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

Highlights In This Issue…

Features

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

Routing Suggestions:

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

Medicare B Update!

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Publications Staff
Terri Drury
Millie C. Pérez
Mary Barnes

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

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

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

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

The Provider Outreach & Education Publications team distributes the *Medicare B Update!* on a monthly basis. Monthly publications allow our team to better serve our customers by making valuable information available in a more timely manner.

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

Who Receives the *Update?*

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

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

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

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

Clear Identification of State-Specific Content

Articles common to both states appear at the beginning of the publication. Within common articles, references to phone numbers, addresses, reimbursement amounts, past publications, etc., are state-specific as appropriate. Content specific to Connecticut is next, followed by content specific to Florida. Connecticut and Florida local coverage determination (LCD) summaries are combined into one section. Articles in this section applies to both Connecticut and Florida unless otherwise noted.

Publication Format

The *Update!* is arranged into distinct sections.

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

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

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

Educational resources. Important **addresses, phone numbers**, and **websites** will *always* be in state-specific sections.

Advance Beneficiary Notices

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

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

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

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

Patient Liability Notice

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

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users. Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found on CMS's BNI website at *http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage.*

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

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

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

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

Connecticut
Medicare Part B Redeterminations Appeals
PO Box 45010
Jacksonville, FL 32232-5010

OR

Florida
Medicare Part B Redeterminations Appeals
PO Box 2360
Jacksonville, FL 32231-0018

CLAIMS

New Deadline for Required Submission of the Form CMS-1500 (08-05)

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

Provider Types Affected

Physicians and suppliers who qualify for an exemption from the mandatory electronic claims submission requirements, and who submit Medicare claims to carriers, Medicare administrative contractors (MACs), and durable medical equipment Medicare administrative contractors (DME MACs) using the paper claim Form CMS-1500.

Provider Action Needed

CR 5616, from which this article is taken, announces that, beginning July 2, 2007, you must use the Form CMS-1500, version (08-05) for paper claims submission to Medicare. Claims received on or after July 2, 2007, using Form CMS-1500, version (12-90) will be rejected.

Make sure that your billing staffs use Form CMS-1500 (08-05) for your claims, beginning July 2, 2007.

Background

The Form CMS-1500 is the paper claim form that physicians and suppliers, who qualify for an exemption from the mandatory electronic claims submission requirements (as set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32), use to submit claims.

CR 5568, released March 19, 2007, instructed Medicare contractors to continue to accept the earlier (12-90) version of Form CMS-1500 (tentatively until June 1, 2007), because of reports that some vendors had printed the newer (08-05) version of the form incorrectly. After analysis, however, the problem does not appear to be as widespread as previously suspected.

Therefore, CR 5616, from which this article is taken, announces, based on the information at hand, that beginning July 2, 2007, you will need to submit claims using the Form CMS-1500 (08-05).

Note: CR 5616 addresses submission of the revised Form CMS-1500 paper claim form only, and has no bearing on the implementation of the national provider identifier (NPI), nor does CR 5616 mandate the submission of the NPI by July 1, 2007.

Additional Information

You may find more information about the official instruction issued to your Medicare contractor on this issue (CR 5616) at *http://www.cms.hhs.gov/Transmittals/downloads/R1247CP.pdf* on the CMS Web site.

If you have any questions, please contact your carrier, MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5616	Related Change Request (CR) #: 5616
Related CR Release Date: May 25, 2007	Effective Date: July 1, 2007
Related CR Transmittal #: R1247CP	Implementation Date: July 2, 2007

Clarification—Revisions to Incomplete or Invalid Claim Instructions

As a result of change request 5391, the Centers for Medicare & Medicaid Services (CMS) has revised the instructions related to searching contractor's internal files to correct certain missing or incomplete claims data on electronic claims, which are governed by HIPAA.

Effective for claims received on or after July 1, 2007, First Coast Service Options, Inc. (FCSO) will return as unprocessable, claims for services that are missing or contain invalid "required" or "conditional" data elements as outlined in CMS IOM Publication 100-04, Chapter 1, Sections 80.3.2.1.1 through 80.3.2.1.3. FCSO will not search their internal files to correct these claims or services. Examples of these data elements include:

- If a claim lacks a valid Medicare Health Insurance Claim Number (HICN).
- A claim does not contain complete information for the billing provider such as an invalid legacy and/or NPI number.

Additional Information

For complete details, please see the official instruction regarding this change, which may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1187CP.pdf* on the CMS Web site.

You may also view the MLN Matters article MM5391 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5391.pdf*

Source: Publication 100-04, Chapter 1, Sections 80.3.2.1.1 through 80.3.2.1.3

AMBULANCE

Medicare Payments for Ambulance Transports

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

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MAC) for ambulance services or who initiate ambulance transports for their Medicare patients.

Provider Action Needed

STOP – Impact to You

According to a recent study conducted by the Office of the Inspector General (OIG), "Medicare Payments for Ambulance Transports," during the calendar year 2002 twenty-five percent of ambulance transports did not meet Medicare's program requirements. This resulted in an estimated $402 million of improper payments. In two out of three cases, third-party providers (most likely not the patient) who requested transports may not have been aware of Medicare's requirements for ambulance transports.

CAUTION – What You Need to Know

Liability for overpayment resulting from a denied ambulance transport claim depends on the type of denial. A denial due to coverage reasons (such as when other forms of transportation are not contraindicated) may result in a liability to the Medicare beneficiary unless he or she lacks constructive knowledge that the service is not covered. Claims denied due to level of service requirements are often down-coded to a lower level of ambulance service. In this case, the ambulance supplier is generally liable in the event of an overpayment.

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. It is important to know whether the use of an ambulance transport for your patient would be covered by Medicare, and if so, what level of service would be covered. Please refer to the *Background* section of this special edition article for information about payment and level of service requirements for ambulance transports.

Background

Some key provisions of the OIG Report are as follows:

Medicare Coverage of Ambulance Transports

When evaluating coverage of ambulance transport services, two separate questions are considered:

1. Would the patient's health at the time of the service be jeopardized if an ambulance service was not used? If so, Medicare will cover the ambulance service whether it is emergency or non-emergency use of the transport. If not, the Centers for Medicare & Medicaid Services (CMS) will deny the transport claim. Additionally, Medicare does not cover non-ambulance transports.
2. Once coverage requirements are met, Medicare asks the following question: What level of service (determined by medical necessity) is appropriate with regard to the diagnosis and treatment of the patient's illness or injury? If the incorrect level of service is billed and subsequently denied, Medicare will usually reimburse at a lower rate reflecting the lower level of services judged appropriate.

Levels of ambulance service are differentiated by the equipment and supplies carried in the transport and by the qualifications and training of the crew. They include:

a) Basic life support

b) Advanced life support

c) Specialty care transport

d) Air transport – fixed wing and rotary wing

Emergency Ambulance Transport

An emergency transport is one provided after the sudden onset of a medical condition that manifests itself with acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to:

- Place the patient's health in serious jeopardy;
- Result in serious impairment of bodily functions; or
- Result in serious dysfunction of any bodily organ.

Symptoms or conditions that may warrant an emergency ambulance transport include, but are not limited to:

- Severe pain or hemorrhage;
- Unconsciousness or shock;
- Injuries requiring immobilization of the patient;
- Patient needs to be restrained to keep from hurting himself or others;
- Patient requires oxygen or other skilled medical treatment during transportation; and
- Suspicion that the patient is experiencing a stroke or myocardial infarction. See chapter 15 of the *Medicare Claims Processing Manual* (Pub. 100-4) and chapter 10 of the *Medicare Benefit Policy Manual* (Pub. 100-2) at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Non-Emergency Ambulance Transports

Non-emergency ambulance transportation is appropriate with a patient who is bed-confined AND his/her condition is such that other methods of transportation are contraindicated; OR if the patient's condition, regardless of bed-confinement, is such that transportation by ambulance is medically required (patient poses a danger to him or herself or to others). **Bed-confinement alone is neither sufficient nor necessary to determine the coverage for Medicare**

Medicare Payments for Ambulance Transports, continued

benefits. To be considered bed-confined, **the patient must be unable to do all three of the following**:

- Get up from bed without assistance
- Ambulate
- Sit in a chair or wheelchair.

Documentation Requirements

Ambulance suppliers are not required to submit documentation in addition to the uniform Medicare billing form CMS-1500 submitted by independent ambulance suppliers to Medicare carriers or A/B MACs or the UB-04 (form CMS-1450) billed to FIs or A/B MACs by ambulance suppliers that are owned by or affiliated with a Medicare Part A provider such as a hospital.

However, ambulance suppliers are required to retain documentation that contains information about the personnel involved in the transport and the patient's condition and to be made available to Medicare FIs, carriers, and A/B MACs upon request. Ambulance suppliers are also required to obtain a Physician Certification Statement (PCS) for non-emergency transports. The PCS states the reason(s) a patient requires non-emergency transportation by ambulance. It is effective for 60 days from the date it is signed. The PCS, or proof of the supplier's attempt to obtain it, is required within 48 hours after provision of the ambulance service. The "trip ticket" is documentation used in emergency transports and contains the date, mileage, crew, origin, destination, type and level of ambulance service provided, patient condition, the type of service, and supplies provided to the patient while in transport.

How to Avoid Improper Billing

- Be sure that coverage criteria and level of service criteria for ambulance transport are met and that it is backed up with the appropriate documentation. For guidance, you may wish to refer to change request (CR) 5422 "Ambulance Fee Schedule – Medical Conditions List – Manualization," which contains an educational guideline that was developed to assist ambulance providers and suppliers communicate the patient's condition to Medicare FIs, carriers, and A/B MACs as reported by the dispatch center and as observed by the ambulance crew. The link to this CR is provided below.
- Maintain documentation that will help to determine whether ambulance transports meet program requirements when Medicare FIs, carriers, and A/B MACs conduct medical reviews. Be sure to send complete documentation when requested by your FI, carrier, or A/B MAC. Generally, coverage errors for emergency transports were due to documentation discrepancies between the ambulance supplier and the third-party provider (e.g., emergency room records).
- Note whether your FI, carrier, or A/B MAC has implemented origin or destination modifiers such as for a dialysis facility and for non-emergency transports to and from a hospital, nursing home, or physician's office. Be sure to include these modifiers (if available) when billing for ambulance services. They will help your FI, carrier, or A/B MAC to determine, through a prepayment edit process, whether the coverage and/or level of service for ambulance use is correct.

Additional Information

SE0724 is based on the January 2006 U.S. Department of Health and Human Services (HHS) OIG report, *Medicare Payments for Ambulance Transports*, which is located at *http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf* on the OIG HHS Web site.

CR 5422, dated February 23, 2007, "Ambulance Fee Schedule – Medical Conditions List – Manualization Revisions," is located at *http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: SE0724
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

ANESTHESIA

Anesthesia Services Overpayments

The New England Benefit Integrity Support Center (NE-BISC), a Centers for Medicare & Medicaid (CMS) program safeguard contractor (PSC), has identified potential overpayments made by First Coast Service Options, Inc. (FCSO) for services billed to Medicare by anesthesia providers in the Florida Medicare jurisdiction. These overpayments are based upon an apparent provider billing error.

The claims processing system used by FCSO is programmed to convert the total anesthesia minutes reported in the units field of the (electronic version) Form CMS-1500 into 15-minute increments in order to properly adjudicate payment, using the CMS mandated payment methodology. Correct adjudication is dependent upon providers selecting the modifier MJ when billing anesthesia time in minutes. All other anesthesia services are reported per session or per service with the modifier UN.

At this time, FCSO is asking that you verify your billing procedures relative to this issue. Please ascertain that your billing staff and/or clearinghouse are correctly submitting your anesthesia minutes on the electronic version of the Form CMS-1500 using the modifier MJ. In addition, FCSO requests that you perform self-audits on your billing procedures. If you determine that an overpayment exists, please follow the Voluntary Refund process. To access a refund form and instructions for its use, please visit *http://www.floridamedicare.com* and click on the "forms" link under the "Resources/Tools" heading on the left side of the Web site's main page.

FCSO is implementing a corrective action to address this billing issue. Data analysis performed by the PSC identified a wide spectrum of incorrectly billed anesthesia services, ranging from simple over-billing of units to billing medically unbelievable units of anesthesia services per date of service. A system edit is being developed and will be implemented to prevent medically unbelievable billing errors. Units of service that exceed the medically unbelievable threshold will be denied.

CONSOLIDATED BILLING

October Quarterly Update to 2007 Annual Update of HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement

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

Provider Types Affected

Skilled nursing facilities (SNFs) and other providers submitting claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries in SNFs.

What Providers Need to Know

- The 2007 fiscal intermediary (FI) annual update Major Category IV A. mammography screening codes (*77055* and *77056*), that are subject to the consolidated billing (CB) provision of the SNF prospective payment system (PPS) are REMOVED with a retroactive effective date of January 1, 2007. change request (CR) 5636, on which this article is based, removes these two codes from the FI file.
- Healthcare Common Procedure Coding System (HCPCS) codes Q1001 and Q1002 are added to the File 1 Coding file and are effective for dates of service prior to June 30, 2005. Please refer to the *Background* and *Additional Information* sections for more information.

Background

Periodically, the Centers for Medicaid & Medicare Services (CMS) updates the lists of HCPCS codes (for FIs, carriers, and durable medical equipment Medicare administrative contractors [DME/MACs]) that are subject to the CB provision of the SNF PPS. This particular update, however, applies to providers who bill for NTIOLs furnished in ambulatory surgical centers (ASCs) as well as providers billing Medicare FIs for Major Category IV. A. Mammography Screening. The mammography codes for screening and diagnostic mammography services that are **no longer valid as of January 1, 2007 are**:

- Diagnostic mammography, unilateral – *CPT* code *77055*
- Diagnostic mammography, bilateral – *CPT* code *77056*

NTIOLS that are now reimbursable separately by the carrier/MAC for dates of service prior to June 30, 2005 are:

- Q1001 (Category 1, AMO Array Multifocal lens: Model # SA40N); and
- Q1002 (Category 2, Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Lens).

October Quarterly Update to 2007 Annual Update of HCPCS Codes Used for SNF CB, continued

In addition, Medicare edits allow the payment of the $50 additional fee for category 3 NTIOLs for dates of service prior to January 1, 2007, when billed with HCPCS code Q1003. (See MM4361 for additional information about NTIOLs and Q1003 and the article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4361.pdf* on the CMS Web site.)

Remember that:

- With the exception of SNFs, Medicare will not pay providers for services appearing on the list of services **included** in SNF CB.
- Conversely, Medicare will pay non- SNF providers for beneficiary services **excluded** from SNF PPS and CB, even when in a SNF stay.
- SNF CB applies to non-therapy services only when furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.
- FIs, carriers and A/B MACs will not search their files for claims affected by this change to either retract payment for claims already paid or to retroactively pay claims, but will adjust such claims that you bring to their attention.

Additional Information

To see the official instruction (CR 5636) issued to your Medicare carrier, FI or A/B MAC, go to *http://www.cms.hhs.gov/Transmittals/downloads/R1266CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

Also, MM3901 is the article that announced the cessation of the additional $50 payment for NTIOLs for codes Q1001 and Q1002 and that article may be viewed at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3901.pdf* on the CMS Web site.

You may find more information about the new 2007 mammography *CPT* codes by going to CR 5327, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1070CP.pdf* on the CMS website. There, as an attachment to that CR, you will find revised chapter 18 (Preventive and Screening Services), section 20 (Mammography Services) of the *Medicare Claims Processing Manual* (100-04).

MLN Matters Number: MM5636
Related Change Request (CR) #: 5636
Related CR Release Date: June 15, 2007
Effective Date: April 1, 2002
Related CR Transmittal #: R1266CP
Implementation Date: October 1, 2007

DRUGS AND BIOLOGICALS

July 2007 Quarterly Average Sales Price Medicare Part B Drug Pricing File and Revisions to January and April 2007 Files

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

Note: This article was revised on June 25, 2007, to delete references in the title and elsewhere to a revised October 2006 ASP file. All other information is the same.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment regional carriers [DMERCs], DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5646 which informs Medicare providers of the availability of the July 2007 average sales price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 and April 2007 ASP files. Providers should make certain that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303[c]) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals

July 2007 Quarterly ASP Medicare Part B Drug Pricing File and Revisions to January and April 2007 Files, continued

not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. CMS also posts these files to its Web site at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/*.

As announced in late 2006, after carefully examining Section 1847A of the Social Security Act, as added by the Medicare Modernization Act of 2003, CMS has been working further to ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A. As part of this effort, CMS reviewed how the terms "single source drug," "multiple source drug," and "biological product" are operationalized in the context of payment under section 1847A. For the purposes of identifying "single source drugs" and "biological products" subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. CMS will consider:

- The Food and Drug Administration (FDA) approval
- Therapeutic equivalents as determined by the FDA
- The date of first sale in the United States.

For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003, the payment limit under section 1847A for that biological product or single source drug will be based on the pricing information for products produced or distributed under the applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may also be operationalized through use of existing specific HCPCS codes or "not otherwise classified" (NOC) HCPCS codes.

For 2007, a separate fee of $0.152 per international unit (I.U.) of blood clotting factor furnished is payable when a separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis 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. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.
- Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. **The payment allowance limits will not be updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded.
- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department and, then, is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.
- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDAand that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. 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. Medicare contractors determine payment limits for radiopharmaceuticals based on the

July 2007 Quarterly ASP Medicare Part B Drug Pricing File and Revisions to January and April 2007 Files, continued

methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after June 19, 2007, revised January 2007 and April 2007 ASP payment files and the July 2007 ASP file will be available for retrieval from the CMS ASP webpage. 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. The CMS ASP webpage is located at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/* on the CMS Web site. The revised files are applicable to claims based on dates of service as shown in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
July 2007	July 1, 2007 through September 30, 2007
January 2007	January 1, 2007 through March 31, 2007
April 2007	April 1, 2007 through June 30, 2007

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (section 1842[b] [18] [C]); *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm* may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

The official instruction (CR 5646) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1270CP.pdf* on the CMS Web site.

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

MLN Matters Number: MM5646 Related Change Request (CR) #: 5646
Related CR Release Date: June 15, 2007 Effective Date: July 1, 2007
Related CR Transmittal #: R1270CP Implementation Date: July 2, 2007

July 2007 Quarterly Update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast®

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI] including regional home health intermediaries [RHHI]), Medicare administrative contractors [A/B MAC] and durable medical equipment Medicare administrative contractors [DME MAC]) for providing albuterol, levalbuterol, Reclast®, and Zometa® to Medicare beneficiaries.

What Providers Need to Know

Change request (CR) 5645, from which this article is taken, implements the July 2007 quarterly update to the Health Care Procedure Code System (HCPCS) codes for albuterol, levalbuterol, and Reclast®.

Effective for dates of service on or after July 1, 2007, the following HCPCS codes are no longer payable by Medicare: J7611, J7612, J7613, and J7614; and the following are payable by Medicare: Q4093, Q4094, and Q4095. Code J3487 continues in use for Zometa®.

July 2007 Quarterly Update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast®, continued

You should make sure that your billing staffs are aware of these HCPCS code changes.

Background

CR 5645, from which this article is taken, implements the July, 2007 quarterly update to the HCPCS codes for Albuterol, Levalbuterol, and Reclast®.

Effective July 1, 2007, the HCPCS codes in **Table 1** will no longer be payable for Medicare.

Table 1
HCPCS Codes Not Payable for Dates of Service on or after July 1, 2007

HCPCS Code	Short Description	Long Description
J7611	Albuterol non-comp con	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg
J7612	Levalbuterol non-comp con	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
J7613	Albuterol non-comp unit	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
J7614	Levalbuterol non-comp unit	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg

In place of the Table 1 codes, the HCPCS codes displayed in **Table 2** will be payable, effective July 1, 2007.

Table 2
HCPCS Codes Payable for Services on or After July 1, 2007

HCPCS Code	Short Description	Long Description
Q4093	Albuterol inh non-comp con	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)
Q4094	Albuterol inh non-comp u d	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)

In addition, a new code, Q4095 (in **Table 3**) will be effective July 1, 2007, for Reclast®.

Table 3
HCPCS Q4095 Payable for Services on or after July 1, 2007

HCPCS Code	Short Description	Long Description
Q4095	Reclast injection	Injection, zoledronic acid (Reclast), 1 mg

Also, please note the following:

- Currently, Reclast® 5 mg/100 ml bottle (NDC 0078-0435-61) is the only product that should be billed using code Q4095. If other products under the FDA's approval for Reclast® become available, code Q4095 would be used to bill for such products.
- HCPCS code J3487 (short description: Zoledronic acid; long description: Injection, zoledronic acid, 1 mg) is used to bill for products under the FDA's approval for Zometa® or such therapeutically equivalent products that may become available as identified in the FDA's Orange Book.
- Payment limits for the new Q codes will be included in the July 2007 quarterly average sales price payment file, when those files are posted at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage*.
- Payment information for the new Q codes under the hospital outpatient prospective payment system (OPPS) may be found in the July 2007 update of OPPS Addendum A and Addendum B when those addendums are added to the hospital outpatient Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage/*.

July 2007 Quarterly Update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast®, continued

Additional Information

You may find the official instruction, CR 5645, issued to your carrier, FI (including RHHI), A/B MAC or DME MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1260CP.pdf* on the CMS Web site

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5645 Related Change Request (CR) #: 5645
Related CR Release Date: June 1, 2007 Effective Date: July 1, 2007
Related CR Transmittal #: R1260CP Implementation Date: July 2, 2007

Revised HCPCS Codes Relating to Immune Globulin

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

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (carriers; fiscal intermediaries [FI], including regional home health intermediaries [RHHIs]; Medicare administrative contractors [A/B MACs]; and durable medical equipment Medicare administrative contractors [DME MACs]) for immune globulin.

What You Need to Know

CR 5635, from which this article is taken, implements HCPCS coding changes for immune globulin. **On and after July 1, 2007:**

- HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized [e.g. liquid], 500 mg) will no longer be payable by Medicare.
- In its place, the following HCPCS codes are payable: Q4087 (Octagam injection), Q4088 (Gammagard liquid injection), Q4091 (Flebogamma injection), and Q4092 (Gamunex Injection);
- In addition, for services on or after July 1, 2007, two new codes are payable:
  - Q4089 (Rhophylac injection). Note that currently, Rhophylac® is the only product that should be billed using code Q4089. If other products under the Food and Drug Administration's (FDA) approval for Rhophylac® become available, code Q4089 would be used to bill for such products.
  - Q4090 (HepaGam B injection). Note that currently, HepaGam B™, when given intramuscularly, is the only product that should be billed using code Q4090. If other products under the FDA's approval for HepaGam B™ IM become available, code Q4090 would be used to bill for such products. HepaGam B™ when given intravenously should be billed using an appropriate not otherwise classified (NOC) code in the absence of a specific HCPCS code.
- For institutional claims, revenue code 0636 should be used for billing codes Q4087, Q4088, Q4089, Q4090, Q4091, and Q4092.
- As described in CR 5428, Medicare contractors will pay for pre-administration-related services (G0332) associated with intravenous Immune Globulin administration when Q4087, Q4088, Q4091, or Q4092 is billed in lieu of J1567.

Make sure that your billing staffs are aware of these Immune Globulin HCPCS code changes.

Background

CR 5635, from which this article is taken, implements HCPCS coding changes for immune globulin, effective for services on or after July 1, 2007. See below, for details.

HCPCS Code Changes for Immune Globulin, Effective July 1, 2007

HCPCS Code	Short Description	Long Description
Status: Not Payable by Medicare on or after July 1, 2007		
J1567	Immune globulin, liquid	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg
Status: Payable for services on or after July 1, 2007		
Q4087	Octagam Injection	Injection, immune globulin (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg

Revised HCPCS Codes Relating to Immune Globulin, continued

HCPCS Code	Short Description	Long Description
Status: Payable for services on or after July 1, 2007		
Q4088	Gammagard liquid injection	Injection, immune globulin (Gammagard liquid), intravenous, non-lyophilized (e.g. liquid), 500 mg
Q4091	Flebogamma injection	Injection, immune globulin (Flebogamma), intravenous, non-lyophilized(e.g. liquid), 500 mg
Q4092	Gamunex injection	Injection, immune globulin (Gamunex), intravenous, non-lyophilized (e.g., liquid), 500 mg
Status: New/Payable for services on or after July 1, 2007		
Q4089*	Rhophylac injection	Injection, Rho(D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 iu
Q4090^	HepaGam B injection	Injection, hepatitis B immune globulin (HepaGam B), intramuscular, 0.5 ml

*Currently, Rhophylac® is the only product that should be billed using code Q4089. If other products under the FDA approval for Rhophylac® become available, code Q4089 would be used to bill for such products.

^Currently, HepaGam B™, when given intramuscularly, is the only product that should be billed using code Q4090. If other products under the FDA's approval for HepaGam B™ IM become available, code Q4090 would be used to bill for such products. HepaGam B™ when given intravenously should be billed using an appropriate NOC code in the absence of a specific HCPCS code.

Additional Information

You may find the official instruction issued to your Medicare contractor about the revised HCPCS codes relating to Immune Globulin by going to CR 5635, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1261CP.pdf* on the CMS Web site.

Payment limits for the new Q codes will be included in the July 2007 quarterly average sales price payment file, which will be posted at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage.*

In addition, more information regarding the outpatient prospective payment system (OPPS) and the new Q codes in the July update of OPPS Addendum A and Addendum B on the hospital outpatient Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage*.

You might also want to look at CR 5428 (Medicare Payment for Pre-administration-Related Services Associated with IVIG Administration—Payment Extended through CY 2007). The *MLN Matters* article (MM5428) associated with that CR is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5428.pdf* on the CMS Web site.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5635
Related Change Request (CR) #: 5635
Related CR Release Date: June 1, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1261CP
Implementation Date: July 2, 2007

Revisions to Chapter 17, Sections 40 and 100, Regarding Discarded Drugs and Biologicals and Submission of Claims With the Modifier JW, "Drug Amount Discarded/Not Administered to Any Patient"

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

Provider Types Affected

Physicians, hospitals, other providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], regional home health intermediaries [RHHI], Part A/B Medicare administrative contractors [MACs], durable medical equipment Medicare administrative contractors [DME MACs]) for administering or supplying drugs and biologicals.

What You Need to Know

CR 5520, from which this article is taken, revises the *Medicare Claims Processing Manual*, chapter 17, sections 40 and 100.2.9 to include language that references payment for administering (and discarding) both single use vials and single use packages. Specifically, the change is to clarify that Medicare will cover the amount of a single use vial or single use package of a drug or biological that was discarded along with the amount of that single use vial/package that was administered to the Medicare patient.

Background

CR 5520, from which this article is taken revises the *Medicare Claims Processing Manual*, chapter 17 (Drugs and Biologicals), sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) to ensure the proper billing of discarded drugs and biologicals in both single use vials and single use packages.

These revisions are summarized as follows:

- The Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals and other providers to schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.
- Section 40 of chapter 17 is amended to address single use vials/packages of drugs and boilogicals. If after administering a dose/quantity of the drug or biological to a Medicare patient, a physician, hospital or other provider must discard the remainder of a single use vial or other single use package, the program provides payment for the amount of drug or biological administered and the amount discarded, up to the total amount of the drug or biological as indicated on the vial or package label.
- Section 100.2.9 is amended to show that CMS will reimburse physicians, providers and suppliers for the amount of a drug or biological administered (and for the amount discarded) when:
- The participating competitive acquisition program (CAP) physician has made a good faith effort to minimize the unused portion of the CAP drug or biological in scheduling patients and in ordering, accepting, storing, and using the drug or biological;
- In its process of supplying the drug or biological to the participating CAP physician, the approved CAP vendor has made a good faith effort to minimize the unused portion of the drug or biological.

Note: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Additional Information

You can view CR 5520, the official instruction issued to your Medicare contractor, by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1248CP.pdf* on the CMS Web site. You will find the revised *Medicare Claims Processing Manual*, chapter 17 (Drugs and Biologicals), sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) as an attachment to that CR. If you have any questions, please contact your FI, RHHI, carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5520
Related Change Request (CR) #: 5520
Related CR Release Date: May 25, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1248CP
Implementation Date: July 2, 2007

DURABLE MEDICAL EQUIPMENT

July Quarterly Update for 2007 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule

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

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME regional carriers [DMERCs], DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5641, which provides the July 2007quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error or that may no longer be paid under the fee schedule. Be sure billing staff are aware of these changes.

Background

The quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), chapter 23, section 60; *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS Web site.

CR 5641 provides specific instructions regarding the July quarterly update for the 2007 DMEPOS fee schedule. 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], and [i]). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in Title 42 of the *Code of Federal Regulations* (42 CFR 414.102).

Key Points

The following are key changes in the July 2007 quarterly update of the DMEPOS fee schedule including the Healthcare Common Procedure Coding System (HCPCS) codes:

- **HCPCS code E0762** (Transcutaneous electrical joint stimulation device system, includes all accessories) is:
- **Added** to the fee schedule on **July 1, 2007, and**
- **Effective** for claims submitted with dates of service on or after **January 1, 2007**.
- HCPCS codes added July 1, 2007 with dates of service on or after July 1, 2007 are:
- **K0553** Combination Oral/Nasal Mask, Used With Continuous Positive Airway Pressure Device, Each
- **K0554** Oral Cushion For Combination Oral/Nasal Mask, Replacement Only, Each
- **K0555** Nasal Pillows For Combination Oral/Nasal Mask, Replacement Only, Pair
- Suppliers must use the **modifier KL** on claims for all diabetic supplies that are **delivered via mail** with dates of service on or after **July 1, 2007,** with the following codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258 and A4259. The modifier KL must be used with diabetic supplies that are ordered remotely (i.e., by phone, email, Internet, or mail) and delivered to the beneficiary's residence by common carriers (e.g., U.S. postal service, Federal Express, United Parcel Service) and not with items obtained by beneficiaries from local supplier storefronts.
- Fee schedule amounts for HCPCS code E2374 (Power Wheelchair Accessory, Hand or Chin Control Interface, Standard Remote Joystick [Not Including Controller]), Proportional, Including all Related Electronics and Fixed Mounting Hardware, Replacement Only) are being revised to correct errors in the fee schedule calculation. Medicare contractors will adjust previously processed claims with dates of service on or after January 1, 2007, if resubmitted as adjustments.
- If suppliers re-submit previously processed claims for **code K0864 in Puerto Rico with dates of service from November 15, 2006, through March 31, 2007,** the DME MACs and DMERCs will adjust the claims for payment.

Also, after consulting with the Food and Drug Administration, the Centers for Medicare & Medicaid Services (CMS) determined that ultraviolet light therapy systems are classified as class II devices and are not class III devices. Thus, suppliers should not submit the class III modifier KF with claims for HCPCS codes E0691, E0692, E0693 and E0694 with dates of service on or after January 1, 2005. CMS is removing HCPCS codes E0691, E0692, E0693, and E0694, billed with the modifier KF, from the fee schedule, effective July 1, 2007 and as of that date, Medicare contractors will reject claims for HCPCS codes E0691, E0692, E0693, and E0694, which contain the modifier KL and a date of service on or after January 1, 2005. Medicare contractors will adjust previously processed claims for E0691, E0692, E0693 and E0694 with dates of service on or after January 1, 2007, if suppliers resubmit the claims as adjustments.

The HCPCS Quarterly Update public use file, containing the long and short descriptors for all new codes, is available for downloading at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp*.

July Quarterly Update for 2007 DMEPOS Fee Schedule, continued

Additional Information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

For complete details regarding this CR please see the official instruction (CR 5641) issued to your Medicare A/B MAC, FI, DMERC, DME MAC, RHHI or carrier. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1263CP.pdf* on the CMS Web site.

MLN Matters Number: MM5641
Related Change Request (CR) #: 5641
Related CR Release Date: June 8, 2007
Effective Date: January 1, 2007 for implementation of fee schedule amounts for codes in effect on January 1, 2007; July 1, 2007 for all other changes
Related CR Transmittal #: R1263CP
Implementation Date: July 2, 2007

MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

Update to the 2007 Medicare Physician Fee Schedule Database

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

Provider Types Affected

Physicians and providers who submit claims to Medicare contractors (fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], carriers) for services rendered to Medicare beneficiaries that are paid based on the Medicare physician fee schedule database (MPFSDB).

Provider Action Needed

STOP – Impact to You

Payment files for the MPFS were issued based on the December 1, 2006 Medicare physician fee schedule final rule. Change request (CR) 5614, amends those files and includes new/revised codes for the Physician Quality Reporting Initiative (PQRI).

CAUTION – What You Need to Know

Physicians and providers may want to pay particular attention to **Attachment 1** of CR 5614 that identifies the changes included in the July Update to the 2007 MPFSDB—the **highlights of attachment 1 are:**

- Effective for dates of service on or after July 1, 2007 category II modifier 8P will be recognized in addition to category II modifiers 1P, 2P and 3P. (**Note**: Modifier 8P is intended to be used as a "reporting modifier" to allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified.)
- Effective for dates of service on or after January 1, 2007, Medicare contractors will update their systems to reflect 11 base units for *CPT* code *00797*.
- This CR 5614 lists the new category II HCPCS codes that will be added to the MPFSDB with a status indicator of "M" for the PQRI.

GO – What You Need to Do

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

Background

Section 1848 (c)(4) of the Social Security Act provides for the establishment of the policies needed in order to implement relative values for physicians' services. CR 5614 is the official document that announces these changes in the Medicare schedule. Rather than duplicate all the additions, deletions and changes in this article, the Centers for Medicare & Medicaid Services (CMS) directs you to **CR 5614, which contains lengthy lists of these items.** CR 5614 is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1258CP.pdf* on the CMS Web site.

As mentioned above, the key portion of CR 5614 is Attachment 1, which includes the following information:

Update to the 2007 Medicare Physician Fee Schedule Database, continued

- Several changes retroactive to January 1, 2007. The changes are for the following CPT/HCPCS codes:
  - *00797* (base units set to 11);
  - *0115T*, *0116T*, and *0117T* (procedure status is now N);
  - *19301* (short descriptor is Partial mastectomy);
  - *33208* (work RVUs set to 8.72);
  - *75365*-TC (diagnostic indicator set to 02); and
  - *77422*, *77423*, G9041, G9042, G9043, G9044 (PE RVU changes).
- Codes *0024T* and *0133T* are assigned a procedure status of I effective for dates of service on or after July 1, 2007.
- As previously mentioned, modifier 8P is added for the PQRI program.
- The list of G codes that are no longer used for the PQRI program as of July 1, 2007.
- The list of new *CPT* category II codes, new G codes and the new/revised descriptors for the codes that will be used for the PQRI, effective for dates of service on or after July 1, 2007.
- Information on category III codes (*0178T* through *0180T* (all of which deal with electrocardiograms), *0181T* (*corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report*), and *0182T* (*High dose rate_electronic brachytherapy, per fraction*), which are effective for dates of service on or after July 1, 2007.
- Effective July 1, 2007, HCPCS codes J1567, J7611, J7612, J7613, and J7614 will be assigned a procedure status of I.
- Information related to HCPCS codes Q4087 through Q4095, which are added to the MPFSDB as of July 1, 2007 with a status indicator of E.

Also, attachment 3 (which is informational only) states that the Performance Payment Indicator has been changed to '1' for the extensive list of carrier priced codes identified in attachment 3.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5614) issued to your Medicare carrier, FI, or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1258CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5614
Related Change Request (CR) #: 5614
Related CR Release Date: May 29, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R1258CP
Implementation Date: July 2, 2007

Connecticut Fees

Code/Mod	Par	Non-Par	Limiting Charge
G9041	$28.95	$27.50	$31.63
G9042	$16.76	$15.92	$18.31
G9043	$16.76	$15.92	$18.31
G9044	$14.09	$13.39	$15.39
33208	$547.07	$519.72	$597.67
77422	$120.29	$114.28	$131.42
77423	$162.93	$154.78	$178.00

Update to the 2007 Medicare Physician Fee Schedule Database, continued

Florida Fees

	Participating			Nonparticipating			Limiting charge		
Code/Mod	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04
G9041	$25.92	$26.67	$27.52	$24.62	$25.34	$26.14	$28.32	$29.14	$30.07
G9042	$14.17	$14.93	$15.77	$13.46	$14.18	$14.98	$15.48	$16.31	$17.23
G9043	$14.17	$14.93	$15.77	$13.46	$14.18	$14.98	$15.48	$16.31	$17.23
G9044	$12.04	$12.67	$13.39	$11.44	$12.04	$12.72	$13.15	$13.84	$14.63
33208	$499.25	$518.38	$541.10	$474.29	$492.46	$514.05	$545.43	$566.33	$591.15
77422	$98.75	$106.18	$114.66	$93.81	$100.87	$108.93	$107.88	$116.00	$125.27
77423	$132.80	$142.19	$152.79	$126.16	$135.08	$145.15	$145.08	$155.34	$166.92

Emergency Update to the 2007 Medicare Physician Fee Schedule Database

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the May 2007 Medicare B Update! pages 11-12.

Note: This article was revised on January 12, 2007 to reflect that change request (CR) 5459 was revised by CMS. The article was revised to reflect the new CR release date, transmittal number, and the Web address for accessing CR 5459. All other information remains the same.

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs]) for professional services paid under the Medicare physician fee schedule (MPFS).

Background

This article and related CR 5459 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS final rule. CR 5459 amends those payment files.

Key Points

You may wish to **review Attachment 1** of the CR 5459, which is located at *http://www.cms.hhs.gov/Transmittals/downloads/R1143CP.pdf* on the CMS Web site. The following key points summarize the specifics that are identified in the attachment to CR 5459.

- The physician fee schedule status indicators for oncology demonstration codes G9050 to G9062 for 2007 are **"I"; these codes are invalid** for Medicare use in 2007, thus, payment will not be made for these codes in 2007. (For more details on the Oncology Demonstration, see the *MLN Matters article* at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4219.pdf* on the CMS Web site.)
- Oncology **demonstration codes** G9076, G9081, G9082, G9118, G9119, G9120, G9121, G9122, and G9127 are **deleted and will not be paid for services provided after December 31, 2006, in 2007.**
- Active Oncology demonstration codes in the range G9063 to G9139 have status indicators of "M" on the Medicare physician fee schedule database. (Note: See requirement above for discontinued oncology demonstration codes within this range). Those filing claims may report these codes for oncology disease status in 2007, but payment will not be made for these codes for services provided after December 31, 2006.
- Category II codes *3047F* and *3076F* and category III code *0152T* have been deleted for 2007.
- G codes G0377 and G8348 through G8368 will be added to the 2007 HCPCS file.
- Q codes Q4083, Q 4084, Q4085, and Q4086 will be added, even though they are not on the 2007 HCPCS file. Note that corresponding ASP amounts will be reflected in updated 2007 ASP pricing files to be posted to the CMS Web site.
- Incorrect Diagnostic Supervision Indicators were assigned to some codes and these codes and correct indicators are listed in the attachment to CR 5459.
- Corrected Multiple Procedure Codes of 0 and Diagnostic Family Imaging Indicators of 99 have been assigned to codes G0389, G0389-TC, *70554*, *70554*-TC, *70555*, *70555*-TC, *76776*, and *76776*-TC.
- As identified in the attachment to CR5459, correct work, practice expense, and/or malpractice relative value units (RVUs) have been assigned for codes *44180*, *44186*, *73223*, *73223*-26, *76775*, *76775*-TC, *76775*-26, *93503*, *93539*, *93540*, *93541*, *93542*, *93543*, *93544*, *93545*, *95060*, *95065*, G0389, G0389-TC, and G0389-26.

Emergency Update to the 2007 Medicare Physician Fee Schedule Database, continued

- As a result of the Tax Relief and Health Care Act of 2006, effective January 1, 2007, G0377 (Administration of vaccine for Part D drug) is added to the MPFS with a status indicator of X. Payment for HCPCS code G0377 is linked to *CPT* code *90471* (just as payment is made for G0008, G0009, and G0010). For 2007 only, the legislation provides for Part B to pay for the administration of a covered Part D vaccine. When a physician administers a Part D vaccine, the physician should use G0377 to bill the local carrier for the administration of the vaccine. Payment to the physician will be on an assigned basis only. Normal beneficiary deductible and coinsurance requirements apply to this administration. Payment for Part D covered vaccines is made solely by the participating Prescription Drug Plan. Medicare will not pay for the vaccine itself.
- Effective January 1, 2007, the following G codes are added to the MPFSDB with a status indicator of M: G8348, G8349, G8350, G8351, G8352, G8353, G8354, G8355, G8356, G8357, G8358, G8359, G8360, G8361, G8362, G8363, G8364, G8365, G8366, G8367, and G8368.
- CMS has established separate payment for sodium hyaluronate products that have come on the market since October 2003. Four interim Q codes are in effect for these products as of January 1, 2007, i.e., Q4083 (Hyalgan/supartz inj per dose), Q4084 (Synvisc inj per dose), Q4085 (Euflexxa inj per does), and Q4086 (Orthovisc inj per dose).
- Procedure status I is assigned to J7319, effective January 1, 2007.
- Effective January 1, 2007, the HCPCS codes Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, and Q9964 will be assigned to procedure status indicator E.
- As a courtesy to the public, CMS has established RVUs for a number of codes, even though the codes are either bundled or not valid for Medicare purposes. These codes are *38204*, *38207*, *38208*, *38209*, *38210*, *38211*, *38212*, *38213*, *38214*, and *38215*. The RVUs are listed for these codes in the attachment to CR 5459.

Additional Information

For complete details regarding this change, please see the official instruction (CR 5459) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5459 *Revised*
Related Change Request (CR) #: 5459
Related CR Release Date: January 11, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R1152CP
Implementation Date: January 2, 2007

RADIOLOGY

Bone Mass Measurements

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the June 2007 Medicare B Update! pages 14-16.

Note: This article was revised June 4, 2007, to clarify the Medicare summary notices on page 3. Essentially, MSN 16.10 will be issued with a denied claim as well as either MSN 36.1 or MSN 36.2, depending on if an ABN was issued. All other information remains the same.

Provider Types Affected

Physicians, practitioners and hospitals that bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for BMM services.

Provider Action Needed

STOP – Impact to You

Effective for dates of service on or after January 1, 2007, Medicare will pay for BMM services for dual-energy X-ray absorptiometry (*CPT 77080*) when this procedure is used to monitor osteoporosis drug therapy. In addition, new *CPTs* were assigned to BMMs.

Bone Mass Measurements, continued

CAUTION – What You Need to Know

Medicare edits will deny claims that are not consistent with revised BMM policy and providers may be liable for noncovered BMMs unless they have issued an advanced beneficiary notice (ABN) as required. This article explains the changes as a result of the CY2007 physician fee schedule final rule.

GO – What You Need to Do

See the remainder of this article for important information regarding billing Medicare for BMMs.

Background

This article and related change request (CR) 5521 wants providers to know that on June 24, 1998, the Centers for Medicare & Medicaid Services (CMS) published an interim final rule with comment period (IFC) in the *Federal Register* entitled *"Medicare Coverage of and Payment for Bone Mass Measurements."* This IFC implemented section 4106 of the BBA by establishing 42 CFR 410.31, Bone Mass Measurement: Conditions for Coverage and Frequency Standards. This new regulation defined BMM and individuals qualified to receive a BMM, established conditions for coverage under the "reasonable and necessary" provisions of 1862(a)(1)(A) of the Act, and established frequency standards governing when qualified individuals would be eligible for a BMM.

On December 1, 2006, CMS published the CY 2007 physician fee schedule final rule, which included changes to 42 CFR 410.31. These changes may be found in chapter 15, section 80.5 of the *Medicare Benefit Policy Manual* and in chapter 13, section 140 of the *Medicare Claims Processing Manual*. The revised manual sections are attached to CR 5221. The Web address for viewing CR 5221 is available in the "Additional Information" section at the end of this article.

Key Points

Listed is a summary of the revisions and additions to chapter 13 of the *Medicare Claims Processing Manual* and chapter 15 of the *Medicare Benefit Policy Manual*.

Chapter 13

- Effective for dates of service on and after January 1, 2007, the CY 2007 physician fee schedule final rule expanded the number of beneficiaries qualifying for BMM by reducing the dosage requirement for glucocorticoid (steroid) therapy from 7.5 mg of prednisone per day to 5.0 mg. It also changed the definition of BMM by removing coverage for a single-photon absorptiometry (SPA) as it is not considered reasonable and necessary under section 1862 (a)(1)(A) of the Act.
- Effective for dates of services on and after January 1, 2007, the following changes apply to BMM:
- New 2007 *CPT* bone mass codes have been assigned for BMM. The following codes will replace current codes, however the *CPT* descriptors for the services remain the same:

77078 replaces *76070*
77079 replaces *76071*
77080 replaces *76075*
77081 replaces *76076*
77083 replaces *76078*

- BMM is not covered when a procedure other than dual-energy X-ray absorptiometry is used to monitor osteoporosis drug therapy. Therefore, Medicare will not pay for procedure codes *76977*, *77078*, *77079*, *77081*, *77083* and G0130 when billed with the following ICD-9-CM diagnosis codes:

  733.00 733.01 733.02 733.03 733.09 733.90 255.0

- BMM is covered when dual-energy X-ray absorptiometry is used to monitor osteoporosis drug therapy. Therefore, Medicare will pay procedure code *77080* when billed with the following ICD-9-CM diagnosis codes or any of the other valid ICD-9-CM diagnoses that are recognized by Medicare contractors appropriate for bone mass measurements:

  733.00 733.01 733.02 733.03 733.09 733.90 255.0

- In informing beneficiaries about the denials of claims processed for BMMs, Medicare will use the following Medicare summary notice (MSN) messages, effective for services on or after January 1, 2007:
  - MSN# 16.10: "Medicare does not pay for this item or service." (FIs should not include this MSN.)
  - If an advance beneficiary notice (ABN) **was issued**, the following MSN will also follow:
    MSN# 36.1: "Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review."
  - If an ABN **was not** issued the following MSN will also follow:
    MSN# 36.2: "It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility."

Note: Medicare will not cover single photon absorptiometry and procedure code *78350* will be denied (using MSN# 16.10) for services on or after January 1, 2007.

- Effective January 1, 2007 the following remittance advice (RA) messages will be issued when Medicare denies BMM claims:

  Claim adjustment reason code 50: "These are non-covered services because this is not deemed a "medical necessity" by the payer".

  - If an ABN was issued the RA issued is M38: "The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay."

Bone Mass Measurements, continued

- If an ABN was not issued RA, remark code is M27: "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."
- Advance beneficiary notices (ABNs) physicians, practitioners and hospitals are liable for payment unless they issue an appropriate ABN. More information on ABNs may be found in chapter 30, sections 40.3-40.3.8 of the *Medicare Claims Processing Manual*, located at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopofPage* on the CMS Web site.

Chapter 15

- **Definition of BMM**: a radiologic, radioisotopic, or other procedure that meets all of the following conditions:
  - Is performed to identify bone mass, detect bone loss, or determine bone quality.
  - Is performed with either a bone densitometer (other than single-photon or dual-photon absorptiometry) or a bone sonometer system that has been cleared for marketing for BMM by the Food and Drug Administration (FDA) under 21 CFR part 807, or approved for marketing under 21 CFR part 814.
  - Includes a physician's interpretation of the results.
- **Conditions for Coverage**
  - Medicare covers BMM if it is ordered by a qualified physician or non-physician practitioner, who is treating the beneficiary following an evaluation of the need for a BMM and the appropriate BMM to be used.
  - The BMM must be performed under the appropriate level of supervision as defined in 42 CFR 410.32(b).
  - The BMM must be reasonable and necessary for diagnosis and treatment of a beneficiary who meets at least one of the following conditions:
- A woman who has been determined by the physician or qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.

  Note: Since not every woman who has been prescribed estrogen replacement therapy (ERT) may be receiving an "adequate" dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating nonphysician practitioner from ordering a bone mass measurement for her. If a BMM is ordered for a woman following a careful evaluation of her medical need, however, it is expected that the ordering treating physician (or other qualified treating nonphysician practitioner) will document in her medical record why he or she believes that the woman is estrogen-deficient and at clinical risk for osteoporosis.
  - An individual with vertebral abnormalities as demonstrated by an X-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture.
  - An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone, or greater, per day, for more than three months.
  - An individual with primary hyperparathyroidism.
  - An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.
- In the case of any individual whom being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy, the BMM must be performed with a dual-energy X-ray absorptiometry system (axial skeleton).
- In the case of any individual who meets the above conditions and who has a confirmatory BMM, the BMM is performed by a dual-energy X-ray absorptiometry system (axial skeleton) if the initial BMM was not performed by a dual-energy X-ray absorptiometry system (axial skeleton). A confirmatory baseline BMM is not covered if the initial BMM was performed by a dual-energy X-ray absorptiometry system (axial skeleton).
- **Frequency Standards**
  - Medicare pays for a screening BMM once every two years.
  - Medicare may pay for more frequent screenings when medically necessary. Examples include, but are not limited to, the following medical circumstances:
    - Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than 3 months.
    - Confirming baseline BMMs to permit monitoring of beneficiaries in the future.
- **Noncovered BMMs occur** when they are not considered reasonable and necessary under section 1862 (a) (1) (A) of the Act.
  - Single photon absorptiometry (effective January 1, 2007).
  - Dual photon absorptiometry (established in 1983).

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5521) issued to your Medicare carrier, FI or A/B MAC. That instruction consists of three transmittals, i.e.:

- Transmittal 69, which contains the *Medicare National Coverage Determination*, which is at *http://www.cms.hhs.gov/Transmittals/downloads/R69NCD.pdf* on the CMS Web site;
- Transmittal 70, which contains the revised *Medicare Benefit Policy Manual* sections, is at *http://www.cms.hhs.gov/Transmittals/downloads/R70BP.pdf* on the CMS Web site; and
- Transmittal 1236 contains the *Medicare Claims*

Bone Mass Measurements, continued

Processing Manual revisions and is at *http://www.cms.hhs.gov/Transmittals/downloads/R1236CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

A brochure outlining 'Bone Mass Measurements' is available at *http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass_06-08-05.pdf*.

MLN Matters Number: MM5521 *Revised*
Related CR Release Date: May 11, 2007
Related CR Transmittal #: R1236CP,R70BP, R69NCD
Related Change Request (CR) #: 5521
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

Clarification of Manual Instruction Regarding Scope of Portable X-ray Benefit

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

Provider Types Affected

Medicare providers who submit claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), carriers) for services rendered to Medicare beneficiaries for portable X-rays.

Provider Action Needed

STOP – Impact to You

Currently, the *Medicare Benefit Policy Manual*, Publication 100-02, chapter 15, section 80.4.3, relating to the scope of portable X-ray benefit is **not completely consistent with regulations at 42 CFR 410.32(c)(3)(i).** The manual section states that "skeletal films involving arms and legs" are covered services under the portable X-ray benefit.

CAUTION – What You Need to Know

In order to make certain the manual conforms to the regulations, the Centers for Medicare & Medicaid Services (CMS) is revising the **manual to state that the benefit includes "skeletal films involving extremities".** Although, the language differences are slight, the use of **"extremities**" in the regulation instead of "arms and legs" **delineates coverage beyond 'arms and legs' to the hands, feet, toes, fingers, wrist and ankle.** Language is also being added to **include the coverage of diagnostic mammograms, when certain requirements are met.**

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes. Also, be aware that Medicare contractors will adjust claims previously processed incorrectly, if you bring those claims to their attention.

Background

CR 5536 is the official document that announces these changes in Medicare processes. Attached to this document is the revised section of the *Medicare Benefit Policy Manual* section 80.4.3 - **Scope of Portable X-ray Benefit** *(*Rev.71, Issued: 05-25-07, Effective: N/A; Implementation: July 2, 2007*)* the manual revision reads as follows and the **bolded sections** are new:

In order to avoid payment for services, which are inadequate or hazardous to the patient, the scope of the covered portable X-ray benefit is defined as:

- Skeletal films involving **the extremities**, pelvis, vertebral column, *or* skull
- Chest films which do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examinations)
- Abdominal films which do not involve the use of contrast media*; and*
- Diagnostic mammograms if the approved portable X-ray supplier, as defined in 42 CFR part 486, subpart C, meets the certification requirements of section 354 of the Public Health Services Act, as implemented by 21 CFR part 900, subpart B.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5536) issued to your Medicare carrier, FI, or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R71BP.pdf* on the CMS Web site.

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

Clarification of Manual Instruction Regarding Scope of Portable X-ray Benefit, continued

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5536
Related CR Release Date: May 25, 2007
Related CR Transmittal #: R71BP
Related Change Request (CR) #: 5536
Effective Date: N/A
Implementation Date: July 2, 2007

GENERAL COVERAGE

Quarterly Update to Medically Unlikely Edits, Version 1.2, Effective July 1, 2007

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

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare contractors (fiscal intermediaries [FIs], carriers, Part A/B Medicare administrative contractors [A/B MACs], DME Medicare administrative contractors [DME/MACs], durable medical equipment regional carriers [DMERCs], and/or regional home health intermediaries [RHHIs]).

Background

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as medically unlikely edits (MUEs). The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs. Key points of CR 5603 are as follows:

- CR 5603 announces the upcoming release of the next version of the MUEs, which is version 1.2.
- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- CR 5603 states that Medicare carriers and A/B MACs will **deny** the entire claim line from providers with units of service that exceed MUE criteria and pay the other services on the claims, where the claims are processed by either Medicare's DME system (VMS) or carriers system (MCS).
- FIs and A/B MACs will RTP claims from institutional providers with units of service that exceed MUE criteria and which are processed by Medicare's fiscal intermediary shared system (FISS).

With regard to MUEs, providers are reminded of the following:

- An appeal process will not be allowed for RTP claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the national correct coding contractor.
- Excess **charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"),** and this provision can neither be waived nor subject to an advanced beneficiary notice (ABN).

Additional Information

To see the official instruction (CR 5603) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1265CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5603
Related Change Request (CR) #: 5603
Related CR Release Date: June 12, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1265CP
Implementation Date: July 2, 2007

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

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

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Medicare administrative contractors [A/B MACs], durable medical equipment administrative contractors [DMACs], and fiscal intermediaries (FIs) including regional home health intermediaries [RHHIs]).

What Providers Need to Know

CR 5643, from which this article is taken, reminds the Medicare contractors and providers that the annual International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) update will be effective for dates of service on and after October 1, 2007 (for institutional providers, effective for discharges on or after October 1, 2007).

You may see the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS Web site at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage*, or at the National Center for Health Statistics (NCHS) Web site at *http://www.cdc.gov/nchs/icd9.htm* in June of each year.

Background

ICD-9- CM codes, became mandatory as follows:

- In 1979 for use in reporting provider services on Form CMS-1450.
- On April 1, 1989, for use by all physician services submitted on Form CMS-1500.
- On October 1, 2003 for all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59).

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing* Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 5643 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2007 (for institutional providers, effective for discharges on or after October 1, 2007).

You should remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers [ASCs]), and for all institutional claims; but is not required for ambulance supplier claims.

Additional Information

You may find the official instruction, CR 5643, issued to your Medicare contractor by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1269CP.pdf* on the CMS Web site. As mentioned, you may find the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS Web site at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage*, or at the National Center for Health Statistics (NCHS) Web site at *http://www.cdc.gov/nchs/icd9.htm*, in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for $25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing* Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage* on the CMS Web site.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DMAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5643
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Related CR Transmittal #: R1269CP
Implementation Date: October 1, 2007

Proper Use of Modifier 59

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

Provider Types Affected

Physicians and providers submitting claims to Medicare carriers, or Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of modifier 59. The article only clarifies existing policy.

Background

Under certain circumstances, a physician may need to indicate that a procedure or service was distinct or independent from other services, and modifier 59 may be appropriate depending on the circumstances. Modifier 59 is used to identify procedures/services that are not normally reported together, and this include the following procedures/services that are not ordinarily encountered or performed on the same day by the same physician:

- A different
  - Session or patient encounter,
  - Procedure or surgery,
  - Site or organ system, or
- A separate
  - Incision/excision,
  - Lesion, or
  - Injury (or area of injury in extensive injuries)

When another already established modifier is appropriate, it should be used rather than modifier 59. Modifier 59 is an important National Correct Coding Initiative (NCCI) associated modifier that is often used incorrectly, and it should only be used if no more descriptive modifier is available or when its use best explains the circumstances.

For the NCCI, the primary purpose of modifier 59 is to indicate that two or more procedures are performed at different anatomic sites or during different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes.

NCCI edits define when two procedure Healthcare Common Procedure Coding System (HCPCS)/*Current Procedural Terminology* (*CPT*) codes may not be reported together except under special circumstances.

If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together if the two procedures are performed at:

- Different anatomic sites, or
- Different patient encounters.

Medicare carrier and MAC Part B claim processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit.

Modifier 59 and other NCCI-associated modifiers **should NOT be used** to bypass an NCCI edit unless the proper criteria for use of the modifier is met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.

One of the misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe "different procedure or surgery." The code descriptors of the two codes of a code pair edit usually represent different procedures or surgeries. The related NCCI edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier 59 for such an edit based on the two codes being different procedures/surgeries. However, if the two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures/surgeries on that date of service.

Use of modifier 59 to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/*CPT* coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/*CPT* codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, **it does not include treatment of contiguous structures of the same organ**. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site. Treatment of posterior segment structures in the eye constitutes a single anatomic site.

Examples Of Modifier 59 Usage

Following are some examples developed to help guide physicians and providers on the proper use of modifier 59:

Example 1: Column 1 Code/Column 2 Code 11055/11720

- *CPT 11055* – Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- *CPT 11720* – Debridement of nail(s) by any method(s); one to five

Proper Use of Modifier 59, continued

Policy: Mutually exclusive procedures
Modifier 59 is:

- Only appropriate if procedures are performed for lesions anatomically separate from one another or if procedures are performed at separate patient encounters.
- Don't report *CPT 11055 – 11057* for removal of hyperkeratotic skin adjacent to nails needing debridement.

Example 2: Column 1 Code/Column 2 Code *11719*/*11720*
- *CPT 11719* – Trimming of nondystrophic nails, any number
- *CPT 11720* – Debridement of nail(s) by any method(s); one to five

Policy: Mutually exclusive procedures modifier 59 is only appropriate if the trimming and the debridement of the nails are performed on different nails or if the two procedures are performed at separate patient encounters

Example 3: Column 1 Code/Column 2 Code *17000*/*11100*
- *CPT 17000* – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
- *CPT 11100* – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Policy: HCPCS/CPT coding manual instruction/guideline
Modifier 59 is only appropriate if procedures are performed on separate lesions or at separate patient encounters.

Example 4: Column 1 Code/Column 2 Code *38221*/*38220*
- *CPT 38221* – Bone marrow; biopsy, needle or trocar
- *CPT 38220* – Bone marrow; aspiration only

Policy: Standards of medical/surgical practice
Use of "59" modifier should be uncommon but appropriate for these circumstances:
- Different sites - contralateral iliac crests; iliac crest and sternum;
- Different incisions - same iliac crest; or
- Different encounters.

Example 5: Column 1 Code/Column 2 Code *45385*/*45380*
- *CPT 45385* – Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
- *CPT 45380* – Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

Policy: More extensive procedure
Modifier 59 is only appropriate if the two procedures are performed on separate lesions or at separate patient encounters.

Example 6: Column 1 Code/Column 2 Code *47370*/*76942*
- *CPT 47370* – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
- *CPT 76942* – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Policy: HCPCS/*CPT* coding manual instruction/guideline
Modifier 59 is only appropriate if the ultrasonic guidance service *76942* is performed for a procedure done unrelated to the surgical laparoscopic ablation procedure.

Example 7: Column 1 Code/Column 2 Code *93015*/*93040*
- *CPT 93015* – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- *CPT 93040* – Rhythm ECG, one to three leads; with interpretation and report

Policy: More extensive procedure
Modifier 59 is only appropriate if the rhythm ECG service *93040* is performed unrelated to the cardiovascular stress test procedure at a different patient encounter.

Example 8: Column 1 Code/Column 2 Code *93529*/*76000*
- *CPT 93529* – Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
- *CPT 76000* – Fluoroscopy (separate procedure), up to 1 hour physician time, other than *71023* or *71034* (eg, cardiac fluoroscopy)

Policy: Standards of medical/surgical practice
Modifier 59 is only appropriate if the fluoroscopy service *76000* is performed for a procedure done unrelated to the cardiac catheterization procedure.

Example 9: Column 1 Code/Column 2 Code *95903*/*95900*
- *CPT 95903* – Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study
- *CPT 95900* – Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Policy: More extensive procedure
Modifier 59 is only appropriate if the two procedures are actually performed on different nerves or in separate patient encounters.

Example 10: Column 1 Code/Column 2 Code *97140*/*97530*
- *CPT 97140* – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- *CPT 97530* – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Policy: Mutually exclusive procedures
Modifier 59 is only appropriate if the two procedures are performed in distinctly different 15-minute intervals. The two codes cannot be reported together if performed during the same 15-minute time interval.

Example 11: Column 1 Code/Column 2 Code *98942*/*97112*
- *CPT 98942* – Chiropractic manipulative treatment (CMT); spinal, five regions
- *CPT 97112* – Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

Policy: Standards of medical/surgical practice
Modifier 59 is only appropriate if the physical therapy service *97112* is performed in a different region than the CMT and the provider is eligible to report physical therapy codes under the Medicare program.

Proper Use of Modifier 59, continued

Additional Information

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

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Foot Care Coverage Guidelines

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

Provider Types Affected

This article is for informational purposes only for providers billing Medicare for foot care services. It is an overview of existing policy and no change in policy is being conveyed.

Medicare Podiatry Services

Medicare Covered Foot Care Services

According to the *Medicare Benefit Policy Manual* (MBPM), chapter 15, section 290, Medicare covered foot care services only include medically necessary and reasonable foot care. Any other foot care services that are offered would be considered routine care.

Please note that the treatment of **warts** (including plantar warts) on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

Exclusions from Coverage

Certain foot care related services are not generally covered by Medicare, (though there are some exceptions where certain services will be covered). In general, the following services, whether performed by a podiatrist, osteopath or doctor of medicine, and without regard to the difficulty or complexity of the procedure, **are not covered by Medicare**:

Podiatry Service Excluded	**Exception To Exclusions (Covered by Medicare)**
Routine Foot Care	The presence of a systemic condition – such as metabolic, neurologic, or peripheral vascular disease may require scrupulous foot care by a professional that in the absence of such condition(s) would be considered routine. Mycotic nails – In the absence of a systemic condition, treatment of mycotic nails may be covered when the physician attending the patient's mycotic condition documents that: -There is clinical evidence of mycosis of the toenail, and -The patient has marked limitation of ambulation, [for ambulatory patients] pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. Routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition for the following: -Diabetes mellitus -Chronic thrombophlebitis -Peripheral neuropathies involving feet associated with: -- Malnutrition and vitamin deficiency such as malnutrition (general, pellagra), alcoholism, malabsorption (celiac disease, tropical sprue), and pernicious anemia -- Carcinoma -- Diabetes mellitus -- Drugs and toxins -- Multiple sclerosis -- Uremia (chronic renal disease). Although not intended as a comprehensive list, Chapter 15, Section 290 of the Medicare Benefit Policy Manual (Pub 100-2) lists some of the most commonly underlying conditions that might justify coverage for routine foot care.

Foot Care Coverage Guidelines, continued

Podiatry Service Excluded	Exception To Exclusions (Covered by Medicare)
Flat Foot	None
Subluxation of the Foot	Medical or surgical treatment of subluxation of the ankle joint (talo-crural joint). Reasonable and necessary medical or surgical services, diagnosis, or treatment for medical conditions that have resulted from or are associated with partial displacement of structures.
Supportive Devices for Feet	Orthotic shoes that are an integral part of a leg brace (the expense is included as part of the cost of the brace) Therapeutic shoes for diabetic beneficiaries
Therapeutic Shoes for Individuals with Diabetes	A narrow exception permits coverage of special shoes and inserts for certain patients with diabetes. (MBPM, chapter 15, section 140)

Presumption of Coverage for Routine Services

When evaluating whether the routine services can be reimbursed, a presumption of coverage may be made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, please refer to the *Medicare Benefit Policy Manual (MBPM)*, chapter 15, section 140.

When the routine services are **rendered by a podiatrist**, your Medicare carrier may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the six-month period prior to the rendition of the routine-type services.

The carrier may also accept the podiatrist's statement that the diagnosing and treating M.D. or D.O. also concurs with the podiatrist's findings as to the severity of the peripheral involvement indicated.

Foot Care for Patients with Chronic Disease

Loss of Protective Sensation (LOPS)

Effective for services furnished on or after July 1, 2002, Medicare covers an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim.

The diagnosis of diabetic sensory neuropathy with LOPS should be established and documented prior to coverage of foot care. Other causes of peripheral neuropathy should be considered and investigated by the primary care physician prior to initiating or referring for foot care for persons with LOPS.

Please refer to the *National Coverage Determination Manual*, Section 70.2.1, for additional information.

Treatments for Wound Care

Electrostimulation for Wounds (Claims submitted on or after 7/6/2004)

The Centers for Medicare & Medicaid Services (CMS) will allow for coverage for the use of electrical and electromagnetic stimulation for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers. All other uses of electrical and electromagnetic stimulation for the treatment of wounds are noncovered. Chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence.

Please refer to the national coverage decision: NCA for Electrostimulation for Wounds (CAG-00068R) for additional information. National coverage decisions are available at *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=28* on the CMS Web site.

Hyperbaric Oxygen Therapy for Hypoxic Wounds and Diabetic Wounds of the Lower Extremities (CAG-00060N)

For claims submitted on or after April 1, 2000, hyperbaric oxygen (HBO) therapy in the treatment of diabetic wounds of the lower extremities will be covered in patients who meet each of the following three criteria. Patient has:

- Type I or Type II diabetes and has a lower extremity wound that is due to diabetes
- A wound classified as Wagner grade III or higher
- Failed an adequate course of standard wound therapy (defined below).

The use of HBO therapy will be covered as adjunctive therapy only after there are no measurable signs of healing for at least 30-days of treatment with standard wound therapy and must be used in addition to standard wound care.

Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

For more information about HBO therapy for diabetic wounds of the lower extremities, please refer to the national coverage determination (CAG-00060N). That document is available at *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=37* on the CMS Web site.

Foot Care Coverage Guidelines, continued

Additional Billing Guidelines

Claims Involving Complicating Conditions

- When submitting claims for services furnished to Medicare beneficiaries who have complicating conditions, the name of the M.D. or D.O. who diagnosed the complicating condition must be submitted with the claim, along with the approximate date that the beneficiary was last seen by the indicated physician.
- Document carefully any convincing evidence showing that nonprofessional performance of a service would have been hazardous for the beneficiary because of an underlying systemic disease. Stating that the beneficiary has a complicating condition such as diabetes does not of itself indicate the severity of the condition.
- Exceptional situations include initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only noncovered care.
- The exclusion of foot care is determined by the nature of the service and not according to who provides the service. When an itemized bill shows both covered services and noncovered services that are not integrally related to the covered service, the portion of the charges that are attributable to the noncovered services should be denied.
- Sometimes payment is made for incidental noncovered services that are performed as a necessary and integral part of, and secondary to, a covered procedure. For example, if toenails must be trimmed in order to apply a cast to a fractured foot, then the charge for the trimming of nails would be covered.
- However, a separately itemized charge for this excluded service would not be allowed. Please refer to your Medicare contractor for questions about coverage that is "incident to" a covered procedure.
- Information about coverage Incident to Physician's Professional Services can also be found in the *Medicare Benefit Policy Manual*, chapter 15, Covered Medical and Other Health Services, Section 60 – Services and Supplies.

Therapeutic Shoes for Individuals with Diabetes (MBPM, Chapter 15, Section 140)

- Coverage of depth or custom-molded therapeutic shoes and inserts for individuals with diabetes is available as of May 1, 1993.
- These diabetic shoes are covered if the requirements specified in the *Medicare Benefits Policy Manual*, chapter 15, section 140, regarding certification and prescription are met.
- This benefit provides for a pair of diabetic shoes each equipped so that the affected limb, as well as the remaining limb, is protected, for both feet, even if only one foot suffers from diabetic foot disease.
- Claims for therapeutic shoes for diabetics are processed by the durable medical equipment regional carriers (DMERCs). Therapeutic shoes for diabetics are not DME and are not considered DME nor orthotics, but a separate category of coverage under Medicare Part B.

Related Links

Medicare Manuals

The *Medicare Benefit Policy Manual*, Publication 100-2, chapter 15 may be found at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site.

The *Medicare Program Integrity Manual* may be found at *http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf* on the CMS Web site.

The *Medicare Carrier Manual* can be found at *http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021921* on the CMS Web site.

The *National Coverage Determination Manual* may be found at *http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=keyword&filterValue=national&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS014961* on the CMS Web site.

Local Coverage Decisions

The Medicare Coverage Database provides access to local coverage decision articles published for Medicare contractors. These articles may be found at *http://www.cms.hhs.gov/mcd/index_local_alpha.asp?from=alphaarticle&letter=P* on the CMS Web site.

Related Change Requests and *MLN Matters* Articles

Program memorandum transmittal AB-02-096, change request 2269, "Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes" may be found at *http://www.cms.hhs.gov/Transmittals/downloads/AB02096.pdf* on the CMS Web site.

Program memorandum transmittal AB-02-105, change request 2272, "Medical Review of Medicare Payments for Nail Debridement Services," may be found at *http://www.cms.hhs.gov/Transmittals/Downloads/AB02105.pdf* on the CMS Web site.

MLN Matters article, MM3430, "Reasonable charge update for 2005 splints, casts, dialysis supplies, dialysis equipment, therapeutic shoes and certain intraocular lenses" may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm3430.pdf* on the CMS Web site.

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FRAUD AND ABUSE

Strike Force Formed to Target Fraudulent Billing of Medicare Program By Health Care Companies

Thirty-eight people have been arrested in the first phase of a targeted criminal, civil and administrative effort against individuals and health care companies that fraudulently bill the Medicare program, Attorney General Alberto R. Gonzales and Secretary Michael Leavitt of the U.S. Department of Health & Human Services have announced today.

The arrests in the Southern District of Florida are the result of the establishment of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing data. Since the first phase of strike force operations began on March 1, 2007 in southern Florida, the strike force has obtained indictments of individuals and organizations that have collectively billed the Medicare program for $142,061,059. Charges brought against the defendants in these indictments include conspiracy to defraud the Medicare program, criminal false claims, and violations of the anti-kickback statutes. If convicted, many of the defendants face up to 20 years in prison on these charges.

The strike force is able to identify potential fraud cases for investigation and prosecution quickly through real-time analysis of billing data from Medicare program safeguard contractors (PSCs) and claims data extracted from the Health Care Information System. In phase one operations in Miami, teams have identified two primary schemes that defrauded the Medicare program – infusion therapy and durable medical equipment (DME) suppliers. All of the strike force cases to date target these two areas.

The work of the strike force is just one step in a multi-phase enforcement and regulatory project designed to improve the quality of the industry and reduce the potential for fraud in the durable medical equipment and infusion areas. The Centers for Medicare & Medicaid Services (CMS) is taking steps to increase accountability and decrease the presence of fraudulent providers. The end result will be better service to beneficiaries and savings of billions of dollars that might otherwise go to fraudulent businesses.

"This initiative targets those who steal taxpayer funds intended to provide health care to the elderly," stated Attorney General Gonzales. "Protecting the financial integrity of the Medicare program for generations to come is important to the millions of seniors who rely on this program. Through the collaborative efforts of federal, state and local law enforcement and other agencies, we will concentrate our efforts. The Medicare Fraud Strike Force will allow us to have real-time access to Medicare billing data and provide authority to move quickly to make arrests and bring prosecutions as quickly as possible. With better tools and information sharing, we can expect greater levels of enforcement."

"The Medicare Fraud Strike Force is just one weapon in our arsenal to protect Medicare beneficiaries and taxpayers from fraud. I will be working closely with the Administration and Congress to put processes in place that will improve the industry and eliminate the likelihood for deception," Secretary Leavitt said. "We will be announcing the second step in this multi-year process within the next month. We expect industry leaders will embrace the changes that will improve the quality of the durable medical equipment industry and others who serve our Medicare beneficiaries."

On the morning of May 8, 2007, federal agents arrested 24 people to conclude a sweep in southern Florida of DME supply company owners who were engaged in various schemes to defraud Medicare based on fraudulent prescriptions. The arrests bring the total number of arrests to date to 38.

The indictments outline various types of fraudulent schemes. Those schemes included compounded aerosol medications – a process where a pharmacist makes medicine to meet a special medical need for a patient, rather than dispensing less expensive commercial pharmaceuticals. The indictments allege that the homemade medications were not necessary and that they were only prescribed to defraud Medicare.

In one example, Eduardo Moreno, the owner of multiple DME companies, was arrested on April 7 after being named in a six-count indictment on fraud charges. Two of Moreno's companies – Brenda Medical Supply Inc., and Faster Medical Equipment Inc. – allegedly billed Medicare for more than $1.9 million for services that were not medically necessary. The FBI has seized some of Moreno's assets, including a new Rolls Royce Phantom worth approximately $200,000.

In a five-count indictment out of the Southern District of Florida, Barbara Diaz and Jose Prieto were charged with conspiring to defraud Medicare, submitting false claims to Medicare and money laundering. The indictment alleges that Diaz and Prieto engaged in an "infusion therapy scheme" where patients did not need the drugs that were purportedly used. From March 9 through Dec. 31, 2006, the defendants billed Medicare more than $900,000 for infusion.

Seizure warrants have been used to take money back from bank accounts associated with the activity alleged in the indictment. In one case, HHS-Inspector General agents recovered more than $1.2 million from a corporate bank account after arresting Leider Alexis Munoz, the president and chief executive officer of RTC of Miami, Inc., an infusion clinic located in Hialeah, Fla.

"History has shown that health care fraud is best investigated jointly. The FBI, as part of the Medicare Fraud Strike Force, worked closely with its law enforcement partners and oversight authorities to assist investigations of fraud, waste and abuse across Southern Florida," said Assistant Director Kenneth W. Kaiser, FBI Criminal Investigative Division. "Health care fraud increases the cost of health care for everyone and the FBI remains committed to pursuing any company or individual that attempts to take advantage of the system for personal gain."

Strike Force Formed to Target Fraudulent Billing of Medicare Program By Health Care Companies, continued

"The landscape for fraud in south Florida has changed dramatically over the past two years. CMS has taken aggressive action to curb infusion therapy fraud and other organized fraud actions," said Leslie Norwalk, acting administrator of CMS. We have opened two satellite offices that are dedicated to combating fraud in high-risk areas and we will soon be opening a third. We are sending a strong message to those who seek to defraud the programs that if they engage in fraudulent activity, they will be caught and no longer able to take advantage of the programs to their own gain."

The strike force teams are led by a federal prosecutor supervised by both the Criminal Division's Fraud Section in Washington and the office of U.S. Attorney R. Alexander Acosta of the Southern District of Florida. Each team has four to six agents, at least one agent from the FBI and HHS Office of Inspector General, as well as representatives of local law enforcement. The teams operate out of the federal Health Care Fraud Facility in Miramar, Fla.

The operation is being prosecuted by attorneys from the Criminal Division's Fraud Section and the Major Crimes Section of the U.S. Attorney's Office for the Southern District of Florida, and supervised by Fraud Section Deputy Chief Kirk Ogrosky and Chief of the Criminal Division in Miami, Matthew Menchel. In addition to federal agents, the teams have officers and detectives from the Florida Medicaid Fraud Control Unit and Hialeah Police Department.

An indictment is merely an allegation and defendants are presumed innocent until and unless proven guilty.

Frequently Asked Questions About the Office of Inspector General Advisory Opinion

What is an advisory opinion?
An OIG advisory opinion is a legal opinion issued by the Office of Inspector General ("OIG") to one or more requesting parties about the application of the OIG's fraud and abuse authorities to the party's existing or proposed business arrangement. An OIG advisory opinion is legally binding on the Department of Health & Human Services (the "Department") and the requesting party or parties. It is not binding on any other governmental department or agency. A party that receives a favorable advisory opinion is protected from OIG administrative sanctions, so long as the arrangement at issue is conducted in accordance with the facts submitted to the OIG. However, no person or entity can rely on an advisory opinion issued to someone else.

What law applies to the OIG advisory opinion process?
Congress established the OIG advisory opinion process as part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Information about the process may be found by reviewing the following law and regulations:

Statute
The statute is section 1128D(b) of the Social Security Act (the "Act"), 42 U.S.C. Section 1320a-7d(b) (see *http://www4.law.cornell.edu/uscode/42/1320a-7d.html*).

Regulations
Regulations implementing the process may be found at the following locations:

(a) in the *Code of Federal Regulations* at 42 C.F.R. Part 1008 (see *http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr1008_99.html*); or

(b) in the *Federal Register* by reviewing both the interim final rule at 62 Fed. Reg. 7,350 (1997) and the revised final rule at 63 Fed. Reg. 38,311 (1998) (see our Web page).

Do I have to get an advisory opinion?
No, the advisory opinion process is voluntary. A party's failure to seek an advisory opinion about a transaction or business arrangement may not be introduced into evidence to prove that the party intended to violate the law.

What are appropriate subject matters for advisory opinion requests?
Most advisory opinion requests seek guidance regarding the anti-kickback statute, section 1128B(b) of the Act, or the anti-kickback "safe harbor" regulations at 42 C.F.R. section 1001.952. However, the OIG may also issue advisory opinions regarding the exclusion authorities in section 1128 of the Act, the civil monetary penalty authorities in section 1128A of the Act, and the criminal penalties in section 1128B of the Act. A party seeking an advisory opinion can help us process its request more quickly by identifying the specific subsections of 1128, 1128A, or 1128B of the Act about which the party is seeking an opinion and by providing facts relevant to the specific subsections.

What topics are NOT appropriate for the advisory opinion process?
We cannot address the following topics in an advisory opinion:

- hypothetical situations
- "model" arrangements
- general questions of interpretation
- activities in which the party requesting the advisory opinion is not, and does not plan to be, involved (for example, we cannot issue an opinion to Company A about the business practice of Company B, unless Company A is a current or prospective party to Company B's business practice)
- the fair market value of goods, services, or property
- whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986
- the application of statutes not contained in sections 1128, 1128A, or 1128B of the Act
- the application of section 1877 of the Act (also known as the "Stark" law or "physician self-referral law") (see question below).

How do I request an advisory opinion?
To request an advisory opinion, you must submit a written request that contains certain specified information (see the following question). You should send the original and two copies of the request, via U.S. mail, overnight courier, or hand delivery, to the following address:

Frequently Asked Questions About the Office of Inspector General Advisory Opinion, continued

Chief, Industry Guidance Branch
U. S. Department of Health and Human Services
Office of Inspector General
Office of Counsel to the Inspector General
Room 5527, Cohen Building
330 Independence Avenue, S.W.
Washington, DC 20201

We cannot accept faxed or emailed requests.

What information should an advisory opinion request include?

We have prepared a checklist of the information to submit. In addition, there are "preliminary questions" intended to give requestors an idea of the type of information that the OIG may need to do the analysis. In general, the request must specifically identify the requesting parties (and any other actual or potential parties, to the extent known) and must provide a detailed factual description of the arrangement at issue and copies of any operative documents. For proposed arrangements, we recognize that actual documents may not be available. In such cases, the requesting party can submit draft documents or detailed narrative descriptions of the material terms to be contained in the documents. However, material differences between the drafts or descriptions submitted and the final operative documents may affect the enforceability of the opinion.

Each requesting party must certify the truthfulness of the information submitted (see question below). We cannot issue an opinion to an anonymous requestor. You must designate a contact person who will be available to discuss your request. You must include a non-refundable deposit of $250 (see question below). You may ask for an estimate of the cost for processing your advisory opinion (see question below) and/or designate a "triggering" dollar amount (see question below).

If your request contains trade secrets or confidential commercial or financial information that you believe should be protected from public disclosure, you should identify this information in the manner described in the Department's Freedom of Information Act regulations at 45 C.F.R. section 5.65 (see link). The identification may be more effective if you designate trade secrets or confidential information contained in your request with specificity, instead of generally telling us that the request contains that kind of information.

What certifications are required?

Our regulations (42 C.F.R. section 1008.38) provide that every advisory opinion request must include a signed certification from each requesting party using the following language, as appropriate:

For an existing arrangement

With knowledge of the penalties for false statements provided by 18 U.S.C. 1001 and with knowledge that this request for an advisory opinion is being submitted to the Department of Health and Human Services, I certify that all of the information provided is true and correct, and constitutes a complete description of the facts regarding which an advisory opinion is sought, to the best of my knowledge and belief.

For a proposed arrangement

With knowledge of the penalties for false statements provided by 18 U.S.C. 1001 and with knowledge that this request for an advisory opinion is being submitted to the Department of Health & Human Services, I certify that all of the information provided is true and correct, and constitutes a complete description of the facts regarding which an advisory opinion is sought, to the best of my knowledge and belief. The arrangement described in this request for an advisory opinion is one that [the requestor(s)] in good faith plan(s) to undertake. [This certification may be made contingent on a favorable advisory opinion by adding the phrase "if the OIG issues a favorable advisory opinion."]

The signatory of the certification must be a person with authority to bind the requesting party. In particular, the signatory should be:

- The requesting party, if the requesting party is an individual
- The chief executive officer or comparable officer, if the requesting party is a corporation
- The managing partner, if the requestor is a partnership, or
- The managing member or comparable person, if the requestor is a limited liability company.

How long does it take to get an opinion?

The statute provides that advisory opinions should be issued within 60 days. In addition, the regulations establish a 10-day period for the initial review and processing of the incoming request. The length of time that it takes for the OIG to issue an opinion varies based upon a number of factors, including the complexity of the arrangement, the completeness of the submission, and how promptly the requestor responds to requests for additional information. The time frame for issuing the opinion may be extended to account for the time during which we are waiting for additional information and in certain other circumstances. We may request additional information, as needed, at any time during the processing of an advisory opinion request.

Can I withdraw my request after I've submitted it?

Yes, our regulations permit the requesting party to withdraw its request at any time before the opinion is issued. The requesting party remains liable for any fees incurred up to that point.

Frequently Asked Questions About the Office of Inspector General Advisory Opinion, continued

How much does an advisory opinion cost? Can I set a cap?

We are required by statute to collect a fee for preparing an advisory opinion. The statute provides no exceptions to the fee requirement. We currently charge $86 per hour for the preparation of an opinion. The actual cost of an opinion will vary based upon the amount of work required to prepare the opinion. There is a $250 non-refundable deposit required at the time a request is submitted. We deduct the $250 deposit from the total cost of the opinion, and this balance must be paid in full before the opinion is issued. Both the $250 deposit and the balance due upon completion of the opinion should be made payable to the Treasury of the United States. You can set a cap by designating a "triggering" dollar amount. A "triggering" dollar amount is the maximum amount that you are willing to spend on an advisory opinion. If you designate a "triggering" dollar amount, we will stop processing your request and notify you if the costs have reached, or are likely to exceed, the amount you designate. At that point, you can withdraw the request (you remain liable for the fees incurred) or notify us that you would like us to continue processing the request. If you tell us to proceed, you will be agreeing to pay the fee even though it may exceed your "triggering"amount.

Can I get an estimate of the fee?

Yes, in your request you may ask for a written estimate of the cost involved in processing the advisory opinion. After our initial, 10-day review of the request, we will notify you of our estimate in writing and stop processing your request until you confirm in writing that you want us to continue. A fee estimate is not binding, and the actual cost of the opinion may be higher or lower than the estimate. Your written confirmation may include a new or revised "triggering" dollar amount (see question above).

Will my advisory opinion be released to the public?

Yes, we are required to make opinions available to the public. Advisory opinions are posted on our Website. We remove identifying information, such as the names of the parties, before posting opinions on the Web. In addition, information submitted in connection with an advisory opinion request may be subject to disclosure under the Freedom of Information Act ("FOIA") (see question above). Additional information about FOIA may be found on the OIG Web page.

Will I have an opportunity to discuss my opinion request with OIG staff before it is issued?

Our goal is to render meaningful and informed opinions based on a complete and comprehensive understanding of the facts and circumstances of a given arrangement. We generally find that informal consultation with the requesting parties helps us with our review and analysis of requests. We will initiate discussions with a requesting party's designated contact person at the point at which we would find such discussions useful. We generally conduct these discussions by telephone; in-person meetings are not necessary.

Can I make changes to my proposed arrangement during the advisory opinion process?

Minor revisions to a proposed arrangement generally are not a problem, although they may delay issuance of the opinion. You will be required to submit information about the changes in writing and to certify the supplemental submission. If you need to make major changes, we may suggest that you withdraw the opinion request and submit a new one.

Does the OIG issue opinions about the "Stark" law?

Opinions about the "Stark" law (section 1877 of the Act, also known as the "physician self-referral law") come within the jurisdiction of the Centers for Medicare & Medicaid Services ("CMS"), which operates the Medicare and Medicaid programs. Information about the Stark advisory opinion process is available at 42 C.F.R. sections 411.370-.389 (see *http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr411_02.html*).

The Stark law and the anti-kickback statute are separate statutes, and, depending on the facts, a particular arrangement might implicate one or both statutes. The Stark law applies in the case of direct and indirect financial relationships with referring physicians (as further described in that law). Although the OIG is not authorized to issue opinions about the Stark law, our regulations require that a party requesting an OIG advisory opinion notify us if the party will be separately requesting a Stark opinion from CMS about the same arrangement.

I still have questions about the advisory opinion process. Whom do I call for further information?

If, after reviewing these *Frequently Asked Questions* and the other materials on our Web page, you still have questions about the advisory opinion process, you may call 202-619-0335 and ask to speak to a member of the Industry Guidance Branch.

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

Sign up to our *eNews* electronic mailing list

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

NATIONAL PROVIDER IDENTIFIER

The National Provider Identifier Compliance Deadline is Here!

NPI: Get It. Share It. Use It.

At this point, any covered entity that is noncompliant, and has not implemented a contingency plan, is at risk for enforcement action. Please review the April 2, 2007, CMS "***Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule."*** As this guidance pertains to claims transactions, it means that:

1. Providers must have and use their NPI.
2. Clearinghouses must accept and use NPIs.
3. Health plans must accept and send NPIs in claims transactions.

Providers should be:

1. Aware of contingency plans for any health plans they bill. Contingency plans may differ by health plan.
2. Aware that health plans may lift their contingency plans (and require an NPI on claims or other HIPAA transactions) any time before May 23, 2008.
3. Working with vendors and clearinghouses with whom they contract, to make sure the NPI is being passed to health plans.
4. Paying close attention to how and when health plans will be testing implementation of the NPI.
5. Aware that, for those health plans that did not establish a contingency plan, providers are required to use their NPIs now. This means that if you are not using your NPI, your claim may be rejected or denied.

New Tip Sheet Available

A tip sheet entitled **What the "Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule" Means for Health Care Providers** is now available at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/ContingencyTipSheet.pdf*.

This product provides helpful steps for providers based on the contingency guidance released on April 2, 2007. This guidance does not mean that providers have an extra year to get an NPI, so please view the tip sheet for additional information.

Reminder – Sharing NPIs

Once providers have received their NPIs, they should share them with other providers with whom they do business, and with health plans that request them. In fact, as outlined in current regulation, providers who are covered entities under HIPAA must share their NPIs with any entities that request them for use in standard transactions — including those who need to identify ordering or referring physicians/providers. Providers should also consider letting health plans, or institutions for whom they work (e.g., a large hospital system), share their NPIs for them.

When to Contact the NPI Enumerator for Assistance

Providers should remember that the NPI Enumerator can only answer/address the following types of questions/issues:

- Status of an NPI application, update, or deactivation
- Forgotten/lost NPI
- Lost NPI notification letter
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at *CustomerService@NPIenumerator.com*.

Resources for other kinds of questions may be found at the end of this document.

Please Note: The NPI Enumerator's operation is closed on federal holidays. The federal holidays observed are: New Year's Day, Independence Day, Veteran's Day, Christmas Day, Martin Luther King's Birthday, Washington's Birthday, Memorial Day, Labor Day, Columbus Day, and Thanksgiving.

The National Provider Identifier Compliance Deadline is Here!, continued

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

Testing Medicare Claims

To date, Medicare has encouraged providers to submit both an NPI and a legacy identifier on claims. Medicare is now asking that submitters send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume. If any claim is rejected, the NPI should be verified to make sure it was entered correctly. If the NPI is correct, then data in either NPPES or Medicare provider files should be corrected. The following fields in your NPPES and/or 855 provider enrollment record should be validated:

- EIN (for organization providers)
- Other provider identification numbers. This is where providers, when they apply for their NPIs, list the Medicare legacy identifier(s) that needs to be linked to the NPI.
- Practice location address
- Master address (from provider enrollment records)
- Other address (from provider enrollment records)
- Legal name or legal business name

Once this has been done, test again with a small number of claims. This process will help establish confidence that your claims will be paid. It is critical that you start testing with your NPI now.

While Medicare FFS has announced its contingency plan, it is committed to ending the contingency plan as soon as possible.

Reminder - Medicare FFS Contingency Plan Announced on April 24th

View the associated change request at *http://www.cms.hhs.gov/transmittals/downloads/R1227CP.pdf*, as well as the related MLN Matters article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf* on the CMS Web site. These materials were recently revised; please be sure to visit the links above for the latest information.

Reminder - NPI *MLN Matters* Articles

There are many MLN Matters articles dealing with various topics of NPI relative to the Medicare program. These MLN articles are available at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/MMArticles_npi.pdf.*

Additional Information

More information and education on the NPI may be found at the CMS NPI page *http://www.cms.hhs.gov/NationalProvIdentStand* on the CMS Web site. Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or call the NPI enumerator to request a paper application at 1-800-465-3203.

Getting an NPI is free - not having one can be costly.

Source: Provider Education Resources Listserv, Message 200705-30

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Publication of the National Plan and Provider Enumeration System Data Dissemination Notice (CMS-6060-N)

NPI: Get It. Share It. Use It.

The Centers for Medicare & Medicaid Services (CMS) will be publishing the NPPES Data Dissemination Notice in the *Federal Register*. The notice is now on display at the Office of the Federal Register. It will be published on May 30, 2007.

The notice describes the policy by which CMS will make certain NPPES health care provider data available to covered entities under the Health Insurance Portability and Accountability Act (HIPAA) and to others.

- NPPES health care provider data that are required to be disclosed under the Freedom of Information Act (FOIA) will be made publicly available on June 28, 2007, 30 days after the publication date of the notice.
- The FOIA-disclosable data will be made available in an initial file downloadable from the Internet, with monthly update files also downloadable from the Internet, and in a query-only database whereby users can query by national provider identifier (NPI) or provider name.
- The notice encourages health care providers who have been assigned NPIs to review their NPPES data at this time and make any necessary updates or corrections prior to the end of the 30-day period, to ensure that their information is accurate when disclosed by CMS. (Health care providers who are covered entities under HIPAA are required by regulation to update their NPPES data within 30 days of any change.)
- The notice states that health care providers who wish to delete any NPPES data that was not required to be furnished in order to obtain an NPI may do so prior to the end of the 30-day period if they prefer that those data not be disclosed by CMS.

Publication of the National Plan and Provider Enumeration System Data Dissemination Notice (CMS-6060-N), continued

An advance copy of the notice is available at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/DataDisseminationNPI.pdf* on the CMS NPI Web site.

Important Information:

The PDF version of the notice that is available from this Web page, and the document published in the *Federal Register* may vary slightly if the editor at the Office of the Federal Register makes minor revisions to it. The official version of the notice will be the one that is published in the *Federal Register*.

Additional Information

More information and education on the NPI may be found at the CMS NPI page *http://www.cms.hhs.gov/NationalProvIdentStand* on the CMS Web site. Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Getting an NPI is free - not having one can be costly.

Source: Provider Education Resources Listserv, Message 200705-35

Important NPI Announcement Regarding Data Dissemination and UPIN Registry

NPI: Is Here. NPI Is Now. Are You Using It?

CMS Publishes National Plan and Provider Enumeration System (NPPES) Data Dissemination Notice

On May 30, 2007, the Centers for Medicare & Medicaid Services (CMS) published the data dissemination notice in the *Federal Register.* The final copy of the notice is posted on the CMS NPI Web site at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/DataDisseminationNPI.pdf*.

Data Dissemination Roundtable to be held on June 14, 2007

CMS will host a national roundtable on the data dissemination notice on June 14, 2007, from 2-3:30 p.m. EDT. For registration details, visit the CMS Web site at *http://www.cms.hhs.gov/NationalProvIdentStand/downloads/RegistrationInfoNPI614.pdf*.

New Data Dissemination FAQs Available

CMS has posted new FAQs related to the recently published data dissemination notice. Questions include:

- Where is the national plan and Provider Enumeration System (NPPES) data dissemination policy conveyed?
- What national plan and Provider Enumeration System (NPPES) data will CMS disclose?
- How will CMS make the Freedom of Information Act (FOIA)-disclosable national plan and Provider Enumeration System (NPPES) data available?
- Is there a charge to obtain the Freedom of Information Act (FOIA)-disclosable national plan and Provider Enumeration System (NPPES) health care provider data?
- I want Freedom of Information Act (FOIA)-disclosable data for only the physicians in New York and I want the data on a CD. How do I go about having my request fulfilled?
- When will the Freedom of Information Act (FOIA)-disclosable national plan and Provider Enumeration System (NPPES) health care provider data be available?

To view these FAQs, you should:

1) Go to the CMS dedicated NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand*.
2) Scroll down to the section that says "Related Links Inside CMS"
3) Click on NPI Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated". Look for the word "NEW" in red font to appear beside the most recent FAQs.

Important Information for Medicare Fee-for-Service Providers

CMS Discontinues the Unique Physician Identifier Number (UPIN) Registry

Effective June 29, 2007, CMS will discontinue assigning UPINs to Medicare providers. For further details, visit the change request on this subject at *http://www.cms.hhs.gov/transmittals/downloads/R207PI.pdf* and the associated *MLN Matters* article on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5584.pdf*.

As always, more information and education on the NPI may be found on the CMS NPI page *http://www.cms.hhs.gov/NationalProvIdentStand*.

Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Getting an NPI Is Free – Not Having One May Be Costly

Source: CMS Provider Education Resource 200706-03

National Provider Identifier—Medicare Policy on Subpart Designation

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Third Quarter 2006 Medicare B Update! pages 90-92.

Note: This article was revised on May 18, 2007, to add this statement that Medicare fee-for-schedule (FFS) has announced a contingency plan regarding the May 23, 2007, implementation of the national provider identifier (NPI). For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf* on the CMS Web site.

Provider Types Affected

Provider types affected include organization health care providers and suppliers who are covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and who are enrolled in the Medicare program. These are certified providers and suppliers, supplier groups and supplier organizations, and suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).

(This information does not apply to health care providers who are enrolled in Medicare as individual practitioners, such as physicians and nurse practitioners, nor does it apply to sole proprietors.)

Key Points

- Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions to the new national provider identifier, or NPI.
- For Medicare organization health care providers, the current identifiers could include:

- Online survey certification and reporting (OSCAR) system numbers;
- National supplier clearinghouse (NSC) numbers;
- Provider identification numbers (PINs); and
- Unique physician identification numbers (UPINs) used by Medicare. These numbers are now considered **legacy identifiers or legacy numbers**. Medicare is transitioning from these legacy identifiers to **national provider identifiers**, or **NPIs**.

Note: When applying for an NPI, Medicare providers are urged to include their legacy numbers, particularly their Medicare legacy number, on the NPI application form.

- By regulation, Medicare organization health care providers who are HIPAA covered entities must obtain NPIs. The NPIs will replace the identifiers currently in use in standard transactions with Medicare and with other health plans. Additionally, these **health care providers must determine if they have subparts that need to be uniquely identified** in standard transactions with their own NPIs.

Background

Organization health care providers are corporations, partnerships, or other types of businesses that are considered separate from an individual by the state in which they exist. Subparts of such organization health care providers are also organizations. All of these health care providers would apply for NPIs as organizations (Entity Type 2).

Note: In terms of NPI assignment, an Individual is an Entity Type 1 (individual), and is eligible for a single NPI. As an individual, a physician or nurse practitioner, for example, as well as a sole proprietor/sole proprietorship, cannot have subparts and cannot designate subparts.

Most Medicare organization health care providers (entity type 2 providers) send electronic claims to Medicare (standard transactions), making them covered health care providers (HIPAA covered entities).

Subpart Designation Guidelines

Covered organization health care providers are responsible for determining if they have "subparts" that need to have NPIs. If they do, the covered organization health care providers must ensure that the subparts obtain their own unique NPIs, or they must obtain them for them.

Below are some guidelines to help determine if an enrolled Medicare organization health care provider has a subpart, which will need its own unique NPI.

Regarding all of the entities that could be considered subparts:

- A subpart is not itself a separate legal entity, but is a part of a covered organization healthcare provider that is a legal entity. (All covered entities under HIPAA are legal entities.)
- A subpart furnishes health care as defined at 45 CFR 160.103. (This information can be found at *http://www.hhs.gov/ocr/regtext.html* on the Department of Health and Human Services (DHHS) Web site.)

Regarding some or all of the entities that a Medicare covered organization health care provider could consider as subparts:

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.
- A subpart may or may not have a taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part.

National Provider Identifier—Medicare Policy on Subpart Designation, continued

Federal statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI Final Rule. If such statutes or regulations exist, the health care providers to whom they apply would need NPIs in order to ensure they can continue to be uniquely identified.

- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part must have its own unique NPI.

Medicare Organization Subpart Examples

Enrolled Certified Providers and Suppliers

An enrolled provider (a hospital) owns 10 home health agencies, all operating under the TIN (tax identification number) of the hospital. Because the hospital and each of the 10 home health agencies is separately surveyed and enters into its own provider agreement with Medicare, Medicare encourages that the hospital mirror its Medicare enrollment and obtain a total of 11 unique NPIs in order to help avoid claims processing delays (one NPI for the hospital, and one for each of the 10 home health agencies).

Enrolled Supplier Group or Supplier Organization

An enrolled independent diagnostic testing facility (IDTF) has four different locations, and each one must be separately inspected by the carrier. All four locations operate under a single TIN. Because each location is separately inspected in order to enroll in Medicare, Medicare encourages the IDTF to mirror its Medicare enrollment and obtain a total of four unique NPIs in order to help avoid claims processing delays (one NPI for each location).

Enrolled Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI. federal regulations require that each location of a Medicare DMEPOS supplier have its own unique billing number. In order to comply with that regulation, each location must have its own unique NPI.

Please note that regardless of how subparts are determined and NPIs obtained, Medicare payments, by law, may be made only to an enrolled Medicare provider or supplier.

Important Medicare NPI Implementation Dates

January 3, 2006 - October 1, 2006

Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI.

Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

October 2, 2006 - May 22, 2007

CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim.

Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.

Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.

May 23, 2007 – Forward

CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

Final Notes About NPIs

With regard to enrolled organization health care providers or subparts who **bill more than one** Medicare contractor:

- An enrolled organization health care provider or subpart is expected to use a single (the same) NPI when billing more than one Medicare contractor.
- For example, a physician group practice billing a Maryland carrier and also billing a Pennsylvania carrier would use a single (the same) NPI to bill both carriers.

With regard to enrolled organization health care providers or subparts who bill **more than one type** of Medicare contractor:

- Generally, the type of service being reported on a Medicare claim determines the type of Medicare contractor who processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type (fiscal intermediary, carrier, RHHI, DMERC) of Medicare contractor.
- In certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as **more than one type of provider**.

For example, an ambulatory surgical center enrolls in Medicare as a Certified Supplier, and bills its services to a carrier. If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a Supplier of DME and bill the DME to a DMERC. This ambulatory surgical center would obtain a single NPI and use it to bill the carrier and the DMERC.

National Provider Identifier—Medicare Policy on Subpart Designation, continued

- Medicare expects that this ambulatory surgical center would report two different taxonomies when it applies for its NPI:
- Ambulatory Health Care Facility—Clinic/Center - Ambulatory Surgical (261QA1903X); and
- Suppliers—Durable Medical Equipment & Medical Supplies (332B00000X) or the appropriate sub-specialization under the 332B00000X specialization.

With regard to enrolled organization health care providers who determine subparts for **reasons unrelated to** Medicare statutes, regulations or policies:

- Consistent with the NPI Final Rule, covered organization health care providers may designate subparts for reasons that are not necessarily related to Medicare statutes or regulations.
- If a Medicare organization health care provider designates as subparts entities **other than** those who are enrolled Medicare providers, and those subparts obtain their own NPIs and use those NPIs to identify themselves in HIPAA standard transactions with Medicare, **those NPIs will not identify enrolled Medicare providers**. Medicare is not required to enroll them.

  NPI Final Rule, page 3441 says the following: "If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls."

Additional Information

Medicare's NPI Responsibilities

Medicare will:

- Use NPIs to **identify** health care providers and subparts in HIPAA standard transactions

  NPI Final Rule, page 3469: section 162.412(a): "A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider's identifier is required."

- Ensure that the NPIs it receives in HIPAA standard transactions are valid
- Reject HIPAA standard transactions that contain invalid NPIs.

Valid NPIs, however, like the provider identifiers used today, must be "known" to Medicare. Medicare is not permitted to make payments for services rendered by non-Medicare providers, nor is it permitted to reimburse providers who are not enrolled in the Medicare program. Medicare will return, with appropriate messages, any HIPAA standard transactions containing valid but unrecognizable NPIs.

Related Links

In preparation for the release of the Electronic File Interchange (EFI) system, CMS released several documents on the EFI process. EFI, also referred to as "bulk enumeration," is a process by which a health care provider or group of providers can have a particular organization (the "EFIO") apply for NPIs on their behalf.

EFI documents posted to the Web include a summary, user's guide, and technical companion manual. Visit *http://www.cms.hhs.gov/NationalProvIdentStand/07_efi.asp* to download these new items.

NPI-related information, including how to apply for an NPI and a new fact sheet for health care providers who are individuals, is available at *http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS Web site.*

The NPI Final Rule may be found at: *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf* on the CMS Web site.

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Medicare's Implementation of the National Provider Identifier: The Second in the Series of Special Edition *MLN* Matters Articles on NPI-Related Activities

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the First Quarter 2006 Medicare B Update! pages 55-57.

Note: This article was revised on May 18, 2007, to add this statement that Medicare fee-for-schedule (FFS) has announced a contingency plan regarding the May 23, 2007, implementation of the national provider identifier (NPI). For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf* on the CMS Web site.

Provider Types Affected

Providers and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries. In addition, organizations or associations that represent providers and plan to obtain NPIs for those providers should take note of this article.

Part 1: Information That Applies to All Providers

Background

All healthcare providers are eligible to receive NPIs. All HIPAA covered healthcare providers, whether they are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, a provider's NPI will not change. The NPI remains with the provider regardless of job or location changes.

HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use only the NPI to identify covered healthcare providers in standard transactions by May 23, 2007. Small health plans must use only the NPI by May 23, 2008.

Obtaining and Sharing Your NPI

Providers and suppliers may now apply for their NPI on the National Plan and Provider Enumeration System (NPPES) Web site, *https://nppes.cms.hhs.gov*. The NPPES is the only source for NPI assignment.

The NPI will replace healthcare provider identifiers in use today in standard healthcare transactions by the above dates. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

Healthcare providers should apply for their NPIs as soon as it is practicable for them to do so. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment. Providers may apply for an NPI in one of three ways:

- An easy Web-based application process is available at *https://nppes.cms.hhs.gov*.
- A paper application may be submitted to an entity that assigns the NPI (the enumerator). A copy of the application, including the enumerator's mailing address, is available at *https://nppes.cms.hhs.gov*. A copy of the paper application may also be obtained by calling the enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

Knowing the NPI Schedule of Your Health Plans and Practice Management System Companies

Providers should be aware of the NPI readiness schedule for each of the health plans with which they do business, as well as any practice management system companies or billing companies (if used). They should determine when each health plan intends to implement the NPI in standard transactions and keep in mind that each health plan will have its own schedule for this implementation. Your other health plans may provide guidance to you regarding the need to submit both legacy numbers and NPIs.

Providers should submit their NPI(s) on standard transactions only when the health plan has indicated that they are ready to accept the NPI. Providers should also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date.

Sharing Your NPI

Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are:

- Any provider with which they do business (e.g., pharmacies);
- Health plans with which they conduct business; and
- Organizations where they have staff privileges.

We understand that providers have many questions related to EFI or bulk enumeration, NPPES Data Dissemination, and the Medicare subparts policy. We have included information currently available on these key topics in this article and will continue to provide updates, as more information becomes available.

Medicare's Implementation of the NPI: The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities, continued

Electronic File Interchange (EFI) - Formerly Known as Bulk Enumeration

The Centers for Medicare & Medicaid Services (CMS) is in the process of putting into place a mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many healthcare providers, with provider approval, to the NPPES within a single electronic file. For example, a large group practice may want to have its staff handle the NPI applications for all its members. If an organization/provider employs all or a majority of its physicians and is willing to be considered an EFI submitter, EFI enumeration may be a good solution for that group of providers.

The EFI Steps

Once EFI is available, concerned entities will follow these steps:

- An organization that is interested in being an EFI organization will log on to an EFI home page (currently under construction) on the NPPES Web site (*https://nppes.cms.hhs.gov*) and download a certification form.
- The organization will send the completed certification form to the enumerator to be considered for approval as an EFI organization (EFIO).
- Once notified of approval as an EFIO, the entity will send files in a specified format, containing NPI application data, to the NPPES.
- Providers who wish to apply for their NPI(s) through EFI must give the EFIO permission to submit their data for purposes of applying for an NPI.
- Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.
- The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s). An EFIO may also be used for updates and deactivations, if the providers agree to do so.

National Plan and Provider Enrollment System (NPPES) Data Dissemination Policy

CMS expects to publish a notice regarding its approach to NPI data dissemination in the coming months. The notice will propose the data dissemination strategy and processes. The approach will describe the data that CMS expects to be available from the NPPES, in compliance with the provisions of the Privacy Act, the Freedom of Information Act, the Electronic FOIA Amendments of 1996, the NPPES System of Records Notice, and other applicable regulations and authorities.

Crosswalks

Each health plan may create its own crosswalk, to cross check NPI and legacy identifiers. To that end, CMS stresses the importance of healthcare providers entering all of their current identification numbers onto their NPI application to facilitate the building of the crosswalks.

Subparts of a Covered Organization

Covered-organization healthcare providers (e.g., hospitals, suppliers of durable medical equipment, pharmacies, etc.) may be made up of components (e.g., an acute care hospital with an ESRD program) or have separate physical locations (e.g., chain pharmacies) that furnish health care, but are not themselves legal entities. The final NPI rule calls these entities ***"subparts"*** to avoid confusion with the term healthcare "components" used in HIPAA privacy and security rules. Subparts cannot be individuals such as physicians, e.g., group practices may have more than one NPI, but individual members of that group practice by definition are not and cannot be "subparts."

The NPI was mandated to identify each healthcare provider, not each service address at which health care is furnished. Covered organization providers must designate as subparts (according to the guidance given in the NPI final rule) any component(s) of themselves or separate physical locations that are not legal entities and that conduct their own standard transactions. Covered organizations/providers must obtain NPI(s) for their subparts, or instruct the subparts to obtain their own NPIs. The subparts would use their NPIs to identify themselves in the standard transactions they conduct.

The NPI final rule also gives covered organizations/providers the ability to designate subparts should there be other reasons for doing so. Federal regulations or statutes may require healthcare providers to have unique billing numbers in order to be identified in claims sent to federal health programs, such as Medicare.

In some cases, healthcare providers who need billing numbers for federal health programs are actually components of covered healthcare providers. They may be located at the same address as the covered organization provider or they may have a different address.

In situations where such federal regulations or statutes are applicable, the covered organization providers would designate the components as subparts and ensure that they obtain NPI(s) in order to use them in standard transactions. The NPI will eventually replace the billing numbers in use today.

What Providers Can Do to Prepare for NPI Implementation

- Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.
- Check with your billing services, vendors, and clearinghouses about NPI compliance and what you need to do to facilitate the process.
- Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.
- Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

Medicare's Implementation of the NPI: The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities, continued

Part 2: Information That Applies to Medicare FFS Providers Only

All Medicare providers are reminded that they will be required to use the NPI *in Medicare claims transactions.*

NPI Transition Plans for Medicare FFS Providers

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

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

Crosswalk

The Medicare health plan is preparing a crosswalk to link NPI and Medicare legacy identifiers exclusively for Medicare business, which should enable Medicare to continue claims processing activities without interruption. NPI(s) will be verified to make sure that they were actually issued to the providers for which reported. Medicare will use the check digit to ensure the NPI(s) are valid.

Subparts Policy

CMS is currently developing policy on how Medicare providers should identify Medicare subparts. Further details will be provided when this policy is finalized.

Resources for Additional Information

Coming Soon*:* CMS is developing a MLN Web page on NPI for Medicare FFS providers, which will house all Medicare fee for service educational resources on NPI, including links to all *MLN Matters* articles, frequently asked questions, and other information. CMS will widely publicize the launch of this Web page in the coming weeks.

You may wish to visit *http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp#TopOfPage* regularly for the latest information about the NPI.

You may go to *http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/CoveredEntityFlowcharts.pdf* to access a tool to help establish whether one is a covered entity under the administrative simplifications of HIPAA.

A helpful tool that provides an overview of the NPI and the application process for obtaining an NPI is available at *http://www.cms.hhs.gov/apps/npi/npiviewlet.asp.*

The *Federal Register* notice containing the NPI final rule is available at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf* on the CMS Web site.

There are some non-CMS Web sites that have information on NPI-related issues. While CMS does not necessarily endorse those materials, there may be information and tools available that might be of value to you.

You may also find some industry implementation recommendations and white papers on the NPI at *http://www.wedi.org*, which is the site of the Workgroup for Electronic Data Interchange (WEDI).

Medicare's Implementation of the NPI: The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities, continued

MLN Matters Number: SE0555 *Revised* | Related Change Request (CR) #: N/A
Related CR Release Date: N/A | Effective Date: N/A
Related CR Transmittal #: N/A | Implementation Date: N/A

Discontinuance of the Unique Physician Identification Number Registry

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5584 which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning unique physician identification numbers (UPINs) on June 29, 2007.

CAUTION – What You Need to Know

The national provider identifier (NPI) is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare fee-for-service [FFS] contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.) Information on that contingency plan is at *http://www.cms.hhs.gov/NationalProvIdentStand/downloads/NPI_Contingency.pdf* on the CMS website.

GO – What You Need to Do

If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the National Plan and Provider Enumeration System (NPPES) Web site at *https://nppes.cms.hhs.gov/*. See the *Background* and *Additional Information* sections of this article for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) was required by law to establish an identifier that could be used in Medicare claims to uniquely identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the Medicare program. Medicare claims for services that were ordered or for services that resulted from referrals must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health and Human Services published a final rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the NPI. The NPI will replace all legacy provider identifiers that are used in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007 (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007, but see the note in the following box regarding the May 23, 2007, implementation by Medicare.

Important Note: Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the NPI. In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007. For more information on this contingency plan, please visit the NPI dedicated website at *http://www.cms.hhs.NationalProvIdentStand/*. This contingency plan does not affect CMS plans to discontinue assigning UPINs on June 29, 2007, or to disable the UPIN "look-up" functionality as of September 30, 2007.

Discontinuance of the Unique Physician Identification Number Registry, continued

The CMS will discontinue assigning on June 29, 2007, but CMS will maintain its UPIN public "look-up" functionality and registry Web site (*http://www.upinregistry.com/*) through September 30, 2007.

Additional Information

For additional information regarding NPI requirements and use, please see *MLN Matters* articles, MM4023 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf*) titled Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms, and MM4293 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf*) titled Revised CMS-1500 Claim Form, which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the NPI and renamed CMS-1500 (08-05).

The official instruction (CR 5584) issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R207PI.pdf* on the CMS website.

If you have any questions, please contact your Medicare carrier, intermediary, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found on the CMS Web site at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5584	Related Change Request (CR) #: 5584
Related CR Release Date: May 31, 2007	Effective Date: May 29, 2007
Related CR Transmittal #: R207PI	Implementation Date: June 29, 2007

Clarification of the National Provider Identifier Reporting Requirements for Ambulance Service Claims

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

Provider Types Affected

Providers and suppliers who bill Medicare carriers and Medicare administrative contractors (MACs) for ambulance services.

What You Need to Know

CR 5564, from which this article is taken, notifies carriers and MACs to not require you to include the ordering/referring physician's national provider identifier (NPI) on your claims for ambulance services.

You should make sure that your billing staffs are aware of this exception.

Background

Section 1833(q) of the Social Security Act (the Act), requires that the ordering/referring physician's name be provided on all claims for Medicare covered services and items resulting from a physician's order or referral. In addition, when the NPI reporting requirements go into effect according to the Medicare fee-for-service NPI contingency plan, the ordering/referring physician's NPI will also be required on these claims; except, however, on claims for ambulance services (as explained in the paragraphs below). (See *MLN Matters* article, MM5595, available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf* on the CMS Web site for details about the NPI contingency plan.)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. In response to this mandate, the Centers for Medicare & Medicaid Services (CMS) in the national provider identifier (NPI) final rule (published on January 23, 2004) established the NPI as this standard.

Although providers/suppliers may begin reporting the NPI as early as January 1, 2007, all health care providers covered under HIPAA must comply with the requirements of the NPI final rule in accordance with Medicare's NPI contingency plan. At the appropriate date, Medicare will reject claims in which the appropriate name and NPI are not entered in the required fields of the Form CMS-1500 paper claim format, version 08-05 (fields 17 and 17B, respectively), and the ANSI X12 837-P electronic claim format, version 4010A (NM1 segment of the 2310A and/or 2420E loop, respectively).

However, ambulance services (particularly transports provided in response to a 911 or 911-equivalent emergency call) are often ordered by someone other than a physician. In these situations, the name and the NPI of the ordering/referring physician are not available. Thus, CMS does not feel that it is appropriate to require that this information be submitted on the claim form. Therefore, CR 5564, from which this article is taken, instructs carriers and the MACs that the ordering/referring physician's NPI is not required on claims for ambulance services.

Clarification of the NPI Reporting Requirements for Ambulance Service Claims, continued

Additional Information

You may find the official instruction, CR 5564, issued to your carrier or MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1251CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5564 Related Change Request (CR) #: 5564
Related CR Release Date: May 25, 2007 Effective Date: July 1, 2007
Related CR Transmittal #: R1251CP Implementation Date: July 2, 2007

Stage 3 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice

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

Provider Types Affected

Physicians, providers, and suppliers who conduct Health Insurance Portability and Accountability Act (HIPAA) standard transactions, such as claims and eligibility inquiries, with Medicare.

Provider Action Needed

STOP – Impact to You

Be aware that stage 3 of the NPI implementation is nearing. This article discusses impact of the NPI Stage 3 implementation on remittance advice transactions.

CAUTION – What You Need to Know

Make sure you have your NPI, know how to use it, and are prepared to receive it back in your remittance advice processes.

GO – What You Need to Do

Read the remainder of this article and be sure your staff is aware of how the NPI implementation impacts the remittance advice transactions you receive.

Background

This article discusses Stage 3 of Medicare's fee-for-service (FFS) processes for the NPI and reflects Medicare processing of claims submitted with NPIs. Submitted NPIs will be cross-walked to the Medicare legacy number(s) for processing. Medicare's internal provider files will continue to be based upon records established in relation to the legacy identifiers. The crosswalk may result in:

Scenario I: Single NPI cross-walked to single legacy number
Scenario II: Multiple NPIs cross-walked to single Medicare legacy number
Scenario III: Single NPI cross-walked to multiple Medicare legacy numbers

CMS will adjudicate Medicare FFS claims based upon a unique NPI/legacy combination for scenarios II and III, but the remittance advice, both electronic and paper, and any output using PC Print or Medicare Remit Easy Print (MREP) will have only NPI as the primary provider identification. The TIN will be used as the secondary identifier for the Payee. The NPI regulation permits continued use of taxpayer identification number (TIN) for tax purposes if the implementation guide allows it.

The companion documents and flat files for both Part A and B will be updated to reflect these changes and the updated documents will be posted at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage* on the CMS Web site.

The following three scenarios refer to Medicare reporting of NPIs in remittance advice processes.

Note that current requirements concerning the reporting of provider names and addresses still apply.

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

- **Electronic Remittance Advice (ERA)** - Under this scenario, Medicare will report the NPI at the payee level as the payee primary ID, and the TIN (employer identification number [EIN]) social security number [SSN] [EIN/SSN]) in the REF segment as Payee Additional ID. Medicare will report any relevant rendering provider NPI at the claim level if different from the payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will also report relevant rendering NPI(s) at the service line level if different from the claim level, rendering provider NPI. Under this scenario, there will be one remittance advice, and one check/electronic funds transfer (EFT) per NPI.
- **Standard Paper Remittance (SPR)** - Medicare will insert the appropriate payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.

Clarification of the NPI Reporting Requirements for Ambulance Service Claims, continued

- **PC Print Software** - Medicare will show the payee NPI at the header level and add the relevant rendering provider NPI at the claim level if different from the payee NPI.
- **MREP Software** - Medicare will show the payee NPI at the header level and add any relevant rendering provider NPI at the claim level if different from the payee NPI, and any relevant rendering NPI(s) at the service line level if different from the claim level rendering provider NPI.

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

- **ERA** - Under this scenario, Medicare will report the NPI at the Payee level as the payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then add any relevant rendering provider NPI at the claim level if different from the payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add any relevant Rendering NPI(s) at the service line level if different from the claim level rendering provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** - Medicare will insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** - Same as Scenario I.
- **MREP Software** - Same as Scenario I.

Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:

- **ERA** - Under this scenario, Medicare will report the NPI at the payee level as the payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then, Medicare will add any relevant rendering provider NPI at the claim level if different from the payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add relevant rendering NPI(s) at the service line level if different from the claim level, rendering provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** - Insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional notes.
- **PC Print Software** - Same as Scenario I.
- **MREP Software** - Same as Scenario I.

Implementation

While these changes are effective for dates of service on or after July 2, 2007, the changes will be implemented as follows:

- For claims submitted to DMERCs and/or DME MACs, the changes will be implemented on July 1, 2007.
- For claims submitted to other Medicare contractors, the implementation will occur on October 2, 2007.

Additional Information

If you have questions, please contact your Medicare carrier, FI, Part A/B Medicare administrative contractors (A/B MAC), durable medical equipment regional carrier (DMERC), DME/MAC, and/or regional home health intermediary (RHHI), at their toll-free number which may be found at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

For complete details regarding this change request (CR) please see the official instruction (CR 5452) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf* on the CMS website. The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* are attached to CR 5452.

MLN Matters Number: MM5452
Related Change Request (CR) #: 5452
Related CR Release Date: May 18, 2007
Effective Date: July 2, 2007
Related CR Transmittal #: R1241CP
Implementation Date for DME suppliers: July 2, 2007
Implementation Date for other providers: October 1, 2007

Correction of Business Requirement 4320.19 as Contained in CR 4320 Regarding National Provider Identifier Information

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the September 2006 Medicare B Update! pages 31-32.

Note: This article was revised on May 18, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf* on the CMS Web site.

Provider Types Affected

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

Impact on Providers

This article is based on change request CR5217, which instructs your Medicare carrier/DMERC/DME MAC, or FI/RHHI to provide specific national provider identifiers (NPIs) for those providers identified in electronic claims, such as a billing, pay-to, rendering or other provider, that have already obtained NPIs.

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

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

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

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

Additional Information

CR 4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms" can be located at *http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf* on the CMS Web site.

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

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

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

MLN Matters Number: MM5217 *Revised*
Related Change Request (CR) #: 5217
Related CR Release Date: August 18, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R235OTN
Implementation Date: November 20, 2006

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

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

Special note regarding remittance advice transactions: Just as it is important to understand when and where to report national provider identifiers (NPIs) in claim transactions, it is crucial that providers understand and be ready to accept the provider identifiers as reported on remittance advice transactions. This article discusses what provider identifiers Medicare will report on remittances under stage 2 of Medicare's NPI implementation. However, the processes will change as Medicare moves to stage 3 implementation of the NPI. A key difference is that NPIs will be returned in many remittance transactions as the payee and the TIN as the additional payee identifier rather than the current practice of reporting TIN and legacy number respectively, even though the provider may have included the legacy number and the NPI on their claim. Providers need to review, and understand the impact of, Stage 3 on remittances as discussed in the *MLN Matters* article MM5452, which is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf* on the CMS Web site.
Also, note that this article was revised on May 7, 2007, to add this statement that Medicare fee-for-service (FFS) has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf* on the CMS Web site.

Provider Types Affected

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

Background

This article instructs the Shared System Maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advice (ERA) – transaction 835, and Standard Paper Remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007.

The Centers for Medicare & Medicaid Services (CMS) has defined legacy provider identifiers to include OSCAR, national supplier clearinghouse (NSC), provider identification numbers (PIN), National Council of Prescription Drug Plans (NCPDP) pharmacy identifiers, and unique physician identification numbers (UPINs). CMS's definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as employer identification numbers (EINs) or social security numbers (SSNs).

Medicare has published CR 4320 ( ) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via direct data entry screens, or on paper claim forms.

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

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

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

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

Key Points

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

Scenario I: Single NPI cross-walked to single legacy number
Scenario II: Multiple NPIs cross-walked to single Medicare legacy number
Scenario III: Single NPI cross-walked to multiple Medicare legacy numbers

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

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

During stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers. The companion documents will be updated to reflect these changes and the updated documents will be posted at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage* on the CMS Web site.
Important Note: The following scenarios will change under Stage 3 of Medicare's NPI implementation. To see the changes,

Stage 2 NPI Changes for Transaction 835, and SPRA, and Changes in Chapter 22 – RA, continued

see *MLN Matters* article MM5452, which is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf* on the CMS Web site.

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

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

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

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

Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:

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

Implementation

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

Additional Information

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

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

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

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

Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or Paper Claim Forms

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Third Quarter 2006 Medicare B Update! pages 93-95.

Note: This article was revised on May 18, 2007, to add this statement that Medicare fee-for-service (FFS) has announced a contingency plan regarding the May 23, 2007 implementation of the national provider identifier (NPI). For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf* on the CMS Web site.

Provider Types Affected

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

Provider Action Needed

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

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began accepting applications for and issuing NPIs on May 23, 2005. Applications can be made by mail, and online at *https://nppes.cms.hhs.gov* on the CMS Web site.

CMS has endorsed the Workgroup for Electronic Data Interchange (WEDI) Dual NPI-Legacy Identifier strategy for cross-health care industry implementation of the NPI.

The *Dual Use of NPI & Legacy Identifiers* paper is available at: *http://www.wedi.org/snip/public/articles/*. (Once at the site, scroll down and look for the paper issued on January 22, 2006.)

The remainder of this article describes CMS' current plans for a staged process leading to full implementation of the adoption of the NPI in Medicare transactions involving providers.

Background

Implementation involves acceptance and processing of transactions that use the NPI in lieu of the previously used OSCAR, UPIN, PIN, and national supplier clearinghouse (NSC) numbers. The WEDI strategy provides for four stages during which system change schedules of trading partners will occur independently of each other.

Medicare fee-for-service (FFS) transaction implementation for NPI will occur in the following stages:

Stage 1 (January 1, 2006 – October 1, 2006)

During this stage, the NPI will be accepted on inbound claims, other than NCPDP claims, and other transactions but will not be used for Medicare processing. CR 4320 focuses primarily on Stage 1 of the NPI implementation process. During stage 1:

- The "Legacy Identifier" (pre-NPI provider identifiers) will be used to identify providers while Medicare carriers, DMERCs, and intermediaries make sure that X12 837 version 4010A1 claims and other X12 HIPAA adopted transactions are not rejected due to the presence of an NPI.
- (Transactions may be submitted with or without an NPI during stage 1, as long as the Medicare legacy identifier is still reported.)
- Additionally, NPIs will be edited to verify that they meet basic structure requirements established for NPIs.
- Medicare will allow NPIs on the X12 270 version 4010A1 eligibility inquiry and the 276 claim status inquiry and return them in the respective X12 271 or 277 response, as long as the legacy identifier is also reported in the 270 or the 276.
- NPIs, as well as legacy identifiers, will be reported in coordination of benefit claims sent to trading partners when submitted on claims submitted to Medicare.
- NPIs will NOT be reported in the following outbound transactions during Stage 1, even if an NPI was submitted on related claims:
  - X12 835 claims; or
  - SPRs (standard paper remittance) formats.
- Medicare carriers, DMERCs, and intermediaries must **reject the following transactions if submitted with NPIs**, since it is not possible to report both NPIs and legacy identifiers for providers in these transactions:
  - NCPDP claims;
  - DDE claims, claim status and eligibility inquiries;
  - UB-92 (CMS-1450) paper claims (the National Uniform Billing Committee [NUBC] announced that the use of the UB-04, which is able to report the NPI and a legacy identifier for each provider involved with a claim, will begin March 1, 2007, and that May 22, 2007, is the last day that a payer should accept a UB-92 form). Since it is not possible to report both a legacy identifier and an NPI on the UB-92, submitters of the UB-92 will be limited to reporting of their legacy identifier on those claims; and
  - CMS-1500 paper claims until the National Uniform Claim Committee implements a revised 1500 and CMS announces its implementation of that revised form.

Stage 1 Use and Editing of NPI Numbers Received in EDI Transactions, via DDE Screens, or Paper Claim Forms, continued

The NUCC has approved a revised CMS-1500 form and has announced that payers should begin to accept the revised form effective October 1, 2006. Between October 1, 2006, and January 31, 2007, payers should accept either the current or the revised CMS-1500 form. Effective February 1, 2007, and later, payers should accept only the revised CMS-1500 form. Both the NPI and the legacy identifier can be reported on the revised CMS-1500 form, but not on the form currently in use. Until a provider begins to use the revised form, that provider will be limited to submission of legacy identifiers on the non-revised CMS-1500 form.

Stage 2: (October 2, 2006 – May 22, 2007)

During this stage:

- Providers, clearinghouses, and billing services will be directed to provide a Medicare legacy identifier as a secondary identifier when NPIs are submitted as the primary provider identifiers in their X12 837 claims.
- The legacy identifier alone can still be used to identify those providers that have not yet obtained an NPI.
- The transitional dual NPI-legacy identifier strategy includes the development of a crosswalk between Medicare legacy numbers and their associated NPIs. The crosswalk should help Medicare validate most NPIs to ascertain that they were actually issued to the providers for which reported, and will help to identify transcription errors in a reported NPI. The Crosswalk will begin operating at the onset of stage 2.
- If you use free billing software supplied by your carrier, DMERC, or intermediary/RHHI, it will be modified for stage 2 to permit reporting of your NPI, once received, and your legacy Medicare provider identifier. You will need to download the new version of the software when notified it is available.
  The 835 PC-Print and Easy Print software for printing of remittances will also be updated for stage 2 to permit reporting of NPIs as well as legacy numbers when both are reported in an 835 transaction. Be sure to download the new version of that software when notified it is available.
- DDE screens will be modified for this stage to accept and return both NPIs, when available, and legacy identifiers.
- NPIs, when available in Medicare provider files, as well as legacy identifiers will be returned in 835 transactions and SPRs during stage 2.

Stage 3 (May 23, 2007 – and Later)

Stage 3 involves the transition to full use of the NPI for acceptance and processing of transactions, **except** for coordination of benefits (COB) claims that Medicare sends to small trading partners.

- HIPAA prohibits the reporting of any provider legacy identifiers to other than small health plans during this period (e.g., plans with less than $5 million in annual receipts).
- All claims, including NCPDP claims, and 270, 276, and 277 attachment transactions sent to Medicare, must contain the NPI in lieu of the legacy identifier (please see Stage 4 below regarding claims). Those that do not are to be rejected.
- Legacy identifiers will no longer be sent to coordination of benefits (COB) trading partners or on outbound electronic or paper Medicare transactions or correspondence.

Stage 4 (May 23, 2007 – May 22, 2008)

Stage 4 involves completion of transition to the full use of NPI by all small trading partners. NPIs, rather than legacy identifiers, will be reported in all 837 version 4010A COB and NCPDP claims sent to small trading partners.

Additional Information

CR 4320 is the official instruction issued to your FI, including RHHI, or carrier, including DMERC, regarding changes mentioned in this article. CR 4320 may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf* on the CMS Web site.

You may also want to review *MLN Matters* Special Edition SE0555, concerning the NPI. That article is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM4320 *Revised*
elated Change Request (CR) #: 4320
Related CR Release Date: February 1, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R204OTN
Implementation Date: January 3, 2006

PROVIDER QUALITY REPORTING INITIATIVE

2007 Physician Quality Reporting Initiative Tool Kit is Now Available

2007 PQRI Tool Kit – Five Steps for Success

The Centers for Medicare & Medicaid Services (CMS) has developed a tool kit for the 2007 Physician Quality Reporting Initiative (PQRI) that will assist eligible professionals with successful reporting. This tool kit consists of some existing educational resources plus new measure-specific worksheets designed to walk the user step-by-step through reporting for each measure.

The tool kit is now a featured section on the CMS PQRI Web page. To access the tool kit, visit, *http://www.cms.hhs.gov/PQRI*, and scroll down to the PQRI Tool Kit tab. The page serves as a "Read This First" guide to the resources that are available to download.

The tool kit consists of the following:

1. 2007 PQRI Physician Quality Measures
2. 2007 Coding for Quality Handbook
3. 2007 Code Master
4. *MLN Matters* Article 5640 - Coding & Reporting Principles
5. Data Collection Worksheets

The tool kit will be expanded as new educational resources become available.

Revisions to the final 2007 PQRI Measure Specifications

The CMS announces revisions to the final 2007 PQRI Measure Specifications, version 1.1 to provide certain technical corrections.

Please visit the "Measures/Codes" page of the PQRI Web site at *http://www.cms.hhs.gov/pqri* for the updated measure specifications and release notes.

Source: Provider Education Resources Listserv, Message 200706-24

Physician Quality Reporting Initiative—Education Resources

As a reminder, the CMS has several educational resources to promote and increase an understanding of the Physician Quality Reporting Initiative (PQRI). These resources will provide further guidance that will complement your upcoming Ask-The-Contractor (ACT) calls. Educational resources available on the Web site include:

2007 PQRI – New Educational Products

- Coding for Quality – A Handbook for PQRI Participation
- 2007 PQRI Code Master
- 2007 PQRI Fact Sheet

Frequently Asked Questions

The Centers for Medicare & Medicaid Services has posted Frequently Asked Questions (FAQs). You may access these FAQs by visiting the PQRI Web page at *http://www.cms.hhs.gov*, on the CMS Web site. Go to the overview section, scroll down to the "Related Links Inside CMS" section and click on the link titled "All PQRI FAQs." Continue to check the FAQ section regularly for updates.

PowerPoint Presentations

- 2007 PQRI Preparation and Participation Strategies for Successful Reporting – April 19, 2007
- 2007 PQRI Coding Guidance – Module III – May 24, 2007
- 2007 "Coding for Quality: The Measures, Module 4" – June 13, 2007

You may access these presentations by visiting the PQRI Web page at, *http://www.cms.hhs.gov/PQRI*. Go to the "Educational Resources" section and download the materials.

Source: Provider Education Resources Listserv, Message 200706-18

Final Specifications for the Physician Quality Reporting Initiative Are Now Available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the final specifications for 2007 Physician Quality Reporting Initiative (PQRI) are now available.

To access both the measures and measure specifications documents, visit the PQRI Web page at *http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage* on the CMS Web site. Go to the Measures/Codes section of the page and scroll down to "Downloads."

New Frequently Asked Questions on the 2007 Physician Quality Reporting Initiative

CMS has 15 new frequently asked questions (FAQs) about the PQRI available on its Web site. You may access these FAQs by visiting the PQRI Web page at, *http://www.cms.hhs.gov/PQRI* on the CMS Web site. Go to the Overview section, scroll down to "Related Links Inside CMS" and click on the link titled "All PQRI FAQs."

Testing Opportunity for the Physician Quality Reporting Initiative

Eligible professionals interested in testing their billing system, and practice their readiness for PQRI quality data code reporting, will have a chance to do so prior to July 1, 2007.

You may access the instructions by visiting the PQRI Web page at, *http://www.cms.hhs.gov/PQRI* on the CMS Web site. Go to the Reporting section, scroll down to "Downloads" and click on the link titled "2007 PQRI-Testing Opportunity for the Physician Quality Reporting Initiative" link.

Important 2007 Physician Quality Reporting Initiative Reminder

PQRI reporting begins for dates of services on or after July 1, 2007, and will continue through December 31, 2007.

Source: Provider Education Resources Listserv, Message 200706-04

Materials for PQRI National Provider Call—May 24, 2007

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the materials used during the May 24, 2007, National Provider Call have been posted to the CMS Web site.

Available Materials

- 2007 Physician Quality Reporting Initiative (PQRI) PowerPoint® Presentation on Coding Guidance-Module III, May 24, 2007
- Change request (CR) 5640 - Physician Quality Reporting Initiative (PQRI) Coding & Reporting Principles
- *MLN Matters* Article – MM5640

How to Access the Materials

To access the meeting materials, visit *http://www.cms.hhs.gov/PQRI* on the CMS website and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the "Downloads" section and click on the "**Materials for PQRI National Provider Call, May 24, 2007**" link. As an added benefit, the presentation is also available as an Adobe Acrobat® file.

Question of the Week

Question: What are the financial benefits of participation in the PQRI?

Answer: PQRI participants who reports successfully will be eligible for a lump-sum bonus payment of up to 1.5 percent of the Medicare Physician Fee Schedule allowed charges, for services provided during the reporting period, subject to a cap, as established by the Tax Relief and Health Care Act of 2006 (TRHCA).

Reference: *http://www.cms.hhs.gov/PQRI*.

Source: Provider Education Resources Listserv, Message 200705-33

Sign up to our *eNews* electronic mailing list

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

GENERAL INFORMATION

Carrier Jurisdiction for Ambulance Supplier Claims

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the December 2006 Medicare B Update! pages 43-44.

Note: The Centers for Medicare & Medicaid Services rescinded change request 5203 on June 19, 2007. As a result, this article was rescinded on that date as well.

MLN Matters Number: MM5203
Related CR Release Date: November 3, 2006
Related CR Transmittal #: R1100CP
Related Change Request (CR) #: 5203
Effective Date: January 1, 2008
Implementation Date: January 1, 2008

Attention Physicians Participating in the Competitive Acquisition Program for Medicare Part B Drugs and Biologicals

You may be requested by the Competitive Acquisition Program (CAP) designated carrier, Noridian Administrative Services, LLC to submit copies of medical records for the CAP post-payment review process. This process is mandated by legislation to assure that payment for CAP drug claims from an approved CAP vendor is made only if the drugs were administered to the beneficiary. As a part of this process, Noridian will also calculate and recoup any overpayments made to an approved CAP vendor. Noridian will be requesting beneficiary medical records from a small sample of participating CAP physicians each month to substantiate the administration of drugs furnished by the approved CAP vendor. It is the responsibility of all participating CAP physicians to comply with these requests for medical records.

For more information, you may contact Noridian via their physician contact center at 1-888-671-0536 or visit the Web pages below.

http://www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/PostPay.pdf
https://www.noridianmedicare.com/cap_drug/index.html

Source: CMS Provider Education Resources Listserv 200706-09

Competitive Acquisition Program Educational Materials During the Additional Physician Election Period

An additional election period for physicians who are not currently participating in the Competitive Acquisition Program (CAP) is underway. The CAP is an alternative to the average sales price (ASP) method of acquiring many drugs and biologicals administered incident to a physician's services.

The additional election period began on May 1, 2007, and will end June 15, 2007. Effective dates for physicians who elect to participate during this period will be from August 1, 2007, through December 31, 2007. Please note that this physician election period is only for new CAP elections. It is not necessary to renew CAP election at this time. Requests for termination from the program will not be accepted during this election period.

Additional information about the CAP physician election process, including new educational materials about the physician election process are at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage*.

Additional information about the CAP is available at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp#TopOfPage*.

The list of drugs supplied by the CAP vendor, including NDCs, is in the Downloads section at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp#TopOfPage*.

Completed and signed physician election forms should be returned by mail to your local carrier-the carrier that processes your Part B drug claims after May 1, 2007. Please do not return the completed forms to the Centers for Medicare & Medicaid Services (CMS). In order to qualify for a CAP effective date of August 1, 2007, election forms for the additional election period must be postmarked no later than June 15, 2007.

Source: Provider Education Resources Listserv, Message 200705-27

Do Not Forward Initiative—Reminder

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

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

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

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

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

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

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

Financial Measures for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) released the measures that will be used to evaluate the financial stability of suppliers that bid under the new Medicare DMEPOS Competitive Bidding Program on Friday, May 25, 2007. All bids must include certain financial documentation in order for the supplier to be considered for a contract under the program. CMS and its Competitive Bidding Implementation Contractor (CBIC) will evaluate each bidder's financial documentation to determine whether the supplier will be able to participate in the program and maintain viability for the duration of the contract period.

The financial measures are standard accounting ratios commonly used to evaluate financial health. The following financial ratios will be used:

- Current ratio = current assets/current liabilities
- Collection period = (accounts receivable/sales) x 360
- Accounts payable to sales = accounts payable/net sales
- Quick ratio = (cash + accounts receivable)/current liabilities
- Current liabilities to net worth = current liabilities/net worth
- Return on sales = net sales/inventory
- Sales to inventory
- Working capital = current assets – current liabilities
- Quality of earnings = cash flow from operations/(net income + depreciation)
- Operating cash flow to sales = cash flow from operations/(revenue – adjustment to revenue)

CMS and the CBIC will calculate each bidder's financial ratios using the financial information submitted as part of the bid. CMS and the CBIC will also be utilizing the supplier's credit history in evaluating the financial health of the supplier.

Source: CMS Provider Education Resources Listserv, Message 200705-36

Sign up to our *eNews* electronic mailing list

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

DMEPOS Competitive Bidding Reminder!

The Centers for Medicare & Medicaid Services (CMS) is soliciting bids for the first round of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

Time is running out

Suppliers interested in bidding must first register and receive a user ID and password before they can access the Internet-based bid submission system. Suppliers should register immediately to avoid a delay in being able to submit bids.

The registration deadline is June 30, 2007

Please visit the Competitive Bidding Implementation Contractor (CBIC) Web site at *http://www.dmecompetitivebid.com* to register.

Additional Information

- The contract period for mail order diabetic supplies is April 1, 2008 – December 31, 2009.
- The contract period for all other first round product categories is April 1, 2008 – March 31, 2011.

Suppliers must be accredited or be pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

Please note: All bids are due by 9:00 p.m. prevailing Eastern Time on July 13, 2007.

For more information on the program as well as bidding and accreditation information, please visit *http://www.dmecompetitivebid.com*.

Source: Provider Education Resources Listserv, Messages 200706-22, 200706-28, 200706-36

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

Implementation of the Carrier Jurisdictional Pricing Rules for All Purchased Diagnostic Service Claims

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

Provider Types Affected

Physicians, laboratories, and independent diagnostic testing facilities (IDTFs) who bill carriers/Medicare administrative contractors (MAC) for purchased diagnostic services.

Provider Action Needed

Change request (CR) 5543, from which this article is taken, replaces the temporary physician billing instructions specified in CR 3630 (issued on December 23, 2004) with new billing procedures that (effective October 1, 2007) allow all physicians and suppliers to receive the correct payment amount for all purchased diagnostic services, including those performed outside of their local carrier's/Medicare administrative contractor's (MAC) jurisdiction.

Background

Through CR 3481, the Centers for Medicare & Medicaid Services (CMS), on April 1, 2005, implemented a Medicare physician fee schedule (MPFS) national abstract file containing the Healthcare Common Procedural Coding System (HCPCS) codes, billable as a purchased diagnostic test/interpretation, for every locality throughout the country. With this file's implementation, CMS changed the carrier jurisdictional pricing rules for purchased diagnostic tests/interpretations to allow suppliers (including laboratories, physicians, and independent diagnostic testing facilities) to bill their local carrier/MAC for these services and receive the correct payment amount, regardless of the location where the service was performed. (*See CR 3481, issued on October 29, 2004*).

Note: Carrier jurisdictional pricing rules for all other services payable under the MPFS have remained in effect.

However, CMS delayed implementation of the CR 3481's billing instructions for physicians, because of a previously noted potential problem with reporting the locality data in physician claims for such services performed outside of the local carrier's jurisdiction. Rather, through CR 3630, CMS implemented a temporary change in the carrier jurisdictional pricing rules for purchased diagnostic services to allow physicians providing out-of-jurisdiction diagnostic tests/interpretations to bill their local carrier for these services and receive the local rate.

CR 5543, from which this article is taken, replaces the temporary physician billing instructions specified in CR 3630 with new billing procedures to allow all physicians and suppliers to receive the correct payment amount for all purchased diagnostic services (based on the ZIP code of the location where the service was rendered, in accordance with the carrier jurisdictional pricing rules), including those performed outside of the local carrier's jurisdiction, effective for claims with dates of service on or after October 1, 2007.

Implementation of the Carrier Jurisdictional Pricing Rules for All Purchased Diagnostic Service Claims, continued

CR 5543 key points include:

- Effective for claims with dates of service on or after October 1, 2007, carriers/MACS will use the MPFS national abstract file for purchased diagnostic tests/interpretations to price all claims for purchased diagnostic services based on the ZIP code of the location where the service was rendered, including those submitted by physicians for purchased diagnostic services performed outside of the local carrier's jurisdiction, in accordance with the carrier jurisdictional pricing rules specified in chapter 1, section 10.1.1 of the *Medicare Claims Processing Manual*.
- Physicians and suppliers must begin reporting the rendering physician's/supplier's information and the location where the service was rendered on all claims for purchased tests/interpretations with dates of services on or after October 1, 2007, including those for tests/interpretations performed outside of the local carrier's jurisdiction, following the instructions for submitting a purchased diagnostic service claim in chapter 1, sections 10.1.1.2 and 30.2.9 of the *Medicare Claims Processing Manual.*
- *Physicians/suppliers are not to report the NPI (or provider identification number (PIN)) of the out-of-jurisdiction performing physician/supplier when submitting a claim for a diagnostic service purchased outside of their local carrier's/MAC's jurisdiction.*
- Physicians and suppliers are reminded they may only submit claims for purchased tests/interpretations when these services are performed within the United States. (In this context, the term "United States" means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. See chapter 1, section 10.1.4 of the *Medicare Claims Processing Manual* for additional information.)

Additional Information

You may find the official instruction (CR 5543) issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1250CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5543	Related Change Request (CR) #: 5543
Related CR Release Date: May 25, 2007	Effective Date: October 1, 2007
Related CR Transmittal #: R1250CP	Implementation Date: October 1, 2007

Transitioning the Mandatory Medigap Crossover Process to the Coordination of Benefits Contractor

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], and/or Part A/B Medicare administrative contractors [A/B MACs]), for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5601, which outlines the Centers for Medicare & Medicaid Services (CMS) systematic requirements for the transitioning of its mandatory Medigap ("claim-based") crossover process from its Part B contractors to the COBC. During the period from June through September 2007, CMS' Coordination of Benefits Contractor (COBC) will sign national crossover agreements with Medigap claim-based crossover insurers and will assign new 5-digit Coordination of Benefits (COBA) Medigap claim-based crossover identifiers to these entities for inclusion on incoming Medicare claims. CMS is also preparing a separate CR (CR 5662) that includes the website where provider billing staffs may go to obtain the listing of new COBA Medigap claim-based identifiers for purposes of initiating Medigap claim-based crossovers. Within the next few weeks, following the issuance of CR 5662, providers will also receive more detailed information regarding this change via their Medicare contractors' provider newsletters/bulletins and Web sites.

CAUTION – What You Need to Know

October 1, 2007 is the effective date for completing the transition of the Medigap crossover process to the COBC. At that time, CMS will then only support the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X-12N 837 professional COB (version 4010-A1) claim format and National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claim format for such crossovers. As CMS' COBC assigns the new

Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the COBC, continued

COBA Medigap claim-based ID to the Medigap insurers, it will populate this information on its COB website so that provider billing staffs may access it for purposes of including the new identifiers on incoming Medicare Part B claims, claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and NCPDP Part B drug claims. By October 1, 2007, providers will exclusively be including the new identifiers on incoming claims to initiate Medigap claim-based crossovers.

GO – What You Need to Do

During June through September 2007 CMS will gradually be moving Medigap insurers to the new process. Be certain that your billing staffs are aware of these changes and that claims are sent to Medicare contractors in a timely and correct manner.

Background

Currently, in accordance with section 1842(h)(3)(B) of the Social Security Act and section 4081(a)(B) of Public Law 100-203 (the Omnibus Budget Reconciliation Act of 1987), Part B contractors, including carriers and MACs, and durable medical equipment regional carriers (DMERCs)/ DMACs transfer participating provider claims to Medigap insurers if the beneficiary has assigned rights to payment to the provider and if other claims filing requirements are met. This form of claims transfer is commonly termed "Medigap claims-based crossover." One of the "other" claims filing requirements for Medigap claim-based crossover is that the participating provider must include an Other Carrier Name and Address (OCNA) or N-key identification number on the incoming electronic claim to trigger the crossing over of the claim.

Key Points of CR 5601

- Be aware that during the transition period from June through September 2007 the COBC will assign new 5-byte claim-based Coordination of Benefits Agreement (COBA) IDs to the Medigap insurers on a graduated basis throughout the three month period prior to the actual transition. Until CMS' COBC assigns a new 5-digit COBA Medigap claim-based ID to a Medigap insurer, Medicare will continue to accept the older contractor-assigned OCNA or N-key identifiers for purposes of initiating Medigap claim-based crossovers. During June through September 2007, the affected contractors will also continue to cross claims over as normal to their Medigap claim-based crossover recipients. CMS will be regularly apprising the affected Medicare contractors when -the COBC has assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB website so that contractors **may direct providers to that link for purposes of obtaining regular updates.**
- Effective with claims filed to Medicare on October 1, 2007:
- All participating providers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) should enter CMS' newly assigned COBA Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers.
- All other participating providers shall enter the newly assigned COBA Medigap claim-based ID, left-justified and followed by spaces, within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim **and** within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers.
- Providers will need to make certain that claims are submitted with the appropriate identifier that begins with a "5" and contains "5" numeric digits.
- Be mindful that claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. If your claim does not follow the appropriate format, Medicare will continue to adjudicate your claim as normal but will notify you via the electronic remittance advice (ERA) and the beneficiary via the Medicare summary notice (MSN) that the information reported was insufficient to cause the claim to be crossed over.
- Your Medicare contractor's screening process will also -continue to verify that you participate with Medicare and that the beneficiary has assigned benefits to you as the provider.
- If the claim submitted to the Medicare contractor indicates that the claim contained an invalid claim-based Medigap crossover ID, **the Medicare contractor** will send the following standard message to you, the provider.
- "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. **Please verify your information and submit your secondary claim directly to that insurer."**
- In addition, in these cases, if CMS' Common Working File (CWF) system determines that the beneficiary was identified for crossover on a Medigap insurer's eligibility file, the CWF system will suppress crossover to the Medigap insurer whose information was entered on the incoming claim.
- Also, the Medicare contractor will include the following message on the beneficiary's MSN in association with the claim: (MSN #35.3):
- "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."

Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the COBC, continued

- **REMEMBER:** As CMS's COBC assigns new 5-digit COBA Medigap claim-based identifiers to Medigap insurers, participating providers will be expected to include the new 5 digit identifier on incoming crossover claims for purposes of triggering claim-based Medigap crossovers. Additionally, effective with **October 1, 2007, Medigap claim-based crossovers will occur exclusively through the COBC in the HIPAA ANSI X12-N 837 professional claim format (version 4010A1 or more current standard) and NCPDP claim format**.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5601) issued to your Medicare carrier, A/B MAC, DME MAC, or DMERC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1242CP.pdf* on the CMS Web site.

If you have questions, please contact your Medicare carrier, or A/B MAC, DME MAC, DMERC at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5601	Related Change Request (CR) #: 5601
Related CR Release Date: May 18, 2007	Effective Date: October 1, 2007
Related CR Transmittal #: R1242CP	Implementation Date: October 1, 2007

Important Changes to the Mandatory Medigap Crossover Process

Effective October 1, 2007, the Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits Contractor (COBC) will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on the incoming claim.

Through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the COBC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit Medigap identifier (ID). Providers may reference a weekly updated listing of the newly assigned Coordination of Benefits Agreement (COBA) Medigap claim-based IDs on the CMS Coordination of Benefits Web site at:
http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap Claim-based COBA IDs for Billing Purpose.pdf.

Once the COBC has assigned a new COBA Medigap claim-based ID to a Medigap insurer, participating providers that wish to trigger crossovers to Medigap insurers will be required to include that new identifier, as found on the CMS COB website, on their incoming Medicare claims. Failure to do so will result in their claims not being successfully crossed over to the Medigap insurer. If the older contractor-assigned number is included on the claim, Medicare will include the following standard MA19 message on the provider's electronic remittance advice (ERA) or other production remittance advice for the associated claim(s):

> "Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer."

Claim Filing Instructions

Paper Claims

Participating providers that are permitted under Administrative Simplification Compliance Act (ASCA) to bill Medicare on paper should include the newly assigned 5-digit COBA Medigap claim-based ID in block 9-D of the Form CMS-1500.

Electronic Claims

Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) left-justified in field NM109 of the NM1 segment within the 2330B loop and followed by spaces. Providers should notify their clearinghouses and billing vendors of the impending changes to the existing Medigap claim-based crossover process as soon as possible.

Claims Submitted to Durable Medical Equipment Medicare Administrative Contractors

Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier left-justified within field 301-C1 of the T04 segment of their incoming NCPDP claims and followed by spaces.

Important: For all of the claim submission situations discussed above, suppliers (including retail pharmacies) that bill durable medical equipment Medicare administrative contractors (DMACs) must include an accompanying 4-byte "Z001" identifier with the newly assigned COBA Medigap claim-based crossover ID (for example, 55000Z001) when seeking to trigger Medigap claim-based crossovers during the interim transitional period, which runs from June through September 30, 2007. Providers should notify their clearinghouses and billing vendors of the impending changes to the existing Medigap claim-based crossover process as soon as possible.

Important Changes to the Mandatory Medigap Crossover Process, continued

The full-text CMS transition announcement is posted at:

Connecticut – *http://www.connecticutmedicare.com/common_resource_cross_Medigap%20Crossover%20Transition%20Announcement%20%5BCR%205662%5D.pdf*

Florida – *http://www.floridamedicare.com/common_resource_cross_Medigap%20Crossover%20Transition%20Announcement%20%5BCR%205662%5D.pdf*

Source: Publication 100-20, Transmittal 283, Change Request 5662

Notifying Affected Parties Regarding Changes to the Mandatory Medigap Crossover Process

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DMACs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

What Providers Need to Know

CR 5662, from which this article is taken, outlines the processes that Part B carriers, A/B MACs responsible for Part B claims processing, and DMACs shall follow in notifying affected parties that the mandatory Medigap (claim-based) crossover process is being transitioned to the Coordination of Benefits Contractor (COBC) effective October 1, 2007

Background

The Centers for Medicare & Medicaid Services (CMS) has decided that, effective October 1, 2007, all mandatory Medigap ("claim-based") crossovers will now be accomplished through its Coordination of Benefits Contractor (COBC). Further, CMS has decided that, in accordance with Public Law 104-191 and 45 *Code of Federal Regulations* (CFR) 160, it will **only** –transmit claims to Medigap claim-based crossover recipients in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional (version 4010A1) coordination of benefits (COB) claim format or in the National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 format.

Note: The systematic requirements relating to this transition were communicated via change request (CR) 5601, as reflected in *MLN Matters* article MM5601 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf* on the CMS Web site.)

Starting with June 2007, CMS' COBC will gradually begin to assign new Medigap claim-based COBA identifiers (range 55000 to 59999) to Medigap insurers that have not voluntarily moved to the COBA eligibility file-based crossover process. CMS anticipates that the COBC will complete the execution of crossover agreements with Medigap claim-based insurers and assign new COBA Medigap claim-based identifiers to these entities by August 31, 2007. As the COBC assigns a new COBA Medigap claim-based ID to a Medigap claim-based crossover recipient, CMS will alert all Part B contractors, including MACs, and DMACs via e-mail of this action on a weekly basis. The CMS alert will include the following information: affected entity's name; the entity's multiple formerly contractor-assigned Other Carrier Name and Address (OCNA) or N-key identifiers; and its newly assigned COBA Medigap claim-based ID. Upon receipt of the CMS alert, the affected contractors shall manually add the newly assigned COBA Medigap claim-based ID to their existing insurer screens or tables to replace the formerly assigned OCNA or N-key identifier. Contractors shall also maintain a link to the COB Web site (*http://www.cms.hhs.gov/COBAgreement*) for purposes of receiving updates to the COBA Medigap claim-based ID listing.

The affected contractors shall post CMS' Medigap claim-based crossover transition announcement in its entirety on their Web sites that are accessed by the public and insurers. These contractors shall also mail the CMS announcement on a one-time basis to their electronic Medigap claim-based crossover recipients and shall also notify their paper claim recipients through information included with their next scheduled claim mailings.

Providers should note the following: Effective October 1, 2007, the COBC will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on the incoming claim. The primary change for providers resulting from this transition will be that they will need to include a new Medigap identifier, even in advance of October 1, 2007, on their incoming Medicare claims to trigger crossovers to Medigap insurers. During June through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the COBC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit COBA Medigap claim-based identifier (ID). Providers may reference a weekly updated listing of the newly assigned COBA Medigap claim-based IDs for Medicare billing purposes at the following Web site:
http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap Claim-based COBA IDs for Billing Purpose.pdf. Once the COBC has assigned a new COBA Medigap claim-based ID to a Medigap insurer, participating providers that wish to trigger crossovers to Medigap insurers will be required to include that new identifier, as found on the CMS COB Web site, on their incoming Medicare claims. Failure to do so will result in their claims not being successfully crossed over to the Medigap insurer. If the older contractor-assigned number is included on the claim, Medicare will include the standard MA19 message—'Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer.

Notifying Affected Parties Regarding Changes to the Mandatory Medigap Crossover Process, continued

Please verify your information and submit your secondary claim directly to that insurer.'—on the provider's electronic remittance advice (ERA) or other production remittance advice for the associated claim(s). Participating providers that are permitted under Administrative Simplification Compliance Act (ASCA) to bill Medicare on paper should include the newly assigned 5-digit COBA Medigap claim-based ID within block 9-D of the CMS-1500 claim form. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) left-justified in field NM109 of the NM1 segment within the 2330B loop and followed by spaces. **(See important note that follows regarding the submission of claims to DMACs.)**

Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier left-justified within field 301-C1 of the T04 segment of their incoming NCPDP claims and followed by spaces.

IMPORTANT: For all of the claim submission situations discussed above, suppliers (including retail pharmacies) that bill DMACs must include an accompanying 4-byte "Z001" identifier with the newly assigned COBA Medigap claim-based crossover ID (for example, 55000Z001) when seeking to trigger Medigap claim-based crossovers during the interim transitional period, which runs from June through September 30, 2007.

Providers should notify their clearinghouses and billing vendors of the impending changes to the existing Medigap claim-based crossover process as soon as possible.

Additional Information

You may find the official instruction, CR 5662, issued to your carrier, MAC, or DMAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R283OTN.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5662
Related Change Request (CR) #: 5662
Related CR Release Date: June 15, 2007
Effective Date: June 15, 2007
Related CR Transmittal #: R283OTN
Implementation Date: July 16, 2007

New Products Available from CMS Medicare Learning Network

The following products are now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

- The *Medicare Disproportionate Share Hospital Fact Sheet*, which provides information about methods to qualify for the Medicare disproportionate share hospital (DSH) adjustment and Medicare DSH payment adjustment formulas.
- The *Critical Access Hospital Fact Sheet*, which provides general information about critical access hospitals.
- The *Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians* which contains rural health information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005 (also now available in CD-ROM format)
- The *Inpatient Psychiatric Facility Prospective Payment System Fact Sheet* which provides general information about the inpatient psychiatric facility prospective payment system (IPF PPS), how payment rates are set, and the rate year 2008 update to the IPF PPS.
- The *Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet*, which provides information about inpatient rehabilitation facility prospective payment system rates and classification criterion.

To place your order for these products, visit *http://www.cms.hhs.gov/mlngeninfo*, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page."

Source: CMS Provider Education Resource 200706-02

Organ Transplant Application Update

On March 30, 2007, the Department of Health and Human Services (DHHS) issued regulations authorizing the survey and certification of transplant programs. The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for monitoring compliance with the Medicare Conditions of Participation. Prior to this new regulation, organ transplant programs were approved for Medicare participation either through ESRD Conditions of Coverage (renal programs) or National Coverage Decisions (non-renal). The new regulation established Conditions of Participation for all covered organ transplant programs.

All hospital transplant programs, approved for Medicare participation as of June 28, 2007, (approved either under the ESRD Conditions of Coverage or the National Coverage Decisions), must submit a request for new approval under the Conditions of Participation established by the new regulation. This request must be submitted to CMS by **December 26, 2007**, (180 days from the effective date of the regulation.) Requests may be:

Mailed to:
Centers for Medicare & Medicaid Services
Attention: Sherry Clark
7500 Security Blvd.
Mailstop: S2-12-25
Baltimore, MD 21244

Faxed To:
(410) 786-0194
Attention: Sherry Clark

THERE IS NO OFFICIAL APPLICATION FORM. Each approved program should prepare a letter to CMS formally requesting Medicare approval for their program(s) under the new Hospital Conditions of Participation: Requirements for Approval and Re-approval of Transplant Centers to Perform Organ Transplants. A hospital may submit one request for approval of all their transplant programs within one letter. However, the approval request must include all the essential information about each program. Please visit the CMS/Survey and Certification Web site at *http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp* for the specific information that must be included in an approval request. CMS is deleting the requirement that each program must submit a signed statement from the Organ Procurement Transplant Network (OPTN) verifying that the program is in compliance with all the data submission requirements of that organization. CMS will not require that this statement be submitted with provider letters requesting approval under the new Conditions of Participation. CMS has been working with the Health Resources and Services Administration (HRSA) and the United Network for Organ Sharing (UNOS, HRSA's contractor to operate the OPTN) to develop a report that would provide CMS with the percentage of required forms programs have submitted to the OPTN within the timeframe outlined in the regulation.

CMS will notify each applicant upon receipt of the approval request, will review the information submitted, and will schedule an on-site review of the program(s).

Please be advised that CMS will not launch the approval process until the program has entered a formal request for approval under new the Conditions of Participation and the necessary information concerning the program(s) has been received. If a program does not submit a request for approval under the new Conditions of Participation by December 28, 2007, CMS will conclude that the program no longer desires Medicare participation and will begin the process to withdraw Medicare approval.

If you have any questions concerning the approval requests, timelines for the regulation, the information that must be submitted with the approval request, or the survey and certification process, please direct your inquiries to Sherry Clark in the Survey and Certification Group at CMS at (410) 786-8476.

Source: Provider Education Resources Listserv, Message 200706-21

National Men's Health Week

June 11-17 is National Men's Health Week. The goal of this annual week-long observance is to heighten the awareness of preventable health problems and encourage early detection and treatment of disease among men and boys. In keeping with the goal of National Men's Health Week, the Centers for Medicare & Medicaid Services (CMS) continues its initiative focused on motivating seniors and others with Medicare to make the most of Medicare's preventive services and maintaining healthy lifestyles by asking health care providers to use this week as an opportunity to encourage patients with Medicare to take advantage of preventive services and screenings for which they may be eligible. Medicare pays for a full range of preventive services and screenings such as colorectal and prostate cancer screenings and diabetes and cardiovascular screenings. These screenings can help men with Medicare stay healthy and detect conditions like cancer, diabetes, and cardiovascular disease early when treatment works best. CMS hopes that you will join with us in spreading the word to Medicare beneficiaries and their caregivers.

How Can You Help?

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about potentially life saving preventive services and screenings. While Medicare pays for more preventive benefits, many men with Medicare don't fully realize that utilizing preventive services and screenings covered by Medicare can help them live longer, better, healthier lives. As a health care professional you can help your patients with Medicare understand the importance of disease prevention, early detection and lifestyle modifications that support a healthier life.

- Talk with your patients with Medicare about their risk for disease and lifestyle modifications that can help reduce risk of disease and complications.
- Educate your patients about the benefits of using preventive services and screenings.

National Men's Health Week, continued

- Discuss with them which Medicare-covered preventive services and screenings are right for them and encourage utilization by providing referrals for appropriate services for which they may be eligible.

Working together we can ensure that men with Medicare receive the preventive services and screenings that are right for them.

For More Information

For more information about Medicare-covered preventive services and screenings, including coverage, coding and billing guidelines, please visit the following CMS Web site:

- The *MLN* Preventive Services Educational Products Web Page – This Web page is a one-stop shop for provider educational information on coverage, coding, and billing of Medicare-covered preventive benefits. The web page contains a descriptive listing of the products, which include: articles, a guide, brochures, quick reference charts, web-based training courses, a video program, a slide presentation, seasonal flu information, and a bookmark, as well as product ordering information and links to other related CMS and non CMS prevention resources and Web sites. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage.*

For products to share with your Medicare patients go to *http://www.medicare.gov.*
To learn more about National Men's Health Week, please visit *http://www.menshealthweek.org/.*

Thank you for joining with CMS in spreading the message about prevention and early detection and ensuring that men and all people with Medicare take full advantage of their preventive benefits.

Source: CMS Provider Education Resources Listserv 200706-07

Sign up to our *eNews* electronic mailing list

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

LOCAL COVERAGE DETERMINATIONS

Unless otherwise indicated, articles apply to both Connecticut and Florida.

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

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

Effective and Notice Dates

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

Electronic Notification

To receive quick, automatic notification when new LCDs are posted to the Web site, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *http://www.connecticutmedicare.com or http://www.floridamedicare.com* , click on the "eNews" link on the navigational menu and follow the prompts.

More Information

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

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

Local Coverage Determinations - Table of Contents

Advance Notice Statement

Advance beneficiary notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity (see page 5).

LCD REVISIONS

EPO: Epoetin alfa—LCD Revision

This local coverage determination (LCD) was last revised on May 3, 2007. Since that time, the LCD has been revised. Under the list of medically necessary ICD-9-CM diagnosis codes, the following ICD-9-CM diagnosis codes were deleted: 571.40, 571.41 and 571.49. These were replaced with ICD-9-CM codes 070.54 and 070.70.

In addition, the following ICD-9-CM codes were also added to the list of medically necessary ICD-9-CM codes: 205.10 and 205.11. These codes allow for appropriate billing of the covered off-label indication for chronic myelomonocytic leukemia, which may be considered a form of MDS.

In addition to the coding changes, this LCD was broken out into individual Florida B and Connecticut B LCDs. The coding guidelines were also revised as appropriate.

Effective Date

This revision is effective for services rendered on or after August 10, 2007. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

91110: Wireless Capsule Endoscopy—LCD Revision

This local coverage determination (LCD) was last revised on January 1, 2007.

Since that time, the LCD was revised to include the addition of ICD-9-CM codes 280.0 (*iron deficiency anemias, secondary to blood loss [chronic])* and 280.9 (*iron deficiency anemia, unspecified)* in the "ICD-9 Codes that Support Medical Necessity" section of the LCD for procedure code *91110*.

Coverage guidelines for wireless capsule endoscopy of the small bowel and esophagus remain the same. The ICD-9-CM codes are only surrogate for the indication of documented continuous blood loss and anemia secondary to obscure bleeding of the small bowel.

Effective Date

This revision is effective for services rendered on or after June 21, 2007. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

ADDITIONAL INFORMATION

Independent Diagnostic Testing Facilities Specialty 47 Resources

The last article published in regard to the Medicare guidelines for independent diagnostic testing facilities (IDTFs) was posted in the June 2007 *Medicare B Update!*. Since that time, these resources have been revised to add the following paragraph:

Supervising Physician Qualification/Proficiency Requirements

The CMS On-line Manual System, Pub. 100-8, *Program Integrity Manual*, Chapter 13, Section 13.5.1 (*http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf*) outlines that "reasonable and necessary" services are "ordered and/or furnished by qualified personnel." Services will be considered medically reasonable and necessary only if performed by appropriately trained providers.

As stated in the *Code of Federal Regulations*, section 410.33, the supervising physician must evidence proficiency in the performance and interpretation of each type of diagnostic procedure performed by the IDTF. The proficiency may be documented by certification in specific medical specialties or subspecialties or by criteria established by the carrier for the service area in which the IDTF is located. In this regard, First Coast Service Options, Inc. (FCSO) has determined that the supervising physician must be board certified in the specialty listed on the following "Credentialing Matrix" **OR** meet the following criteria:

> Training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty or must reflect extensive continued medical education activities. If these skills have been acquired by way of continued medical education, the courses must be comprehensive, offered or sponsored or endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States, and designated by the American Medical Association (AMA) as Category 1 Credit.

Independent Diagnostic Testing Facilities Specialty 47 Resources, continued

The "Credentialing Matrix Technician Qualifications" for procedure code *75635* has been revised to "Professional component code must be performed by a physician".

Also, the "Credentialing Matrix Technician Qualifications" for procedure code *76801 – 76857* has been revised to read: Credentialed by ARDMS: RDMS-OB/GYN or ARRT: R.T.-S.

The "Credentialing Matrix" column titled "MD Qualification/Proficiency Requirements" has also been revised to "Supervising Physician Qualification/Proficiency Requirements".

The full text of these resources may be viewed on the provider education website at *http://www.floridamedicare.com* or *http://www.connecticutmedicare.com.*

CONNECTICUT ONLY - LCD REVISION

62263: Epidural—LCD Revision

This local coverage determination (LCD) was last revised on October 1, 2006. Since that time, the LCD was revised to include the addition of ICD-9-CM code range 338.11-338.19 for acute postoperative pain management.

In addition, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was updated to include "Acute pain management in the postoperative surgical patient for patients who have undergone major abdominal, thoracic, orthopedic, or obstetrics and gynecological operations."

Effective Date

This revision is effective for services rendered on or after June 4, 2007. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

CONNECTICUT ONLY - ADDITIONAL INFORMATION

Emerging Diagnostic Technology – NC-stat System, NeuroMetrix®—Revision of Coding Instructions

An article was published in the November 2006 *Medicare B Update!* (page 25) on the automated nerve conduction testing system, NC-stat device, marketed by NeuroMetrix®.

The article noted that First Coast Service Options, Inc. (FCSO) does not currently have a local coverage determination (LCD) that addresses coverage criteria for this automated diagnostic test and until a specific code is established by *Current Procedural Terminology* (*CPT*) that describes automated testing, this procedure must be billed with code *95999 (Unlisted neurological or neuromuscular diagnostic procedure)* and not with current *CPT* codes *95900*, *95903*, or *95904* for nerve conduction studies.

A new draft LCD for electromyography and nerve conduction studies was presented at the February 2007 Carrier Advisory Committee (CAC) meeting. The draft LCD mentioned that automated nerve conduction testing performed by the NC-stat system or similar devices should be billed with the unlisted code *95999*.

Following the comment period of the draft LCD, FCSO decided that until further clarification is received from the American Medical Association (AMA) panel, the use of the nerve conduction study codes (*95900*, *95903*, & *95904*) could be billed with the NC-stat system and similar devices effective for services rendered on or after June 30, 2007, (the effective date of the LCD). The use of these specific codes is based on the assumption that the procedures performed meet the specifics of the code descriptor and the supervision requirements are met. The above verbiage regarding the unlisted code for NC-stat system or similar devices was removed from the final LCD pending any clarification from the *CPT* Advisory Committee and Editorial Panel.

FLORIDA ONLY - LCD REVISION

43644: Surgical Management of Morbid Obesity—LCD Revision

This local coverage determination (LCD) was last revised on April 17, 2007. Change request 5477, issued on April 27, 2007, clarified claims processing instructions related to bariatric surgery. Therefore, the LCD was revised to include noncovered procedures billed with *CPT* code *43999 (Unlisted procedure, stomach.)*
The following bariatric surgery procedures are noncovered when billed using *CPT* code *43999* (*Laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy and open adjustable gastric banding*).

Effective Date

This revision is effective for claims processed on or after May 29, 2007, for services rendered on or after February 21, 2006. The full text of this LCD is available through our provider education Web site at *http://www.floridamedicare.com* on or after this effective date.

FLORIDA ONLY - ADDITIONAL INFORMATION

Emerging Diagnostic Technology–NC-stat System, NeuroMetrix®—Revision of Coding Instructions

An article was published in the November 2006 *Medicare B Update!* (page 25) on the automated nerve conduction testing system, NC-stat device, marketed by NeuroMetrix®.

The article noted that First Coast Service Options, Inc. (FCSO) does not currently have a local coverage determination (LCD) that addresses coverage criteria for this automated diagnostic test and until a specific code is established by *Current Procedural Terminology* (*CPT*) that describes automated testing, this procedure must be billed with code *95999 (Unlisted neurological or neuromuscular diagnostic procedure)* and not with current *CPT* codes *95900*, *95903*, or *95904* for nerve conduction studies.

The LCD for nerve conduction studies covered *CPT* codes *95900-95904* and was last updated on October 1, 2006. Since that time, the LCD was completely revised to include additional *CPT* codes for H-reflex studies, neuromuscular junction, and electromyography, and the LCD title and Contractor's Determination Number were changed to "Electromyography and Nerve Conduction Studies (95860)." The draft LCD also mentioned that automated nerve conduction testing performed by the NC-stat system or similar devices should be billed with the unlisted code *95999*. This draft LCD was presented at the February 2007 Carrier Advisory Committee (CAC) meeting.

Following the comment period of the draft LCD, FCSO decided that until further clarification is received from the American Medical Association (AMA), the use of the nerve conduction study codes (*95900*, *95903*, & *95904*) could be billed with the NC-stat system and similar devices effective for services rendered on or after June 30, 2007, (the effective date of the LCD). The use of these specific codes is based on the assumption that the procedures performed meet the specifics of the code descriptor and the supervision requirements are met. The above verbiage regarding the unlisted code for NC-stat system or similar devices was removed from the final LCD pending any clarification from the *CPT* Advisory Committee and Editorial Panel.

CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

July 2007 – August 2007

Podiatry Seminar – Topics based on data analysis, session includes discussion of new initiatives and changes in the Medicare program

When: July 25, 2007
Time: Location and time to be determined.
Type of Event: In-person seminar

Ask the Contractor Teleconference (ACT) – Topic to be determined

When: August 18, 2007
Time: 12:00 p.m. – 1:00 p.m.
Type of Event: Teleconference

If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to 904-791-6035. Keep checking our Web site, *www.connecticutmedicare.com*, or listening to information on the FCSO Provider Education Registration Hotline, (203) 634-5527, for details and newly scheduled events!

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to event advertisement.
- For event and registration details, check our Web site (*www.connecticutmedicare.com*) or call our registration hotline at (203) 634-5527 a few weeks prior to the event.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, Zip Code: _____

FLORIDA EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

July 2007 – September 2007

Hot Topics Teleconference – Updates to the Medicare Program

When: July 12, 2007
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

Ask the Contractor Teleconference – Topics to be determined

When: August 16, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Hot Topics Teleconference – Topics to be determined

When: September 13, 2007
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

More events will be planned soon for this quarter. Keep checking our Web site, *www.floridamedicare.com*, or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events!

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to event advertisement.
- For event and registration details, check our Web site (*www.floridamedicare.com*) or call our registration hotline at (904) 791-8103 a few weeks prior to the event.

Registrant's Name: _____

Registrant's Title: _____

Provider 's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, Zip Code: _____

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

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

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

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

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

Attention: Correspondence

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

Attention: Financial Services

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

Attention: Fraud and Abuse

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

Attention: Freedom of Information (FOIA)

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

Attention: Medical Review

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

Attention: MSP

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

Attention: Pricing/ Provider Maintenance

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

Attention: Resolutions

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

MAILING ADDRESS EXCEPTIONS

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

Redeterminations/Appeals

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

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

Hearings

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

Post Office Box for Appeals/Hearings:

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

Electronic Media Claims/EDI

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

Post Office Box for EDI:

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

Claims

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

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

CONNECTICUT MEDICARE PHONE NUMBERS

Beneficiary Services
1-800-MEDICARE ***(toll-free)***
1-866-359-3614 *(hearing impaired)*
First Coast Service Options, Inc.

Provider Services
Medicare Part B
1-888-760-6950

Interactive Voice Response
1-866-419-9455

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

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

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

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

Electronic Funds Transfer Information
1-203-639-3219

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

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

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

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

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

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

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

Health Insurance Counseling Program
1-800-994-9422

Area Agency on Aging
1-800-994-9422

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

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

MEDICARE WEB SITES

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

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

Florida Medicare Part B Mail Directory

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

Redetermination Requests
Medicare Part B Claims Review
P.O Box 2360
Jacksonville, FL 32231-2100

Fair Hearing Requests
Medicare Hearings
Post Office Box 45156
Jacksonville FL 32232-5156

Administrative Law Judge Hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration Manager

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

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

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

MISCELLANEOUS

Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For Education Event Registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare Claims for Railroad Retirees:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and Abuse
First Coast Service Options, Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Florida Medicare Phone Numbers

PROVIDERS

Toll-Free
Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992

BENEFICIARY

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

For Education Event Registration (*not* toll-free)**:**
1-904-791-8103

EMC

Format Issues & Testing:
1-904-354-5977 option 4
Start-Up & Front-End Edits/Rejects:
1-904-791-8767 option 1
Electronic Funds Transfer
1-904-791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
PC-ACE Support:
1-904-355-0313
Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
Help Desk:
(Confirmation/Transmission):
1-904-905-8880 option 1

DME, ORTHOTIC OR PROSTHETIC CLAIMS

Cigna Government Services
1-866-270-4909

MEDICARE PART A

Toll-Free:
1-866-270-4909

Medicare Web sites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com

Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

ORDER FORM — 2007 PART B MATERIALS

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO with the account number listed by each item.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

QUANTITY	ITEM	ACCOUNT NUMBER	COST PER ITEM
	***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Hardcopy or CD-ROM distribution is limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers who meet the above criteria must register to receive the *Update!* in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason can be shown why the electronic publication available free of charge on the Internet cannot be utilized. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2006 through September 2007 (back issues will be sent upon receipt of order).	700395	$85.00 (Hardcopy) $20.00 (CD-ROM)
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