <http://www.cms.hhs.gov/providers/drugs/asp.asp> 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/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: MM4140
 Related Change Request (CR) #: 4140
 Related CR Release Date: November 4, 2005
 Effective Date: January 1, 2005
 Related CR Transmittal #: 746
 Implementation Date: January 3, 2006

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

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

Provider Types Affected

All Medicare providers who bill Medicare for Part B drugs

Provider Action Needed

STOP – Impact to You

CR4160 revises the payment allowance limits in the October 2005 Medicare Part B drug pricing files.

CAUTION – What You Need to Know

The revised October 2005 payment allowance limits apply to dates of service October 1, 2005, through December 31, 2005.

GO – What You Need to Do

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

Background

The Medicare Modernization Act of 2003 (MMA), Section 303(c), revises the methodology for paying for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs are paid based on the new average sales price (ASP) drug payment methodology.

The ASP file, used in the ASP methodology, is based on data CMS receives quarterly from manufacturers.

Each quarter, the Centers for Medicare & Medicaid Services (CMS) will update your carrier and fiscal intermediary (FI) payment allowance limits with the ASP drug pricing files based on these manufacturers' data.

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, and CMS will update the payment allowance limits quarterly.

Exceptions to General Rule

However, there are exceptions to this general rule as summarized below:

- For **blood and blood products** (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003.

Specifically, the payment allowance limits for blood and blood 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.

- For **infusion drugs** furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, payment allowance limits 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 DME is implanted. **The payment allowance limits will not be updated in 2005.**

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

- For **influenza, pneumococcal, and hepatitis B vaccines**, payment allowance limits are 95 percent of the AWP as reflected in the published compendia.
- For **drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File**, payment allowance limits are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing.

In determining the payment limit based on WAC, carriers/FIs will follow the methodology specified in Chapter 17 of the *Medicare Claims Processing Manual* for calculating the AWP, but substitute WAC for AWP. Chapter 17 (Drugs and Biologicals) is available at http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf on the CMS website:

The payment limit is 100 percent of the WAC for the lesser of the lowest brand or median generic. Your carrier or FI may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files.

If available, CMS will provide the payment limits either directly to the requesting carrier/FI or by posting an MS excel file on the CMS web site. If the payment limit is available from CMS, carriers/FIs will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

- For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File**, payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Payment limits for radiopharmaceuticals are based on the methodology in place as of November 2003.

Your carrier/FI will not search and adjust claims that are processed prior to implementation of this change unless you bring such claims to their attention.

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

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

Implementation

The implementation date for the instruction is November 28 2005

Additional Information

The official instructions issued to the intermediary regarding this change can be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR4160. Click on the link to open and view the CR.

If you have questions, please contact your carrier/intermediary at their toll-free number which may be found at <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: MM4160
 Related CR Release Date: October 28, 2005
 Related CR Transmittal #: 729

Related Change Request (CR) #: 4160
 Effective Date: October 1, 2005
 Implementation Date: November 28, 2005

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

LABORATORY

2006 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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

Provider Types Affected

Clinical laboratories

Provider Action Needed

This article and related CR4144 contain important information regarding:

- The 2006 annual updates to the clinical laboratory fee schedule;
- Mapping for new codes for clinical laboratory tests; and
- Laboratory costs related to services subject to reasonable charge payments.

It is important that affected laboratories understand these changes to ensure correct and accurate payments from Medicare.

Background

Update to Clinical Laboratory Fees

In accordance with §1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2006 is zero (0) percent.

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the

National Limitation Amount (NLA).

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

For a cervical or vaginal smear test (pap smear), §1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge.

The 2006 national minimum payment amount is \$14.76 (\$14.76 plus zero percent update for 2006). The affected codes for the national minimum payment amount include the following Current Procedure Terminology (CPT) codes:

88142	88143	88147	88148	88150	88152
88153	88154	88164	88165	88166	88167
88174	88175	G0123	G0143	G0144	G0145
G0147	G0148	P3000			

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with section 1833(h)(4)(B)(viii) of the Act.

Access to 2006 Clinical Laboratory Fee Schedule

Internet access to the 2006 clinical laboratory fee schedule data file should be available after November 18, 2005, at <http://www.cms.hhs.gov/suppliers/clinlab> on the CMS website.

Interested providers should use the Internet to retrieve the 2006 clinical laboratory fee schedule. It will be available in multiple formats: Excel™, text, and commadelimited.

Public Comments

On July 18, 2005, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input regarding the payment relationship between 2005 codes and new 2006 CPT codes. The meeting announcement was published in the *Federal Register* on May 27, 2005, and on the CMS web site on June 20, 2005.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at <http://www.cms.hhs.gov/suppliers/clinlab> on the CMS website. Additional written comments from the public were accepted until September 23, 2005.

Comments after the release of the 2006 laboratory fee schedule can be submitted to the address listed below so that CMS may consider them for the development of the 2007 laboratory fee schedule. Comments should be in written format and include clinical, coding, and costing information. To make it possible for CMS and its contractors to meet a January 3, 2007 implementation date, comments must be submitted before August 1, 2006 to:

Centers for Medicare & Medicaid Services (CMS)
Center for Medicare Management

Division of Ambulatory Services
Mail stop: C4-07-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Additional Pricing Information

The 2006 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615).

For dates of service on or after September 1, 2005, the fee for clinical laboratory travel code P9603 is \$0.935 per mile and for code P9604 is \$9.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient.

The standard mileage rate for transportation costs was increased by the federal government's Treasury Department to 48.5 cents a mile effective September 1, 2005 and this increase is incorporated into the fees for travel codes P9603 and P9604. If the federal government revises the standard mileage rate for calendar year 2006 or a portion of 2006, CMS will issue a separate notice regarding the change.

The 2006 laboratory fee schedule also includes codes that have a 'QW' modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2006 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were determined by Medicare by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping Information for New and Revised Codes

This information is shown in the following table:

New Code:	Is Priced At The Same Rate As:	New Code:	Is Priced At The Same Rate As:
80195	80197	82271	82270
82271QW	82270	82272	82270
82272QW	82270	83631	The sum of 83520 and 87015
83695	83520	83700	Deleted code 83715
83701	Deleted code 83716	83704	The sum of deleted codes 83716 and 85004
83721QW	83721	83880QW	83880
83900	83901 (x2)	83907	87015 (x2)
83908	83898	83909	83904
83914	83904	85576QW	85576
86200	83520	86355	Deleted code 86064
86357	Deleted code 86379	86367	Deleted code 86587
86480	The sum of the rates of 86353 and 83520	86586	Deleted code 86587
86703QW	86703	87209	87207 (x3)
87807QW	87807	87900	87904 (x5)

Laboratory Costs Subject to Reasonable Charge Payment in 2006

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with §42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update.

The inflation-indexed update for year 2006 is 2.5 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23, Section 80- 80.8. (The web address for this manual is provided in the *Additional Information* section below.)

If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When these services are performed for independent dialysis facility patients, *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 8, Section 60.3 instructs that payment is made on a reasonable charge basis. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis.

Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Transmittal 496, Billing for Blood and Blood Products (Change Request (CR) 3681), issued March 4, 2005, provided instructions and established a new HCPCS modifier BL (Special Acquisition of Blood and Blood Products) to better specify the blood product charge in the hospital outpatient setting.

Because blood product services can also be performed in physician offices, independent laboratories, renal dialysis facilities, and other outpatient settings, contractors and shared system maintainers must update their files to accept the modifier BL as a valid modifier for Medicare Part B claims. Providers should submit a separate blood product charge for application of the blood deductible (BL modifier) from a blood product charge to which the blood deductible should not apply.

Transmittal 496 and *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 17, Section 231, provides further instructions on billing for blood products using the BL modifier. (See the *Additional Information* section below for CMS website access to *Medlearn Matters* article MM3681, which discusses CR3681.)

Those codes paid on a reasonable charge basis (as qualified by the above text) are:

Blood Products

P9010	P9011	P9012	P9016	P9017	P9019	P9020
P9021	P9022	P9023	P9031	P9032	P9033	P9034
P9035	P9036	P9037	P9038	P9039	P9040	P9044
P9050	P9051	P9052	P9053	P9054	P9055	P9056
P9057	P9058	P9059	P9060			

Also, the following codes should be applied to the blood deductible, as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Pub. 100-01, Chapter 3, Section 20.5-20.54:

P9010	P9011	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058	

Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041 P9043 P9045 P9046 P9047 P9048, should be obtained from the Medicare Part B Drug Pricing Files.

Transfusion Medicine

86850	86860	86870	86880	86885	86886	86890
86891	86900	86901	86903	86904	86905	86906
86920	86921	86922	86923	86927	86930	86931
86932	86945	86950	86960	86965	86970	86971
86972	86975	86976	86977	86978	86985	G0267

Reproductive Medicine Procedures

89250	89251	89253	89254	89255	89257	89258
89259	89260	89261	89264	89268	89272	89280
89281	89290	89291	89335	89342	89343	89344
89346	89352	89353	89354	89356		

Implementation

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

Additional Information

Instructions for calculating reasonable charges are located in the *Medicare Claims Processing Manual* (Pub. 100-04) Chapter 23, Sections 80-80.8 at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the CMS website.

Information on the blood deductible is available in the *Medicare General Information, Eligibility, and Entitlement Manual*, Pub. 100-01, Chapter 3, Section 20.5-20.54. That manual is available at http://www.cms.hhs.gov/manuals/101_general/ge101index.asp on the CMS website.

The official instructions issued to the carrier/intermediary regarding this change can be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. On the above page, scroll down while referring to the CR NUM column on the right to find the links for CR4144. Click on the links to open and view the files for those CRs.

To review a *Medlearn Matters* article about CR3681, go to <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3681.pdf> on the CMS website.

If you have questions, please contact your carrier/intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/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: MM4144

Related Change Request (CR) #: 4144

Related CR Release Date: November 10, 2005

Effective Date: January 1, 2006

Related CR Transmittal #: 750

Implementation Date: January 3, 2006

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

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4161, which announces the implementation of changes to the list of codes associated with the 23 negotiated laboratory NCDs.

CAUTION – What You Need to Know

These changes to the list of codes are a result of revised NCD and coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs. They are necessary for the correct processing of claims using the most current negotiated lab NCDs and code lists.

GO – What You Need to Do

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

Background

The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in the *Federal Register* as a final rule on November 23, 2001. (See below for links to the Final Rule.)

The Centers for Medicare & Medicaid Services (CMS) funded the development of software (laboratory edit module) to be incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs are processed uniformly throughout the nation effective January 1, 2003. (See below for more information contained in the *Medicare Claims Processing Manual*.)

Note: The laboratory edit module for the NCDs is updated quarterly as necessary to reflect coding updates and substantive changes to the NCDs developed through the NCD process.

Change Request (CR) 4161 announces the changes that will be included in the January 2006 release of the edit module for clinical diagnostic laboratory services. Changes are being made to the NCD code lists (as described below) to accommodate changes to the list of codes that have been made through the NCD and/or coding analysis process as explained in the final *Federal Register* notice. (See reference below.)

The Final Rule, *Federal Register* Volume 66, Number 226, can be found at http://www.access.gpo.gov/su_docs/fedreg/a011123c.html. The *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 16, Section 120.2) is available at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the CMS website. The final *Federal Register* notice, Volume 70, Number 37, dated February 25, 2005, can be found at http://www.access.gpo.gov/su_docs/fedreg/a050225c.html.

Code Changes

CR4161 announces the following changes:

- **ICD-9-CM code V76.44** (special screening for malignant neoplasms, prostate) will be removed from the list of ICD-9-CM codes not covered by Medicare.

This list of codes affects all 23 negotiated laboratory NCDs.

- **ICD-9-CM code V76.44** (special screening for malignant neoplasms, prostate) will be added to the list of ICD-9-CM codes that do not support Medical Necessity in the Blood Counts NCD.
- **ICD-9-CM codes 158.8** (Malignant neoplasms, specific parts of peritoneum) and **158.9** (Malignant neoplasms, peritoneum, unspecified) will be added to the list of ICD-9-CM codes covered by Medicare in the Tumor Antigen by Immunoassay CA 125 NCD.

Decision memoranda explaining these changes can be found by going to <http://cms.hhs.gov/coverage> on the CMS website and clicking on the National Coverage Analysis in the Coverage Database section of the Web page. These changes become effective for services furnished on or after January 1, 2006.

Implementation

The implementation date for the instruction is January 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/manuals/transmittals/comm_date_dsc.asp on the

CMS website. From that web page, look for CR4161 in the CR NUM column on the right and click on the file for that CR.

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/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: MM4161
 Related Change Request (CR) #: 4161
 Related CR Release Date: November 18, 2005
 Effective Date: January 1, 2006
 Related CR Transmittal #: 758
 Implementation Date: January 3, 2006

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New Waived Tests

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

Provider Types Affected

Suppliers and providers billing Medicare carriers for laboratory tests

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

This article is based on Change Request (CR) 4136, which includes new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments (CLIA) of 1988.

CAUTION – What You Need to Know

The following tests are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under the CLIA: Clearview Ultra FOB Test; Clarity Hemosure One-Step Immunological Fecal Occult Blood Test; Branan Medical Corporation ToxCup Drug Screen Cup; ReliaLAB Inc. InstaRead Lithium System (fingerstick or venipuncture whole blood); Roche Diagnostics AccuChek Instant Plus Dual Testing System; Acon Laboratories, Inc. FSH One Step Menopause Test Strip (Professional Use); Acon Laboratories, Inc. FSH One Step Menopause Test Device (Professional Use); Biosite Triage Meter (Whole Blood); Biosite Triage Meter Plus (Whole Blood); Acon Mononucleosis Rapid Test Strip (Whole Blood); Acon Mononucleosis Rapid Test Device (Whole Blood); iCassette Multi-Drug, Multi-Line Screen Test Device; accutest Multi-Drug, Multi-Line Screen Test Device; and RediScreen Multi-Drug; Multi-Line Screen Test Device.

GO – What You Need to Do

Please see the *Background* section of this article for further details regarding the effective dates and CPT codes for these approved waived tests.

Background

The regulations of the Clinical Laboratory Improvement Amendments (CLIA) of 1988 require a facility to be appropriately certified for each test performed. To ensure that the Centers for Medicare & Medicaid Services (CMS) pays only for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Waived Tests Requiring QW Modifier

The descriptions, Current Procedural Terminology (CPT) codes, and effective dates of the latest tests approved by the Food and Drug Administration (FDA) as waived tests under the CLIA are as follows.

Waived Test Requiring QW Modifier	CPT Code/Modifier	Effective Date
1. Clearview Ultra FOB Test	82274QW, G0328QW	August 18, 2004
2. Clarity Hemosure One-Step Immunological Fecal Occult Blood Test	82274QW, G0328QW	March 16, 2005
3. Branan Medical Corporation ToxCup Drug Screen Cup	80101QW	July 19, 2005
4 ReliaLab Inc. InstaRead Lithium System (fingerstick or venipuncture whole blood)	80178QW	April 22, 2005
5. Roche Diagnostics AccuChek Instant Plus Dual Testing System	82962 and 82465QW	August 24, 2005
6. Acon Laboratories, Inc. FSH One Step Menopause Test Strip Professional Use	83001QW	August 24, 2005
7. Acon Laboratories, Inc. FSH One Step Menopause Test Device Professional Use	83001QW	August 24, 2005
8. Biosite Triage Meter (Whole Blood)	83880QW	August 26, 2005
9. Biosite Triage Meter Plus (Whole Blood)	83880QW	August 26, 2005
10. Acon Mononucleosis Rapid Test Strip (Whole Blood)	86308QW	September 1, 2005
11. Acon Mononucleosis Rapid Test Device (Whole Blood)	86308QW	September 1, 2005
12. iCassette Multi-Drug, Multi-Line Screen Test Device	80101QW	July 8, 2005
13. accutest Multi-Drug, Multi-Line Screen Test Device	80101QW	September 1, 2005
14. RediScreen Multi-Drug, Multi-Line Screen Test Device	80101QW	September 1, 2005

To be recognized as a waived test, the CPT codes for these new waived tests must have the modifier QW.

Tests That Do Not Required QW Modifier

However, the tests listed in the following table (also included on the first page of the list attached to CR4136) do not require a QW modifier to be recognized as a waived test:

Waived Tests Not Requiring QW Modifier	CPT Codes Not Requiring Modifier QW
Dipstick or tablet reagent urinalysis – non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen	81002
Urine pregnancy tests by visual color comparison	81025
Fecal occult blood	82270, 82271 G0107 (Contact your Medicare carrier for claims instructions.)
Blood glucose by glucose monitoring devices cleared by the FDA for home use	82962
Hemoglobin by copper sulfate – non-automated	83026
Ovulation tests by visual color comparison for human luteinizing hormone	84830
Blood count; spun microhematocrit	85013
Erythrocyte sedimentation rate – non-automated	85651

HCPCS Codes 83880QW, 82271, 83037, 83037QW

The new waived CPT/Healthcare Common Procedure Coding System (HCPCS) code, **83880QW**, has been assigned for the B-type natriuretic peptide (BNP) test performed using the Biosite Triage Meter (Whole Blood) and the Biosite Triage Meter Plus (Whole Blood).

The new waived code, 80178QW, has been assigned for the lithium test performed using the ReliaLAB Inc. InstaRead Lithium System (fingerstick or venipuncture whole blood).

For 2006, the new CPT/HCPCS code **82271** replaced the CPT code 82273 and is for tests for blood, occult, by peroxidase activity (e.g., guaiac), qualitative; other sources. The CPT/HCPCS code 82271QW is effective January 1, 2006, and replaces the CPT/HCPCS code 82273QW for the following test systems:

- Aerscher Hemaprompt FG;
- SmithKline Gastrocult; and
- Beckman Coulter Primary Care Diagnostics Gastrocult.

For 2006, the new CPT/HCPCS code 82272 was developed to cover blood, occult, by peroxidase activity (e.g., guaiac), feces, single specimen, (e.g., from digital rectal exam) testing. This code has been added to the existing codes for fecal occult blood tests with an effective date of January 1, 2006.

For 2006, the new CPT/HCPCS code **83037** was developed to cover the testing for hemoglobin; glycosylated (A1c) by a device cleared by the FDA for home use. The following previously listed tests have been assigned the CPT/HCPCS code **83037QW** with an Effective Date of January 1, 2006:

- Bio-Rad Micromat II Hemoglobin A1c Prescription Home Use Test;
- Cholestech GDX A1C Test (Prescription Home Use);

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- Metrika A1c Now for Prescription Home Use (K020234);
- Provalis Diagnostics Glycosal™ HbA1c Test; and
- Provalis Diagnostics In2it In-Office Analyzer (II) A1C Prescription Home Use Test System.

Note: See the attachment to CR4136 for a complete listing of tests granted waived status under CLIA.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction (CR4136) may be viewed at <http://new.cms.hhs.gov/transmittals/downloads/R779CP.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/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: MM4136
 Related Change Request (CR) #: 4136
 Related CR Release Date: December 16, 2005
 Effective Date: January 1, 2006
 Related CR Transmittal #: 779
 Implementation Date: January 3, 2006

PHYSICAL/OCCUPATIONAL THERAPY

Therapy Caps To Be Effective January 1, 2006

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

Provider Types Affected

Therapists and providers who bill Medicare carriers or fiscal intermediaries (FIs) for therapy services for their patients

Provider Action Needed

STOP – Impact to You

Beginning January 1, 2006, financial limitation of therapy services (therapy caps) will be implemented. This limitation is similar to the limitation implemented on September 3, 2003, except for a change in the dollar amount. **The dollar amount for the 2006 limitation on physical therapy and speech-language pathology services from January 1, 2006, through December 31, 2006, will be \$1,740.00. The limitation on occupational therapy services is also \$1,740.00.**

CAUTION – What You Need to Know

Carriers and FIs will not change the way outpatient therapy service claims (physical therapy, including outpatient speech-language pathology, and occupational

therapy) were processed from September 1, 2003 through December 7, 2003.

GO – What You Need to Do

Remember that services must meet the Medicare policies in the Medicare Benefit Policy Manual (publication 100-02), Chapter 15, Sections 220 and 230. This manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS website.

Background

Financial limitations on therapy services (therapy caps) are currently described in the Medicare Claims Processing Manual (Pub. 100-04), chapter 5, section 10.2, which is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS website. The dollar amount for the limitations in 2006 is based on the Medicare Economic Index that is published in the final rule for the Medicare Physician Fee Schedule in November, 2005.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, required payment under a prospec-

tive payment system for outpatient rehabilitation services (physical therapy, including outpatient speech-language pathology, and occupational therapy). Section 4541(c) of the BBA required the application of a financial limitation to all outpatient rehabilitation services (except outpatient departments of hospitals). These limits were in effect in 1999, but were removed by law in 2000-2002. The statutory limits went back into effect September 1, 2003. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 re-enacted the moratorium and extended it until December 31, 2005.

Additional Information

There is additional information located on the Rehabilitation Therapy Information Resource for Medicare website located at http://new.cms.hhs.gov/TherapyServices/01_overview.asp#TopOfPage on the CMS website.

You will also find a powerpoint demonstration on outpatient therapy caps on that site under the heading,

“Therapy Cap Status”. (Outpatient Therapy Caps - PowerPoint Demonstration posted November 14, 2005.

The official instruction issued to your FI or carrier regarding this change may be found by going to <http://www.cms.hhs.gov/transmittals/downloads/R759CP.pdf> on the CMS website.

Please refer to your local FI or carrier if you have any questions. 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: MM4115
 Related Change Request (CR) #: 4115
 Related CR Release Date: November 18, 2005
 Effective Date: January 1, 2006
 Related CR Transmittal #: 759
 Implementation Date: January 3, 2006

RADIOLOGY

Calendar Year 2005 Payment for Medicare Part B Radiopharmaceuticals Not Paid on a Cost or Prospective Payment Basis

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

Provider Types Affected

All providers billing carriers, fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs), for Medicare Part B radiopharmaceuticals

Provider Action Needed

STOP – Impact to You

Medicare Part B radiopharmaceuticals payment allowance limits are not subject to the average sales price (ASP), effective January 1, 2005.

CAUTION – What You Need to Know

Effective January 1, 2005, the payment allowance limits for radiopharmaceuticals are determined by the payment methodology in place under Part B as of November 2003.

GO – What You Need to Do

If you require adjustments on radiopharmaceuticals claims processed prior to January 1, 2005, contact your carrier, FI, or RHHI.

Background

In accordance with section 303(c) of the Medicare Modernization Act (MMA) of 2003, effective January 1, 2005, drugs and biologicals not paid on a cost or prospective basis are paid based on the ASP.

However, section 303(h) of the MMA of 2003 provided for the continuation of the payment methodology under Medicare Part B, prior to the MMA for radiopharmaceuticals, effective January 1, 2005. Therefore, the payment allowance limits for radiopharmaceuticals are based on the payment methodology under Part B, as of November 2003.

This article and related CR4053 supersede instructions

provided in CR3783, transmittal 528, dated April 22, 2005, which stated that Medicare carriers, FIs, and RHHIs will determine payment allowance limits for radiopharmaceuticals based on the ASP. The payment allowance limits for radiopharmaceuticals are not subject to the ASP.

Additional Information

Medlearn Matters article MM3783, titled “MMA - July 2005 Quarterly ASP Medicare Part B Drug Pricing File, Effective July 1, 2005,” can be viewed at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3783.pdf> on the CMS website.

The official instruction issued to your carrier/FI/RHHI regarding this change may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_disc.asp on the CMS website.

From that Web page, look for CR4053 in the CR NUM column on the right and click on the file for that CR.

If you have any questions, please contact your Medicare carrier/FI/RHHI at their toll-free number, which may be found at <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).

Related Change Request (CR) #: 4053
 Medlearn Matters Number: MM4053
 Related CR Release Date: November 1, 2005
 Related CR Transmittal #: 738
 Effective Date: January 1, 2005
 Implementation Date: December 5, 2005

SURGERY

Expansion of Coverage for Percutaneous Transluminal Angioplasty

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

This information was previously published in the Fourth Quarter 2005 Medicare B Update! pages 56-58.

Note: This article was revised on November 23, 2005, to add important information regarding diagnostic coding in the "Note" box at the top of page 5 of this article. All other information remains the same.

Provider Types Affected

Hospitals, physicians, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for percutaneous transluminal angioplasty (PTA) services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

MM3811 and related CR3811 announce the expansion of Medicare coverage for PTA of the carotid artery.

CAUTION – What You Need to Know

Effective March 17, 2005, Medicare revised its coverage of PTA of the carotid artery as detailed in this article and CR 3811.

GO – What You Need to Do

If you are a provider of PTA services, be aware of the coverage changes and make certain that your billing staff is aware of the expanded national coverage allowed to Medicare beneficiaries receiving PTA services

Background

Medicare covers PTA of the carotid artery concurrent with carotid stent placement when all the requirements stipulated by the Food and Drug Administration (FDA)-approved policies for Category B Investigational Device Exemption (IDE) clinical trials are met, effective for dates of service on or after July 1, 2001.

PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent for an FDA-approved indication is covered, when all the requirements stipulated by the FDA-approved policies for post-approval studies are met, for dates of service on or after October 12, 2004.

Expanded Coverage

Effective March 17, 2005, The Centers for Medicare & Medicaid Services (CMS) expanded the coverage of PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent with embolic protection for the following:

- Patients who are at high risk for carotid endarterectomy (CEA) and who also have symptomatic carotid artery stenosis = 70%. Coverage is limited to procedures performed using FDA-approved carotid artery stenting systems and embolic protection devices;
- Patients who are at high risk for CEA and have symptomatic carotid artery stenosis between 50% and 70% in accordance to the Category B IDE

clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (Medicare National Coverage Determination (NCD) Manual, Section 310.1), or according to the NCD on carotid artery stenting (CAS) post-approval studies (Medicare NCD Manual, Section 20.7); and

- Patients who are at high risk for CEA and have asymptomatic carotid artery stenosis = 80% (according to the Category B IDE clinical trials regulation (42 CFR 405.201)), as a routine cost under the clinical trials policy (Medicare NCD Manual 310.1), or according to the NCD on CAS post-approval studies (Medicare NCD Manual, Section 20.7).

CMS defines high risk patients as those having significant comorbidities and/or anatomic risk factors and are considered by a surgeon to be poor candidates for CEA. The significant comorbidities, include, but are not limited to, those listed in Section 20.7 of the Medicare NCD Manual as follows:

- Congestive heart failure (CHF) class III/IV;
- Left ventricular ejection fraction (LVEF) < 30%;
- Unstable angina;
- Contralateral carotid occlusion;
- Recent myocardial infarction (MI);
- Previous CEA with recurrent stenosis ;
- Prior radiation treatment to the neck; and
- Other conditions that were used to determine patients at high risk for CEA in the prior CAS trials and studies, such as ARCHER, CABERNET, SAPPHIRE, BEACH, and MAVERIC II.

Symptoms of carotid artery stenosis include carotid transient ischemic attack (distinct focal neurologic dysfunction persisting less than 24 hours), focal cerebral ischemia producing a non-disabling stroke (modified Rankin scale < 3 with symptoms for 24 hours or more), and transient molecular blindness (amaurosis fugax). Patients who have had a disabling stroke (modified Rankin > 3) would be excluded from coverage.

The appropriate documentation confirming that a patient is at high risk for CEA and records of the patient's symptoms of carotid artery stenosis should be available in the patient medical records prior to performing any procedure.

The degree of carotid artery stenosis should be measured by duplex Doppler ultrasound or carotid artery angiography and recorded in the patient medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure.

If the stenosis is determined to be less than 70% by angiography, the CAS should not proceed.

- Carotid artery stenting with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes.

All facilities must at least meet the minimum standards outlined in Pub 100-03, Section 20.7 of the NCD Manual in order to receive coverage for CAS for high-risk patients. Briefly, facilities must have high quality X-ray imaging equipment, device inventory, staffing, and infrastructure to support a dedicated CAS program.

- Advanced physiologic monitoring, including real time and archived physiologic, hemodynamic, and cardiac rhythm monitoring equipment, and associated support staff capable of interpreting findings and responding appropriately.
- Readily available emergency management equipment and systems, such as resuscitation equipment, a defibrillator, vasocative and antiarrhythmic drugs, endotracheal intubation capability, and anesthesia support.
- A clearly delineated program for granting CAS privileges and for monitoring the quality of the individual interventionists and the program as a whole. The oversight committee for this program is encouraged to apply published standards from national specialty societies recognized by the American Board of Medical Specialties to determine appropriate physician qualifications.

Examples of standards and clinical competence guidelines include those published in the December 2004 edition of the American Journal of Neuroradiology and those published in the August 18, 2004, Journal of the American College of Cardiology.

- A data collection system maintained by the facility or its contractor on all CAS procedures done at that facility. The data must be analyzed routinely to ensure patient safety (to be determined by the facility but should not be less frequent than 6-month intervals), will be used in re-credentialing the facility, and must be made available to CMS upon request.

For evaluation purposes, all facilities must provide written documentation to CMS indicating it meets one of the following criteria:

- Was a FDA-approved site that enrolled patients in prior CAS IDE trials, such as SAPHIRE, and ARCHER;
- Is a FDA-approved site that is participating and enrolling patients in ongoing CAS IDE trials, such as CREST;

- Is a FDA-approved site for one or more FDA post-approval studies; or
- Has provided a written affidavit to CMS affirming that the facility meets the minimum facility standards.

The affidavit must include the facility's name and complete address, Medicare provider number, point-of-contact name and telephone number, CAS procedure data collection mechanism, and a senior facility administrative official's signature. (Note that a new affidavit is required every two years.)

The affidavit should be sent to:

Director, Coverage and Analysis Group
7500 Security Boulevard, Mail-stop C1-09-06
Baltimore, MD 21244

Note: Performance of PTA to treat obstructive lesions of the vertebral and cerebral arteries remains noncovered. All other indications of PTA for which CMS has not specifically indicated coverage remain noncovered.

Additional Information

All providers should note that the following relate to services on or after March 17, 2005:

- FIs and carriers will only pay CAS claims from providers who are listed on the approved facility list which is at: <http://www.cms.hhs.gov/coverage/carotid-stent-facilities.asp>.
- Carriers will pay claims containing ICD-9 CM 433.10 and any of the following procedure codes: 37215, 37216, 0075T, or 0076T, for beneficiaries meeting the high risk criteria previously specified.
- FIs will pay claims containing ICD-9 CM 433.10 and both procedures codes 00.61 and 00.63.
- FIs will reject claims that do not have both procedure codes 00.61 and 00.63
- FIs and carriers will deny CAS services for patients at high risk if the appropriate diagnosis code is not on the claim and use the appropriate Medicare Summary Notice (MSN) message and claim adjustment reason code in doing so.
- FIs and carriers will deny claims where the service was performed in an unapproved facility and use the appropriate MSN message and claim adjustment reason code in doing so.

Providers must also bill V70.7 (Exam – clinical trial) as a secondary diagnosis for claims with “From” dates **before** October 1, 2005. Providers must bill V70.7 in order to avoid unintentional Medicare Code Editor (MCE) editing. For claims that have “From” dates **on or after** October 1, 2005, hospitals are not required to bill V70.7 as the unintentional MCE editing will be corrected.

Coding for Carotid Artery Stents— IMPORTANT INFORMATION

In the American Hospital Association's (AHA's) publication *Coding Clinic for ICD-9-CM*, First Quarter 2002, page 10 (and corrected in Second Quarter 2002, page 19), there is a Q&A regarding coding of bilateral carotid

artery stenosis. The answer said, "Assign only code 433.10, (Occlusion and stenosis of precerebral arteries, Carotid artery, without mention of cerebral infarction) as the principal diagnosis." The correction notice changed that advice to use code 433.30 (Occlusion and stenosis of precerebral arteries, multiple and bilateral, without mention of cerebral infarction) instead of 433.10.

In an effort to reduce the confusion, CMS has decided to allow hospitals to be able to code both 433.30 and 433.10, in either principal diagnosis or secondary diagnosis positions, on the claim. Code 433.30 will identify the bilateral condition, while 433.10 will specifically identify the carotid vessel.

You may also want to review the following Medlearn Matters article MM3489 and CR3489 for additional information relating to Medicare coverage of PTA. They are available at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3489.pdf> and http://www.cms.hhs.gov/manuals/pm_trans/R314CP.pdf on the CMS website.

The official instruction issued to your carrier/FI regarding this change may be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website.

From that web page, look for CR3811 in the CR NUM column on the right, and then click on the files for that CR. You will see two versions of CR3811. One version identified by transmittal number 33 contains the NCD Manual revision, and transmittal number 531 contains the revisions to the Medicare Claims Processing Manual.

If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at <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).

Related Change Request (CR) #: 3811

Medlearn Matters Number: MM3811

Related CR Release Date: April 22, 2005 *Revised*

Related CR Transmittal #: 33 and 531

Effective Date: March 17, 2005

Implementation Date: July 5, 2005

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Coverage by Medicare Advantage Plans for Implantable Automatic Cardiac Defibrillator Services Not Previously Included in MA Capitation Rates

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

Provider Types Affected

All Medicare providers billing either a Medicare carrier or fiscal intermediary (FI) for ICDs for Medicare beneficiaries who are also members of Medicare Advantage (MA) plans

Provider Action Needed

STOP – Impact to You

Be aware that, effective for services provided on and after January 1, 2006, your Medicare carrier or FI will no longer pay fee-for-service (FFS) claims for the expanded coverage of ICD services rendered to MA beneficiaries.

CAUTION – What You Need to Know

Related CR4133 instructs Medicare carriers and FIs to no longer pay FS claims for the expanded coverage of ICD services (described in CR3604) that you provide to MA beneficiaries. These services are now part of the MA capitation rates.

GO – What You Need to Do

Make sure that your billing staffs are aware of these changes and also the basis for billing Medicare.

Background

In CR3604 (January 27, 2005), Medicare expanded ICD coverage for the following new indications:

- Patients with ischemic dilated cardiomyopathy (IDCM), documented prior myocardial infarction (MI), New York Heart Association (NYHA) Class II and III heart failure, and measured left ventricular ejection fraction (LVEF) \leq 35%;
- Patients with nonischemic dilated cardiomyopathy (NIDCM) $>$ 9 months, NYHA Class II and III heart failure, and measured LVEF \leq 35%;
- Patients who meet all current Centers for Medicare & Medicaid Services (CMS) coverage requirements for a cardiac resynchronization therapy (CRT) device and have NYHA Class IV heart failure; and
- Patients with NIDCM $>$ 3 months, NYHA Class II or III heart failure, and measured LVEF \leq 35%.

At that time, because this new coverage exceeded the significant cost threshold for managed care organizations, services related to these newly covered indications for Medicare Advantage (MA) beneficiaries were not part of the MA capitation rates, but rather were paid on a FFS basis.

See *Medlearn Matters* article MM3604 regarding this issue at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3604.pdf> on the CMS website.

Adjustment in MA Rates

Beginning January 1, 2006, the MA rates are appropriately adjusted to account for the expanded coverage of ICD services, and MA plans are now liable for payment relating directly to providing these services. Thus CR4133:

- Instructs your carriers and FIs to no longer pay FFS for the expanded coverage of ICD services that you provide to MA beneficiaries, effective for services performed on and after January 1, 2006;
- Requires MA plans to furnish, arrange, and/or make appropriate payment for these services; and
- Notes that MA enrollees are liable for the MA plan's cost sharing of these services.

Conditions for Denying Claims

CR4133 provides that Medicare systems will now deny, for beneficiaries in MA plans, claims that meet all of the conditions described in the following categories:

Outpatient Claims Processed by Your FI

- Date(s) of service on or after January 1, 2006; **and**
- Condition code 78 (New coverage not implemented by HMO); **and**
- One of the following HCPCS codes: G0297, G0298, G0299, or G0300.

Hospital Inpatient Claims

- Discharge date is on or after January 1, 2006;
- and**
- Condition code 78;
- and**
- ICD-9CM 37.94.

Medlearn Matters Number: MM4133

Related CR Release Date: October 28, 2005

Related CR Transmittal #: 186

Related Change Request (CR) #: 4133

Effective Date: January 1, 2006

Implementation Date: January 3, 2006

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

Stem Cell Transplantation

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services related to stem cell transplantation

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4173, which includes clarifying language specific to the current national coverage policy on stem cell transplantation.

CAUTION – What You Need to Know

CR4173 clarifies that stem cell transplantation and high-dose chemotherapy are both integral to the course of treatment and are covered as a single entity.

Professional Part B Claims

- Date(s) of service is/are on or after January 1, 2006;
- and**
- Modifier KZ (New coverage not implemented by managed care);
- and**
- CPT code 33249.

Finally, CR4133 instructs your carriers and FIs, when denying these services, to use:

- Medicare Summary Notice (MSN) 11.3 ("Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them"); and
- Claim adjustment reason code 24 ("Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan").

Additional Information

You can find more information about billing for ICD services for MA Plan beneficiaries by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that web page, look for "4133" in the CR NUM column on the right, and click on the file for that CR.

Indications and limitation of coverage for ICDs are located in the *Medicare National Coverage Determinations Manual* (Pub. 100-03), Chapter 1, Part 1, section 20.4 (Implantable Automatic Defibrillators).

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/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).

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) has a coverage policy for stem cell transplantation, and the Medicare National Coverage Determination (NCD) Manual (Publication 100-03, Section 110.8) states that stem cell transplantation is a process in which stem cells are harvested from either a patient's or donor's bone marrow or peripheral blood for intravenous infusion.

Autologous stem cell transplants (AuSCT) must be used to effect hematopoietic reconstitution following

severely myelotoxic doses of chemotherapy (High Dose Chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor's stem cell or bone marrow is obtained and prepared for intravenous infusion and may also be used to restore function.

CR4173 clarifies existing NCD policy language and corresponding claims processing language as follows:

“Bone marrow and peripheral blood stem cell transplantation is a process which includes mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual transplant. When bone marrow or peripheral blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow or peripheral blood stem cell transplantation is non-covered, none of the steps are covered.”

Note: There is no change to existing CMS coverage policy or claims processing instructions.

Implementation

The implementation date for the instruction is January 3, 2006, and will be effective for dates of service on or after November 28, 2005.

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Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. Those instructions are in two parts. The first part is the actual change to the *Medicare National Coverage Determinations (NCD) Manual*, which includes the actual policy language regarding stem cell transplantation. That part may be viewed at <http://new.cms.hhs.gov/transmittals/downloads/R45NCD.pdf> on the CMS website.

The second part contains the changes to the *Medicare Claims Processing Manual*. Those changes are available at <http://new.cms.hhs.gov/transmittals/downloads/R766CP.pdf> on the CMS website.

If you have questions, please contact your carrier or FI 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: MM4173
 Related Change Request (CR) #: 4173
 Related CR Release Date: December 6, 2005
 Effective Date: November 28, 2005
 Related CR Transmittal #: 45 and 776
 Implementation Date: January 3, 2006

Providing Medicare with Data for Certain Implantable Cardioverter Defibrillators

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

Provider Types Affected

Physicians and other providers needing to register Medicare patients receiving the Implantable Cardioverter Defibrillator (ICD) as primary prevention of sudden cardiac death

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) has entered into an agreement with the American College of Cardiology National Cardiac Data Registry (ACC-NCDR) and determined that its ICD Registry satisfies Medicare's requirements for reporting data on primary prevention ICDs.

CAUTION – What You Need to Know

Because the ACC-NCDR is now available, CMS will stop accepting data on the ICD Abstraction Tool through the Quality Network Exchange (QNet) on April 30, 2006.

GO – What You Need to Do

In order for providers to continue to satisfy the National Coverage Determination (NCD) requirements for primary prevention ICDs, they will need to transition out of QNet and begin using the ACC-NCDR. CMS recommends that hospitals contact ACC-NCDR by January 1, 2006, to ensure that enrollment is complete by April 2006.

Background

When CMS expanded coverage for ICDs in January 2005, one of the requirements was for data to be reported by the provider for beneficiaries receiving ICDs for the primary prevention of sudden cardiac arrest. Information regarding this policy is available at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf on the CMS website.

CMS established the ICD Abstraction Tool through QNet (<http://qnetexchange.org/public>), a system used by hospitals to report quality data to Medicare, to make available a data reporting system for providers that meets the data reporting requirements outlined in the NCD.

CMS intended for the ICD Abstraction Tool to be temporary until a more complete registry became available; the result is the ACC-NCDR.

Additional Information

Because the ACC-NCDR is now available, the ICD Abstraction Tool through Qnet will stop accepting data on April 30, 2006. For providers to continue to satisfy the NCD requirements for primary prevention ICDs, they will need to transition out of QNet and begin using ACC-NCDR. CMS recommends that hospitals contact ACC-NCDR by January 1, 2006, to ensure that enrollment is complete by April 2006.

Hospitals will need to work with the ACC-NCDR directly regarding participation. Information is available on the Web at <http://www.waccncdr.com/webncdr/ICD> or by telephone at 1-800-253-4636, ext. 451.

Although the ACC-NCDR only enrolls hospitals, all provider types are responsible for ensuring that data is reported to the registry. Physicians and hospitals will need to work closely to ensure that all data elements are available for abstraction and entry into the registry.

Use of the QR modifier for physician and hospital outpatient claims remains the same. The QR modifier should continue to be appended to claims for ICD insertion when data is reported on the procedure. Data reporting, and therefore the QR modifier, is required for claims of primary prevention ICDs.

Reporting data for primary prevention of ICD implants is a requirement of Medicare coverage. Without appropriately reported data, Medicare may be unable to approve claims and/or may be required to take action to recoup payments already made if data reporting discrepancies are discovered through post-payment claims analysis.

Medlearn Matters Number: SE0578
 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

Instructions for Reporting New HCPCS Code V2788 for Presbyopia-Correcting Intraocular Lenses

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for intraocular lenses (IOLs)

Provider Action Needed

This instruction provides guidance regarding the new Healthcare Common Procedure Coding System (HCPCS) code, V2788 Presbyopia-Correcting Intraocular Lenses (PC IOL). It is being established as a code for reporting non-covered charges associated with the insertion of a presbyopia-correcting lens.

Providers may report this code on claims to reflect the PC-IOL when inserted in lieu of the conventional IOL in conjunction with correcting cataract surgery. The new HCPCS code will be part of the annual HCPCS update and is not a payable service for Medicare on the HCPCS file for 2006.

Background

The Centers for Medicare & Medicaid Services (CMS) announce that Section 120 has been added to Publication 100-04, Chapter 32, which outlines general policy, payment, and billing procedures for PC-IOLs. Much of this information was previously released in Change Request 3927 in August, 2005.

A *Medlearn Matters* article (MM3927) on the subject can be viewed at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3927.pdf> on the CMS website. As stated in CR3927, the new coverage policy was effective for dates of service on and after May 3, 2005.

CR4184 provides a new HCPCS code, effective January 1, 2006, for reporting **non-covered** charges associated with the insertion of a presbyopia-correcting lens. That code is V2788. Medicare carriers and intermediaries will use an appropriate claim adjustment reason code such as 96 (non-covered charges) when denying non-covered PC-IOL charges. The carrier or intermediary will also send an appropriate message to the beneficiary via a Medicare Summary Notice to inform the beneficiary of the denial.

CPT Codes

Physicians and hospitals are to report one of the following Current Procedure Terminology (CPT) codes on these claims:

- **66982** - Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic development stage.
- **66983** – Intracapsular cataract with insertion of intraocular lens prosthesis (one stage procedure).
- **66984** – Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification).
- **66985** – Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract extraction.
- **66986** – Exchange of intraocular lens.

Implementation

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

Additional Information

For complete details, please see CR4184, the official instruction issued to your carrier or intermediary regarding this change, which may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R801CP.pdf> on the CMS website.

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

Medlearn Matters Number: MM4184
 Related Change Request (CR) #: 4184
 Related CR Release Date: December 30, 2005
 Effective Date: January 1, 2006
 Related CR Transmittal #: R801CP
 Implementation Date: January 3, 2006

GENERAL COVERAGE

Telehealth Originating Site Facility Fee Payment Amount Update

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

Provider Types Affected

All providers who bill Medicare for the telehealth originating site facility fee

Provider Action Needed

CR4201, upon which this article is based, provides the calendar year 2006 telehealth originating site facility fee payment update. Beginning on and after January 1, 2006, the telehealth originating site facility fee is \$22.47.

Background

Section 1834(m) of the Social Security Act (the Act) established the amount Medicare paid as the telehealth originating site facility fee for services provided from October 1, 2001, through December 31 2002. The amount was set at \$20.

For such services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee was increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI).

The 2006 MEI increase is 2.8%. Thus, for calendar year 2006, the payment amount for HCPCS code Q3014 (telehealth originating site facility fee) is 80% of the lesser of the actual charge or \$22.47 (2.8% x \$21.86 [the 2005 fee – see below] + \$21.86).

Note that the beneficiary is responsible for any unmet deductible amount or coinsurance

For reference, the Medicare telehealth originating site facility fees and MEI increases by the applicable time period are shown in the table below:

Medicare Telehealth

Originating Site Facility Fee	MEI Increase	Period
\$20.00	N/A	10/01/2001-12/31/2002
\$20.60	3%	01/01/2003-12/31/2003
\$21.20	2.9%	01/01/2004-12/31/2004
\$21.86	3.1%	01/01/2005-12/31/2005
\$22.47	2.8%	01/01/2006-12/31/2006

Additional Information

You can find more information about the telehealth originating site facility fee payment amount by going to <http://new.cms.hhs.gov/transmittals/downloads/R41BP.pdf> on the CMS website.

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/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: MM4201

Related Change Request (CR) #: 4201

Related CR Release Date: December 16, 2005

Effective Date: January 1, 2006

Related CR Transmittal #: 41

Implementation Date: January 18, 2006

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List of Medicare Telehealth Services

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

Provider Types Affected

Registered dietitians, nutrition professionals, and other providers of Medicare telehealth services billing Medicare carriers or fiscal intermediaries (FIs) for such services

CAUTION – What You Need to Know

CR4204, from which this article is taken, expands the list of Medicare telehealth services to include individual MNT (as represented by HCPCS codes G0270, 97802 and 97803); and adds registered dietitians and nutrition professionals to the list of practitioners eligible to furnish, and receive payment, for telehealth.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) has added individual medical nutrition therapy (MNT) to the list of Medicare telehealth services.

GO – What You Need to Do

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

Background

The use of a telecommunications system may substitute for a face-to-face, “hands on” encounter for consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, and end-stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site).

In the calendar year 2006 Physician Fee Schedule-Final Rule (CMS-1502-FC), CMS expanded the list of Medicare telehealth services to include individual MNT as described by HCPCS codes G0270, 97802, and 97803. Therefore, effective January 1, 2006, the telehealth modifiers “GT” (via interactive audio and video telecommunications system) and modifier “GQ” (via asynchronous telecommunications system) are valid when billed with these HCPCS codes.

Additionally, since certified registered dietitians and nutrition professionals (as defined in 42 CFR, Section 410.134) are the only practitioners permitted by law to furnish MNT, registered dietitians and nutrition professionals have been added to the list of practitioners who may furnish and receive payment for a Telehealth service.

Publication 100-02 (*Medicare Benefit Policy Manual*), Chapter 15, Sections 270.2 and 270.4, and Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12, Section 190, have been revised to implement this addition to the list of Medicare telehealth services.

Be aware, nonetheless, that this expansion to the list of Medicare Telehealth services does not change the eligibility criteria, conditions of payment, payment or billing methodology applicable to Medicare telehealth services as set forth in these manuals. For example, originating sites must be located in either a non-MSA county or rural health professional shortage area, and can only include a physician’s or practitioner’s office, hospital, critical access hospital (CAH), rural health clinic, or federally qualified health center.

Further, you must use an interactive audio and video telecommunications system that permits real-time communication between the distant site physician, or practitioner, and the Medicare beneficiary, and as a condition of payment, the patient must be present and participating in the telehealth visit.

The only exception to this interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In these circumstances, Medicare payment is permitted for Telehealth services when asynchronous store-and-forward technology is used.

Finally, you should remember that if the distant site is a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to this CAH, it should bill its regular fiscal intermediary for the professional Telehealth services provided, using any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

Additional Information

You can find more information about telehealth services by going to <http://www.cms.hhs.gov/Transmittals/downloads/R790CP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R43BP.pdf> on the CMS website. These Web addresses contain CR4204.

You might also want to look at the following manuals:

- Online manual 100-02 (*Medicare Benefit Policy Manual*), Chapter 15 (Covered Medical and Other Health Services), Sections 270.2 (List of Medicare Telehealth Services) and 270.4 (Payment – Physician/Practitioner at a Distant Site); and
- Manual 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Practitioner Billing), Sections 190.3 (List of Medicare Telehealth Services), 190.5 (Payment Methodology for Physician/Practitioner at the Distant Site), 190.6 (Originating Site Facility Fee Payment Methodology), and 190.7 (Contractor Editing of Telehealth Claims).

You can find these revised manual sections as attachments to CR4204.

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: MM4204

Related Change Request (CR) #: 4204

Related CR Release Date: December 23, 2006

Effective Date: January 1, 2006

Related CR Transmittal #: R790CP and R43BP

Implementation Date: April 3, 2006

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Lung Volume Reduction Surgery

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

Provider Types Affected

All Medicare providers who submit claims to Medicare carriers or fiscal intermediaries (FIs) for lung volume reduction surgery (LVRS)

Provider Action Needed

STOP – Impact to You

CR 4149 outlines the newly modified requirements for facilities eligible to perform LVRS and the updated manual paragraphs on the National Emphysema Treatment Trial (NETT) published by the Centers for Medicare & Medicaid Services (CMS).

CAUTION – What You Need to Know

Beginning November 17, 2005, CMS will allow facilities certified under the disease specific care certification program for LVRS by the Joint Commission of Health Care Organizations (Joint Commission) to be Medicare approved LVRS facilities. Hospitals that are Medicare approved for lung or heart lung transplant will continue to be approved for LVRS. NETT facilities are no longer automatically approved for LVRS. These hospitals will have 18 months to become approved under one of the other existing mechanisms.

GO – What You Need to Do

Be aware of the new requirements for LVRS facilities.

Background

Between 1997 and 2003, CMS covered LVRS when provided under the protocol of the National Emphysema Treatment Trial (NETT), a clinical trial sponsored by the National Heart Lung and Blood Institute and CMS. On January 1, 2004, a national coverage determination became effective that allowed coverage of LVRS, outside of a trial, for patients with certain clinical indications and when performed at approved hospitals (CR 2688).

CR 4149 updates the requirements for hospitals to become approved as Medicare LVRS facilities. CMS will maintain an updated listing of approved LVRS facilities on the CMS website at http://new.cms.hhs.gov/MedicareApprovedFacilities/04_lvrs.asp#TopOfPage.

Note: The NETT has ended and CR 4149 removes outdated language from the *Medicare National Coverage Determinations Manual* that refers to coverage for LVRS under the protocol of that trial.

Medicare will consider LVRS reasonable and necessary only when the following requirements are met:

- Effective for services performed on or after November 17, 2005, LVRS is performed at a facility that is:
 - “ Certified by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) under the LVRS Disease Specific Care Certification Program (program standards and requirements as printed in the Joint Commission’s October 25, 2004, Disease Specific Care Certification Program packet); or
 - “ Performed at facilities that are Medicare-approved for lung or heart-lung transplantation.

CMS further determines that LVRS performed between January 1, 2004 and May 17, 2007, may be performed at facilities that:

- Were approved by the National Heart Lung and Blood Institute to participate in the National Emphysema Treatment Trial
- Are Medicare-approved for lung or heart-lung transplantation.

Implementation

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

Additional Information

The official instructions issued to your carrier/intermediary regarding this change may be found on the CMS website at <http://new.cms.hhs.gov/transmittals/downloads/R768CP.pdf>.

The changes to Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, section 240.1, are attached to CR 4149.

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

Medlearn Matters Number: MM4149
 Related Change Request (CR) Number: 4149
 Related CR Release Date: December 2, 2005
 Related CR Transmittal Number: 768
 Effective Date: November 17, 2005
 Implementation Date: March 2, 2006

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PROVIDER ENROLLMENT

New CMS National Provider Identifier Web Page

Announcing the new CMS Web page dedicated to providing the latest national provider identifier (NPI) news for fee-for-service (FFS) Medicare providers!

Visit <http://www.cms.hhs.gov/providers/npi/default.asp> on the Web! While this page is dedicated to the Medicare FFS community, it contains helpful information and links that may benefit all health care providers.

Reminder: Health care providers are required by law to apply for an NPI. To apply online, visit: <https://nppes.cms.hhs.gov>.

Source: CMS Joint Signature Memorandum (JSM) 06033, dated November 2, 2005

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

Eliminate the Use of Surrogate UPIN on Medicare Claims

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), using surrogate unique physician identification numbers UPINs

Provider Action Needed

This article is based on change request 4177, which directs your carrier or DMERC to no longer accept the surrogate UPIN OTH000 to identify ordering or referring physicians on claims submitted by billers, suppliers, physicians, and nonphysician practitioners. (Beneficiary submitted claims and mass immunization claims are excluded.)

Background

The Social Security Act (Section 1833(q)) requires that all physicians who meet the definition of a physician (Section 1861(r)) must have a UPIN, and that all claims for services ordered or referred by one of these physicians include the name and UPIN of the ordering/referring physician.

Currently, suppliers, physicians, and non-physician practitioners are allowed to bill for diagnostic, radiology, consultation services, and equipment with the use of Surrogate UPIN OTH000. Surrogate UPINs were intended to be used during an interim period when a UPIN has been requested but has not yet been received.

CR4177 announces that CMS will no longer accept the Surrogate UPIN OTH000 to identify the ordering or referring physicians on claims submitted by billers, suppliers, physicians, and non-physician practitioners, effective for dates of service April 1, 2006, and later: (Beneficiary submitted claims and mass immunization claims are excluded.)

- Durable medical equipment (DME) suppliers, physicians, non-physician practitioners, and billers must submit the

UPIN assigned to the ordering or referring physician; and

- Medicare carriers, DMERCs, and FIs will return, as unprocessable, all claims submitted with Surrogate UPIN OTH000.

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 regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website.

From that web page, look for CR 4177 in the CR NUM column on the right, and click on the file for that CR.

If you need to obtain another physician's UPIN for billing purposes, you may find that UPIN by going to <http://www.upinregistry.com>.

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/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: MM4177

Related Change Request (CR) #: 4177

Related CR Release Date: November 10, 2005

Effective Date: April 1, 2006

Related CR Transmittal #: 752

Implementation Date: April 3, 2006

PRESCRIPTION DRUG COVERAGE**Important Information about Medicare Coverage of Drugs under Part B and the New Medicare Prescription Drug Coverage (Part D), and Vaccines Administered in a Physician's Office – The Ninth in the Medlearn Matters Series on the New Prescription Drug Plans**

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

Provider Types Affected

Physicians, healthcare professionals, providers, suppliers, and their staff

Key Points to Remember

- Drugs covered under Fee-For-Service (FFS) Medicare Parts A/B that are paid to institutional providers (hospitals, SNFs, etc.) as part of a bundled payment are paid by fiscal intermediaries (FIs).
- Drugs covered under FFS Medicare Part B that are billed by physicians and suppliers are paid by carriers (including DMERCs).
- FIs and carriers do not, and will not, pay claims for Part D drugs. Providers should not submit claims for Part D covered drugs to FIs or carriers.
- Drugs covered under Part D are paid by Medicare Part D Drug Plans, such as Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs), for enrolled beneficiaries.
- Providers must have a contractual relationship with a Medicare Part D Drug Plan to bill these plans for drugs provided to enrolled beneficiaries. A state specific list of Medicare Part D Drug Plans can be found at <http://www.medicare.gov/medicarereform/map.asp> on the CMS website.

Highlights

This article highlights the differences in how drugs are covered and which drugs are covered by Medicare Part B and the new Medicare prescription drug coverage (Part D). It also offers additional guidance on the effect of Part D on vaccines given to Medicare patients in a physician's office. Those currently billing Medicare Part B for drugs or for vaccines may wish to pay particular attention to this article.

Drugs Covered Under Part B and Part D**Part A/B Covered Drugs Set by Statute**

Traditional Part A/B Medicare does not cover most outpatient prescription drugs. Under Part A, Medicare bundled payments made to hospitals and skilled nursing facilities (SNFs) generally cover all drugs provided during a covered Part A stay. (An exception is clotting factor supplied during a stay, which is paid separately from the bundled payment.)

Medicare also makes payments under Part B to physicians for drugs or biologicals that are **not** usually self administered.

Coverage is usually limited to drugs or biologicals **administered by infusion or injection**. If the injection is self-administered (e.g., Imitrex), it is not covered.

Physicians, healthcare professionals, providers, and suppliers may also bill Medicare Part B for other limited types of drugs as follows:

Durable Medical Equipment (DME) Supply Drugs

These are drugs that require administration by the use of a piece of covered DME (e.g., a nebulizer, or external or implantable pump). The statute does not explicitly cover DME drugs; they are covered as a supply necessary for the DME to perform its function.

The largest Medicare expenditures for drugs furnished as a DME supply are for inhalation drugs, (e.g., albuterol sulfate, ipratropium bromide) which are administered in the home through the use of a nebulizer.

The other category of drugs Medicare covers as a DME supply are drugs for which administration with an infusion pump in the home is medically necessary (e.g., some chemotherapeutic agents).

Immunosuppressive Drugs

These include drugs used in immunosuppressive therapy (such as cyclosporine) for a beneficiary who has received a Medicare covered organ transplant.

Hemophilia Clotting Factors

These include hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors.

Oral Anti-Cancer Drugs

These are drugs taken orally during cancer chemotherapy, provided they have the same active ingredients and are used for the same indications as are chemotherapy drugs that would be covered if they were not self-administered but were administered instead as incident to a physician's professional service.

Oral Anti-emetic Drugs

These are oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen as a full therapeutic replacement for an intravenous anti-emetic drug within 24 or 48 hours of chemotherapy administration depending on the drug.

Pneumococcal Vaccine

This refers to the vaccine and its administration to a beneficiary if ordered by a physician.

Hepatitis B Vaccine

This includes the vaccine and its administration to a beneficiary who is at high or intermediate risk of contracting Hepatitis B. High risk groups include the following:

- Individuals with ESRD;
- Individuals with hemophilia who received Factor VIII or IX concentrates;
- Clients of institutions for mentally handicapped individuals;
- Persons who live in the same household as a Hepatitis B Virus (HBV) carrier;
- Homosexual men; and
- Illicit injectable drug abusers.

Intermediate risk groups include staff in institutions for the mentally handicapped and workers in healthcare professions who have frequent contact with blood or blood-derived body fluids during routine work.

Influenza Vaccine

This refers to the vaccine and its administration when furnished in compliance with any applicable state law. The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Antigens

These are prepared by a physician (usually an allergist) for a specific patient. The physician or physician's nurse generally administers them in the physician's office. In some cases, the physician prepares antigens and furnishes them to a patient who has been taught to self-administer them at home.

Erythropoietin (EPO)

EPO is used for treating anemia in persons with chronic renal failure who are on dialysis.

Parenteral Nutrition

Parenteral nutrients are covered under the prosthetic benefit. They are available to beneficiaries who cannot absorb nutrition through their intestinal tract. Parenteral nutrition is administered intravenously and is regulated as a drug by the FDA.

Intravenous Immune Globulin Provided in the Home

The MMA created a benefit for the provision of intravenous immune globulin (IVIG) for beneficiaries with a diagnosis of primary immune deficiency disease. Coverage is provided if a physician determines that the administration of IVIG in the patient's home is medically appropriate. Payment is limited to that for the IVIG itself and does not cover items and services related to administration of the product.

Part B Covered Drugs in the Context of a Professional Service**Drugs Furnished "Incident to" a Physician's Service**

These are injectable or intravenous drugs that are administered predominantly by a physician or under a physician's direct supervision as "incident to" a physician's professional service. The statute limits coverage to drugs that are not usually self-administered. (If a drug is not self-administered by more than 50 percent of Medicare beneficiaries, it is considered "not usually self-administered.")

Separately Billable ESRD Drugs

Most drugs furnished by dialysis facilities are separately billable. The largest Medicare expenditures for such drugs are for erythropoietin (EPO), which is covered for dialysis beneficiaries when it is furnished by independent and hospital-based ESRD facilities, as well as when it is furnished by physicians.

Separately Billable Drugs Provided in Hospital Outpatient Departments

For Calendar Year 2005, Medicare continues to pay separately for drugs, biologicals, and radiopharmaceuticals whose median cost per administration exceeds \$50, while packaging the cost of drugs, biologicals, and radiopharmaceuticals whose median cost per administration is less than \$50 into the procedures with which they are billed.

Drugs Covered as Supplies or – "Integral to a Procedure"

Some drugs are covered as supplies that are an integral part of a procedure that is a diagnostic or therapeutic service, including radiopharmaceuticals (both diagnostic and therapeutic) and low osmolar contrast media. Other examples of drugs covered under the "integral to a procedure" provision include eye drops administered before cataract surgery.

Blood

Medicare does make separate payment for blood and blood products and these products are regulated as biological agents by the Food and Drug Administration (FDA).

GENERAL INFORMATION

Drugs Furnished as a Part of a Service in Provider Settings

Also covered are drugs furnished as a part of a service in the following provider settings:

- Drugs packaged under the Hospital Outpatient Prospective Payment System;
- Drugs furnished by ESRD facilities and included in Medicare's ESRD composite rate;
- Osteoporosis drugs provided by home health agencies under certain conditions;
- Drugs furnished by critical access hospitals' (CAH) outpatient departments;
- Drugs furnished by a Rural Health Clinic (RHC);
- Drugs furnished by Federally Qualified Health Centers (FQHC);
- Drugs furnished by Community Mental Health Centers (CMHC);
- Drugs furnished by ambulances; and
- Separately billable drugs provided in Comprehensive Outpatient Rehabilitation Facilities (CORF).

Part D Covered Drugs

Definition of a Part D Covered Drug

A Part D covered drug is a drug that is:

- Available only by prescription;
- Approved by the FDA (or is a drug described under section 1927(k)(2)(A)(ii) or (iii) of the Social Security Act);
- Used and sold in the United States; and
- Used for a medically accepted indication (as defined in section 1927(k)(6) of the Act).

A covered Part D drug includes prescription drugs, biological products, insulin as described in specified paragraphs of Section 1927(k) of the Act, and vaccines licensed under Section 351 of the Public Health Service Act. The definition also includes "medical supplies associated with the injection of insulin (as defined in regulations of the Secretary)." CMS defines those medical supplies to include syringes, needles, alcohol swabs, and gauze.

Part D Excluded Drugs

The definition of a covered Part D drug excludes any drug for which, as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual, even though a deductible may apply.

In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Medicaid under section 1927(d)(2) of the Act, with the exception of smoking cessation agents.

The drugs or classes of drugs that may currently be otherwise restricted under Medicaid include the following:

- Agents when used for anorexia, weight loss, or weight gain;
- Agents when used to promote fertility;
- Agents when used for cosmetic purposes or hair growth;
- Agents when used for the symptomatic relief of cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
- Nonprescription drugs;
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be

purchased exclusively from the manufacturer or its designee as a condition of sale;

- Barbiturates; and
- Benzodiazepines.

While these drugs or uses are excluded from basic Part D coverage, Medicare Part D drug plan sponsors can generally include them as part of supplemental benefits, provided they otherwise meet the definition of a Part D drug.

Because non-prescription drugs do not otherwise meet the definition of a Part D drug, the Part D drug plans may not include such drugs as part of supplemental benefits; however, under certain conditions as part of a plan utilization management program (including a step-therapy program), non-prescription drugs can be provided at no cost to enrollees. The cost of these drugs to the plan would be treated as administrative costs under such programs.

For more detailed information about Part B drugs and Part D coverage, please refer to the report at <http://www.cms.hhs.gov/pdps/PartBandPartDdoc-revised7-27-05.pdf> on the CMS website. This report provides excellent detail on the overall issue of Part B and Part D drugs. For example, this report discusses the following:

- Situations in which a billing entity would have to decide whether, for a given drug, to bill Part B or Part D, based on characteristics of the beneficiary or medical use of the drug;
- Situations where the form of the drug determines where it is covered; and
- Situations where Part B coverage is in the context of another service.

Vaccines Administered in a Physician's Office

This section discusses the vaccines currently covered by Medicare Part B, and includes a few commonly asked questions regarding vaccine coverage under Medicare Part B and Part D. Basically, if a vaccine is currently covered under Part B, the vaccine will remain covered under Part B when the new Part D goes into effect on January 1, 2006. Medicare Part B currently covers the following immunizations (as discussed earlier in this article):

- Pneumococcal pneumonia vaccine;
- Hepatitis B vaccine;
- Influenza virus vaccine; and
- Other vaccines (e.g., tetanus toxoid) when directly related to the treatment of an injury or direct exposure to a disease or condition.

Key Questions

Will All Vaccines be Covered under Part D, Effective January 1, 2006?

No. As just mentioned, if a vaccine was previously covered under Part B, it will continue to be covered under Part B. If it was previously not covered, then it will need to be covered under Part D. Pneumococcal and influenza vaccines are not covered under Part D because of Part B coverage.

Hepatitis B vaccine is covered under Part B for individuals at high or intermediate risk; for all other individuals, it would be covered under a Part D benefit. All other currently available vaccines and all future vaccines would be covered under Part D, but could be subject to plan prior authorization requirements to determine medical necessity.

If a Company That Offers Medicare Part D Drug Plans Determines, Through a Prior Authorization Program, that a Hepatitis B Vaccine is Going to be Administered by a Physician, Can This Company Deny the Claim Based on Part B Coverage in the Setting?

No. Since the Part B benefit for Hepatitis B vaccine is separate from the “incident to” benefit, the determination about whether it is a Part D drug depends solely on characteristics of the beneficiary.

However, if the plan sponsor determines based on Medicare Part B guidelines that the individual is at high or medium risk for Hepatitis B, the company should deny the claim.

For all other individuals, the vaccine would be a “Part D drug,” and would be covered unless the plan had otherwise established medical necessity criteria for the vaccine as part of its approved prior authorization program. In this case, only low risk individuals who meet the plan’s criteria would be eligible to receive the vaccine.

Additional Information

Websites for Part B and Part D Coverage Information

Medicare Claims Processing Manual http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp
 Medicare Benefit Policy Manual http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp

Medicare Coverage Database

<http://www.cms.hhs.gov/mcd/search.asp>

Carrier, DMERC, and Fiscal Intermediary Contacts by Region

<http://www.cms.hhs.gov/medlearn/tollnums.asp>

Medicare Drug Information Resource

<http://www.cms.hhs.gov/providers/drugs/default.asp>

Hospital Outpatient Prospective Payment System 2005

<http://www.cms.hhs.gov/providers/hopps/fr2005.asp>

Palmetto GBA <http://www.palmettogba.com>

AdminaStar <http://www.adminastar.com>

CIGNA <http://www.cignamedicare.com>

National/Local Coverage Determinations

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

Medicare Part B versus Part D Coverage Issues <http://www.cms.hhs.gov/pdps/PartBandPartDdoc-revised7-27-05.pdf>

Medicare Prescription Drug Coverage Information for Providers

<http://www.cms.hhs.gov/medlearn/drugcoverage.asp>

Prescription Drug Plans <http://www.cms.hhs.gov/pdps/>

Medlearn Matters Number: SE0570

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Medicare Prescription Drug Coverage Information

Reminder: Please join CMS officials every Tuesday at 2pm EST for the Physician/Part D implementation Open Q&A conference call. 1-800-619-2457 Pass code: RBDML. This call is intended for physicians and other prescribers, we have similar weekly conference calls for pharmacies and long term care.

Medicare prescription drug coverage is here. Retail pharmacies filled several hundred thousand Medicare prescriptions on January 1st alone. The Centers for Medicare & Medicaid Service (CMS) staff and the Prescription Drug Plans (PDPs) have been working around the clock to fix problems and refine processes. Pharmacists have become “Part D experts” and have made the benefit work despite the inevitable challenges associated with the first few days of a huge new program. The CMS recognizes the important role physicians and other health care professionals have played in helping people learn about the new benefit and we appreciate your efforts this fall to help us raise awareness and educate people with Medicare about this new program.

To help you care for your patients and easily obtain information about Part D formularies and whether a specific drug is covered by a Part D plan, Epocrates, Inc. has provided Part D formulary information through their free Epocrates Rx[®] software, which is available through their web-based system or hand-held Personal Digital Assistant (PDA) system. This is online and operational as of now and can be accessed through <http://www.epocrates.com>. For those physicians and office managers that don’t use PDAs, Epocrates also has an easy to use web interface. This free feature allows anyone to review formularies using any computer with an Internet connection. <http://www2.epocrates.com/products/online/>.

CMS has also created a web-based formulary finder:

<http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp>. The CMS Formulary Finder provides a list of all Part D plans in a given state and links directly to a plan’s home page for a complete formulary. It also provides general information about a plan’s drug utilization and appeals process. In mid-January the CMS Formulary Finder will be linked directly to individual plan formularies.

It is important to note that during January all plans will have a transition process that will allow enrollees to continue their current drugs. During this period, the physician can work with their patients to adjust drugs to new formularies or request formulary exceptions. We sincerely appreciate your efforts in helping us provide important prescription drug coverage to people with Medicare.

Source: Provider Education Resources Listserv, Message 200601-2

GENERAL INFORMATION

Appeals of Claims Decisions: Redeterminations and Reconsiderations

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare for services

Provider Action Needed

Medicare providers who appeal claims decisions made by Medicare carriers and fiscal intermediaries (FIs), including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs), need to be aware of the new appeals processes.

Background

The purpose of CR3944 is to notify Medicare contractors (FIs or carriers, including DMERCs) and Medicare providers about the upcoming transition to the new second level of the appeals process.

The **"redetermination"** is the first level of appeal. It is a second look at the Part A or B claim and supporting documentation by an employee of the contractor (Medicare carrier or intermediary) who was not involved in the initial claim determination. In performing a redetermination of the services requested by the appellant, Medicare contractor personnel must examine all issues in the claim.

The Medicare claims appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new, second level in the administrative appeals process, called a **"reconsideration."** This new **"reconsideration"** is different from the previous first level of appeal for Part A claims performed by FIs. These appeals are processed by Qualified Independent Contractors (QICs).

Additional Information

Rather than repeat the extensive details of CR3944 in this article, the Centers for Medicare & Medicaid Services (CMS) encourages physicians, providers, and suppliers who wish to appeal an initial determination of a Medicare claim made by a Medicare carrier or FI to review CR3944. The new/ revised manual sections of Chapter 29 of the *Medicare Claims Processing Manual* that are attached to CR3944 contain many important details for those wishing to file claims determination appeals. You can find CR3944 by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website.

From that Web page, look for CR3944 in the CR NUM column on the right, and click on the file for that CR.

If you bill a Medicare FI, you may also wish to review Medlearn Matters article MM3530 and/or CR3530.

They are available as follows:

Med learn Matters article MM3530 MMA, "Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title-Appeals Transition – BIPA521 Appeals), is available at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3530.pdf> on the CMS website.

CR3530, "Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title-Appeals Transition – BIPA 521 Appeals), is available at http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf on the CMS website.

In addition, if your request for a redetermination is dismissed by the Medicare contractor, you may wish to understand your appeal rights with regard to that dismissal. These rights are discussed in CR3939, which can also be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. Once at that page, look for CR3944 in the CR NUM column on the right and click on the file for that CR.

Please refer to your local FI, carrier, or DMERC if you have questions on this issue. To find their toll-free phone numbers, 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).

Related Change Request (CR) #: 3944

Medlearn Matters Number: MM3944

Related CR Release Date: September 23, 2005

Related CR Transmittal #: 688

Effective Date: May 1, 2005, for appeals of claims submitted to Medicare intermediaries and January 1, 2006, for appeals of claims submitted to carriers

Implementation Date: December 16, 2005, for Medicare

intermediaries and January 1, 2006, for Medicare carriers

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

Appeals of Claims Decisions: Redeterminations and Reconsiderations and Appeals Rights for Dismissals

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

Provider Types Affected

Physicians, providers, and suppliers who appeal initial claims determinations by Medicare

Provider Action Needed

The purpose of CR3939 is to notify Medicare contractors (fiscal intermediaries (FIs) or carriers, including durable medical equipment regional carriers (DMERCs)) and Medicare providers about the upcoming transition to the new second level of the appeals process.

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a “reconsideration.” This new “reconsideration” is different from the previous first level of appeal for Part A claims performed by FIs. Reconsiderations will be processed by Qualified Independent Contractors (QICs).

Rather than repeat the extensive details of CR3939 in this article, the Centers for Medicare & Medicaid Services (CMS) encourages physicians, providers, and suppliers who wish to appeal an initial determination of a Medicare claim made by a Medicare carrier or FI to review CR3939. The new/ revised manual sections of Chapter 29 of the Medicare Claims Processing Manual that are attached to CR3939 contain many important details for those wishing to file claims determination appeals. You can find CR3939 by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website.

From that Web page, look for CR3939 in the CR NUM column on the right, and click on the file for that CR.

The key new or revised sections contained in CR3939 include information on:

- Filing a request for redetermination;
- Appeal rights for dismissals of redetermination requests, including sample dismissal letters and notices;
- Filing requests for reconsiderations, the second level of appeal;
- Time limits for filing reconsideration requests; and
- How reconsideration decisions are effectuated.

If you bill a Medicare FI, you may also wish to review Medlearn Matters article MM3530 and/or CR3530.

They are available as follows:

Medlearn Matters article MM3530 MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries (CR Title-“Appeals Transition – BIPA 521 Appeals”) is available at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3530.pdf> on the CMS website.

CR3530 Revisions to Medicare Appeals Process for Fiscal Intermediaries (CR Title-“Appeals Transition – BIPA 521 Appeals”) is available at http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf on the CMS website.

Please refer to your local FI, carrier, or DMERC if you have questions on this issue. To find their toll free phone numbers 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).

Related Change Request (CR) #: 3939

Medlearn Matters Number: MM3939

Related CR Release Date: October 21, 2005

Related CR Transmittal #: 724

Effective Date: January 1, 2006, for appeals of initial determination of claims by Medicare carriers; May 1, 2005, for initial claim determinations by Medicare Fiscal Intermediaries (FIs) Implementation Date: December 16, 2005, for FIs and January 1, 2006, for carriers

CMS Makes First Awards to Medicare Administrative Contractors

CONTRACTING REFORM WILL LOWER ADMINISTRATIVE COSTS, IMPROVE QUALITY AND SERVICE FOR DURABLE MEDICAL EQUIPMENT BENEFITS

The Centers for Medicare & Medicaid Services (CMS) announced today that it has awarded contracts for four specialty contractors who will be responsible for handling the administration of Medicare claims from suppliers of durable medical equipment, prosthetics and orthotics. The new contracts awarded represent a first step in CMS’ initiatives designed to improve service to beneficiaries and providers, support the delivery of coordinated and quality care, and provide greater administrative efficiency and effectiveness for fee-for-service Medicare.

To view the entire press release, please visit <http://www.cms.hhs.gov/apps/media/press/release.asp?counter=1749>

Source: Provider Education Resources Listserv, Message 200601-2

Change in the Amount in Controversy Requirements for Administrative Law Judge and Federal District Court Appeals

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an annual reevaluation, beginning in 2005, of the dollar amount in controversy required for an administrative law judge (ALJ) hearing or federal district court review. The amount in controversy increases by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved.

Based on this regulation, **effective January 1, 2006**, the amount in controversy for an ALJ hearing request will increase to \$110.00, and the amount in controversy for a federal district court review will increase to \$1,090.00.

For ALJ hearing requests made **before January 1, 2006**, the amount in controversy remains \$100.00, and the amount in controversy for a federal district court review requested **prior to January 1, 2006**, remains \$1,050.00.

Source: CMS Pub. Joint Signature Memorandum 06034, October 31, 2005

Changes to Chapter 29 – General Appeals Process in Initial Determinations

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

Provider Types Affected

Physicians, providers, and suppliers who submit Part A or Part B fee-for-service claims to Medicare

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. It is different from the previous first level of appeal for Part A claims performed by fiscal intermediaries (FIs). Reconsiderations will be processed by qualified independent contractors (QICs).

CR4019 focuses on the general appeals process in initial determinations. CR4019 contains a considerable amount of information that is pertinent to the entire process of Medicare claims appeals, and focuses specifically on the additions of Sections 200 to 260 to Chapter 29 of the *Medicare Claims Processing Manual*.

Key Points

Centers for Medicare & Medicaid Services (CMS) Decisions Subject to the Administrative Appeals Process

The Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. These decisions are subject to appeal with the SSA.

Minor Errors and Omissions

Providers should be aware that there is no need to appeal a claim if the provider has made a minor error or omission in filing the claim, which, in turn, caused the claim to be denied. In the case where a minor error or omission is involved, the provider can request that the Medicare contractor reopen the claim so the error or omission can be corrected, rather than having to go through the appeals process.

Who May Appeal

CR4019 (Additions to Chapter 29) defines and describes the individuals and entities who have the right to appeal a Medicare contractor’s initial determination. (Medicare contractors are carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs).) An individual who has a right to appeal is referred to as a “party.”

Provider or Supplier Appeals When the Beneficiary Is Deceased

When a provider or supplier appeals on behalf of a deceased beneficiary, and the provider or supplier otherwise does not have the right to appeal, it is the contractor’s responsibility to determine whether another party is available to appeal. CR4019 describes what must be done in this situation.

Parties to an Appeal

Any of the persons/entities who may appeal Medicare’s decision to deny or reduce payment are parties to an appeal of a claim for items or services payable under Part A or Part B.

Steps in the Appeals Process: Overview

The process of appeal described in CR4019 is effective for all redeterminations issued on or after May 1, 2005, by Medicare FIs and all redeterminations issued on or after January 1, 2006, by carriers. The appeals process consists of five levels. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal. No appeal can be accepted until an initial determination has been made for the claim. The following chart outlines the steps in the Medicare appeal process:

The Medicare Fee-for-Service Appeals Process

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold to be Met or Amount in Controversy (AIC)
1. Redetermination			
Performed by the Medicare Contractor	120 days from date of receipt of the notice initial determination (MSN or RA). (The notice of initial determination is presumed to be received five days from the date of the notice unless there is evidence to the contrary.)	Part A – FI (MAC) Part B – Carrier (MAC)	None
2. Reconsideration			
<ul style="list-style-type: none"> Performed by QIC Case file prepared by the Medicare contractor and forwarded to the QIC.** Medicare contractor may have effectuation responsibilities for decisions made by the QIC. 	180 days from date of receipt of the redetermination	Part A and B – QIC	None
3. Administrative Law Judge (ALJ) Hearing			
<ul style="list-style-type: none"> Case file prepared by the QIC and forwarded to the HHS Office of Medicare Hearings and Appeals (OMHA). Medicare contractor may have effectuation responsibilities for decisions made at the ALJ level. 	60 days from the date of receipt of the reconsideration notice	Part A and B – HHS OMHA Field Office	At least \$100 remains in controversy*** <i>For requests made on or after January 1, 2006, at least \$110 remains in controversy</i>
4. Departmental Appeals Board (DAB) Review			
<ul style="list-style-type: none"> Contractor may have effectuation responsibilities for decisions made at the DAB level. 	60 days from the date of receipt of the ALJ hearing decision/dismissal	Part A and B – DAB	None
5. Federal Court (Judicial) Review			
<ul style="list-style-type: none"> Medicare contractor may have effectuation responsibilities for decisions made at the Federal Court level. 	60 days from date of receipt of DAB decision or declination of review by DAB		At least \$1,050 remains in controversy*** <i>For requests made on or after January 1, 2006, at least \$1,090 remains in controversy</i>

*Where to Appeal - Part A includes Part B claims filed with the FI.

** In accordance with the appropriate manual section and the Joint Operating Agreement (JOA).

***Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy (AIC) requirement will increase by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of \$10 will be rounded to the nearest multiple of \$10.

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Where to Appeal

Where a party must file an appeal depends on the level of appeal. The above chart indicates where appellants should file appeal requests for each level of appeal.

When to Appeal – Time Limits for Filing Appeals and Good Cause for Extension of the Time Limit for Filing Appeals

The time limits for filing appeals vary according to the type of appeal. The table above indicates the time limits for filing appeal requests for each level of appeal. These time limits may be extended if good cause for late filing is shown.

Good Cause - General Procedure to Establish Good Cause for Late Filing

Procedures to establish good cause are effective for all requests for redeterminations received by FIs on or after May 1, 2005, and all requests for redeterminations received by the carrier on or after January 1, 2006.

The new Section 240 of Chapter 29 of the *Medicare Claims Processing Manual* lists the general procedure for establishing good cause for late filing; when a favorable decision for good cause is made; and when an unfavorable decision for good cause is made. A listing of conditions and examples that may establish good cause for late filing by beneficiaries, or by providers, physicians, and suppliers, can be found in Section 240, which is attached to CR4019.

Amount in Controversy (AIC) Requirements

The AIC requirements apply only to the ALJ and Federal Court Levels. The chart above indicates the AIC as well as the method of calculating the AIC, for the Medicare appeals process.

Additional Information

The official instruction issued to your FI or carrier 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 CR4019 in the CR NUM column on the right, and click on the file for that CR. All of the new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR4019. These sections provide excellent detail that explains the revised appeals process.

Please refer to your local FI or carrier for more information 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).

Related Change Request (CR) #: 4019
Related CR Release Date: October 7, 2005
Effective Date: May 1, 2005

Medlearn Matters Number: MM4019
Related CR Transmittal #: 695
Implementation Date: January 9, 2006

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Documentation and Coding Guidelines for Medicare's 2006 Oncology Demonstration

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

Provider Types Affected

Hematologists and oncologists participating in the 2006 demonstration

Provider Action Needed

This *Medlearn Matters* Special Edition article should be viewed in conjunction with *Medlearn Matters* article MM4219, which relates to Change Request (CR) 4219.

That CR, titled "2006 Oncology Demonstration," informs the Medicare carriers about the Medicare policy and claims processing procedures applicable to the 2006 Oncology Demonstration. MM4219 may be found at

<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4219.pdf> on the CMS website.

Medicare makes additional payments on claims submitted related to this demonstration when those claims contain the requisite information for making that additional payment, and the claims are submitted in conjunction with a qualifying visit. As noted in CR4219, a separate *Medlearn Matters* Special Edition article would be written to provide the oncology community with additional information on documentation and coding guidelines. This *Special Edition* article is for that specific purpose.

Background

Overview

The purpose of the 2006 oncology demonstration project is to capture the spectrum of services oncologists provide to Medicare beneficiaries with the listed cancers in SE0589 and CR 4219. Another purpose is to determine to what extent practice guidelines parallel care that hematologists/oncologists provide.

To those ends, the demonstration project is asking what the primary focus is of each evaluation and management (E & M) visit (to capture the spectrum), and with respect to that primary focus, whether or not the care follows practice guidelines.

Participation

Participation in this project 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. The demonstration only applies to E & M visits with patients who have a diagnosis in one of the 13 listed categories, and where the primary focus of the visit is management of that cancer, its complications, and the complications of its treatment. Eligible visits should include

an ICD-9 code on the claim for one of the included cancers, and that cancer should be the first listed cancer diagnosis on the claim form. The cancer does not need to be the first listed diagnosis of any kind on the claim form.

Medicare does make additional payment on claims containing the necessary information requested in this demonstration. Three separate G codes, one from each category, must be supplied for each submission to qualify for that payment –i.e., one code for disease status, one for the primary focus of the visit, and one for guideline adherence.

Documentation

Physicians must identify the appropriate G-code for:

- Primary focus of visit
- Current disease state
- Adherence to guidelines

Physicians must also supply documentation in the patient chart in order to bill for the demonstration as described below. Local Medicare carriers have been advised that further documentation requirements are not to be imposed.

One alternative, that fully satisfies the documentation requirements, is to identify the source of the guideline (the American Society of Clinical Oncology, National Comprehensive Cancer Network, both, or “no guideline available”) consulted for reporting of guideline adherence and annotating the chart to reflect that source, using a phrase such as:

- Demonstration project – ASCO;
- Demonstration project – NCCN;
- Demonstration project – ASCO & NCCN, or BOTH;
- Demonstration project – No guideline available, or NONE or;
- Demonstration project – Clinical Trial, or CT.

Reporting the title of the specific guideline that was consulted is not required.

“Demonstration Project – Clinical Trial” should be used when the patient is on an IRB-approved clinical trial relevant to the service delivered during that visit.

Physicians do not have to provide additional documentation in the patient record beyond the elements listed above.

An alternative approach to documentation would be to use a template (e.g., “a flowsheet”), which would also fulfill all requirements under the demonstration. An example of such a template is included at the end of this article. The use of a documentation template such as the example provided fulfills all documentation requirements under the demonstration. If such a template is used, then physicians do not have to provide any additional documentation in the patient record. Local carriers are instructed to not impose additional documentation requirements.

Coding Guidance

Intent of the coding guidance

CMS is issuing this guidance to help ensure that reporting throughout the oncology community is consistent and data are meaningful. The guidance issued below is intended to clarify some of the distinctions between codes, and contextualize them within the general goals of the demonstration project.

Primary Focus of the Visit

The primary treating physician should determine the single code that best reflects the primary focus of that E & M visit on that particular day. It is assumed that many

different issues are addressed in most E & M visits, and so physicians should make what to them seems the best choice. A narrative description of each code and a theoretical example follow.

G9050 Oncology Work-up Evaluation

This code should be used for visits where the patient is being evaluated or reevaluated prior to or after a treatment course or contemplated treatment course. It is assumed that such visits occur usually when there is insufficient information about extent of disease or other characteristics of disease to support informed treatment decision making.

G9051 Oncology Treatment Decision/Treatment Management

This code should be used for all visits in which cancer directed therapy is being offered, described or discussed, therapy is being provided by the coding physician or by another physician (for instance, radiation therapy delivered at another facility), or the effect of therapy is being evaluated.

This code should also be used for visits in which the patient’s treatment course is altered (such as when doses are reduced), during treatment “holidays”, and visits where the focus is management of toxicities or complications of treatment. Cancer directed therapy includes hormonal therapies and other therapies given for extended periods of time to prevent disease recurrence or relapse.

G9052 Oncology Surveillance for Disease

This code should be used for visits for patients who:

- Have completed definitive cancer-directed therapy (surgery, radiotherapy, chemotherapy, or combination);
- Have no definitive evidence of “active” disease at present;
- In whom further treatment (surgery, radiotherapy, chemotherapy) would likely be considered in the setting of disease recurrence;
- The primary focus of the visit is coordinating and explaining disease surveillance, or interpreting and explaining the results of that surveillance.

G9053 Oncology Expectant Management of Patient

This code should be used for visits for patients who:

- Have completed definitive cancer-directed therapy, or in which such treatment has been deferred (surgery, radiotherapy, chemotherapy, or combination);
- Have suggestive radiologic, clinical, or biochemical evidence of disease;
- Would likely be offered further active treatment (surgery, radiotherapy, chemotherapy) in the setting of disease progression (at primary or distant site);
- The primary focus of the visit is coordinating and explaining expectant management, or interpreting and explaining the results of that management.

G9054 Oncology Supervision Palliative

This code should be used for visits for patients who meet the following criteria:

- Cancer-directed therapy expected to prolong life is not being provided;
- It is not expected that such cancer directed therapy would be provided or offered in the future;
- The patient has active or suspected cancer that is expected to progress;
- The primary focus of the visit is managing, coordinating and explaining disease palliation.

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coordinating and explaining disease palliation.

Cancer directed therapy aimed at palliation of symptoms might be provided or coordinated in these visits e.g., palliative radiation therapy for bone metastases or chemotherapy for symptom alleviation.

G9055 Oncology Visit Unspecified

This code should be used for visits in which the primary focus is other than any of the listed options.

A Theoretical Patient

Staging

Initial visit after diagnosis – staging eval. (G9050)

Stage established – treatment course recommended/accepted (G9051)

Therapy

Visit during/between cycles (G9051)

NED

Conclusion of treatment course – NED (G9051)

Visit to discuss/plan/interpret surveillance (G9052)

Another visit to discuss/plan/interpret surveillance (G9052)

Urgent visit for back pain – high suspicion or dz recurrence/metastases. Appropriate tests ordered (G9050)

EOD eval

Definitive evidence of metastatic disease..Treatment options discussed (G9051)

Therapy

Treatment course begun (G9051)

Treatment stopped for toxicity (G9051)

Dz progression – treatment changed (G9051)

New treatment continued (G9051)

Dz progression – palliative options (G9054)

Palliation

Coordination with palliative care (G9054)

Guideline Adherence

The treating physician should choose the single code that best reflects whether or not patient management adheres to practice guidelines, and if not, the best listed reason why not.

G9056 Oncology Practice Guidelines (Management adheres to guidelines)

Specifics about when to choose this code are discussed below in the section describing how guideline adherence should be evaluated with respect to the primary focus of the visit.

G9057 Oncology Practice Guidelines (Management differs from the guidelines as a result of enrollment in clinical trial)

This code is reserved for patients who are on an institutional review board approved clinical trial that dictates the care being provided in that visit. This will most often be relevant to visits in which the primary focus is on treatment, although some protocols may include experimental variation in evaluation, surveillance, expectant management, or palliation. If the primary focus of the visit (e.g. treatment) is the subject of the experiment, this code should be submitted. If the primary focus of the visit belongs to a category other than the one being evaluated in the clinical trial, then the treating physician should determine if that management

adheres to guidelines.

Note: NCCN guidelines specify participation in a clinical trial as a recommended management strategy. For the purposes of this demonstration, if management differs from that specified in guidelines due to the patient's enrollment on an institutional review board approved clinical trial, G9057 should be reported as described above.

G9058 Oncology Practice Guidelines (Management differs from the guidelines because the physician disagrees with the guidelines)

This code is reserved for management that differs from guidelines because the treating physician disagrees with the recommendations included in the guideline.

G9059 Oncology Practice Guidelines (Management differs from the guidelines because the patient opts for different treatment)

This code is reserved for situations in which management differs from guidelines because the patient has chosen to receive alternative therapy or no therapy, despite the physician recommending management that parallels guidelines.

G9060 Oncology Practice Guidelines (Management differs from guidelines for reasons associated with patient illness)

This code is reserved for situations in which management differs from the guidelines because the patient's performance status, co-morbid illness, or other limitations preclude the management recommended in the guidelines.

G9061 Oncology Practice Guidelines (Patient's condition not addressed by guidelines)

This code is reserved for situations in which the recommended treatment or management for the patient's specific cancer and disease status is not addressed in the guidelines.

G9062 Oncology Practice Guidelines (Management differs from guidelines for other reasons)

This code is reserved for situations in which the management differs from the guidelines for a reason not listed above.

Disease Status

The physician providing the E&M service on that day should determine the single code that best represents the disease status of the patient's cancer. The disease status code should be relevant to the cancer that is the first listed cancer diagnosis on the claim form (not necessarily the first listed diagnosis).

Note that, while there are 68 disease codes in total, for any given patient with an eligible diagnosis, a range of only 3 to 6 codes (depending on the specific diagnosis) needs to be considered.

Disease status should be based on the best available data at the time of the visit, unless otherwise specified. No additional diagnostic tests or evaluations should be performed for the purposes of further determining disease status for the purposes of this demonstration project.

Determining if Management is Adherent to Guidelines – Evaluating Guidelines based on the Primary Focus of Visit

The primary focus of the visit as documented should link to the guidelines that are to be evaluated. If the primary focus of the visit is work-up/evaluation, for instance, then the guidelines that should be referenced are those that describe the recommendations for work-up/evaluation. What

follows is a simple table and accompanying list of items to consider in the guidelines when coding for guideline adherence for a particularly focus of a visit, followed by a narrative description.

Focus of the visit	What to look for
G9050 Oncology work-up evaluation	Compare tests obtained to those recommended in guidelines
G9051 Oncology treatment decision/treatment management	Compare chemotherapy, hormonal therapy, immunotherapy, and radiotherapy treatments offered or provided to those recommended in guidelines
G9052 Oncology surveillance for disease	Compare surveillance approach, such as tests and frequency of tests, to that recommended in guidelines
G9053 Oncology expectant management of patient	Compare expectant management approach, such as tests and frequency of tests, to that recommended in guidelines
G9054 Oncology supervision of palliative therapies	Compare management of patient’s primary symptom, complaint, or complication in that visit to that recommended in guidelines
G9055 Oncology visit unspecified	Compare relevant management to relevant guidelines

G9050 Oncology work-up evaluation

When coding for guideline adherence, compare the tests listed in the guidelines for initial diagnosis or evaluation of recurrence to what is being ordered for the patient. If largely similar, with most or all recommended tests ordered/obtained and few or no tests ordered/obtained that are not recommended, code that management adheres to practice guidelines

G9051 Oncology treatment decision/treatment management

When coding for guideline adherence, compare the active cancer directed treatments (specifically chemotherapy, hormonal therapy, immunotherapy and/or radiotherapy) that are being discussed, considered, offered, or provided to those recommended in the guidelines. If treatment(s) that are recommended are being offered or provided, and treatment(s) that are not recommended are not being offered or provided, then code that management adheres to practice guidelines.

1. Chemotherapy, hormonal therapy, and immunotherapy treatments that are offered or being provided should be considered to parallel guidelines if they are being provided as part of a recommended combination, at the doses and for the number of cycles or duration that is recommended (or at reduced doses or number of cycles for patient specific reasons), and as the “line” of therapy that is recommended.
2. Radiotherapy should be coded as adherent to guidelines if the patient has been recommended to receive radiotherapy, been referred for radiotherapy, or is receiving/has received radiotherapy.
3. If multi-modality therapy is recommended, treatment should be coded as adherent to guidelines if all modalities are offered or provided, meeting the criteria listed in 1 and 2 above.

Note: Surgical therapy is not a focus of this demonstration project, so the treating physician is not expected to assess the appropriateness of surgical care in the context of guidelines for the purpose of identifying the appropriate G code.

G9052 Oncology surveillance for disease

When coding for guideline adherence, compare the tests and frequencies listed in the guidelines for disease surveillance with the tests and frequencies recommended in the guidelines. If largely similar, with most or all recommended tests ordered/obtained at approximately the recommended intervals, and few or no tests ordered/obtained that are not recommended, code that management adheres to practice guidelines

G9053 Oncology expectant management of patient

When coding for guideline adherence, compare the tests and frequencies listed in the guidelines for expectant management with the tests and frequencies recommended in the guidelines. If largely similar, with most or all recommended tests ordered/obtained at approximately the recommended intervals, and few or no tests ordered/obtained that are not recommended, code that management adheres to practice guidelines.

G9054 Oncology supervision of palliative therapies

When coding for guideline adherence in association with this code, the relevant guidelines on supportive care and palliation should be consulted. High quality palliative care is by its nature multi-dimensional in nature, making its delivery challenging, and making coding for guideline adherence burdensome. To simplify participation in the demonstration project, the coding physician should report whether the patient’s primary symptom, complaint, or complication that is being managed in that visit is being managed according to practice guidelines, as judged by the treating physician.

G9055 Oncology visit unspecified

When coding for guideline adherence in association with this code, the guidelines covering the relevant service should be consulted, or if no guidelines exist, that should be reported.

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Additional Information

For additional information, please see *Medlearn Matters* article MM4219, which can be viewed at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4219.pdf> on the CMS website. CR4219, the official instruction issued to your carrier may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R36DEMO.pdf> on the CMS website.

Example of a Documentation Flowsheet

On the following page, there is an example of a flowsheet that could be included in the chart of a patient with breast cancer. Hypothetical data have been entered for one visit, occurring on January 1, 2006.

To use this flowsheet, the treating physician, for a visit on a particular day, checks one code from each of first two areas, and annotates the flowsheet to designate the guideline that was consulted for that visit next to the relevant code in the guideline adherence category.

Completed in this manner, this flowsheet would satisfy all documentation requirements.

The source of the guideline can be annotated as follows: American Society of Clinical Oncology (ASCO), National Comprehensive Cancer Network (NCCN), both guidelines consulted (BOTH), no guideline available (NONE), patient on Clinical Trial (CT).

Date 1/1/06	Primary Focus of Visit	
	G9050	Work-up, evaluation, or staging at the time of cancer diagnosis or recurrence
X	G9051	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	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	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	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	Other, unspecified service not otherwise listed
	Disease State	
	G9071	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
X	G9072	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	Invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; Stage IIIA-IIIIB; and not T3, N1, M0; and ER and/or PR positive; with no evidence of disease progression, recurrence, or metastases
	G9074	Invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; Stage IIIA-IIIIB; and not T3, N1, M0; and ER and PR negative; with no evidence of disease progression, recurrence, or metastases
	G9075	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	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
	Practice Guideline Use	
ASCO	G9056	Management adheres to guidelines
	G9057	Management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial
	G9058	Management differs from guidelines because the treating physician disagrees with guideline recommendations
	G9059	Management differs from guidelines because the patient, after being offered treatment consistent

Date 1/1/06	Primary Focus of Visit	
	G9060	with guidelines, has opted for alternative treatment or management, including no treatment Management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines
	G9061	Patient's condition not addressed by available guidelines
	G9062	Management differs from guidelines for other reason(s) not listed

Medlearn Matters Number: SE0588

Related Change Request (CR) #: 4219

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Implementation Date: N/A

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

Hurricanes Katrina and Rita -Transportation of Evacuees with Medical Needs

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 transportation services provided to evacuees of Hurricanes Katrina and Rita

Provider Action Needed

STOP – Impact to You

This Special Edition article provides a summary of the Department of Health and Human Services (DHHS) Fact Sheet regarding the transportation of Hurricanes Katrina and Rita evacuees with medical needs.

CAUTION – What You Need to Know

If you made your own medical transportation arrangements, prior to or after the DHHS established the HHS Medical Travel Center services contract, then the normal Medicare coverage rules apply

GO – What You Need to Do

As you receive inquiries from providers or beneficiaries seeking to discharge a patient (or to help those patients return home), you should provide them with the information contained in this special edition article. Please review the questions and answers at the end of this special edition article, and take appropriate action to use the instructions in your claims submissions.

Background

The Centers for Medicare & Medicaid Services (CMS) is providing this Special Edition article to give you important information regarding the transportation of Hurricanes Katrina and Rita evacuees with medical needs. This special edition article:

- Explains the HHS Medical Travel Center services;
- Defines which individuals are eligible for medical transportation;
- Provides information for beneficiaries;
- Defines the role of the Discharge Planner;
- Describes the different types of transfers; and
- Provides a list of transportation-related Questions and Answers directed to patients, providers, Medicare carriers and FIs, and Discharge Planners.

Hurricane Evacuation

Because of Hurricanes Katrina and Rita, many people were forced to evacuate their homes and healthcare facilities in Texas, Mississippi, and Louisiana.

Evacuees included many Medicare beneficiaries, including some with serious and/or ongoing medical needs, and assisting these evacuees has included dealing with significant difficulties and has raised questions regarding:

- The logistics of transporting the patients back to their home states, and
- The costs and billing for these medical transportation services.

In response to these and many more questions, DHHS created a Fact Sheet to provide information and answer frequently asked questions regarding certain issues resulting from Hurricanes Katrina and Rita.

The DHHS Fact Sheet provides instructions and answers questions pertaining to the provision of transportation for evacuees from Texas, Louisiana, and Mississippi who:

- Are currently patients in healthcare facilities,
- Have out-patient/on-going medical needs, or
- Were evacuated by air lift out of their home state.

Note: The DHHS Fact Sheet may be viewed at <http://www.hhs.gov/katrina/factsheet.html> on the DHHS website.

In many counties and parishes in Texas, Mississippi, and Louisiana, the healthcare infrastructure will not support the return of evacuees with medical needs. Evacuees may need to continue to shelter in their host state, or travel to an interim location to be closer to friends and family until Texas, Mississippi, and Louisiana can support their return.

Texas is currently accepting the return of patients and those evacuees with ongoing medical needs to select counties in Texas.

Mississippi is currently accepting the return of patients and those evacuees with ongoing medical needs to select counties in Mississippi.

Louisiana is:

- Accepting the return of evacuees who are currently patients in healthcare facilities on a case-by-case basis only. All healthcare facilities in Louisiana are responsible for gaining approval from the Louisiana Department of Health and Hospitals before accepting the transfer of evacuees into the state. If there is not a receiving facility available, the evacuee may access transportation to an interim location in another state where family and friends may reside.
- NOT accepting the return of evacuees with medical needs who are not patients at healthcare facilities. When Louisiana determines it is able to support the return of evacuees with out-patient/on-going medical needs, additional guidance will be disseminated.

HHS Medical Travel Center

The DHHS established a transportation program to support the return of evacuees with medical needs from Texas, Mississippi and Louisiana. The HHS Medical Travel Center is under contract with HHS to arrange transportation for evacuees who require en-route medical care and/or medical transport to include a non-medical attendant to an institution or to a private residence, as appropriate.

If the evacuee's originating medical facility is not available in their home state or if their residence and community medical infrastructure is not suitable, evacuees will be allowed to travel to an interim location in the continental United States.

The HHS Medical Travel Center will then return the evacuee to their home of record when a medical facility there is available, or they can return to a safe community/home environment.

The HHS Medical Travel Center provides transportation services without cost to providers. Providers (and patients) who use the HHS Medical Travel Center services will not incur any charge, and they should not bill Medicare. The HHS Medical Travel Center will be paid directly by HHS as per its contract.

The HHS Medical Travel Center can be reached at 1-866-753-9344. The phone lines are open everyday 7:00 a.m. to 5:00 p.m. Central Daylight Time (CDT).

Before contacting the HHS Medical Travel Center or their home state, all medical evacuees must register with the Federal Emergency Management Agency (FEMA) and obtain a Disaster Registration Number from the FEMA Registration Center at 1-800-621-FEMA. This phone line is operational 24 hours a day, 7 days a week.

Important Information for Discharge Planners

For evacuees in health care facilities or special needs shelters with a discharge planner, the discharge planners are responsible for:

- Determining if an evacuee must be transferred to a receiving facility or can be discharged to a private residence;
- Identifying a receiving facility/residence in the evacuee's home state or an interim state if necessary;
- Determining the evacuee's medical requirements during transport; and
- Arranging for a FEMA registration number for the evacuee and any non-medical assistants.

Facility to Facility Transfer

Once the discharge planner has completed these tasks, they may contact the HHS Medical Travel Center to arrange for medical transportation. In order to complete the transportation process, discharge planners must complete and submit a Documentation of Medical Necessity form provided by the HHS Medical Travel Center. This form will be provided planners when they call the HHS Medical Travel Center, and it is available at <http://www.hhs.gov/katrina> on the HHS website.

Facility to Non-Facility Transfer

If the discharge planner determines that the evacuee can be discharged to a residence, the discharge planner must call the evacuee's home state, which will be acting as a receiving point of contact. Please see below for information on how to contact the evacuee's home state.

Evacuees in a Shelter, Hotel, or Private Home

Evacuees should call their home state to access transportation if they:

- Have medical needs, and
- Are sheltering in a hotel, private residence, or other facility that **cannot provide discharge planning**.

Guidance from the Home State

The evacuee's home state will determine if the evacuee can ride commercial transportation and if their state medical system can support their ongoing medical needs. If the state medical system cannot support the evacuee's ongoing medical needs, the home state will help the evacuee find an interim location in another state, if appropriate.

Texas

Texas evacuees with medical needs may contact the 2-1-1 telephone service (if calling within Texas) or 1-888-312-4567 (if out-of-state) to initiate access to appropriate transportation and receive an evaluation of the community medical infrastructure to support the return. The Texas phone lines are open everyday 8:00 a.m. to 5 p.m., Central Daylight Time (CDT).

Mississippi Department of Health

Mississippi evacuees with medical needs may contact the Mississippi State Health Department at 601-576-7300 to initiate access to appropriate transportation. The Mississippi phone lines are open Monday to Friday 8:00 a.m. to 5 p.m., Central Daylight Time (CDT).

Louisiana Department of Health and Hospitals

Louisiana is not currently accepting the return of evacuees with out-patient and/or ongoing medical needs. Evacuees from Louisiana with medical needs sheltering in a hotel, residence or other facility that cannot provide discharge planning must have their current medical attendant or family member contact the HHS Medical Travel Center to initiate access to appropriate transportation.

The evacuee's medical attendant must complete and submit a Documentation of Medical Necessity form provided by the HHS Medical Travel Center to complete the transportation process. This form will be provided for the evacuee's medical attendant when they call the HHS Medical Travel Center or is available online at <http://www.hhs.gov/katrina> on the HHS website. If a family member is completing this form for the patient, it must be signed by the patient's current local healthcare provider.

Questions and Answers (Q&As)

Below are frequently asked questions about the transportation of Hurricane Katrina and Rita evacuees. CMS will be posting these Q & As at <http://www.cms.hhs.gov/hki> on the CMS website:

Q1. What is the first step in the process no matter what category of evacuee I am?

A1. Register for Disaster Assistance and obtain a FEMA Disaster Registration number via 1-800-621-FEMA.

Q2. What if the evacuee or patient I am arranging care for doesn't have a FEMA Disaster Registration number?

A2. Call the FEMA Registration Center at 1-800-621-FEMA to register for Disaster Assistance and obtain a FEMA Disaster Registration number.

Q3. Will this travel system arrange transportation for National Disaster Medical System (NDMS) patients as well as those persons who became patients in similar facilities after evacuating?

A3. Yes, the HHS Medical Travel Center will arrange transportation for all evacuees that currently require en-route medical care and/or medical transport, back to their home state or to an interim state. Discharge planners at medical facilities/shelters should contact the HHS Medical Travel Center to arrange for transportation of their evacuees.

Evacuees from Texas and Mississippi with medical needs who do not have a discharge planner should contact their home state. Evacuees from Louisiana with medical needs who do not have a discharge planner should contact the HHS Medical Travel Center and will need their healthcare provider to complete the forms.

Q4. Will evacuees or medical facilities incur any transportation costs using this travel system?

A4. The HHS Medical Travel Center covers all transportation costs; there will be neither bills nor co-pays and no insurance forms will be necessary.

Evacuees who can travel via commercial transportation must make their own arrangements to the airport or station.

Q5. Can a healthcare facility be reimbursed by the HHS Medical Travel Center for transportation arrangements already made? Can a healthcare facility make transportation arrangements for evacuees in the future and be reimbursed by the HHS Medical Travel Center?

A5. No. The HHS Medical Center will not reimburse facilities or states that have already made transportation arrangements for evacuees. All future transportation arrangements for evacuees should be made through the HHS Medical Travel Center or appropriate state system.

Q6. What are the criteria for deciding if an evacuee needs enroute medical care and/or medical transportation, and who makes this determination?

A6. If the evacuee is currently a patient at a medical facility and has a discharge planner coordinating their transportation, the healthcare facility discharge planner will determine if the evacuee requires medical transportation.

If the evacuee is not sheltering at a facility with discharge planning, the evacuee's home state or, in the case of Louisiana, the evacuee's medical attendant or accompanying family member, will determine if the evacuee is able to travel via commercial air or ground transportation.

Commercial airlines are very flexible in accepting people with such medical needs as oxygen and wheelchairs. If that is all that is required, a routine commercial flight will be arranged by FEMA for the evacuee and their family members if the evacuee meets the necessary qualifications.

Q7. Will the HHS Medical Travel Center perform discharge planning or provide clinical validation of evacuees?

A7. No. The discharge planners in the healthcare facilities and/or the evacuee's home state will provide that function PRIOR to movement. The HHS Medical Travel Center will provide safe, efficient, and effective medical transport en-route.

Q8. Who arranges for the discharge planning of evacuees, including destination, special medical equipment required, or other relevant transportation concerns?

A8. The discharge planners of the healthcare facility in which the evacuee resides should coordinate all arrangements for the evacuee with the receiving institution.

This includes working with the evacuee's home state, hospital, and/or nursing home to identify a receiving institution if the originating facility is not able to receive patients. Evacuees without discharge planners will need to contact their home state for assistance.

Q9. What if an evacuee requires en-route medical care and/or medical transport and has multiple accompanying family members (who are also evacuees) who must return with the evacuee?

A9. The HHS Medical Travel Center will provide a medical attendant to support en-route medical care if required. The HHS Medical Travel Center will make all reasonable efforts to accommodate at least one family member during medical transport. If the HHS Medical Travel Center is unable to do so, a separate transportation program will attempt to ensure family members will travel to the destination along a similar schedule. Both of these systems require all travelers to have a FEMA Disaster Registration Number.

Q10. If an evacuee is living in a hotel or a home (and therefore does not have a discharge planner) and has medical needs (e.g., requires oxygen or stabilized transport), how does the evacuee arrange for travel home?

A10. With the exception of Louisiana citizens, evacuees can call their home state to access travel arrangements. Their home state will act as their discharge planner and will determine if the evacuee can travel via commercial air or ground

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transportation and work with the evacuee to ensure that the medical infrastructure in their home community is ready to accept them. If the evacuee's home state determines that they can travel via commercial means, a separate transportation program will arrange their transportation. If the evacuee cannot travel by commercial means, the HHS Medical Travel Center will arrange for their transportation.

If the evacuee is a citizen of Louisiana and is living in a hotel or a home in a host state, he or she will not be able to return to Louisiana at this time. If their medical attendant or a family member determines that they can travel via commercial means, a separate transportation program will arrange their travel to an interim state. If the evacuee cannot travel by commercial means, the HHS Medical Travel Center will arrange for their transportation to an interim state and the evacuee's medical attendant should complete the necessary paperwork for the travel.

Q11. What if the evacuee wants to return to his or her original healthcare facility and that facility is not able to receive patients?

A11. There are three potential options if the originating facility is not able to receive patients:

- The evacuee's discharge planner can identify another facility within the evacuee's home state. Transportation will be provided to another suitable facility within the home state with final transportation to the originating facility to be arranged by the HHS Medical Travel Center when the originating facility is able to receive patients;
- The evacuee's discharge planner can identify a facility in an interim state where family members or other relatives or relations of the evacuee reside.
- The HHS Medical Travel Center will provide transportation to the interim state facility with final transportation to the originating facility to be arranged when it is able to receive patients; or
- The evacuee must continue to be cared for by the current host state with final transportation to the originating facility to be arranged by the HHS Medical Transport Center when the originating facility is able to receive patients.

Q12. As a discharge planner, do I have to arrange for transportation from my healthcare facility to the airfield (if aeromedical transportation is being used)?

A12. No, the HHS Medical Travel Center provides door-to-door service. See question Q4.

Q13. As a discharge planner, do I need to fill out and submit a particular discharge planning form when making travel arrangements for my patient evacuee?

A13. Yes. The HHS Medical Travel Center will fax or email you a Documentation of Medical Necessity form to complete. The information you provide on this form will help the HHS Medical Travel Center provide the necessary medical care enroute for your evacuee. This form is also available at <http://www.hhs.gov/katrina> on the HHS website.

Q14. What if a discharge planner needs to move an evacuee within the state? Do these travel systems arrange that transportation?

A14. Yes, all of these travel systems arrange for intra- and inter-state transportation.

Q15. How will hospitals and other providers be reimbursed for the medical care they provided to evacuees?

A15. Remember, with the use of the HHS Medical Travel System, there are no transportation costs associated with the return of evacuees to their home state or an interim state. However, there are many ways for providers to be reimbursed for services provided to evacuees:

Existing Health Care Insurance

Many evacuees have existing health insurance coverage. Providers should bill an evacuee's private health insurer, if one exists;

Medicare

Many evacuees are covered under the Medicare program. Providers should contact their local Medicare carrier or fiscal intermediary, if they have questions regarding Medicare reimbursement for evacuee health care.

On January 1, 2006, the Medicare prescription drug benefit begins. CMS will work closely with evacuees and those who provide insurance counseling to the elderly to ensure that those evacuees who want to enroll in a drug plan will be able to do so. We are also taking steps to let those elderly evacuees who qualify for extra help in paying for their drug costs know about the availability of this program.

National Disaster Medical System (NDMS)

Some evacuees received medical treatment via the NDMS. At the request of FEMA, CMS and DHHS is developing payment mechanisms for those patients who entered NDMS hospitals via the Federal Coordinating Centers as part of the NDMS evacuation. Specifics about how to submit claims for these patients will be made available on the CMS website (<http://www.cms.gov>).

Medicaid

Many evacuees will qualify for Medicaid, either because they were eligible in their home state, or because they are now eligible because of a loss of income and/or resources. CMS has approved Medicaid waivers for many states. Under these waivers, effective retroactively to August 24, 2005, evacuees who have been displaced from their home as a result of Hurricane Katrina will be provided the opportunity to enroll through a streamlined process to receive services under the Medicaid or SCHIP programs in whatever state they are now physically present.

Medicaid and SCHIP providers should work with their states to submit claims and receive payment. States are putting in place modifications to their current claims processing systems to accept such claims, and all payments for Medicaid and SCHIP eligible persons will be handled through the states.

Uncompensated Care

Through the waiver process mentioned above, CMS is working with states with large numbers of evacuees to put in place processes for handling those claims which would otherwise have been uncompensated. Providers should contact their state for information on how those claims will be submitted and how payments will be processed.

CMS will be providing information on these payment mechanisms on the CMS website (<http://www.cms.hhs.gov/emergency/>). CMS will also be sharing information with provider and patient-based national and state trade and professional associations, and the states via the state Emergency Operations Centers.

Note: All HHS press releases, fact sheets, and other press materials are available at <http://www.hhs.gov/news> on the HHS website.

Additional Information

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/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).

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Influenza/Flu Season and Available Resources for Providers

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

Provider Types Affected

Physicians, non-physician practitioners, providers and other health care professionals who bill Medicare carriers or fiscal intermediaries (FIs) for flu vaccines and vaccine administration.

Provider Action Needed

Special Edition 0580 is published by the Centers for Medicare & Medicaid Services (CMS) to alert providers to influenza resources that are available to them and their patients. While some of these resources are not CMS-sponsored websites or products, they are respected informational sites and products sponsored by health care professionals.

CMS Resources

The following are CMS web-based resources.

Immunization Educational Resource Web Guide

The Immunization Educational Resource Web Guide is one-stop shopping for informational and educational resources related to CMS immunization initiatives and is available at <http://www.cms.hhs.gov/medlearn/refimmu.asp> on the CMS website. Available resources include the following (click on each title to access the web site address):

Medlearn Articles

- Article MM3936 provides guidelines for payment of vaccines and their administration at Renal Dialysis facilities.
- Article MM3618 provides information about billing vaccines.

Brochures

Adult Immunizations and Hepatitis Vaccine Benefits. This is a two-sided brochure that can be downloaded and printed.

Provider Education

The following publications address Medicare preventative services:

- How to Bill Medicare for Influenza and Pneumococcal Vaccinations
- Medicare Preventive Services Educational Resource Web Guide
- Quick Reference Information: Medicare Preventive Services
- Medlearn Matters - articles intended to explain or clarify PMs (pre-10/01/2003) and CRs (10/01/2003 to present)
- Downloadable Publications Electronic versions of publications designed to aid in understanding the Medicare program
- Web-Based Training Modules (WBTs) - Training courses covering various Medicare topics, including General Program Information, Payment Policy, Preventive Services, and Office Management Information

Other CMS Resources

Other helpful CMS resources include the following:

- **2005 Administrative Fee Allowances** This publication describes the fees Medicare pays for flu vaccine administration.
- **Medicare Preventive Services Influenza/ Pneumococcal Immunizations Web Page:** This Web page contains information and resources related to Adult Immunizations including immunization data, billing and coding instructions, and other resources.
- **Fact Sheets and News Releases Regarding Medicare and Preventive Services**
- **Frequently Asked Questions**

Other Resources

The following are resources that are not CMS websites but providers may find them useful.

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American Lung Association (ALA) Flu Center

The ALA flu center site is located at <http://www.flucliniclocator.org/>. This site enables individuals to input their zip code and find a flu clinic location in their area.

Providers are able to add their flu clinic to this site by visiting <http://lungusa2.org/embargo/flucliniclocator05/> on the Internet.

2-1-1 Information and Referral Service

The Consumer Education Working Group would like health care providers to know about another new resource to help citizens find a flu shot this fall. It is anticipated that this service will go hand-in-hand with the ALA's Flu Locator site. Those who do not have Internet access can call the 2-1-1 information and referral service and the operator can then use the Flu Locator site to help the person find a nearby influenza clinic.

2-1-1 is an easily remembered telephone number that helps callers find critical health and human services available in their community. Callers can get answers to questions such as shelter locations after a natural disaster, traveler aid, emergency funding, or flu vaccination clinic locations.

2-1-1 serves approximately 139 million Americans - over 46% of the US population. One hundred and seventy-one (171) active 2-1-1 systems cover all or part of 32 states (including 14 states with 100% coverage) plus Washington, DC and Puerto Rico.

When this system is connected nationwide, it will provide easy access to social service resources for everyone. The technology ensures that a real person will answer every time – no recorded messages. Anyone with flu vaccine can register with a local 2-1-1 call center. The call center will include that information in their database and make it available to the community.

For more information about 2-1-1, go to <http://www.211.org> or <http://www.airs.org> on the Internet.

Influenza Pocket Guides/Information about Vaccines

Although hard copy versions of the Influenza Pocket Guides are no longer available, electronic and camera-ready versions are available, copyright free and can be found at <http://www.immunize.org/influenza/pocketguide.htm> on the Internet.

Comprehensive information about vaccines and vaccine-preventable diseases can be found at <http://www.vaccineinformation.org> on the Internet.

Medlearn Matters Number: SE0580

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Related CR Transmittal #: N/A Implementation Date: N/A

Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) today announced a new initiative designed to measure how satisfied providers in the fee-for-service (FFS) program are with the services of the contractors that are responsible for processing their claims, educating them about changes in Medicare policies, and responding to provider inquiries.

The initiative, the Medicare Contractor Provider Satisfaction Survey (MCPSS) will be administered on an annual basis. It is designed to garner quantifiable data on provider satisfaction levels with key services performed by the 42 FFS contractors that process and pay more than \$280 billion in Medicare claims each year.

“The Medicare program depends on health care providers all over the country to serve our beneficiaries, and this new survey will help us work with the Medicare contractors to help us serve our providers as effectively as possible,” said CMS Administrator Mark B. McClellan, M.D., Ph.D. “As we implement the most significant contractor reforms in the history of the Medicare program, provider satisfaction will be one of the key considerations.”

The MCPSS is one of the tools CMS will use to measure provider satisfaction levels, as a result of the Medicare Modernization Act (MMA) of 2003. It was developed with extensive input from providers, and information about the survey has been disseminated to providers through a variety of channels, including Open Door Forum conference calls with providers, and Medlearn Matters articles posted on the CMS website. CMS will conduct ongoing outreach to providers throughout the survey process.

“We are bringing satisfaction measures and other quality measures to many aspects of Medicare, to get the best possible performance for the dollars we spend,” added Dr. McClellan. “This survey is very important provider

feedback, and so we are identifying ways in which we can get the maximum provider participation.”

The MCPSS will query 25,000 randomly selected providers (e.g., physicians, suppliers, healthcare practitioners, and institutional providers), a statistically valid and representative sample of the 1.2 million who serve Medicare beneficiaries. Those providers selected to participate in the survey will be notified by mail during the first week of January 2006. The survey is designed so that it can be completed in less than a half hour. Survey responses can be submitted via a secure website, mail or fax and will be accepted through January 25, 2006.

The survey questions will focus on seven key areas of provider-contractor interactions, including:

- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

CMS will use the MCPSS results for Medicare contractor oversight. Contractors will be able to use the survey results to improve the services they offer to providers. CMS plans to make the survey results available via an online reporting system in early July 2006.

Further information about the MCPSS is available at: <http://www.cms.hhs.gov/MCPSS/>

Source: Provider Education Resources Listserv, Message 200601-01, CMS Joint Signature Memorandum 05564, October 11, 2005

Medicare Deductible, Coinsurance, and Premium Rates for 2006

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

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 4132, which updates the Centers for Medicare & Medicaid Services (CMS) claims processing systems and the *Medicare General Information, Eligibility, and Entitlement Manual* (Pub.100-01) with the new 2006 Medicare deductible, coinsurance, and premium rates for 2006.

Background

Medicare beneficiaries using covered Part A services (inpatient hospital services, skilled nursing facilities (SNFs), home health services, and hospice care) and Part B services (physician services, outpatient hospital services, medical equipment and supplies, and other health services and supplies) may be subject to deductible and coinsurance requirements.

Beneficiaries are responsible for an inpatient hospital deductible amount (which is deducted from the amount payable by the Medicare program to the hospital) for inpatient hospital services furnished during a spell of illness.

After the 60th day that a beneficiary receives inpatient hospital services (during a spell of illness), he or she is responsible for a coinsurance amount equal to one fourth of the inpatient hospital deductible per day for the **61st-90th day** spent in the hospital.

After the 90th day spent in the hospital during a spell of illness, the beneficiary may elect to use his or her 60 lifetime reserve days of coverage. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

For SNF services furnished during a spell of illness, the beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the **21st-100th day in an SNF**.

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment.

The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 10 percent penalty is assessed for two years for every year they could have enrolled and failed to enroll in Part A.

Under Supplementary Medical Insurance (SMI), all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute.

When SMI enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

The following includes Medicare Part A and Part B deductible, coinsurance, and premium amounts for 2006:

A. Medicare Part A Deductible, Coinsurance, and Premium Amounts for 2006:

- **Deductible:** \$952.00 per benefit period or spell of illness;
- **Coinsurance:**
 - \$238.00 a day for days 61-90 in each period;
 - \$476.00 a day for days 91-150 for each “Lifetime Reserve” day used; and
 - \$119.00 a day in an SNF for days 21-100 in each benefit period; and
- **Premium:**
 - \$393.00 per month for those who must pay a premium;
 - \$432.30 per month for those who must pay a premium **and** must pay a 10 percent increase;
 - \$216.00 per month for those who have 30-39 quarters of coverage; and
 - \$237.60 per month for those who have 30-39 quarters of coverage **and** must pay a 10 percent increase.

The table below compares deductible and coinsurance amounts for 2005 and 2006:

Year	Inpatient Hospital, Deductible 1st 60 Days	Inpatient Hospital, Coinsurance 61st-90th Days	60 Lifetime Reserve Days Coinsurance	SNF Coinsurance
2005	\$912	\$228	\$456	\$114
2006	\$952	\$238	\$476	\$119

B. Medicare Part B Deductible, Coinsurance, and Premium Amounts for 2006:

- **Deductible:** \$124.00 per year;
- **Coinsurance:** 20 percent; and
- **Premium:** \$88.50 per month.

GENERAL INFORMATION

Implementation

The implementation date for the instruction is January 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/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that web page, look for CR4132 in the CR NUM column on the right, and click on the file for that CR.

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/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: MM4132
Related CR Release Date: November 4, 2005
Related CR Transmittal #: 31

Related Change Request (CR) #: 4132
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

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

Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs)

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

This information was previously published in the First Quarter 2006 Medicare B Update! pages 68-70.

Note: This article was revised on October 28, 2005, due to a revision to CR3953. The changes to the article are the new CR release date and transmittal number shown above. The other changes made are: 1.) The Visiting Nurse Service of New York/EverCare program has been cancelled. 2.) the contact information for the CIGNA Healthcare program in Georgia has been corrected. 3.) the Start Date for the XL Health program in Tennessee has been updated from Nov. 2005 to Jan. 2006. All other information from transmittal 27 remains the same. **Please note that the important date for the provider is the date that the program starts in your area.**

Provider Types Affected

Physicians and providers in any one of the eight geographic areas described below:

Organization Selected by CMS to Provide Program	Geographic Areas to be Served
1. Aetna Life Insurance Company, LLC	Chicago, Illinois counties
2. American Healthways	Maryland and the District of Columbia
3. CIGNA Health Support	Northwest Georgia
4. Health Dialog Services Corporation	Western Pennsylvania
5. Humana, Inc.	Central and South Florida
6. LifeMasters Supported SelfCare, Inc.	Oklahoma
7. McKesson Health Solutions	Mississippi
8. XLHealth Corporation	Selected counties in Tennessee

Provider Action Needed

STOP – Impact to You

This article includes information from Change Request (CR) 3953 that describes the new Medicare Health Support Programs (MHSPs), formerly known as Chronic Care Improvement Programs, and identifies the eight organizations selected by the Centers for Medicare & Medicaid Services (CMS) to provide MHSPs to certain beneficiaries enrolled in the traditional Fee-For-Service (FFS) Medicare program.

CAUTION – What You Need to Know

CMS is implementing Phase I: Developmental of the Medicare Health Support Initiative. The eight Medicare Health Support Organizations (MHSOs) selected by CMS will serve approximately 180,000 Medicare beneficiaries who have congestive heart failure and/or diabetes among their chronic conditions. Eligible beneficiaries do not have to change plans or providers to participate, and participation is totally voluntary. Participation in an MHSP does not restrict access to other Medicare services and will be provided at no extra cost to beneficiaries.

GO – What You Need to Do

See the *Background* and *Additional Information* sections for more information on this new program.

Background

This article provides information about CMS’ implementation of the Medicare Health Support Programs (MHSPs), formerly known as Chronic Care Improvement Programs. Section 721 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) adds a new section 1807, “Voluntary Chronic Care Improvement Under Traditional Fee-for-Service (FFS) Medicare” to the Social Security Act.

This section requires Medicare to provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs (now known as MHSPs) and to proceed with expansion regionally or possibly nationwide if the pilot programs (or program components) are successful.

This initiative represents one of multiple strategies developed by the Department of Health and Human Services (DHHS) to help chronically ill beneficiaries stay healthier, accelerate the adoption of health information technology, reduce avoidable costs, and diminish health disparities among Medicare beneficiaries nationally.

Some key points about the MHS initiative are as follows:

- The MHSPs will test whether providing additional health education and support services for targeted chronically ill Medicare beneficiaries who are in traditional FFS Medicare will lead to improved clinical quality and satisfaction and lower costs to Medicare.
- CMS has entered into agreements with selected organizations (MHSOs) to provide MHSPs to targeted Medicare FFS beneficiaries (about 20,000 beneficiaries serviced by each MHSO) who have congestive heart failure and/or diabetes.
- The first MHSPs will be phased in during 2005, operate for three years, and be tested through comparative analysis with beneficiaries randomly assigned to regional control groups. The statute provides for expansion of the MHS initiative if the pilot programs or program components are successful.
- The programs will offer support services—such as self-care guidance and answers to questions about medications—for chronically ill beneficiaries who are invited by CMS to participate. The goal is to help them adhere to their prescribed treatment plans and ensure that they seek the medical care they need to reduce their health risks. Coordination and collaboration with participants’ healthcare providers to enhance communication of relevant clinical information are also key components of the MHSPs.
- Participation in MHSPs will not restrict access to care and will be provided at no cost to eligible beneficiaries. Such beneficiaries do not have to change from their existing plans, nor do they have to change physicians or providers in order to participate. Further, they may stop participating at any time.
- MHSOs will be paid by CMS, outside of the Medicare FFS claims payment system, a fixed administrative fee per participant per month.
- The MHSOs will not focus on any single disease, but will help participants manage their health holistically.
- The MHSOs will *not* pay any claims on behalf of enrolled beneficiaries and a beneficiary’s participation will not affect how claims from their physicians/providers are processed by Medicare.
- The following chart identifies the MHSO, provides information about selected program features of the MHSPs to be offered, and delineates the geographic areas served by the MHSOs:

MHSO	Selected Program Features	Geographic Area
Aetna Life Insurance Company, LLC	<ul style="list-style-type: none"> • Advance Practice Nursing Program for home health and nursing homes • Customized care plans • Caregiver education • Blood pressure monitors and weight scales provided based on participant need • Physician communication • Physician web access to clinical information • 24-hour nurse line 	Chicago, IL counties
American Healthways	<ul style="list-style-type: none"> • Personalized care plans • Direct-mail and telephonic messaging • Supplemental telephonic coaching • Gaps in care generate physician prompts • Intensive case management services as necessary • Remote monitoring devices (weight, blood pressure (bp), and pulse) based on participant need • Physician web access to clinical information • Physician communication • 24-hour nurse line 	MD and DC

GENERAL INFORMATION

MHSO	Selected Program Features	Geographic Area
CIGNA Health Support, LLC	<ul style="list-style-type: none"> • Personalized plan of care • Telephonic nurse interventions • Oral and written communication in addition to telephonic coaching • Home monitoring equipment (weight, bp, and glucometers) based on participant need • Intensive case management for frail elderly and institutionalized participants, as required • Data exchange with physicians • 24-hour nurse line 	Northwest GA
Health Dialog Services Corporation	<ul style="list-style-type: none"> • Personal health coaches develop individual care management plans • Personal health coaches develop individual • Health education materials (web-based, faxed or mailed) • In-home biometric monitoring • Behavioral health case management and intensive case management as needed • Data exchange with physicians • Active involvement of other community agencies • 24-hour nurse line 	Western PA
Humana, Inc.	<ul style="list-style-type: none"> • Trademarked Personal Nurse (PN) program model • Group education and support sessions • Biometric monitoring equipment, including glucometers and weight scales as necessary • Core telephonic support supplemented with RNs, social workers, and pharmacists in the field interacting with providers and beneficiaries with complex needs • Data exchange with physicians • On-site meetings with physicians and CME (continuing medical education) programs • Physician web access to clinical information • Electronic medical recordkeeping systems will be piloted in five small physician-group practices • Active involvement of other community agencies • 24-hour nurse line 	Central and South FL
LifeMasters Supported SelfCare	<ul style="list-style-type: none"> • Single nurse as primary contact for beneficiary • Supported self-care model including education, medication compliance, behavior change • Home visits as appropriate • Team of local and call center-based nurses, physicians, pharmacists, and health educators • Digital weight scale and bp monitors • Physician communication including customized care plans, alerts, decision support applications; access to patient care record and biometric monitoring data • Physician outreach includes in-person orientation for high volume physician practices • Physician web access to clinical information • Active involvement of other community agencies • 24-hour nurse line 	OK

MHSO	Selected Program Features	Geographic Area
McKesson Health Solutions	<ul style="list-style-type: none"> • Extensive physician involvement, including on-site staff support • Data exchange with physicians • Physician web access to clinical information • Telephonic outreach • Mail, fax, workbooks • Remote monitoring and biometric equipment for selected high risk participants • Pharmacist review of medications and collaboration with physicians • Management of long-term care residents and intensive case management, including end-of-life • 24-hour nurse line 	MS
XLHealth Corporation	<ul style="list-style-type: none"> • Biometric monitoring including glucometers and weight scales as necessary • RNs, social workers, and pharmacists in the field, interacting with providers and beneficiaries with complex needs • Medication counseling sessions by pharmacists at retail pharmacies • Specialized program for higher risk patients • Medication management and compliance • Data exchange with physicians • Physician web access to clinical information • 24-hour nurse line 	Selected counties in Tennessee

Physicians and providers with questions regarding the programs can find additional information at <http://www.cms.hhs.gov/medicarereform/ccip/> on the CMS website, or they may direct their inquiries directly to the following MHSO contacts:

Aetna Life Insurance Company, LLC:
 Kathleen Giblin
 Aetna Health Management, LLC
 151 Farmington Avenue, RT11
 Hartford, CT 06156
 Or call 888-713-2836 or visit <http://www.aetna.com>

American Healthways:
 Michael Montijo, M.D., American Healthways
 American Healthways, Inc.
 3841 Green Hills Village Drive
 Nashville, TN 37215
 Or call 866-807-4486
 or visit <http://www.medicarehealthsupport.com>

Health Dialog Services Corporation:
 Molly Doyle
 Health Dialog Services Corporation
 60 State Street, Suite 1100
 Boston, MA 02109
 Or call 800-574-8475 or visit
<http://www.myhealthsupport.com> (available August 2005)

Humana, Inc.:
 Heidi Margulis
 Humana, Inc.
 500 West Main Street, 6th Floor
 Louisville, KY 40202
 Or call 800-372-8931 or
 visit <http://www.greenribbonhealth.com>

LifeMasters Supported SelfCare:
 Ron Lau, c/o Mel Lewis
 LifeMasters Supported SelfCare
 5000 Shoreline Court S#300 South
 San Francisco, CA 94080
 Or call 888-713-2837 or visit <http://www.lifemasters.com>

McKesson Health Solutions:
 Sandeep Wadhwa
 McKesson Health Solutions
 335 Interlocken Parkway
 Broomfield, CO 80021
 Or call 800-919-9110 or visit <http://www.mckesson.com>

XLHealth Corporation:
 Paul Serini XLHealth Corporation
 351 West Camden Street, Suite 100
 Baltimore, Maryland 21201
 Or call 877-717-2247

CIGNA Health Support:
 Elizabeth Sanford
 CIGNA TLP 11H
 1601 Chestnut Street
 Philadelphia, PA. 19355
 Or call 866-563-4551 or
 visit www.mhsgeorgia.com (available August 2005)

Note: The start date for the XL Health program in Tennessee is January, 2006. The start date for the Humana program is November, 2005. All other programs started in August or September of 2005.

GENERAL INFORMATION

Implementation

The implementation date for the instruction is October 20, 2005.

Additional Information

For complete details of CR3953, please see the official instruction issued by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that Web page, look for CR3953 in the CR column on the right and click on the file for that CR.

The Medicare Fact Sheet that describes the Medicare Health Support programs may be found on the Web at <http://www.cms.hhs.gov/medicarereform/ccip/> on the CMS website. This document is an excellent overview of the program.

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

Medlearn Matters Article MM3410 provides some background information on the “Use of Group Health Plan Payment System to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries Under Section 721 of the MMA” and can be viewed by going to <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3410.pdf> on the CMS website.

Related Change Request (CR) #: 3953

Medlearn Matters Number: MM3953

Related CR Release Date: October 28, 2005 *Revised*

Related CR Transmittal #: 30

Effective Date: October 20, 2005

Implementation Date: October 20, 2005

Full Replacement of and Rescinding CR 3504 - Modification to Online Medicare Secondary Payer Questionnaire

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

CR4098 clarifies recent changes made to the “Medicare Secondary Payer Questionnaire.”

CAUTION – What You Need to Know

This CR identifies all of the changes that were made to CR3504 **and** makes additional changes to the model questionnaire. These changes will assist providers in identifying other payers that may be primary to Medicare.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) received information that a prior instruction (CR3504) did not specifically mention all of the changes that were made to the “Medicare Secondary Payer (MSP) Questionnaire.” CR4098 identifies all of the changes made as part of CR3504 and makes additional changes to the model questionnaire.

The *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1, available as an attachment to CR4098, provides a model: “Admission Questions to Ask Medicare Beneficiaries.”

The model contains questions that may be printed out and used as a guide to help identify other payers. (The website for accessing CR4098 is provided in the *Additional Information* section of this article.)

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

- **Parts IV and V** of the model questionnaire adds the response: “No, Never Employed.”
- In **Parts IV, V, and VI** of the model questionnaire, providers should use “Policy Identification Number” to mean a number that is sometimes referred to as the health insurance benefit package number.
- **Parts IV, V, VI** of the model questionnaire adds “Membership Number” and it refers to the unique identifier assigned to the policyholder/patient.
- **Part V**, question 2 of the model questionnaire uses “spouse” instead of “family member.”
- **Part V**, question 4 changes the model questionnaire to read:
Are you covered under the group health plan of a family member other than your spouse?
_____Yes _____No.
Name and address of your family member’s employer: _____
- **Part V** of the old question 4 is changed to ask whether the beneficiary is covered under a group health plan (GHP) and a question number 5 is added to gather the pertinent information about the GHP.
- In **Part VI**, question 6 now reads: “Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?” Providers who use the model questionnaire to elicit MSP information from their Medicare patients should take special note of these changes.

Implementation

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

Additional Information

The official instructions issued to your Medicare carrier or intermediary regarding this change and the model questionnaire can be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. On the above page, scroll down the CR NUM column on the right to find the links for CR4098. Click on the links to open and view the files for this CR.

If you have questions, please contact your carrier/intermediary at their toll-free number which may be found at <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: MM4098

Related Change Request (CR) #: 4098

Related CR Release Date: October 21, 2005

Effective Date: January 21, 2006

Related CR Transmittal #: 41

Implementation Date: January 21, 2006

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

Physician Voluntary Reporting Program Using Quality G-Codes

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

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. 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. And 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 36 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 36 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.

GENERAL INFORMATION

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 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/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that Web page, look for CR4183 in the CR NUM column on the right, and click on the file for that CR.

Appendices accompanying CR4183 contain the specific G-Codes and their descriptors as they relate to the developed quality measures reflected in the above table.

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/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).

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.

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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 angiotensin-converting 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 left ventricular systolic dysfunction

Numerator:

G8030: Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on betablocker therapy

G8031: Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on betablocker therapy

G8032: Clinician documented that heart failure patient was not eligible candidate for beta-blocker 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, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, or 428.9; **and**

Patient who has documentation of an LVEF < 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 E&M services are provided for a patient with documented left ventricular systolic dysfunction.

The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. 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: Antiplatelet therapy for patient with coronary artery disease**Numerator:**

G8036: Coronary artery disease patient documented to be on antiplatelet therapy

G8037: Coronary artery disease patient not documented to be on antiplatelet therapy

G8038: Clinician documented that coronary artery disease patient was not eligible candidate for antiplatelet 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, 99241-99245, 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 with the listed E&M services provided for a patient with coronary artery disease. This measure is intended to reflect the quality of services provided for the management of patients with coronary artery disease. Antiplatelet therapy consists of aspirin, clopidogrel, or combination of aspirin and dipyridamole.

Measure: Low-density lipoprotein control in patient with coronary artery disease**Numerator:**

G8040: Coronary artery disease – patient with low-density lipoprotein documented to be less than or equal to 100mg/dl

G8039: Coronary artery disease – patient with low-density lipoprotein documented to be greater than 100mg/dl

G8041: Clinician documented that coronary artery disease patient was not eligible candidate for low-density lipoprotein measure

G8182: Clinician has not provided care for the cardiac patient for the required time for low-density lipoprotein measure (6 months)

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, 99241-99245, 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 CPT services are provided for a patient with coronary artery disease. This measure is intended to reflect the quality of services provided for the management of patients with coronary artery disease.

Measure: Osteoporosis assessment in elderly female patient**Numerator:**

G8051: Patient (female) documented to have been assessed for osteoporosis

G8052: Patient (female) not documented to have been assessed for osteoporosis

G8053: Clinician documented that (female) patient was not an eligible candidate for osteoporosis assessment measure

Denominator:

CPT 99201-99205, 99211-99215, 99241-99245, 99304-99306, 99307-99310, or 99341-99350; *and*

Female patients 75 years of age or older

GENERAL INFORMATION

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 counseling the patient about the risk of osteoporosis and the potential need for preventive therapy.

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: Assessment of hearing acuity in elderly patient

Numerator:

G8057: Patient documented to have received hearing assessment

G8058: Patient not documented to have received hearing assessment

G8059: Clinician documented that patient was not an eligible candidate for hearing assessment measure

Denominator:

CPT 99201-99205, 99211-99215, 99241-99245, 99304-99306, 99307-99310, 99341-99350, 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 an annual clinical examination and history of hearing capacity as part of a medically necessary visit.

Measure: Assessment for urinary incontinence in elderly patients

Numerator:

G8060: Patient documented for the assessment of urinary incontinence

G8061: Patient not documented for the assessment of urinary incontinence

G8062: Clinician documented that patient was not an eligible candidate for urinary incontinence assessment measure

Denominator:

CPT 99201-99205, 99211-99215, 99241-99245, 99304-99306, 99307-99310, 99341-99350, 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 history of patient's absence or presence of urinary incontinence.

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: Warfarin therapy in heart failure patient with atrial fibrillation**Numerator:**

G8183: Patient with heart failure and atrial fibrillation documented to be on warfarin therapy

G8184: Clinician documented that patient with heart failure and atrial fibrillation was not an eligible candidate for warfarin 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**

CPT 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99218-99220, 99234-99236, 99304-99306, 99307-99310, 99324-99328, 99334-99337, or 99221-99223; **and**

ICD-9 427.31

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes for heart failure and atrial fibrillation are used with the listed CPT services. This measure should reflect the quality of the services for the management of atrial fibrillation for a patient with heart failure.

GENERAL INFORMATION

Measure: Smoking cessation intervention in newly diagnosed chronic obstructive pulmonary disease

Numerator:

G8093: Newly diagnosed chronic obstructive pulmonary disease (COPD) patient documented to have received smoking cessation intervention, within 3 months of diagnosis,

G8094: Newly diagnosed chronic obstructive pulmonary disease (COPD) patient not documented to have received smoking cessation intervention, within 3 months of diagnosis

Denominator:

ICD-9 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 494.0, 494.1, 496, or 493.20 – 493.22; *and*

CPT 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99324-99328, 99334-99337, 99304-99306, 99307-99310, or G0375; G0376

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are used and the listed E&M services are provided to patients with documented COPD.

Measure: Prescription of calcium and vitamin D supplements in osteoporosis

Numerator:

G8099: Osteoporosis patient documented to have been prescribed calcium and vitamin D supplements

G8100: Clinician documented that osteoporosis patient was not an eligible candidate for calcium and vitamin D supplement measure

Denominator:

ICD-9: 733.00, 733.01, 733.02, 733.03, or 733.09; *and*

CPT 99201-99205, 99211-99215, 99241-99245, 99304-99306, 99307-99310, 99324-99328, 99334-99337, or 99341-99350

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 for a patient with osteoporosis. It is anticipated that this measure reflects the services provided for the primary management of osteoporosis.

Measure: Antiresorptive therapy and/or parathyroid hormone treatment in newly diagnosed osteoporosis

Numerator:

G8103: Newly diagnosed osteoporosis patients documented to have been treated with antiresorptive therapy and/or parathyroid hormone treatment within 3 months of diagnosis

G8104: Clinician documented that newly diagnosed osteoporosis patient was not an eligible candidate for antiresorptive therapy and/or parathyroid hormone treatment measure within 3 months of diagnosis

Denominator:

ICD-9: 733.00, 733.01, 733.02, 733.03, or 733.09; *and*

CPT 99201-99205, 99211-99215, 99241-99245, 99304-99306, 99307-99310, 99324-99328, 99334-99337, or 99341-99350

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 for a patient with osteoporosis. It is anticipated that this measure reflects the services provided for the primary management of osteoporosis.

Measure: Bone mineral density testing and osteoporosis treatment and prevention following osteoporosis associated nontraumatic fracture

Numerator:

G8106: Within 6 months of suffering a nontraumatic fracture, female patient 65 years of age or older documented to have undergone bone mineral density testing or to have been prescribed a drug to treat or prevent osteoporosis

G8107: Clinician documented that female patient 65 years of age or older who suffered a nontraumatic fracture within the last 6 months was not an eligible candidate for measure to test bone mineral density or drug to treat or prevent osteoporosis

Denominator:

ICD-9: 733.00, 733.01, 733.02, 733.03, or 733.09; *and*

CPT 99201-99205, 99211-99215, 99241-99245, 99304-99306, 99307-99310, 99324-99328, 99334-99337, or 99341-99350; *and*

Female patient 65 and older

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 an elderly female patient with nontraumatic fracture.

This measure should reflect quality of services for the detection of osteoporosis related complications in the elderly female population. It is anticipated that the clinician who provides primary management of the patient would submit this measure.

Measure: Annual assessment of function and pain in symptomatic osteoarthritis

Numerator:

G8185: Patients diagnosed with symptomatic osteoarthritis with documented annual assessment of function and pain

G8186: Clinician documented that symptomatic osteoarthritis patient was not an eligible candidate for annual assessment of function and pain measure

Denominator:

ICD-9: 715.00-715.98;*and*

CPT 99201-99205, 99211-99215, 99241-99245, 99304-99306, 99307-99310, 99324-99328, 99334-99337, or 99341-99350\

Instructions:

This measure is reported whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with symptomatic osteoarthritis. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. This measure should reflect quality of services for the primary management of osteoarthritis.

Measure: Influenza vaccination

Numerator:

G8108: Patient documented to have received influenza vaccination during influenza season

G8109: Patient not documented to have received influenza vaccination during influenza season

G8110: Clinician documented that patient was not an eligible candidate for influenza vaccination measure

Denominator:

CPT: 99201-99205, 99211-99215, 99241-99245, 99304-99306, 99307-99310, 99324-99328, 99334-99337, 99341-99350, or G0008;*and*

Patients 50 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 patients for the purpose of providing preventive services. This indicator should be provided only on an annual basis.

Measure: Mammography

Numerator:

G8111: Patient (female) documented to have received a mammogram during the measurement year or prior year to the measurement year

G8112: Patient (female) not documented to have received a mammogram during the measurement year or prior year to the measurement year

G8113: Clinician documented that female patient was not an eligible candidate for mammography measure

G8114: Clinician did not provide care to patient for the required time of mammography measure (i.e., measurement year or prior year)

Denominator:

CPT 99201-99205, 99211-99215, 99241-99245, 99304-99306, 99307-99310, 99324-99328, 99334-99337, 99341-99350, or G0344;*and*

Female patients age 40 or over

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients for the purpose of providing preventive services. This indicator should be provided only on an annual basis.

Measure: Pneumococcal vaccination

Numerator:

G8115: Patient documented to have received pneumococcal vaccination

G8116: Patient not documented to have received pneumococcal vaccination

G8117: Clinician documented that patient was not an eligible candidate for pneumococcal vaccination measure

Denominator:

CPT 99201-99205, 99211-99215, 99241-99245, 99304-99306, 99307-99310, 99324-99328, 99334-99337, 99341-99350; G0009, or G0344;
and

Patients 65 years of age or older

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Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients for the purpose of providing preventive services. This indicator shall not be reported more than once a year.

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: Antidepressant medication duration for patient diagnosed with new episode of major depression

Numerator:

G8129: Patient documented as being treated with antidepressant medication for at least 6 months continuous treatment phase

G8130: Patient not documented as being treated with antidepressant medication for at least 6 months continuous treatment phase

G8131: Clinician documented that patient was not an eligible candidate for antidepressant medication for continuous treatment phase

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. This measure is anticipated to reflect that the primary management of the acute treatment for depression including continuous treatment (beyond 12 weeks) where clinically appropriate.

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 thromboembolism prophylaxis

G8156: Patient without documented receipt of thromboembolism 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

GENERAL INFORMATION

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.

Measure: Pre-operative beta-blocker for patient with isolated coronary artery bypass graft

Numerator:

G8161: Patient with isolated coronary artery bypass graft documented to have received pre-operative beta-blockade

G8162: Patient with isolated coronary artery bypass graft not documented to have received pre-operative beta-blockade

G8163: Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for pre-operative beta-blockade measure

Denominator:

Patients with coronary artery bypass graft as listed: CPT: 33510, 33511, 33512, 33513, 33514, 33516, 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 should reflect the primary management of the surgical patient undergoing isolated coronary artery bypass surgery.

Measure: Prolonged intubation in isolated coronary artery bypass graft surgery

Numerator:

G8164: Patient with isolated coronary artery bypass graft documented to have prolonged intubation

G8165: Patient with isolated coronary artery bypass graft not documented to have prolonged intubation

Denominator:

Patients with coronary artery bypass graft as listed: CPT: 33510, 33511, 33512, 33513, 33514, 33516, 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 isolated coronary artery bypass graft surgery. This measure should reflect the management of the surgical patient undergoing coronary artery bypass graft surgery. This measure is not intended to encourage the inappropriate early extubation of patients. The treating clinician should continue to make the appropriate clinical determination regarding the necessity for intubation.

Measure: Surgical re-exploration in coronary artery bypass graft surgery

Numerator:

G8166: Patient with isolated coronary artery bypass graft documented to have required surgical reexploration

G8167: Patient with isolated coronary artery bypass graft did not require surgical re-exploration

Denominator:

Patients with coronary artery bypass graft *as listed*: CPT: 33510, 33511, 33512, 33513, 33514, 33516, 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. It is anticipated that there may be clinical reasons for a patient to undergo re-exploration. This measure is not anticipated to discourage the treating physician from making the appropriate clinical decision for surgical re-exploration.

Measure: Aspirin or clopidogrel on discharge for patient undergoing isolated coronary artery bypass graft**Numerator:**

G8170: Patient with isolated coronary artery bypass graft documented to have been discharged on aspirin or clopidogrel

G8171: Patient with isolated coronary artery bypass graft not documented to have been discharged on aspirin or clopidogrel

G8172: Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for antiplatelet therapy at discharge measure

Denominator:

Patients with coronary artery bypass graft: CPT: 33510, 33511, 33512, 33513, 33514, 33516, 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 should reflect the primary management of the surgical patient undergoing isolated coronary artery bypass surgery.

Medlearn Matters Number: MM4183

Related Change Request (CR) #: 4183

Related CR Release Date: November 2, 2005

Effective Date: January 1, 2006

Related CR Transmittal #: 31

Implementation Date: January 3, 2006

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Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

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

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

The complete list, including changes made from March 1, 2005 through June 30, 2005, of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 Health Care Claim Adjustment Reason Codes can be found at <http://www.wpc-edi.com/codes>.

CAUTION – What You Need to Know

Please refer to the *Additional Information* section of this article for remark and reason code changes approved June 30, 2005.

GO – What You Need to Do

Be sure your staff is aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination of benefits transactions.

The remittance advice remark code list is maintained by CMS, and used by all payers. Additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities. This list is updated three times a year, and posted at <http://wpc-edi.com/codes>.

The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets three times a year when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes. This updated list is posted three times per year.

GENERAL INFORMATION

Additional Information

The following lists summarize changes made from March 1, 2005 through June 30, 2005:

Remittance Advice Remark Code Changes

Code	New/ Modified/ Deactivated /Retired	Current Narrative	Comment
N348	New	You chose that this service/supply/drug would be rendered/ supplies and billed by a different practitioner/supplier.	Medicare Initiated
N349	New	The administration method and drug must be reported to adjudicate this service.	Not Medicare Initiated
N350	New	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure.	Not Medicare Initiated
N351	New	Service date outside of the approved treatment plan service dates.	Not Medicare Initiated
N352	New	There are no scheduled payments for this service. Submit a claim for each patient visit.	Not Medicare Initiated
N353	New	Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim.	Not Medicare Initiated
N354	New	Incomplete/invalid invoice	Not Medicare Initiated
N355	New	The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days.	Medicare Initiated
N356	New	This service is not covered when performed with, or subsequent to, a non-covered service.	Not Medicare Initiated

GENERAL INFORMATION

Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
N21	Modified	Your line item has been separated into multiple lines to expedite handling.	Modified effective August 1, 2005
M25	Modified	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	Modified effective August 1, 2005
M26	Modified	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	Modified effective August 1, 2005
M27	Modified	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified effective August 1, 2005
MA01	Modified	The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.	Modified effective August 1, 2005
MA02	Modified	The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.	Modified effective August 1, 2005
MA03	Modified	If you do not agree with the approved amounts and \$100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time. At the reconsideration, you must present any new evidence, which could affect our decision.	Modified effective August 1, 2005

GENERAL INFORMATION

Code	New/ Modified/ Deactivated /Retired	Current Narrative	Comment
MA83	Modified	Did not indicate whether we are the primary or secondary payer.	Modified effective August 1, 2005
MA94	Modified	Did not enter the statement “Attending physician not hospice employee” on the claim form to certify that the rendering physician is not an employee of the hospice.	Modified effective August 1, 2005
N122	Modified	Add-on code cannot be billed by itself.	Modified effective August 1, 2005
N125	Modified	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The requirements for a refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to Section 1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.	Modified effective August 1, 2005
N29	Modified	Missing documentation/orders/notes/ summary/report/chart.	Modified effective August 1, 2005
N225	Modified	Modify N225 - Incomplete/invalid documentation/orders/notes/ summary/report/chart.	Modified effective August 1, 2005
M23	Modified	Missing invoice	Modified effective August 1, 2005

Code	New/ Modified/ Deactivated /Retired	Current Narrative	Comment
Reason Code Changes			
167	New	This (these) diagnosis (es) is (are) not covered. New as of June, 2005 168 New Payment denied as Service(s) have been considered under the patient’s medical plan. Benefits are not available under this dental plan.	New as of June, 2005
169	New	Payment adjusted because an alternate benefit has been provided.	New as of June, 2005
170	New	Payment is denied when performed/billed by this type of provider.	New as of June, 2005
171	New	Payment is denied when performed/billed by this type of provider in this type of facility.	New as of June, 2005
172	New	Payment is adjusted when performed/billed by a provider of this specialty.	New as of June, 2005
173	New	Payment adjusted because this service was not prescribed by a physician.	New as of June, 2005
174	New	Payment denied because this service was not prescribed prior to delivery.	New as of June, 2005
175	New	Payment denied because the prescription is incomplete.	New as of June, 2005
176	New	Payment denied because the prescription is not current.	New as of June, 2005
177	New	Payment denied because the patient has not met the required eligibility requirements.	New as of June, 2005
178	New	Payment adjusted because the patient has not met the required spend-down requirements.	New as of June, 2005
179	New	Payment adjusted because the patient has not met the required waiting requirements.	New as of June, 2005

Code	New/ Modified/ Deactivated/Retired	Current Narrative	Comment
180	New	Payment adjusted because the patient has not met the required residency requirements.	New as of June, 2005
181	New	Payment adjusted because this procedure code was invalid on the date of service.	New as of June, 2005
182	New	Payment adjusted because the procedure modifier was invalid on the date of service.	New as of June, 2005
183	New	The referring provider is not eligible to refer the service billed.	New as of June, 2005
184	New	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	New as of June, 2005
185	New	The rendering provider is not eligible to perform the service billed.	New as of June, 2005
186	New	Payment adjusted since the level of care changed.	New as of June, 2005
187	New	Health Savings account payments	New as of June, 2005
188	New	This product/procedure is only covered when used according to FDA recommendations.	New as of June, 2005
189	New	“Not otherwise classified” or “unlisted” procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	New as of June, 2005
D21	New	This (these) diagnosis (es) is (are) missing or are invalid.	New as of June, 2005
23	Modified	Payment Adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.	Modified June, 2005
47	Retired	This (these) diagnosis (es) is (are) not covered, missing, or are invalid.	Inactive as of February, 2006
30	Retired	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	Inactive as of February, 2006
B6	Retired	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	Inactive as of February, 2006

In September 2005, the Claim Adjustment Status Code Maintenance Committee approved a new reason code of 192 (Non-standard adjustment code from paper remittance advice), effective January 1, 2006. Reason Code 192 will be used by providers who must submit claims electronically under the Administrative Simplification Compliance Act when:

- Medicare is not the primary payer; and
- Providers have received paper remittance advice containing proprietary codes from the previous payer(s).

For additional information about Remittance Advice, please refer to **Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers** on the CMS website.

The official instruction issued to your FI/carrier/DMERC/RHHI regarding this change may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R743CP.pdf> on the CMS website.

If you have any questions, please contact your FI/carrier/DMERC/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: MM4123 Related Change Request (CR) #: 4123
 Related CR Release Date: November 4, 2005 Effective Date: January 1, 2006
 Related CR Transmittal #: 743 Implementation Date: January 3, 2006

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Requirements for Voided, Canceled, and Deleted Claims

CMS has issued the following "Medlearn Matters... Information for Medicare Providers" article. This information was previously published in the First Quarter 2006 Medicare B Update! pages 76-78.

Note: This article was revised on November 10, 2005, to clarify language in item 4 under "Acceptable Claims Deletions" on page 2. All other information remains the same.

Provider Types Affected

All Medicare physicians, providers, and suppliers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs)

Provider Action Needed

This Medlearn Matters article is based on information contained in Change Request (CR) 3627, which describes new Centers for Medicare & Medicaid Services (CMS) procedures and specific instructions to Medicare contractors (carriers, intermediaries, and DMERCs) for voiding, canceling, and deleting claims. As a result of these changes, providers should note that some claims they were able to delete in the past will no longer be deleted from Medicare's systems, but will instead become denied claims.

Background

The Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) has verified instances in which Medicare claims have been voided, canceled, or deleted by Medicare carriers, DMERCs, and FIs. Further, the Medicare contractors have not traditionally maintained an audit trail for the voided, canceled, or deleted claims. The OIG has indicated that Medicare must maintain an audit trail for voided, canceled, and deleted claims.

CMS is therefore implementing requirements for Medicare contractors (carriers/FIs, including DMERCs and regional home health intermediaries (RHHIs)) to:

- Deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons;
- Cancel, void, or delete claims that are unprocessable for acceptable reasons;
- Return as unprocessable claims that meet conditions mentioned below for the return of unprocessable claims; and
- Maintain an audit trail for all canceled, voided, or deleted claims that Medicare systems have processed far enough to have assigned a claim control number (CCN) or document control number (DCN).

Note: CR3627 requires that Medicare carriers, intermediaries, and DMERCs keep an audit trail on these claims once a CCN or DCN has been assigned to the claim.

Acceptable Claims Deletions

Below is a list of acceptable reasons a Medicare contractor may cancel, delete, or void a claim:

1. The current CMS 1500 form or the current CMS 1450 form is not used.
2. The front and back of the CMS 1500 (12/90) claim form are required on the same sheet and are not submitted that way (claims submitted to carriers only).
3. A breakdown of charges is not provided, i.e., an itemized receipt is missing.
4. Only six line items may be submitted on each CMS 1500 claim form (Part B only).
5. The patient's address is missing.
6. An internal clerical error was made.
7. The Certificate of Medical Necessity (CMN) was not with the claim (Part B only).
8. The CMN form is incomplete or invalid (Part B only).
9. The name of the store is not on the receipt that includes the price of the item (Part B only).

Note: The Medicare contractor must keep an audit trail for all claims in the above "Acceptable Claims Deletions" category if a CCN or a DCN was assigned to the claim.

Unacceptable Claims Deletions

The following are unacceptable reasons for Medicare contractors to void, cancel, or delete claims:

1. A provider notifies the Medicare contractor that claim(s) were billed in error and requests the claim be deleted (carrier claims only).
2. The provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (Type of Bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review. (FI claims only)
3. The patient's name does not match any Health Insurance Claim Number (HICN).

- A claim meets the criteria to be returned as unprocessable under the incomplete or invalid claims instructions in the *Medicare Claims Processing Manual*, Chapter 1, Section 80.3.2.ff, which is available at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the CMS website.

Medicare contractors must deny or reject claims in the above “Unacceptable Claims Deletions” category.

Return as Unprocessable Claims

Medicare contractors may return a claim as unprocessable for the following reasons:

- Valid procedure codes were not used and/or services are not described (e.g., block 24D of the CMS 1500) (Part B only).
- The patient’s HICN is missing, incomplete, or invalid (e.g., block 1A of the CMS 1500).
- The provider number is missing or incomplete.
- No services are identified on the claim.
- Block 11 (insured policy group or FECA Number) of the CMS 1500 is not completed to indicate whether an insurer primary to Medicare exists (Part B only).
- The beneficiary’s signature information is missing (Part B only).
- The ordering physician’s name and/or UPIN are missing/invalid (blocks 17 and 17A of the CMS 1500).
- The place of service code is missing or invalid (block 24B of the CMS 1500 – Part B only).
- A charge for each listed service is missing (e.g., block 24F of the CMS 1500).
- The days or units are missing (e.g., block 24G of the CMS 1500).
- The signature is missing from block 31 of the CMS 1500 (Part B only).
- Dates of service are missing or incomplete (block 24A of the CMS 1500).
- A valid HICN is on the claim, but the patient’s name does not match the name of the person assigned that HICN.

Summary

In summary, CMS believes the following:

- The problems listed under the “Acceptable Claims Deletions” heading are valid reasons to void/delete/cancel a claim if the Medicare contractor maintains an audit trail; and
- Claims with problems listed under the “Unacceptable Claims Deletions” heading should be denied or rejected by Medicare, and the decision to deny/reject the claim should be recorded in the Medicare contractor’s claims processing system history file.

If a Medicare contractor determines that a claim is unprocessable before the claim enters that contractor’s claims processing system (i.e., the claim processing system **did not assign a CCN or DCN** to the claim):

- The claim may be denied; and
- The contractor does not have to keep a record of the claim or the deletion.

If a Medicare contractor determines that a claim is unprocessable after the claim enters their claims processing system (i.e., the claim processing system **did assign a CCN or DCN** to the claim):

- The denied or rejected claim will not be totally deleted from Medicare’s claims processing system. The Medicare contractor must maintain an audit trail for all deleted claims that have entered the claims processing system (i.e., the system assigned a CCN or DCN to the claim).

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that Web page, look for CR3627 in the CR NUM column on the right, and click on the file for that CR.

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/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).

Related Change Request (CR) #: 3627
 Related CR Release Date: June 17, 2005
 Effective Date: October 1, 2005

Medlearn Matters Number: MM3627
 Related CR Transmittal #: 159
 Implementation Date: October 3, 2005

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Termination of the Existing Eligibility File-Based Crossover Process at All Medicare Contractors

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 services to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4231, which informs Medicare contractors (carriers, DMERCs, FIs, and RHHIs) about their responsibilities regarding the discontinuance of the current eligibility file-based crossover process effective January 3, 2006. **The impact of CR4231 is primarily on CMS trading partners as defined later in this article. The article is primarily informational for providers.**

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) will discontinue the current eligibility file-based crossover process effective January 3, 2006, and CR 4231 outlines the processes that Medicare contractors must follow when trading partners request a waiver to enable them to move into crossover production with the CMS Coordination of Benefits Contractor (COBC) beyond January 3, 2006.

GO – What You Need to Do

This article is informational only for providers, so they may be aware of the potential for changes in how their claims are forwarded to CMS trading partners for coordination of benefits activities. See the Background Section of this article for further details regarding the termination of the existing eligibility file-based crossover process.

Background

CMS has been testing its national Coordination of Benefits Agreement (COBA) consolidated crossover process with over 120 trading partners starting in July 2004. During this time, CMS and its Coordination of Benefits Contractor (COBC) have brought the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 Coordination of Benefits (COB) claim files into high degrees of compliancy with the Version 4010-A1 837 Institutional and Professional Claim Implementation Guides. Starting in June 2005, CMS has been moving trading partners into crossover production with the COBC, and this trend has recently been accelerating.

Note: “Trading Partner” is defined as an issuer of an insurance policy that supplements Medicare or a State agency responsible for administration of Title XIX of the Social Security Act. It is also defined as a federal agency, or contractor thereof, that administers and provides health care benefits for its eligible beneficiaries or an entity working under contract with a self-insured employer plan or an insurer to adjudicate claims and perform other insurance functions. A trading partner does not include entities that merely receive, route, and/or translate files, such as health care clearing-houses, network service vendors, data transmission services, and billing services. CMS and its COBC may, however, transmit crossover claims to trading partners through one of these entities.

CMS recently provided guidance to all Medicare contractors (carriers, DMERCs, FIs, and RHHIs) regarding the discontinuance of the existing eligibility file-based crossover process effective December 31, 2005 (JSM-06026), and described a waiver process that trading partners who will not be moving into COBA crossover production by December 31, 2005, must follow.

In addition, CR4231 is being issued to:

- Clarify all Medicare contractor requirements as they relate to the discontinuance of the existing eligibility file-based crossover process; and
- Update the end date for the existing Medicare eligibility file-based crossover process to January 3, 2006, for Medicare contractor purposes.

This will enable the Medicare contractors to initiate the termination process for those trading partners **that have not moved** to COBA production by December 31, 2005.

Note: The “eligibility file” is the data file provided by the Trading Partner containing the records required to identify Medicare beneficiaries for purposes of receiving Medicare Part A and B crossover claims and reporting existing prescription drug coverage by the trading partner.

CMS Medicare contractors will not cross claims over to trading partners beyond January 3, 2006, pursuant to signed crossover agreements and the submission of COB eligibility files. As of January 3, 2006, CMS’ COBC will exclusively cross over all claims to trading partners in the HIPAA ANSI X12-N 837 COB (version 4010-A1) formats via the COBA eligibility file-based crossover process, unless:

1. Medicare contractors have submitted waiver requests to CMS on behalf of their current trading partners no later than December 16, 2005 (Note: Trading partners would need to have submitted these requests to the Medicare contractors no later than December 7, 2005), and

2. CMS has approved the trading partners' waiver requests in advance of January 3, 2006. (**Note:** CMS plans to reach a decision on all waiver requests no later than December 21, 2005, unless late waiver requests must be addressed.)

Termination Process Notifications to Trading Partners That Have Not Requested a Waiver

All Medicare contractors will begin the termination of the existing eligibility file based crossover process with each individual trading partner that has not requested and received a waiver no sooner than January 3, 2006.

Impact on Mandatory Medigap ("Claim-Based") Crossovers

The January 3, 2006, end date **does not apply** to mandatory Medigap ("claim based") crossovers, which are authorized by the Omnibus Budget Reconciliation Act of 1987 [Public Law 100-203, Section 4081(a)(B)], and currently supported by Part B and DMERC contractors.

Implementation

The implementation date for this instruction is January 9, 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://new.cms.hhs.gov/transmittals/downloads/R198OTN.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/medlearn/tollnims.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: MM4231	Related Change Request (CR) #: 4231
Related CR Release Date: December 9, 2005	Effective Date: January 9, 2006
Related CR Transmittal #: 198	Implementation Date: January 9, 2006

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Unsolicited/ Voluntary Refunds

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

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

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

Erroneous Guidance – Basis to Waive Penalty

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

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare and who face penalties as a result of such billings

Provider Action Needed

STOP – Impact to You

Providers and suppliers may not be subject to a penalty if the basis for the penalty that would have otherwise been applicable was that the provider acted in accordance with erroneous guidance from the Medicare program.

CAUTION – What You Need to Know

Medicare can grant a waiver of a penalty when ALL of the following conditions are present::

- The guidance was erroneous.
- The guidance was issued by the Secretary of the Department of Health and Human Services or was issued by a Medicare contractor (carrier, fiscal intermediary, durable medical equipment regional carrier (DMERC) or regional home health intermediary (RHHI)) acting within the scope of the contractor's Medicare contract authority.
- The guidance was in writing.
- The guidance related to the furnishing of an item or service or to the submission of a claim for benefits for furnishing such item or service with respect to the provider or supplier submitting such claim.
- The guidance was issued timely.
- The provider or supplier accurately and fully presented the circumstances relating to such items, services, and claim to the Medicare contractor or to the Centers for Medicare & Medicaid Services (CMS), and did so in writing.
- The provider or supplier followed the guidance provided by the Medicare contractor (or by CMS).

GENERAL INFORMATION

GO – What You Need to Do

Review CR3898 if you feel you are being subjected to a penalty for acting in accordance with erroneous guidance from the Medicare program.

Background

Section 903^o of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to as MMA, establishes a basis for waiving penalties and interest charges levied on providers and suppliers who incurred such penalties and/or interest as a result of following Medicare guidance, which turned out to be erroneous. **CR3898 details the conditions under which a provider or supplier may seek a waiver of a penalty due to such erroneous guidance. CR3898 does not address the waiver of interest charges.**

Additional Information

Full details of the process for seeking and obtaining a waiver can be found in Chapter 33 (Miscellaneous Hold Harmless Provisions), Section 10 (Erroneous Program Guidance: Basis to Waive Penalty) of the *Medicare Claims*

Processing Manual. That material is attached to CR3898, which can be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website.

From that website, look for CR3898 in the CR NUM column on the right, and click on the file for that CR.

For additional information relating to this issue, please refer to your local carrier or intermediary at their toll-free number, which may be found at <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: MM3898
Related Change Request (CR) #: 3898
Related CR Release Date: November 1, 2005
Effective Date: July 24, 2003
Related CR Transmittal #: 739
Implementation Date: January 19, 2006

Centers for Medicare & Medicaid Services Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

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

Provider Types Affected

Sample of 25,000 Medicare providers served by 42 Medicare Fee-for-Service (FFS) Contractors, including fiscal intermediaries (FIs), carriers, durable medical equipment regional carriers (DMERCs), and rural home health intermediaries (RHHIs)

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) would like to provide a channel for you to voice your opinions about the services you receive from your Fee-for-Service (FFS) Contractors. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to garner quantifiable data on provider satisfaction with the performance of FFS contractors. The MCPSS is one of the tools CMS will use to carry out the measurement of provider satisfaction levels, a requirement of the Medicare Modernization Act (MMA). Specifically, the survey will enable CMS to gauge provider satisfaction with key services performed by the 42 contractors that process and pay the more than \$280 billion in Medicare claims each year. Those Medicare contractors will use the results to improve service. CMS will use the results to improve its oversight of and increase the efficiency of the administration of the Medicare program.

CAUTION – What You Need to Know

The first national implementation of the MCPSS will begin January 3, 2006. If you have been selected, you will receive a notification packet in the mail with background information about the survey, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet website. The letter will also include a phone number that you can call to request a paper copy of the survey instrument to submit your responses by mail or fax, if you prefer to do so.

GO – What You Need to Do

Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the

time to complete and submit your survey responses as soon as possible. The data collection period will continue through January 25, 2006.

Background

The 2006 survey will query approximately 25,000 randomly selected providers – those physicians, healthcare practitioners, and facilities that serve Medicare beneficiaries across the country – on the seven key areas of the provider contractor interface:

- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

It contains a total of 76 questions and takes approximately 21 minutes to complete. The deadline for survey submission is January 25, 2006. CMS will analyze the data and release a summary report in July that will be made available on the Internet. Each contractor will also receive an individual report on their performance in June. The MCPSS will be conducted on an annual basis. CMS has awarded a contract to Westat, a survey research firm, to administer the MCPSS.

Additional Information

For questions or additional information about the MCPSS, please visit <http://www.cms.hhs.gov/MCPSS/> on the CMS website.

Medlearn Matters Number: SE0602
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 3, 2006
Related CR Transmittal #: N/A
Implementation Date: January 3, 2006

HIPAA - THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Medical Review Matching of Electronic Claims and Additional Documentation in the Medical Review Process

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Provider Action Needed

STOP – Impact to You

Other than certain limited exceptions, such as for providers that employ very few employees, the Centers for Medicare & Medicaid Services (CMS) currently instructs all initial claims to be filed electronically. This is true even when the claim will be subjected to prepayment medical review.

CAUTION – What You Need to Know

Generally, Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), cannot require or permit the voluntary submission of paper claims. If any supporting paper documentation is necessary for medical review, it can only be solicited by the contractor and submitted through the Additional Documentation Request (ADR) or alternate contractor process that permits matching. This supporting documentation must be submitted separately from an electronic claim, at the contractors' request.

Exception: At their discretion, some contractors accept unsolicited paper supporting documentation, if they can match the electronic claim and paper documentation.

GO – What You Need to Do

File initial claims electronically when subjected to prepayment medical review unless you are in an "excepted" category. Unless your contractor informs you that they accept supporting paper documentation with the electronic claim, submit all supporting documentation through the regular ADR process, or alternate contractor process that permits matching.

Background

Although Medicare contractors may use any information they deem necessary to make a prepayment or post-payment claim review determination, contractors may not require providers or suppliers to file initial claims on paper to Medicare when the claim requires additional documentation.

The Administrative Simplification Compliance Act requires providers, with very few exceptions, to submit claims electronically.

Medicare contractors may not require or request of any provider the submission of supporting documentation with the initial claim(s) through contractor developed forms, local policies, or any other communication with providers. Medicare contractors may only request supporting documentation through the ADR process or alternate contractor process that enables matching of the documentation to the initial claim.

Additional Information

The *Medicare Claims Processing Manual*, Chapter 24, Section 90, contains information regarding the limited circumstances under which your contractor may request paper claims. The manual is available at http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf on the CMS website.

The official instruction issued to your carrier/intermediary/DMERC/RHHI 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 CR4052 in the CR NUM column on the right, and click on the file for that CR.

You may also wish to refer to *Medlearn Matters* article MM3440 on the requirements to submit claims electronically. That article is available at <http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3440.pdf> on the CMS website.

If you have any questions, contact your carrier/DMERC/FI/RHHI at their toll free number, which is available at <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).

Related Change Request (CR) #:4052

Medlearn Matters Number: MM4052

Related CR Release Date: November 10, 2005 *Revised*

Related CR Transmittal #: 131

Effective Date: February 10, 2006

Implementation Date: February 10, 2006

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Addition of Hospice Data to HIPAA 270/271 Eligibility Inquiry and Response Transactions

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 Hospice services

Provider Action Needed

This article is based on Change Request (CR) 4193, which adds Hospice data to the Centers for Medicare & Medicaid Services (CMS) Health Insurance Portability and Accountability Act (HIPAA) Health Care Eligibility Benefit Inquiry and Response transaction (270/271). Hospice will be part of the core data elements returned on the 271 response.

Background

CMS is making changes to its Information Technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response in real-time.

CMS is using a phased approach for providing this eligibility transaction on a realtime basis:

- **Extranet:** Clearinghouses, certain providers, and trading partners (as described below) will be permitted to submit 270s via the CMS AT&T communication Extranet (the Medicare Data Communication Network or MDCN). This Extranet is a secure closed private network currently used to transmit data between Medicare Fee-for-Service (FFS) contractors and CMS.
- **Internet:** CMS expects to provide limited internet access to the 270/271 transaction this year. Instructions on accessing eligibility data via this method will be provided prior to the time internet access becomes available.

All electronic 270 files will be processed at the CMS data center, and the CMS data center will use a single consolidated national eligibility database to respond to the eligibility inquiries.

CR4193 revises the *Medicare Claims Processing Manual* (Pub. 100-04) Chapter 31 (ANSI X12 Formats Other than Claims or Remittance), Section 10.2 (Eligibility Extranet Workflow), by adding the following Hospice data to the CMS HIPAA Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

271 Response Data Elements

If a service type code is submitted in a 270 that does not trigger additional Medicare data elements, the following data elements will be returned in the 271 as applicable:

271 Information Returned	Loop	Segment	Element	Data Value
		EB	EB01	X
			EB03	45
			EB04	MA
Hospice Data	2110C		EB06	26
		DTP	DTP01	292
			DTP02	D8 or RD8
			DTP03	Dates

Implementation

The implementation date for the instruction is January 23, 2006.

Additional Information

Medlearn Matters Article MM3883 provides information regarding the access process for beneficiary eligibility inquiries and replies (HIPAA 270 and 271 transactions, Extranet Only). It can be reviewed at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3883.pdf> on the CMS website.

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/R793CP.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: MM4193
 Related CR Release Date: December 29, 2005
 Related CR Transmittal #: R793CP

Related Change Request (CR) #: 4193
 Effective Date: January 23, 2006
 Implementation Date: January 23, 2006

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Completion of Attestation for All 270/271 Transactions

The Centers for Medicare and Medicaid Services (CMS) is making changes to its information technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response in real-time.

Providers are reminded that an attestation form must be completed prior to accessing the real-time eligibility application. This attestation form is available online on the CMS website at <http://www.cms.hhs.gov/it>.

Source: CMS Pub. 100-04, Transmittal 700, CR 4093

Medicare Remit Easy Print Brochure Now Available

The Medicare Remit Easy Print (MREP) brochures are now available from the Medlearn Product Ordering Page which is available at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5. The MREP brochure is available in the Office Management Information section and reads as follows:

Medicare Remit Easy Print (ICN #006740) (October 2005) (Brochure)

The brochure is also available for download from the Medlearn Web page through the Medlearn Products - Medlearn Publications list or it can be downloaded directly at http://www.cms.hhs.gov/MedlearnProducts/downloads/remit_easy_print.pdf. As a reminder, MREP version 1.6 became available for download beginning January 17, 2006.

MREP software allows professional providers (including physicians, suppliers, and qualified nonphysician practitioners) to view and print the Health Insurance Portability and Accountability Act (HIPAA) compliant 835, in the standard paper remittance advice format, from their own computers.

Benefits of **MREP** software include its search capabilities and great reporting features. These brochures may be used during your provider outreach and training activities.

Best of all, MREP software is free!

Source: Provider Education Resources Listserv, Message 200511-01
 Provider Education Resources Listserv, Message 200601-04



MEDICARE B UPDATE!

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*** ATTENTION BILLING MANAGER ***

