Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue…

Features

To receive quick, automatic notification when new publications and other items of interest are posted to our provider education Web sites, subscribe to our *FCSO eNews* mailing list. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers, Connecticut or Florida, click on the "eNews" link located on the upper-right-hand corner of the page and follow the prompts.

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

Routing Suggestions:

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

_____

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FROM THE CONTRACTOR

2007 Medicare Contractor Provider Satisfaction Survey: A Call to Action

First Coast Service Options, Inc (FCSO) is proud to share our results from the second annual 2007 Medicare Contractor Provider Satisfaction Survey, or MCPSS. This survey is an important new tool used by the Centers for Medicare & Medicaid Services (CMS) to measure providers' satisfaction with the performance of fee-for-service contractors.

We are happy to report that our 2007 scores were above the benchmark average for all Part A and Part B contractors. While this survey helps us see what we are doing right, it also shows us what we can do better. We are listening to you, and wish to share with our provider community some improvement processes that we are implementing this year.

What is the MCPSS?

The survey is designed to collect objective and quantifiable data on provider satisfaction with contractors that process and pay Medicare claims. The results help contractors identify areas for improvement to their systems and procedures. The MCPSS asks providers to rate their contractor(s) on seven business services performed by contractors: provider communications; provider inquiries; claims processing; appeals; medical review; provider enrollment; and provider audit and reimbursement (for Part A only).

A Call to Action!

When the results were released in July 2007, FCSO's leadership carefully analyzed the findings for each business function, and developed an action plan for areas that scored below average.

While some processes we perform are mandated by CMS, we have focused on improvement efforts in which we can make a positive impact. One such enhancement is that we will offer more frequent offerings of teleconferences/webcasts to quickly disseminate the latest news and up-to-date information on local coverage determinations (LCDs). The best way to stay informed on LCDs and other Medicare news is to sign up for our listservs available through *www.fcso.com*.

We look forward to incorporating additional process improvements throughout the year. Stay tuned!

The 2008 MCPSS is Approaching

Data collection for the 2008 MCPSS will begin in late November and run until April 2008. Results will be announced in early July. If you are selected to participate in the survey, we encourage you to respond. Your feedback is important to our commitment to delivering excellent customer service. Sampled providers/suppliers have the opportunity to respond by Internet, a telephone interview, or they may request a paper copy of the survey.

More information on the MCPSS, including past and current survey results, is available at *www.cms.hhs.gov/MCPSS* and *www.MCPSStudy.org*.

Source: CMS Joint Signature Memorandum 08016, dated October 12, 2007

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 site. It's very easy to do. Simply go to the Web site, *http://www.fcso.com*, hover over Medicare Providers, select Connecticut or Florida, click on the "eNews" link located on the upper-right-hand corner of the page and follow the prompts.

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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 faxed to (904) 361-0723.

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.

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education Web site, *http://www.fcso.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 Web site(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 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.

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 data interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **general information** section includes fraud and abuse, and Medicare Secondary Payer topics, plus additional topics not included elsewhere.

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

Quarterly Provider Update

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

Providers may access the Quarterly Provider Update by going to the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU listserv to ensure timely notification of all additions to the QPU.

Have You Visited the FCSO Web Site Lately?

In response to feedback we received from you, our valued customers, we recently completed a redesign of the Florida and Connecticut Medicare Web sites. If you haven't visited our Web sites lately, here are some of the things you have missed, hot off the presses!

- A quick 15-second animation that shows you all the latest tips and tools at your disposal to help successfully complete the CMS-855 form (Provider Enrollment Application).
- Information about the latest enhancements and user tools for the provider automated customer service telephone lines.
- The latest list of final Local Coverage Determinations (LCDs).
- The latest information on the National Provider Identifier (NPI).

This information and much more are just a few clicks away! You can access the Florida or Connecticut Medicare provider Web sites anytime by going to *www.fcso.com*. Once there, under "Medicare Providers", click either Florida or Connecticut.

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.

Patient Liability Notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131form as part of the Beneficiary Notices Initiative (BNI) 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 Web site 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

Reader Survey—*Medicare B Update!*

We want readers to find this publication to be a helpful tool that is easy to use and understand. This survey is your opportunity to suggest ways we can better meet your needs. After the survey closes, we will publish the results on our Web site and work to implement suggested enhancements as appropriate. Thank you for taking the time to complete this survey.

Please complete the questions below and fax to us at 1-904-361-0723 by December 21, 2007.

Please Indicate Your Location: ❑ **Connecticut** ❑ **Florida**

Overall Satisfaction

On a scale of 5 to 1, with 5 being very satisfied and 1 being very dissatisfied, how satisfied are you with the publication overall? Please ***circle*** the number that best applies.

5 4 3 2 1

Accuracy

"When I read the *Medicare B Update!* I feel comfortable that the information presented is accurate."

5 4 3 2 1

"When I read the *Medicare B Update!* I am confident that the information is up-to-date."

5 4 3 2 1

Clarity

"Medicare rules and guidelines are complex; however, I generally find the articles in the *Medicare B Update!* clear."

5 4 3 2 1

"Medicare rules and guidelines are complex; however, I usually find the articles in the *Medicare B Update!* easy to read."

5 4 3 2 1

Value

"The *Medicare B Update!* assists me in performing my job."

5 4 3 2 1

Layout/Format

"The *Medicare B Update!* is arranged in a manner that makes it easy to find the information I need."

5 4 3 2 1

Comments/Feedback –

What else could we do to improve the publication for you?

_____

_____

_____

_____

Please complete the questions below and fax to us at 1-904-361-0723 by December 21, 2007, or click on the following link to complete this survey electronically:
http://ikc.incepture.com:80/ikc/survey?IKCSurveyID=07120302361520667810

PROVIDER ENROLLMENT - FLORIDA ONLY

Documentation Requirements for Nonphysician Practitioners

The Centers for Medicare & Medicaid Services (CMS) has established criteria for determining the eligibility of nonphysician practitioners for enrollment and reimbursement under Part B of the Medicare program. Specific guidelines for nonphysician practitioner professions are outlined below. Medicare requires that this information be submitted with the form CMS 855I enrollment application before a provider transaction number may be issued to you.

If you are submitting a CMS 855I application, attach the appropriate degree, certificate, or documentation demonstrating that you have met the requirements for your provider type.

Anesthesiologist Assistant

A qualified anesthesiologist assistant must:

- Be licensed by the state to administer anesthesia **and**
- have successfully completed a six year program for anesthesia assistants, of which two years consists of specialized academic and clinical training in anesthesia.

Audiologist

A qualified audiologist is an individual who must:

- Be licensed by the state as an audiologist.

Certified Nurse Midwife

A certified nurse midwife (CNM) must:

- Be licensed as a nurse midwife.

Certified Registered Nurse Anesthetist

A certified registered nurse anesthetist (CRNA) must:

- Be currently licensed in Florida as a registered nurse **and**
- Be currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists; **or**
- Have graduated within the past 18 months from a nurse anesthesia program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

Note: A copy of the Council on Certification of Nurse Anesthetists, or the Council on Recertification of Nurse Anesthetists card may be submitted as documentation in addition to the state license.

Clinical Nurse Specialist

Coverage is available for services performed by a clinical nurse specialist (CNS) and direct payment can be made to the CNS, or the employer or contractor of the CNS who:

- Is licensed by the state as a registered nurse **and**
- Possesses a master's degree in a defined clinical area of nursing from an accredited educational institution; **and**
- View the accredited educational institutes at *http://www.nursecredentialing.org/accred/searchaccred.cfm*. Ensure the master's degree is from one of these organizations.
- Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for CNSs.

The following are recognized national certifying bodies for CNSs at the advanced level:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses)
- Oncology Nurses Certification Corporation
- AACN Certification Corporation
- National Board on Certification of Hospice and Palliative Nurses

Registered Dietitian or Nutrition Professional

A registered dietitian or nutrition professional is an individual who:

- Is a dietitian or nutrition professional licensed in Florida.

Licensed Clinical Social Worker

A licensed clinical social worker (LCSW) is an individual who:

- Is licensed as a clinical social worker in Florida.

Physical Therapist In Private Practice

Note: A physical therapist (PT) in private practice must maintain a private office even if services are always furnished in patients' homes. If services are furnished in private practice office space, that space would have to be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice.

A qualified PT is an individual who:

- Is licensed by the state as a PT **and** meets one of the following requirements:
  - Has graduated from a PT curriculum approved by (1)*the American Physical Therapy Association, or by (2) the Committee on Allied Health Education and Accreditation of the American Medical Association, or (3) Council on Medical Education of the American Medical Association, and the American Physical Therapy Association; or
  - Prior to January 1, 1966, (1) was admitted to membership by the American Physical Therapy Association, or (2) was admitted to registration by

Documentation Requirements for Nonphysician Practitioners, continued

the American Registry of Physical Therapists, or (3) has graduated from a PT curriculum in a 4-year college or university approved by a state department of education; or

- Has two years of appropriate experience as a PT and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking qualification as a PT after December 31, 1977; or
- Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy; or
- If trained outside the United States, (1) was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy, (2) meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

Occupational Therapist In Private Practice

Note: An occupational therapist (OT) in private practice must maintain a private office even if services are always furnished in patients' homes. If services are furnished in private practice office space, that space would have to be owned, leased, or rented by the practice and used for the exclusive purpose of operating the practice. If the applicant is an organization, the organization must be wholly owned by one or more OT(s) that is practicing at the location.

An OT must:

- Be licensed as an OT in Florida.

Nurse Practitioner

Note: Effective for services rendered after January 1, 1998, any individual who is participating under the Medicare program as a nurse practitioner (NP) for the first time ever, may have his or her professional services covered if he or she meets the qualifications listed below, and he or she is legally authorized to furnish NP services in the state where the services are performed. NPs who were issued billing provider numbers prior to January 1, 1998 may continue to furnish services under the NP benefit.

Qualifications for NPs. In order to furnish covered NP services, a NP must meet the conditions as follows:

A nurse practitioner who applied for Medicare billing privileges for the first time **on or after 01/01/01** must:

- Be a registered professional nurse who is authorized by the state in which services are furnished to practice as an NP in accordance with state law, and
- Must be certified as a NP by a recognized national certifying body* having established standards for NPs.

An NP who applied for Medicare billing privileges for the first time **on or after 01/01/03** must:

- Be a registered professional nurse who is authorized by the state in which services are furnished to practice as an NP in accordance with state law, and
- Must be certified as a NP by a recognized national certifying body* having established standards for NPs and
- Possess a master's degree in nursing.

*The following organizations are recognized national certifying bodies:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
- National Certification Board of Pediatric Nurse Practitioners & Nurses
- Oncology Nurses Certification Corporation
- Critical Care Certification Corporation.

Physician Assistant

A physician assistant (PA) must:

- Be licensed by the state as a PA – temporary licenses are not acceptable.

Clinical Psychologist

A clinical psychologist must:

- Be licensed by the state as a psychologist.

Source: CMS Program Integrity Manual Ch. 10 Sec. 12.4; Code of Federal Regulations, Title 42

Provider Enrollment Educational Events

Watch the Provider Outreach & Education section of our Web sites at *http://www.fcso .com* for upcoming events related to provider enrollment.

AMBULANCE

Ambulance Inflation Factor for Calendar Year 2008

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

Provider Types Affected

Providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

What You Need to Know

CR 5801, from which this article is taken provides the ambulance inflation factor (AIF) for calendar year (CY) 2008. The AIF for CY 2008 is 2.7 percent.

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services.

Specifically, this section of the Act provides for a 2008 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF).

CR 5801, from which this article is taken, furnishes the CY 2008 AIF, which will be 2.7 percent. The following displays the AIF for CY 2008 and for the previous 5 years.

Ambulance Inflation Factor by CY

2008	2.7 percent
2007	4.3 percent
2006	2.5 percent
2005	3.3 percent
2004	2.1 percent
2003	1.1 percent

The national fee schedule for ambulance services was phased in over a five-year transition period beginning April 1, 2002. Further, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established that the ground ambulance base rate (for services furnished during the period July 1, 2004 through December 31, 2009) is subject to a "floor amount."

Payment will not be less than this "floor," which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule.

Some key issues related to the AIF include:

National or Regional Fee Schedules

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division's fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate.

Payments Based on Blended Methodology

During the five-year transition period, your payments have been based on a blended methodology. For CY 2008, this blend is 20 percent regional ground base rate and 80 percent national ground base rate.

Before January 1, 2006, for each ambulance provider or supplier, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional [if it applied]), and to the reasonable cost or charge portion of the blended payment amount. Then, these two amounts were added together to determine each provider or supplier's total payment amount.

As of January 1, 2006, the total payment amount for air ambulance providers and suppliers is based on 100 percent of the national ambulance fee schedule (AFS). As of January 1, 2008, the total payment amount for ground ambulance providers and suppliers is based on either 100 percent of the national AFS or 80 percent of the national AFS and 20 percent of the regional AFS, whichever is greater.

Part B Coinsurance and Deductible Requirements

Part B coinsurance and deductible requirements apply.

Additional Information

You may find more information about the 2008 AIF by going to CR 5801 located at *http://www.cms.hhs.gov/transmittals/downloads/R1375CP.pdf* on the Centers for Medicare & Medicaid (CMS) Web site. There you will find updated *Medicare Claims Processing Manual*, chapter 15 (Ambulance), section 20.6.1 (Ambulance Inflation Factor [AIF]) as an attachment to that CR.

If you have any 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: MM5801
Related Change Request (CR) #: 5801
Related CR Release Date: November 9, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1375CP
Implementation Date: January 7, 2008

Medicare Payments for Ambulance Transports

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

Note: CMS has revised this special edition *MLN Matters* article on November 16, 2007, to correct a reference to a related change request (CR). The reference should have been to CR 5442 instead of CR 5422. The article had previously been changed on November 8, 2007, to clarify when an ambulance transport claim may result in a beneficiary liability (see Caution section). In addition, there was a change made in the *Documentation Requirements* section to note that a physician certification statement (PCS) is required for nonemergency transports only "in some circumstances". It previously implied that it was always required. All other information is unchanged. The *MLN Matters* article SE0724 was published in the July 2007 *Medicare B Update!* (pages 7-8).

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. 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 Medicare would cover the use of an ambulance transport for your patient, and if so, what level of service would be covered. Please refer to the *Background* section of this special edition *MLN Matters* 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 nonemergency use of the transport. If not, the Centers for Medicare & Medicaid Services (CMS) will deny the transport claim. Additionally, Medicare does not cover nonambulance 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
- 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) on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Nonemergency Ambulance Transports

Nonemergency 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 benefits**.

Medicare Payments for Ambulance Transports, continued

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 nonemergency transports **in some circumstances** (see 42 CFR 410.40 link in the *Additional Information* section). The PCS states the reason(s) a patient requires nonemergency 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) 5442 "*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 nonemergency 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

MLN Matters article 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 on the OIG HHS Web site at *http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf*.

CR 5442, dated February 23, 2007, "*Ambulance Fee Schedule – Medical Conditions List – Manualization Revisions*," is located on the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf*.

The regulations at 42 CFR 410.40(d)(2) and (3) state the circumstances when a PCS is required and may be found on the CMS Web site at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410_40.pdf*.

If you have questions, please contact your Medicare contractor 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).

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AMBULATORY SURGICAL CENTER

Implementation of 2008 Ambulatory Surgical Center Payment System Changes

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

Provider Types Affected

Providers who bill contractors (fiscal intermediaries, carriers and Medicare administrative contractors [A/B MAC]) for ambulatory surgical center [ASC) services for Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is required to implement a new ASC payment system no later than January 1, 2008. An overview of the new system has already been provided in the *MLN Matters* article SE0742, which is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf* on the CMS Web site. CR 5680, from which this article is taken, provides additional information on the background, policy, and instructions that your Medicare contractor will use to implement this revised payment system.

Background

Section 626 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to implement a new ASC payment system not later than January 1, 2008. In part, the law requires that ASCs be paid the lesser of the actual charge or the ASC fee schedule payment rates. See *MLN Matters* article SE0742 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf* for an overview of the new ASC payment system.

In addition to the new payment instructions, ASCs will be paid a reduced amount for certain procedures when you receive a partial credit for more than 50 percent of the cost of a medical device. You will need to include a modifier FC on certain procedure codes that include payment for a device, to report that you received a partial credit for more than 50 percent of the cost of the device. For those procedure codes where the modifier FC may be applicable, CMS will provide Medicare contractors with a price for the procedure code, both with and without, the modifier FC.

CR 5680 also includes a number of changes to two Medicare manuals as summarized below. (Only the key changes/revisions are included in this article). These revised manual instructions are attached to CR 5680.

Revisions to the Medicare Claims Processing Manual

(These revisions are attached to CR 5680 at *http://www.cms.hhs.gov/Transmittals/downloads/R1325CP.pdf* on the CMS Web site.) Key revisions are:

Chapter 1 (General Billing Requirements)
Section 30.3.1 (Mandatory Assignment on Carrier Claims)

For colorectal cancer screening colonoscopies (G0105 and G0121), there is no deductible and a 25 percent coinsurance. Effective January 1, 2008, for service G0104, there will be no deductible and the 25 percent coinsurance rate will apply.

Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)
Section 120 (General Rules for Reporting Outpatient Hospital Services)

Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on TOB 83x for ASCs. All ASC providers (including Indian health service providers) must submit their claims to the designated carrier or A/B MAC.

Section 180.1 (General Rules)

Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on TOB 83x for ASCs. All ASC providers (including Indian health service providers) must submit their claims to the designated carrier or A/B MAC

Chapter 14 (Ambulatory Surgical Centers)
Section 10 (General)

Beginning January 1, 2008, Medicare will:

- Pay ASCs (under Part B) for all surgical procedures except those that CMS determines may pose a significant safety risk to beneficiaries or that are expected to require an overnight stay when furnished in an ASC.
- Pay ASCs (under Part B) for certain ancillary services such as certain drugs and biologicals, pass through devices, brachytherapy sources, and radiology procedures.
- Continue to pay ASCs for new technology intraocular lenses and corneal tissue acquisition as it did prior to January 1, 2008.
- Not pay ASCs for procedures that are excluded from the list of covered surgical procedures or covered ancillary services.

To be paid under this provision, a facility must be certified as meeting the requirements for an ASC and must enter into a written agreement with the Centers for Medicare & Medicaid Services (CMS). The *State Operations Manual* describes the certification process, which you may find at: *http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS1201984&intNumPerPage=10.*

Section 10.2. (Ambulatory Surgical Center Services on ASC List)

Under the new payment system, ASC services for which payment is included in the ASC payment include, but are not limited to:

- Nursing technician, and related services
- Use of the facility where the surgical procedures are performed
- Any laboratory testing performed under a clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate waiver.

Implementation of 2008 Ambulatory Surgical Center Payment System Changes, continued

- Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS)
- Medical and surgical supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at:

http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42

- Equipment
- Surgical dressings
- Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at:

http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42)

- Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR located at:

http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42

- Splints and casts and related devices
- Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedures
- Administrative, recordkeeping and housekeeping items and services
- Materials, including supplies and equipment for the administration and monitoring of anesthesia
- Supervision of the services of an anesthetist by the operating surgeon.

In addition, Medicare will pay ASCs separately for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. The services are:

- Brachytherapy sources
- Certain implantable items that have pass-through status under the outpatient prospective payment system (OPPS)
- Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue
- Certain drugs and biologicals for which separate payment is allowed under the OPPS
- Certain radiology services for which separate payment is allowed under the OPPS

Beginning January 1, 2008, the ASC facility payment for drugs and biologicals includes those that are not usually self-administered, and are considered to be packaged into the payment for the surgical procedure under the OPPS. Beginning January 1, 2008, Medicare makes separate payment to ASCs for drugs and biologicals that are furnished integral to an ASC covered surgical procedure and are separately payable under the OPPS.

Section 10.4. (Coverage of Services in ASCs, Which Are Not ASC Facility Services)

Physician Services

Includes most covered services performed in ASCs, which are not considered ASC facility services. Consequently, physicians who perform covered services in ASCs may bill and receive separate payment under Part B. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to beneficiaries in ASC's and the beneficiaries' recovery from the anesthesia.

Implantable Durable Medical Equipment (DME)

If the ASC furnishes items of implantable DME items to beneficiaries, the ASC bills and receives payment from the local carrier or A/B MAC for the surgical procedure and the implantable device. When the surgical procedure is not on the ASC list, the physician bills the carrier or A/B MAC for both the surgical procedure and the implanted device, coding the ASC as the place of service (POS code 24) on the bill.

Non-Implantable DME

If the ASC furnishes items of non-implantable DME to beneficiaries, it is treated as a DME supplier, and all the rules and conditions ordinarily applicable to DME are applicable, including obtaining a supplier number and billing the DME MAC where applicable.

Services of Independent Laboratory

As noted in the *Medicare Claims Processing Manual*, chapter 14, section 10.2, only very limited numbers and types of diagnostic tests are considered ASC facility services and are included in the ASC facility payment rate. Since Section 1861(s) of the Act limits coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics, or hospitals to those that meet the statutory definition of an independent laboratory, in most cases, diagnostic tests that an ASC performs directly are not considered ASC facility services and not covered under Medicare.

The ASC's laboratory must be CLIA certified and will need to enroll with the carrier or A/B MAC, as a laboratory and the certified clinical laboratory must bill for the services provided to the beneficiary in the ASC. Otherwise, the ASC must make arrangements with a covered laboratory or laboratories for laboratory services, as set forth in 42CFR416.49 located at:

http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=737c29dc4bb9dd89c5b72ca82f9b40c5&rgn=div8&view=text&node=42:3.0.1.1.3.3.1.10&idno=42

on the Internet.

Section 20 (List of Covered Ambulatory Surgical Center Procedures)

The complete lists of ASC covered surgical procedures and ASC covered ancillary services; the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations; and the wage adjusted payment rates, and wage indices are available at *http://www.cms.hhs.gov/ASCPAYMENT* on the CMS Web site.

Section 20.1 (Nature and Applicability of ASC List)

The ASC list of covered procedures indicates procedures, which are covered and paid for if performed in the ASC setting. It does not require the covered surgical procedures to be performed only in ASCs. The decision regarding the most appropriate care setting for a given surgical procedure is made by the physician based on the beneficiary's individual clinical needs and preferences. In addition, all the general coverage rules requiring that any procedure be reasonable and necessary for the beneficiary are applicable to ASC services in the same manner as all other covered services.

Implementation of 2008 Ambulatory Surgical Center Payment System Changes, continued

Section 20.2. (Types of Services Included on the List)

The Medicare approved procedures are all considered "surgical procedures" for purposes of ASC coverage, regardless of the use of the procedure. For example, many of the "oscopy" procedures listed - bronchoscopy, laryngoscopy, etc., may be employed for either diagnostic or therapeutic purposes, or even both at the same time, such as when the "oscopy" permits both detection and removal of a polyp. Those procedures are considered "surgical procedures" within the context of the ASC provision. In addition, surgical procedures are commonly thought of as those involving an incision of some type, whether done with a scalpel or (more recently) a laser, followed by removal or repair of an organ or other tissue.

In recent years, the development of fiber optics technology, together with new surgical instruments using that technology, has resulted in surgical procedures that, while invasive and manipulative, do not require incisions. Instead, the procedures are performed without an incision through various body openings. Those procedures, some of which include the "oscopy" procedures mentioned above, are also considered surgical procedures for purposes of the ASC provision, and several are included in the list of covered procedures.

The ASC list of covered surgical procedures is comprised of surgical procedures that CMS determines do not pose a significant safety risk and are not expected to require and overnight stay following the surgical procedure.

Surgical procedures are defined as category I *CPT* codes within the surgical range of *CPT* codes, *10000* through *69999*. Also considered to be included within that code range are level II HCPCS and category III *CPT* codes that crosswalk to or are clinically similar to the category I *CPT* codes in the range.

The surgical codes that are included on the ASC list of covered surgical procedures are those that have been determined to pose no significant safety risk to Medicare beneficiaries when furnished in ASCs and that are not expected to require active medical monitoring at midnight of the day on which the surgical procedure is performed (overnight stay).

Procedures that are included on the inpatient list used under Medicare's hospital outpatient prospective payment system and procedures that can only be reported by using an unlisted category I *CPT* code are deemed to pose significant safety risk to beneficiaries in ASCs and are not eligible for designation and coverage as covered surgical procedures.

Section 30 (Rate-Setting Policies)

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- The cost of the physician's professional services for performing the procedure
- The cost of services furnished by the facility where the procedure is performed (e.g., surgical supplies and equipment and nursing services). For a discussion of the ASC payment methodology, see *MLN Matters* article SE0742 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf* on the CMS Web site.

Section 40.3. (Payment for Intraocular Lens (IOLs)

Beginning January 1, 2008, the Medicare payment for the IOL is included in the Medicare payment for the associated surgical procedure. Consequently, no separate payment for the IOL will be made, except for a new technology IOL as discussed under the *Medicare Claims Processing Manual*, chapter 14, section 40.3.1. If an ASC bills for a new technology IOL that is provided in association with a covered ASC procedure, the contractor will make a separate payment adjustment of $50 for the new technology IOL. The payment for the new technology IOL is subject to beneficiary coinsurance but is not wage adjusted. The hard coded system logic that excludes the $150 for IOLs for multiple surgery reduction will not apply effective for dates of services on or after January 1, 2008.

Section 40.4 (Payment for Terminated Procedures)

Facilities use a modifier 73 to indicate that the procedure terminated prior to induction of anesthesia.

Prior to January 1, 2008, carriers or A/B MACs deduct the allowance for an unused IOL prior to calculating payment for a terminated IOL insertion procedure.

Beginning January 1, 2008, payment for an IOL is included in the payment for the surgical procedure to implant the lens.

Beginning January 1, 2008, Medicare contractors will apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia. Facilities use the modifier 52 to indicate the discontinuance of these applicable procedures.

Beginning January 1, 2008, ASC surgical services billed with the modifier 52 or 73 are not subject to the multiple procedure discount.

Section 40.5. (Payment for Multiple Procedures)

Each surgical procedure has its own *CPT-4* code. When more than one surgical procedure is performed in the same operative session, special payment rules apply even if the services have the same *CPT-4* code number.

When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors base the ASC facility payment rate on 100 percent of the highest paid procedure, plus 50 percent of applicable wage adjusted rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session.

The multiple procedure payment reduction is the last pricing routine applied beginning January 1, 2008, to applicable ASC procedure codes. In determining the ranking of procedures for application of the multiple procedure reduction, contractors shall use the lower of the billed charge or the ASC payment amount. The ASC surgical services billed with modifier 73 and 52 will not be subjected to further pricing reductions (i.e., the multiple procedure price reduction rules will not apply). Payment for an ASC surgical procedure billed with modifier 74 may be subject to the multiple procedure discount if that surgical procedure is subject to the multiple procedure discount.

Section 40.6 (Payment for Extracorporeal Shock Wave Lithotripsy [ESWL])

Beginning January 1, 2008, with the revised ASC payment system, contractors may pay for any of the ESWL services that are included on the ASC list of covered surgical procedures.

Section 40.7 (Offset for Payment for Pass-Through Devices Beginning January 1, 2008)

Under the revised payment system, there can be situations where contractors must reduce (cut back) the approved payment amount for specifically identified procedures when provided in conjunction with a specific

Implementation of 2008 Ambulatory Surgical Center Payment System Changes, continued

pass-through device. This reduction would only be applicable when services for specific pairs of codes are provided on the same day by the same provider. Code pairs subject to this policy would be updated quarterly. The CMS will inform Medicare contractors of the code pairs and the percent reduction taken from the procedure payment rate through a "look-up" table.

Section 40.8 (Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008)

Contractors pay ASCs a reduced amount for certain specified procedures when a device is furnished without cost or for which either a partial or a full credit is received (e.g., device recall). For specified procedure codes that include payment for a device, ASCs are required to include a modifier FB on the procedure code when a device is furnished without cost or for which full credit is received.

If the ASC receives a partial credit for the device, the ASC is required to include the modifier FC on the procedure code. A single procedure code should not be submitted with both a modifier FB and FC. The pricing determination related to the modifiers FB and FC is performed prior to the application of the multiple procedure pricing reductions.

Section 40.9 (Payment for Presbyopia Correcting IOLs (P-C IOLs and Astigmatism Correcting IOLs [A-C IOLs])

CMS payment policies and recognition of P-C IOLs and A-C IOLs are contained in Transmittal 636 (CR 3927) and Transmittal 1228 (CR 5527) respectively. See *http://cms.hhs.gov/center/asc.asp* for a current list of CMS recognized P-C IOL and A-C IOL lenses.

Section 50 (ASC Procedures for Completing the Form CMS-1500)

The place of service (POS) code is 24 for procedures performed in an ASC.

Prior to January 1, 2008, type of service (TOS) code is "F" (ASC Facility Usage for Surgical Services) is appropriate when modifier SG appears on an ASC claim. Otherwise TOS "2" (surgery) for professional services rendered in an ASC is appropriate.

Beginning January 1, 2008, ASCs no longer are required to include the SG modifier on facility claims in Medicare. Modifier TC is required unless the code definition is for the technical component only.

Section 60 (Medicare Summary Notices (MSN), Claim Adjustment Reason Codes, Remittance Advice Remark Codes (RAs)

Section 60.1 (Applicable messages for NTIOLs)

Carriers or A/B MACs will return, as unprocessable, any claims for NTIOLs containing Q1003 alone or with a code other than one of the procedure codes listed in section 40.5.2, chapter 14, of the *Medicare Claims Processing Manual.* They will use the following messages for these returned claims:

- Claim adjustment reason code 16 - Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate;
- RA remark code M67 - Missing/Incomplete/Invalid other procedure codes; and
- RA remark code MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Carriers or A/B MACs will deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC and use the following messages when denying these claims:

- MSN 16.2 - This service cannot be paid when provided in this location/facility; and
- Claims adjustment reason code 58 - Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Carriers or A/B MAC will deny payment for Q1003 if billed by an entity other than a Medicare-approved ASC and use the following messages when denying these claims:

- MSN 33.1 - The ambulatory surgical center must bill for this service; and
- Claim adjustment reason code 170 - Payment is denied when performed/billed by this type of provider.

Carriers or A/B MACs shall deny payment for Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011) and use the following messages when denying these claims:

- MSN 21.11 - This service was not covered by Medicare at the time you received it; and
- Claim adjustment reason code 27 - Expenses incurred after coverage terminated.

Section 60.2 (Applicable messages for ASC 2008 payment changes effective January 1, 2008)

Contractors shall deny services not included on the ASC facility payment files (ASCFS and ASC DRUG files) when billed by ASCs (specialty 49) for POS 24 using the following messages:

- Claim adjustment reason code 8 - The procedure code is inconsistent with the provider type/specialty;
- RA remark code N95 - This provider type/provider specialty may not bill this service; and
- MSN 26.4 – This service is not covered when performed by this provider.

If there is no approved ASC surgical procedure on the same date for the billing ASC in history, contractors will return pass-through device claims/line items, brachytherapy claims/line items, drug code (including C9399) claims/line items, and any other ancillary service claims/line items such as radiology procedure claim/line items on the ASCFS list or ASC DRUG list as unprocessable using the following messages:

- Claim adjustment reason code 16 - Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate;
- RA remark code MA 109 - Claim processed in accordance with ambulatory surgical guidelines; and.
- RA remark code M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

Implementation of 2008 Ambulatory Surgical Center Payment System Changes, continued

Contractors shall deny all ancillary services (e.g., radiology technical component) on the ASCFS list billed by specialties other than specialty 49 provided in an ASC setting (POS 24) using the following messages:

- MSN 16.2 – This service cannot be paid when provided in this location/facility;
- Claim adjustment reason code 171 - Payment is denied when performed/billed by this type of provider in this type of facility;
- RA remark code M97 - Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility; and
- RA remark code M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

Contractors shall deny separately billed implantable devices using the following messages:

- MSN 16.32 - Medicare does not pay separately for this service;
- RA remark code M97 – Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility;
- RA remark codes M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed;
- MA 109 - Claim processed in accordance with ambulatory surgical guidelines; and
- M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (contractor discretion).

If there is a related, approved surgical procedure for the billing ASC for the same date of service, they will also include the following message:

- MSN 16.8 - Payment is included in another service received on the same day.

Chapter 19 (Indian Health Services)
Section 40.2.1 (Provider Enrollment with FI or AB MAC - Ambulatory Surgical Services)

For dates of service prior to January 1, 2008, IHS providers that want to bill for surgeries on the ASC list and receive the ASC rate must contact their designated FI or AB MAC. IHS providers are certified by one of several national accrediting organizations recognized by the Centers for Medicare & Medicaid Services (CMS) and meet the conditions for performing ASC procedures.

IHS hospital outpatient departments are not certified as separate ASC entities. The ASC indication merely means that CMS approved them to bill for ASC services and be paid based on the ASC rates for services on the ASC list. In order to bill for ASC services, the hospital outpatient department must meet the conditions of participation for hospitals defined in 42CFR482 located at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&tpl=/ecfrbrowse/Title42/42cfr482_main_02.tpl* on the Internet.

Authority for Medicare to pay IHS hospital outpatient departments using the freestanding ASC rates was incorporated into public health service (PHS) regulations on December 27, 1989. The first IHS hospital requested and received approval from CMS to bill separately for ASC procedures at the appropriate ASC group payment amount for dates of service on or after October 1, 1987. Previously, the hospital was reimbursed for ASC procedures at the Office of Management and Budget (OMB) negotiated all-inclusive rate (AIR) for outpatient hospital services. The rationale for approving this request was that the hospital was already JCAHO certified; encompassing the ability to perform outpatient surgical procedures, and that acute care hospitals providing surgical inpatient or outpatient services can perform any surgical procedures within their capacity and capability.

Effective for dates of service on or after January 1, 2008, the FI or A/B MAC no longer processes claims for IHS ASCs. All IHS ASC providers, including hospital outpatient departments requesting payment based on freestanding ASC rates and ASCs affiliated with a hospital but operating as a distinct entity for the purpose of performing outpatient surgical services must enroll with and submit their claims to the designated carrier or A/B MAC.

Chapter 26 (Completing and Processing Form CMS-1500 Data Set)
Section 10.7 (Type of Service [TOS])

Effective for services on or after January 1, 2008, the modifier SG is no longer applicable for Medicare ASC services. ASC providers will no longer be required to bill the modifier SG on Medicare ASC facility claims.

Revisions to the Medicare Benefit Policy Manual

Changes to this manual are basically the same, as appropriate, as those made to the *Medicare Claims Processing Manual.* The revised portions of the *Medicare Benefits Policy Manua*l are also attached to CR 5680 at *http://www.cms.hhs.gov/Transmittals/downloads/R77BP.pdf* on the CMS Web site.

Additional Information

Should you have questions, please contact your carrier or A/B MAC at their toll free number 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 two transmittals related to CR 5680 are at *http://www.cms.hhs.gov/Transmittals/downloads/R1325CP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R77BP.pdf* no the CMS Web site. Attached to these transmittals are the revised manual chapters discussed in this article. These transmittals are the official instructions issued to your Medicare contractor.

Also, the *MLN Matters* article providing an overview of the new ASC payment system is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf* on the CMS Web site.

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COMPETITIVE AQUISITION PROGRAM

Competitive Acquisition Program 2008 Physician Election and Impact on Carriers

The 2008 Physician Election Period for the Medicare Part B Drug Competitive Acquisition Program (CAP) began on October 1, 2007, and will conclude on November 15, 2007. The CAP is a voluntary program that offers physicians the option to acquire many drugs they use in their practice from an approved CAP vendor, thus reducing the time they spend buying and billing for drugs. The 2008 CAP program period will run from January 1, 2008, to December 31, 2008.

Physicians are instructed to submit their CAP election forms to their local carrier. As in change request (CR) 4064, local carriers are required to forward a list to the CAP designated carrier of all physicians and practitioners who have elected to participate in the CAP. This list is due on November 22, 2007.

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

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*.

To view and download the billing instructions for CAP physicians, see "CAP Physician Billing Tips" in the Downloads section of the "Information for Physicians" page: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp*.

Source: Provider Education Resources Listserv, Message 200711-09

CONSOLIDATED BILLING

Additional Common Working File Editing for Skilled Nursing Facility Consolidated Billing – Part II

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

Provider Types Affected

Physicians and providers who bill Medicare carriers or Medicare administrative contractors (A/B MAC) for therapy services provided to Medicare beneficiaries in skilled nursing facility (SNF) stays.

What Providers Need To Know

Effective for dates of service on or after April 1, 2001, change request (CR) 5757, from which this article is taken, instructs Medicare carriers and A/B MACs to modify the existing therapy edit for Part B claims processing to ensure that all therapy services are subjected to SNF consolidated billing edits when provided in a covered or noncovered SNF stay.

Background

Since therapy services provided in an SNF must be consolidated when a beneficiary is in a SNF stay, whether covered or noncovered by Medicare, Medicare systems will reject claims with dates of service falling within a SNF stay. As a result of this specific change, Medicare's common working file system will reject claims with dates of service after the posted SNF claim until a discharge claim is processed. The entity furnishing the therapy services must look to the SNF for payment, rather than billing Medicare.

Medicare contractors (carrier or A/B MAC) will re-open and re-process inappropriately denied claims for dates of service on or after April 1, 2001, through April 6, 2008, when you bring such claims to their attention. You should contact your Medicare contractor to have claims re-processed that you feel were erroneously subject to these consolidated billing edits, and denied. However, if you received payment directly from the SNF, you must return that payment to the SNF before requesting payment through the Medicare contractor.

Additional Information

You may see the official instruction (CR 5757) issued to your Medicare carrier or A/B MAC by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1365CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. As an attachment to CR 5757, you will find updated *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing), Sections 110.2.2 (A/B Crossover Edits).

If you have questions, please contact your Medicare Carrier 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: MM5757
Related Change Request (CR) #: 5757
Related CR Release Date: November 2, 2007
Effective Date: April 1, 2001
Related CR Transmittal #: R1365CP
Implementation Date: April 7, 2008

DIABETIC SERVICES

An Overview of Medicare Covered Diabetes Supplies and Services

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

Provider Types Affected

Physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for Medicare-covered diabetes benefits.

Provider Action Needed

This article is informational only and represents no Medicare policy changes.

Background

Diabetes is the sixth leading cause of death in the United States, and approximately 20 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. Millions of people have diabetes and do not know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, and death related to pneumonia and flu. Scientific evidence now shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay much of the illness and complications associated with diabetes.

This special edition article presents an overview of the diabetes services and supplies covered by Medicare (Part B and Part D) to assist physicians, providers, suppliers, and other health care professionals who provide diabetic supplies and services to Medicare beneficiaries.

Medicare Part B Covered Diabetic Supplies

Medicare covers certain supplies if a beneficiary has Medicare Part B and has diabetes. These supplies include:

- Blood glucose self-testing equipment and supplies;
- Therapeutic shoes and inserts; and
- Insulin pumps and the insulin used in the pumps

Blood Glucose Self-testing Equipment and Supplies

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. This includes those who use insulin and those who do not use insulin. These supplies include:

- Blood glucose monitors
- Blood glucose test strips
- Lancet devices and lancets
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies.

If the beneficiary

- **Uses insulin**, they may be able to get up to 100 test strips and lancets every month, and 1 lancet device every 6 months.
- **Does not use insulin**, they may be able to get 100 test strips and lancets every 3 months, and 1 lancet device every 6 months.

If a beneficiary's doctor says it is medically necessary, Medicare will cover additional test strips and lancets for the beneficiary.

Medicare will only cover a beneficiary's blood glucose self-testing equipment and supplies if they get a prescription from their doctor.

Their prescription should include the following information:

- That they have diabetes.
- What kind of blood glucose monitor they need and why they need it (i.e., if they need a special monitor because of vision problems, their doctor must explain that.)
- Whether they use insulin.
- How often they should test their blood glucose.
- How many test strips and lancets they need for one month.

A beneficiary needing blood glucose testing equipment and/or supplies:

- Can order and pick up their supplies at their pharmacy.
- Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order. Their doctor cannot order it for them.
- Must ask for refills for their supplies.
- Needs a new prescription from their doctor for their lancets and test strips every 12 months.

Note: Medicare will not pay for any supplies not asked for, or for any supplies that were sent to a beneficiary automatically from suppliers. This includes blood glucose monitors, test strips, and lancets. Also, if a beneficiary goes to a pharmacy or supplier that is not enrolled in Medicare, Medicare will not pay. The beneficiary will have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor test strips. A beneficiary cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly. Beneficiaries should only pay their coinsurance amount when they get their supply from their

An Overview of Medicare Covered Diabetes Supplies and Services, continued

pharmacy or supplier for assigned claims. If a beneficiary's pharmacy or supplier **does not** accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

Before a beneficiary gets a supply, it is important for them to ask the supplier or pharmacy the following questions:

- Are you enrolled in Medicare?
- Do you accept assignment?

If the answer to either of these two questions is "no," they should call another supplier or pharmacy in their area who answers "yes" to be sure their purchase is covered by Medicare, and to save them money.

If a beneficiary cannot find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.

Therapeutic Shoes and Inserts

If a beneficiary has Medicare Part B, has diabetes, and meets certain conditions (see below), Medicare will cover therapeutic shoes if they need them. The types of shoes that are covered each year include one of the following:

- One pair of depth-inlay shoes **and** three pairs of inserts; or
- One pair of custom-molded shoes (including inserts) if the beneficiary cannot wear depth-inlay shoes because of a foot deformity **and** two additional pairs of inserts.

Note: In certain cases, Medicare may also cover separate inserts or shoe modifications instead of inserts.

In order for Medicare to pay for the beneficiary's therapeutic shoes, the doctor treating their diabetes must certify that they meet **all** of the following three conditions:

- They have diabetes.
- They have at least 1 of the following conditions in one or both feet:
  - Partial or complete foot amputation.
  - Past foot ulcers.
  - Calluses that could lead to foot ulcers.
  - Nerve damage because of diabetes with signs of problems with calluses.
  - Poor circulation.
  - Deformed foot.
- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

- A podiatrist or other qualified doctor must prescribe the shoes.
- A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes to the beneficiary.

Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year, and the fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

Insulin Pumps and the Insulin Used in the Pumps

Insulin pumps worn outside the body (external), including the insulin used with the pump may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. If a beneficiary needs to use an insulin pump, their doctor will need to prescribe it. In the Original Medicare Plan, the beneficiary pays 20 percent of the Medicare-approved amount after the yearly Part B deductible. Medicare will pay 80 percent of the cost of the insulin pump. Medicare will also pay for the insulin that is used with the insulin pump.

Medicare Part B covers the cost of insulin pumps and the insulin used in the pumps. However, if the beneficiary injects their insulin with a needle (syringe), Medicare Part B does not cover the cost of the insulin, but the Medicare prescription drug benefit (Part D) covers the insulin and the supplies necessary to inject it. This includes syringes, needles, alcohol swabs and gauze. The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as the beneficiary is on the Medicare Part D plan's formulary.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or co-payment applies after the yearly Medicare part B deductible has been met. In the original Medicare plan, Medicare covers 80 percent of the Medicare-approved amount (after the beneficiary meets their annual Medicare Part B deductible of $131 in 2007), and the beneficiary pays 20 percent of the total payment amount (after the annual Part B deductible of $131 in 2007). This amount can be higher if the beneficiary's doctor does not accept assignment, and the beneficiary may have to pay the entire amount at the time of service. Medicare will then send the beneficiary its share of the charge.

Medicare Part D Covered Diabetic Supplies and Medications

This section provides information about Medicare prescription drug coverage (Part D) for beneficiaries with Medicare who have or are at risk for diabetes. If a beneficiary wants Medicare prescription drug coverage, they must join a Medicare drug plan. The following diabetic medications and supplies are covered under Medicare drug plans:

- Diabetes supplies
- Insulin
- Anti-diabetic drugs.

Diabetes Supplies

Diabetes supplies associated with the administration of insulin may be covered for all people with Medicare Part D who have diabetes. These medical supplies include the following:

- Syringes
- Needles
- Alcohol swabs
- Gauze
- Inhaled insulin devices.

Insulin

Injectable insulin **not** associated with the use of an insulin infusion pump is covered under Medicare Part D drug plans.

Anti-diabetic Drugs

Anti-diabetic drugs may maintain blood glucose that is not controlled by insulin, and Medicare drug plans can cover anti-diabetics drugs such as:

- Sulfonylureas (i.e. Glipizide, Glyburide)

An Overview of Medicare Covered Diabetes Supplies and Services, continued

- Biguanides (i.e. metformin)
- Thiazolidinediones (i.e. Starlix® and Prandin®)
- Alpha glucosidase inhibitors (i.e. Precose®).

Medicare Part B Covered Diabetic Services

Medicare Part B covers all of the diabetes services listed in this section unless otherwise noted. For people with diabetes, Medicare covers certain services. A doctor must write an order or referral for the beneficiary to get these services. These services include the following:

- Diabetes screenings
- Diabetes self-management training
- Medical nutrition therapy services
- Hemoglobin A1c tests
- Special eye exams.

Diabetes Screenings

Medicare pays for a beneficiary to get diabetes-screening tests if they are at risk for diabetes. These tests are used to detect diabetes early, and some, but not all, of the conditions that may qualify a beneficiary as being at risk for diabetes include:

- High blood pressure
- Dyslipidemia (history of abnormal cholesterol and triglyceride levels)
- Obesity (with certain conditions)
- Impaired blood glucose tolerance
- High fasting blood glucose.

Diabetes screening tests are also covered if a beneficiary answers "yes" to two or more of the following questions:

- Are you age 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, siblings)?
- Do you have a history of gestational diabetes (diabetes during pregnancy)
- Did you deliver a baby weighing more than nine pounds?

Based on the results of these tests, a beneficiary may be eligible for up to two diabetes screenings every year at no cost (no coinsurance, or co-payment or Part B deductible). Medicare will pay for a beneficiary to get two diabetes screening tests in a 12-month period, but not less than six months apart. After the initial diabetes-screening test, the beneficiary's doctor will determine when to do the second test. Diabetes screening tests that are covered include the following:

- Fasting blood glucose tests
- Other tests approved by Medicare as appropriate

Diabetes Self-management Training

Diabetes self-management training (DSMT) helps a beneficiary learn how to successfully manage their diabetes. Their doctor or qualified nonphysician practitioner must prescribe this training for them for Medicare to cover it. A beneficiary can get DSMT if they met one of the following conditions during the last 12 months:

- They were diagnosed with diabetes.
- They changed from taking no diabetes medication to taking diabetes medication, or from oral diabetes medication to insulin.
- They have diabetes and have recently become eligible for Medicare.
- They are at risk for complications from diabetes. A doctor may consider the beneficiary at increased risk if they have any of the following:
- They had problems controlling their blood glucose, have been treated in an emergency room or have stayed overnight in a hospital because of their diabetes.
- They have been diagnosed with eye disease related to diabetes.
- They had a lack of feeling in their feet or some other foot problems like ulcers, deformities, or have had an amputation.
- Been diagnosed with kidney disease related to diabetes.

A beneficiary must get this training from an accredited diabetes self-management education program as part of a plan of care prepared by their doctor or qualified nonphysician practitioner. The American Diabetes Association or the Indian Health Service accredits these programs. Health care providers who have special training in diabetes education teach classes.

A beneficiary is covered by Medicare to get a total of 10-hours of initial training within a continuous 12-month period. One of the hours can be given on a one-on-one basis. The other nine hours must be training in a group class. The initial training must be completed no more than 12-months from the time the beneficiary starts the training.

A doctor or qualified nonphysician practitioner may prescribe 10 hours of individual training if the beneficiary is blind or deaf, has language limitations, or no group classes have been available within two months of the doctor's order. To be eligible for 2 more hours of follow-up training each year after the year the beneficiary received initial training, they must get another written order from their doctor. The two hours of follow-up training can be with a group or they may have one-on-one sessions. A doctor or qualified nonphysician practitioner must prescribe the follow-up training each year for Medicare to cover it.

Beneficiaries learn how to successfully manage their diabetes in DSMT classes, and the training includes information on self-care and making lifestyle changes. The first session consists of an individual assessment to help the instructors better understand the beneficiary's needs. Classroom training includes topics such as the following:

- General information about diabetes, and the benefits and risks of blood glucose control.
- Nutrition and how to manage ones diet.
- Options to manage and improve blood glucose control.
- Exercise and why it is important to ones health.
- How to take ones medications properly.
- Blood glucose testing and how to use the information to improve ones diabetes control.
- How to prevent, recognize, and treat acute and chronic complications from ones diabetes.
- Foot, skin, and dental care.
- How diet, exercise, and medication affect blood glucose.
- How to adjust emotionally to having diabetes.
- Family involvement and support.
- The use of the health care system and community resources.

Note: If a patient lives in a rural area, they may be able to get

An Overview of Medicare Covered Diabetes Supplies and Services, continued

DSMT in a federally qualified health center (FQHC). For more information about FQHCs, visit *http://www.cms.hhs.gov/center/fqhc.asp* on the Centers for Medicare & Medicaid Services (CMS) Web site. FQHCs are special health centers, usually located in urban or rural areas, and they can give routine health care at a lower cost. Some FQHCs are community health centers, tribal FQHC clinics, certified rural health clinics, migrant health centers, and health care for the homeless programs.

Medical Nutrition Therapy Services

In addition to DSMT, medical nutrition therapy (MNT) services are also covered for people with diabetes or renal disease. To be eligible for this service, a beneficiary's fasting blood glucose has to meet certain criteria. Also, their doctor must prescribe these services for them. A registered dietitian or certain nutrition professionals can give these services, and the services include the following:

- An initial nutrition and lifestyle assessment.
- Nutrition counseling (what foods to eat and how to follow an individualized diabetic meal plan).
- How to manage lifestyle factors that affect diabetics.
- Follow-up visits to check on progress in managing diet.

Medicare covers three hours of one-on-one MNT services the first year the service is provided, and two hours each year after that. Additional MNT hours of service may be obtained if the beneficiary's doctor determines there is a change in their diagnosis, medical condition, or treatment regimen related to diabetes or renal disease and orders additional MNT hours during that episode of care.

Foot Exams and Treatment

If a beneficiary has diabetes-related nerve damage in either of their feet, Medicare will cover one foot exam every six months by a podiatrist or other foot care specialist, unless they have seen a foot care specialist for some other foot problem during the past six months. Medicare may cover more frequent visits to a foot care specialist if a beneficiary has had a non-traumatic (not because of an injury) amputation of all or part of their foot or their feet have changed in appearance which may indicate they have serious foot disease.

Hemoglobin A1c Tests

A hemoglobin A1c test is a lab test ordered by the beneficiary's doctor. It measures how well a beneficiary's blood glucose has been controlled over the past three months. Anyone with diabetes is covered for this test if his or her doctor orders it. Medicare may cover this test when a beneficiary's doctor orders it.

Glaucoma Tests

Medicare will pay for a beneficiary to have their eyes checked for glaucoma once every 12 months. This test must be done or supervised by an eye doctor who is legally allowed to give this service in their state.

Special Eye Exam

People with Medicare who have diabetes can get special eye exams to check for eye disease (called a dilated eye exam). An eye doctor who is legally allowed to provide this service in their state must do these exams. The dilated eye exam is recommended once a year and must be performed by an eye doctor who is legally allowed to provide this service in the beneficiary's state.

Diabetes Supplies and Services Not Covered by Medicare

The original Medicare Plan and Medicare drug plans (Part D) don't cover everything. Diabetes supplies and services not covered by Medicare include:

- Eye exams for glasses (eye refraction)
- Orthopedic shoes (shoes for people whose feet are impaired, but intact)
- Routine or yearly physical exams (Medicare will cover a one-time initial preventive physical exam (the "Welcome to Medicare" physical exam) within the first six months of the beneficiary enrolling in Part B—coinsurance and Part B deductible applies.)
- Weight loss programs

Additional Information

CMS has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage* on the CMS Web site.

- *Medicare Learning Network* – The *Medicare Learning Network* (*MLN*) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the *MLN*'s Web page at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS Web site.
- Patient Resources – For literature to share with Medicare patients, please visit *http://www.medicare.gov* on the Internet.
- The National Diabetes Education Program – NDEP (*http://ndep.nih.gov/*) provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.

If you have any questions, please contact your Medicare contractor (carrier, DME MAC, FI, and/or A/B MACs) 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).

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An Overview of Medicare Covered Diabetes Supplies and Services, continued

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

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DRUGS AND BIOLOGICALS

Payment Allowances for the Influenza Virus and Pneumococcal Vaccines

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

Provider Types Affected

Providers who bill Medicare contractors (fiscal intermediaries [FI], carriers, and Medicare administrative contractors [A/B MACs]) for influenza virus and pneumococcal vaccines.

Provider Action Needed

Be sure your billing staff are aware of the billing rates that are effective for influenza and pneumococcal vaccines provided on or after September 1, 2007. These rates apply, **except where the vaccine is furnished in the hospital outpatient department, in which payment for the vaccine is based on reasonable cost.**

Background

Change request (CR) 5744, from which this article is taken, provides the payment allowances for: influenza virus vaccines (*Current Procedural Terminology* (*CPT*) codes *90655*, *90656*, *90657*, *90658*, and *90660*), and pneumococcal vaccine (*CPT 90732* and *90669*); when payment is based on 95 percent of the average wholesale price (AWP).

Effective September 1, 2007, the Medicare Part B payment allowance in these situations is as follows:

Influenza vaccine payments are:

- *CPT 90655* is $16.109
- *CPT 90656* is $17.366
- *CPT 90657* is $6.609
- *CPT 90658* is $13.218
- *CPT 90660* (FluMist, a nasal influenza vaccine) is $21.176 and providers should note that *CPT 90660* may be covered in those cases where the local Medicare contractor determines that its use is medically reasonable and necessary for the beneficiary.

Pneumococcal vaccine payments are:

- *CPT 90732* is $29.730
- *CPT 90669* is $78.803

Please note:

- These rates apply, except where the vaccine is furnished in the hospital outpatient department, where payment is based on reasonable cost.
- Annual Part B deductible and coinsurance amounts do not apply.
- All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- Your Medicare contractors will not search their files to adjust payment for claims paid prior to implementation of these changes; however, they will adjust claims that you bring to their attention.

Additional Information

The official instruction, CR 5744, issued to your Medicare contractor is located at *http://www.cms.hhs.gov/Transmittals/downloads/R1357CP.pdf* on the Centers for Medicare & Medicaid (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: MM5744
Related Change Request (CR) #5744
Related CR Release Date: October 26, 2007
Effective Date: September 1, 2007
Related CR Transmittal #: R1357CP
Implementation Date: November 26, 2007

DURABLE MEDICAL EQUIPMENT

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the November 2007 Medicare B Update! pages 22-23.

Note: This article was revised on November 7, 2007, to change the title to the chart showing the payment limits. That chart should have read "2008" and not "2007". All other information is unchanged.

Provider Types Affected

Physicians, providers, and suppliers billing Medicare contractors (carriers, fiscal intermediaries, [FIs], Medicare administrative contractors [A/B MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for splints, casts, dialysis equipment, and certain intraocular lenses.

Provider Action Needed

Affected providers may want to be certain their billing staffs know of these changes.

Background

For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes.

This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: *http://www.gpoaccess.gov/cfr/retrieve.html* on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The *MLN Matters* article related to CR 5382 may be viewed at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf* on the CMS Web site.

For intraocular lenses, payment is made only on a reasonable charge basis for lenses implanted in a physician's office. CR 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 inflation-indexed charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

Dialysis Supplies Billed With AX Modifier

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses, continued

Dialysis Equipment Billed Without AX Modifier

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes. Contractors will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008, through December 31, 2008. Those 2008 payment limits are at the end of this article.

Additional Information

Detailed instructions for calculating:

- Reasonable charges are located in chapter 23 (section 80) of the *Medicare Claims Processing Manual*.
- Customary and prevailing charges are located in section 80.2 and 80.4 of chapter 23 of the *Medicare Claims Processing Manual*.
- The IIC (inflation indexed charge) are located in section 80.6 of chapter 23 of the *Medicare Claims Processing Manual*. The IIC update factor for 2008 is 2.7 percent.

You may find chapter 23 of the *Medicare Claims Processing Manual* at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS Web site.

For complete details regarding this CR please see the official instruction (CR 5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf* on the CMS Web site.

If you have questions, please contact your Medicare FI, carrier, DME MAC, 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).

2008 Payment Limits for Splints and Casts

Code	Payment Limit
A4565	$7.38
Q4001	$42.01
Q4002	$158.81
Q4003	$30.18
Q4004	$104.49
Q4005	$11.12
Q4006	$25.08
Q4007	$5.58
Q4008	$12.54
Q4009	$7.43
Q4010	$16.72
Q4011	$3.71
Q4012	$8.36
Q4013	$13.52
Q4014	$22.81
Q4015	$6.76
Q4016	$11.40
Q4017	$7.82
Q4018	$12.47
Q4019	$3.91
Q4020	$6.24
Q4021	$5.78
Q4022	$10.44
Q4023	$2.91
Q4024	$5.22

Code	Payment Limit
Q4025	$32.45
Q4026	$101.30
Q4027	$16.23
Q4028	$50.66
Q4029	$24.81
Q4030	$65.31
Q4031	$12.41
Q4032	$32.65
Q4033	$23.14
Q4034	$57.56
Q4035	$11.57
Q4036	$28.79
Q4037	$14.12
Q4038	$35.37
Q4039	$7.08
Q4040	$17.68
Q4041	$17.16
Q4042	$29.30
Q4043	$8.59
Q4044	$14.66
Q4045	$9.96
Q4046	$16.03
Q4047	$4.97
Q4048	$8.02
Q4049	$1.82

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses, continued

MLN Matters Number: MM5740 *Revised*
Related Change Request (CR) #: 5740
Related CR Release Date: September 28, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1344CP
Implementation Date: January 7, 2008

MEDICARE PHYSICIAN FEE SCHEDULE

Medicare Final Rule Announces 2008 Physician Fees and Reforms

The Centers for Medicare & Medicaid Services (CMS) today issued a final physician payment rule designed to improve accuracy of Medicare payments and give physicians and health care professionals additional financial incentives to provide higher quality and value in the delivery of care.

Under the new rule, Medicare estimates that it will pay approximately $58.9 billion to about 900,000 physicians and other health care professionals. The revised payments, quality incentive rates and related policy changes, which will become effective January 1, 2008, are included in the Medicare physician fee schedule (MPFS) final rule. The rule went on display today at the *Federal Register*.

The final rule, effective for services on or after January 1, 2008, will go on display today and will be published in the *Federal Register* on November 27, 2007. The rule may be found at *https://www.cms.hhs.gov/center/physician.asp*.

To view the entire CMS Press Release issued today, go to *http://www.cms.hhs.gov/apps/media/press_releases.asp* on the CMS Web site.

Visit the Medicare Learning Network ~ it's free!

Source: Provider Education Resources Listserv, Message 200711-04

SCREENING SERVICES

Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscsopy

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 contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for colorectal cancer screening 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 billing instructions for the Medicare beneficiary who 1) presents for a screening colonoscopy (or flexible sigmoidoscopy), 2) has no gastrointestinal symptoms, and 3) during their screening colonoscopy (or flexible sigmoidoscopy), have an abnormality identified (such as a polyp, etc.) which is biopsied or removed.

Background

CMS has become aware of confusion regarding billing for colorectal screening arising because of wording in the Medicare physician fee schedule (MPFS) final rule for 2007 (*Federal Register*, Vol. 71, No. 231, page 69665, December 1, 2006 (See the MPFS final rule at *http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1321fc.pdf* on the CMS Web site).

Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscsopy, continued

The relevant section of the 2007 MPFS states, regarding screening colonoscopies, that:

> *"if during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal. "Based on this statutory language, in such instances the test or procedure is no longer classified as a ``screening test." Thus, the deductible would not be waived in such situations.*

The above scenario can be restated as follows:

- A patient presents for a screening colonoscopy (or flexible sigmoidoscopy), and the patient has no gastrointestinal symptoms.
- During the subsequent screening colonoscopy (or flexible sigmoidoscopy), an abnormality is identified (such as a polyp, etc.), and it is biopsied or removed.

CMS advises that, whether or not an abnormality is found, if a service to a Medicare beneficiary starts out as a screening examination (colonoscopy or sigmoidoscopy), then the primary diagnosis should be indicated on the form CMS-1500 (or its electronic equivalent) using the ICD-9 code for the screening examination.

As an example, the above scenario should be billed as follows using claim form CMS-1500 (or its electronic equivalent):

- Item 21 (Diagnosis or Nature of Illness or Injury)
- Indicate the primary diagnosis using the *International Classification of Diseases, Ninth Revision, Clinical Modification*, (*ICD-9-CM*) code for the screening examination (colonoscopy or sigmoidoscopy), and
- Indicate the secondary diagnosis using the ICD-9-CM code for the abnormal finding (polyp, etc.).
- For example, V76.51 (Special screening for malignant neoplasms, colon) would be used as the first listed code, while the secondary code might be 211.3 (Benign neoplasm of other parts of digestive system, colon).
- Item 24D (Procedures, Services, or Supplies)
- Indicate the procedure performed using the CMS Healthcare Common Procedure Coding System/*Common Procedure Terminology* (HCPCS/*CPT*) code for the procedure (biopsy or polypectomy)
- Item 24E (Diagnosis Pointer)
- Enter only "2" (to link the procedure (polypectomy or biopsy) with the abnormal finding (polyp, etc.)

A Medicare beneficiary undergoing a screening colonoscopy (no symptoms and no abnormal findings prior to the procedure) will be responsible for the deductible if a polyp is identified and either biopsied or removed.

When there is no need for a therapeutic procedure, the appropriate HCPCS G-code is reported with the ICD-9-CM code reflecting the indication. Effective January 1, 2007, CMS began waiving the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS G-codes listed in the following:

HCPCS	Descriptor
G0104	Colorectal cancer screening: Flexible sigmoidoscopy
G0105	Colorectal cancer screening: Colonoscopy on individual at high risk
G0121	Colorectal cancer screening: Colonoscopy on individual not meeting criteria for high risk
G0106	Colorectal cancer screening: Barium enema as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening: Barium enema as an alternative to G0105, screening colonoscopy

Additional Information

For related *MLN Matters* articles on colorectal cancer screenings, see articles SE0710 and MM5387, which are available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf*, respectively, on the CMS Web site.

If you have any 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: SE0746
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

THERAPY SERVICES

2008 Annual Update to the Therapy Code List

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

Provider Types Affected

Physicians, therapists, and providers of therapy services billing Medicare carriers, fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), or Part A/B Medicare administrative contractors (A/B MACs) for rehabilitation services.

Provider Action Needed

STOP – Impact to You

One new code will added to the therapy code list for calendar year 2008. *CPT* code *96125* will be used for standard cognitive performance testing per hour of a qualified health care professional's time, both face-to-face with the patient and time interpreting test results and preparing the report.

CAUTION – What You Need to Know

CPT code *96125* is considered "always therapy" regardless of who performs the service and will always require a therapy modifier (GN, GO, GP).

GO – What You Need to Do

Make certain your office staffs are aware of the new code.

Background

Section 1834(k)(5) of the Social Security Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/*Current Procedural Terminology*, 2008 Edition (HCPCS/*CPT-4*) is the coding system used for the reporting of these services.

Therapy services, including "always therapy" services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, Publication 100-4, chapter 5 and the *Medicare Benefit Policy Manual*, Publication 100-2, chapters 12 and 15. That manual is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*.

Additional Information

For complete details regarding CR 5810, please see the official instruction issued to your Medicare FI, RHHI, carrier or A/B MAC. That instruction may be viewed on the CMS Web site by going to *http://www.cms.hhs.gov/transmittals/downloads/R1377CP.pdf*.

If you have questions, please contact your Medicare carrier, FI, RHHI, or A/B MAC at their toll-free number, which can 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: MM5810
Related Change Request (CR) Number: 5810
Related CR Release Date: November 23, 2007
Related CR Transmittal Number: R1377CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

GENERAL COVERAGE

Key Medicare News for 2008 for Physicians and Other Health Care Professionals

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

Provider Types Affected

Physicians and health care professionals and their staff who bill Medicare carriers and/or Medicare administrative contractors (MACs)

Introduction

This special edition article is being provided to keep you, the Medicare physician and health care professional, informed about important Medicare initiatives and new Medicare benefits available in calendar year (CY) 2008.

As you once again make your decision to enroll in or terminate enrollment in the Medicare participation program, the Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to review some important news for 2008. CMS believes this information provides significant benefits to providers and their Medicare patients. It encourages providers to enroll or stay in the Medicare participation program in order to take full advantage of the upcoming changes.

Information You Need to Know

National Provider Identifier (NPI) – Get it! Share it! Use it!

Medicare carriers and A/B MACs began transitioning their systems to start rejecting claims when the NPI and legacy provider identifier pair that are reported on the claim cannot be found on the Medicare crosswalk. We urge you to pay attention to the reject reports you receive. The reject reports will help you and your staff identify problems that cause claims to reject.

You should also ensure that your Medicare enrollment information is up to date. If you need to submit a completed CMS-855 (Medicare provider enrollment form), remember to list all of the NPIs that will be used in place of legacy identifiers. If you need to apply for an NPI or update your information in the National Plan and Provider Enumeration System (NPPES), please include ALL of your Medicare legacy numbers. (NPPES can accept only 20 Other Provider Identifiers, but is being expanded to accept more in the future.) If the information is different between your Medicare enrollment information and your NPPES record, there is a very good chance your claims will reject. NPPES data may be verified at *https://nppes.cms.hhs.gov* on the CMS Web site. Contact the NPI Enumerator at 1-800-465-3203 if you need assistance in viewing your NPPES record.

A recent MLN Matters article lists the informational edits that preceded the reject report messages and their meanings. Visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf* on the CMS Web site to view the article.

Some incorporated physicians and nonphysician practitioners have obtained NPIs as follows: an individual (entity type 1) NPI for the physician or nonphysician practitioner and an organization (entity type 2) NPI for the corporation. If you enrolled in Medicare as an individual and obtained a Medicare provider identification number (PIN) as an individual, and you want to use your NPI and your PIN pair in your Medicare claims, be sure you use your individual NPI with your individual PIN. Pairing your corporation's NPI with your individual PIN will result in your claims being rejected. If you wish to bill Medicare with your corporation's NPI, then you must be sure your corporation is enrolled in Medicare so that it can be assigned a PIN. Please contact your servicing Medicare carrier for more information about this enrollment. Until your corporation has been enrolled in Medicare, you may continue to bill by using your individual NPI with your individual PIN to ensure no disruption in your claims being processed and paid. Please note that similar problems may result if you bill Medicare by using your individual NPI with your corporation's PIN (if the corporation is enrolled and has been assigned a PIN). In other words, when billing with the NPI/PIN pair, you must use compatible NPIs and PINs.

Note that after May 23, 2008, legacy identifiers will not be permitted on any inbound or outbound transactions. This includes inbound claims, crossover claims, both paper and electronic remittance advices, the 276/277 claims status inquiries/replies, NCPDP claims, and the 270/271 eligibility inquiries/replies. Also, for up-to-date information on the NPI, CMS recommends periodic visits to *http://www.cms.hhs.gov/NationalProvIdentStand/* on the CMS Web site.

Unique Physician Identification Numbers

CMS discontinued assigning unique physician identification numbers (UPINs) on June 29, 2007, but will maintain its UPIN public "look-up" functionality and Registry Web site (*http://www.upinregistry.com/*) through May 23, 2008.

Competitive Acquisition Program for Part B Drugs

The Medicare Modernization Act requires CMS to implement a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment system (PPS) basis. This program is an alternative to the average sales price (ASP) methodology for acquiring certain Part B drugs, which are, administered incident to a physician's services. In it, physicians are given a choice between buying and billing these drugs under the ASP system, or selecting a Medicare-approved CAP vendor that will supply these drugs.

Participation in the CAP is voluntary, and each year Medicare physicians can elect to participate. Those who do participate will obtain drugs through CAP vendors; the vendors will bill Medicare for the administered drug and will bill the beneficiary for any applicable co-insurance or deductible.

Key Medicare News for 2008 for Physicians and Other Health Care Professionals, continued

All physicians who participated in the CAP in 2007, and wish to participate in 2008, will need to make the 2008 CAP election during the regular fall election period which will run from October 1, 2007, to November 15, 2007.

Participating physicians can sign up to receive CAP updates from the **CMS-CAP-Physicians-L** electronic mailing list at *http://www.cms.hhs.gov/apps/mailinglists/default.asp?audience=3* on the CMS CAP Information for Physicians Web page (*http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage*).

Physician Quality Reporting Initiative

The Tax Relief and Health Care Act of 2006 (TRHCA) authorizes a physician quality reporting system. This program, which CMS has named the "Physician Quality Reporting Initiative" (PQRI), was implemented on July 1, 2007, and establishes a financial incentive for eligible professionals who participate in a voluntary quality-reporting program.

These eligible professionals, who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment (subject to a cap) of 1.5 percent of total allowed charges for covered Medicare physician fee schedule services during that same period.

The proposed 2008 PQRI quality measures were published in the *Federal Register* as a part of the 2008 Medicare physician fee schedule (MPFS) proposed rule. The final 2008 PQRI measures will be published in the 2008 MPFS final rule and posted at *http://www.cms.hhs.gov/PQRI* on the CMS PQRI Web site.

For more information about the PQRI and to access important educational tools, go to *http://www.cms.hhs.gov/PQRI* on the CMS Web site .

New Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity and DME Information Forms for Claims Processing

Certificates of medical necessity (CMN) provide a mechanism for suppliers of durable medical equipment and medical equipment and supplies to demonstrate that the item they provide meets the minimal criteria for Medicare coverage. Durable medical equipment Medicare administrative contractors (DME MAC) review the documentation that physicians, suppliers, and providers supply on the CMNs and DME information forms (DIFs), and determine if the medical necessity and applicable coverage criteria for selected DMEPOS were met.

On April 13, 2007, CMS announced the development of improved CMNs and DIFs that are consistent with current medical practices and that conform to Medicare guidelines. In this improvement process, CMS revised several CMNs, replaced three CMNs with two DIFs, and revised *Medicare Program Integrity Manual*, chapter 5, Items and Services Having Special DME Review Considerations. Additionally, these new Office of Management and Budget (OMB) approved forms permit the use of a signature and date stamp that resulted in revision of the *Medicare Program Integrity Manual*, Chapter 3, Section 3.4.1.1, Documentation Specifications for Areas Selected for Prepayment or Post Payment Medical Review.

You can learn more about these revised forms by reading *MLN Matters* article MM5571 (based on CR 5571, the official instruction issued to the DME MAC); available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5571.pdf*. The new forms are available at *http://www.cms.hhs.gov/CMSForms/CMSforms/list.asp#TopOfPage* on the CMS Web site.

Preventive Services

Medicare, which began covering preventive services in 1981 with the pneumococcal vaccination, now covers a broad range of services to prevent disease, detect disease early when it is most treatable and curable, and manage disease so that complications can be avoided.

These services include:

- The Initial Preventive Physical Examination (IPPE), also known as the "Welcome to Medicare" visit, which now includes coverage of a one-time preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at-risk beneficiaries (those with a family history of AAA or males age 65 to 75 who have smoked at least 100 cigarettes in their lifetime). It is important to note that in order to receive this AAA ultrasound screening benefit, beneficiaries must be referred by their physician or other qualified non-physician practitioner. You may learn more about the IPPE and AAA ultrasound screening by reading MLN Matters article SE0711, which you may find at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0711.pdf* on the CMS Web site. CMS has also developed a new quick reference information chart entitled "*The ABCs of Providing the Initial Preventive Physical Examination"*. Medicare fee-for-service physicians and qualified nonphysician practitioners may use this two-sided laminated chart as a guide when providing the IPPE. The chart is currently available at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf* on the CMS Web site.
- Adult Immunization—Influenza Immunization, Pneumococcal Vaccination, Hepatitis B Vaccination
- Colorectal Cancer Screening
- Screening Mammography
- Screening Pap Test and Pelvic Examination
- Prostate Cancer Screening
- Cardiovascular Disease Screening
- Glaucoma Screening
- Bone Mass Measurement
- Diabetes Screening, and Self-Management, Medical Nutrition Therapy Services, and Supplies
- Smoking and Tobacco-Use Cessation Counseling.

To learn more details about these preventive benefits, see The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals located at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf* on the CMS Web site.

Key Medicare News for 2008 for Physicians and Other Health Care Professionals, continued

CMS has a variety of educational products and resources to help you become familiar with coverage, coding, billing, and reimbursement for all Medicare-covered preventive services, including:

- The *MLN* Preventive Services Educational Products Web Page, which provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* on the CMS Web site.
- The CMS Web site (*http://www.cms.hhs.gov*) provides information for the individual preventive service covered by Medicare. At the site, select "Medicare," and scroll down to "Prevention."

For products to share with your Medicare patients, visit *http://www.medicare.gov/* on the Internet.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding

Section 302(b) of the Medicare Modernization Act, requires Medicare to replace the current durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) payment methodology, for select items in select areas, with a competitive acquisition process to improve the effectiveness of its payment-setting methodology. This new program will establish payment amounts for certain durable medical equipment, enteral nutrition, and off-the-shelf orthotics by replacing the current payment amounts (under Medicare's DMEPOS fee schedule) with payment rates derived from a bidding process.

Suppliers that want to furnish competitively bid items in a competitive bidding area (CBA) will be required to submit bids to furnish those items, and the winning bids will be used to establish a single Medicare payment amount for each item. Contracts will be awarded to a sufficient number of winning bidders in each CBA to ensure access and service to high quality DMEPOS items.

CMS is phasing in this new program. Bidding for the first phase began in 2007 in CBAs within 10 of the largest metropolitan statistical areas (MSAs), excluding New York, Los Angeles, and Chicago. Prices from the first phase of bidding are scheduled to go into effect in 2008. The program will be expanded into 70 additional MSAs in 2009. After 2009, CMS will expand the program to additional areas.

While this program may have no direct impact on most physicians, it might have impact on where your patients receive their DMEPOS. Some suppliers currently serving your patients may not be selected to continue Medicare participation under the new program and your patients may have to go to new suppliers. While this may happen, please be assured that Medicare will continue to meet the same patient needs for DMEPOS as it has prior to the new program. Medicare is just attempting to meet those concerns in a more cost effective manner in order to protect Medicare funding.

You may find more information about the Medicare DMEPOS competitive bidding program at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/* on the CMS Web site.

Provider Education Updates

The Medicare Learning Network

The Medicare Learning Network (MLN), the brand name for official CMS provider educational products, is designed to promote national consistency in Medicare provider information developed for CMS initiatives. The *MLN* products available on the *MLN* Web page provide easy access to Web-based training courses, comprehensive training guides, brochures, fact sheets, CD-ROMs, videos, educational Web guides, electronic listservs, and links to other important Medicare program information. All educational products are available free of charge and may be ordered and/or downloaded from the *MLN* Web page located at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS Web site. Some of the new information for 2007 on the *MLN* Web page follows.

Physician Educational Tools

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals 2nd Edition – Provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing and reimbursement (August 2007). Available in downloadable format.

Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians – Contains rural health services 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. The primary audience includes rural health providers, suppliers, and physicians (February 2007). Available in hard copy, CD ROM, and downloadable formats.

Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals – Offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, protecting the Medicare trust fund, inquiries, overpayments, and appeals (July 2007). Available in hard copy, CD ROM, and downloadable formats.

Companion Facilitator's Guide To The Medicare Physician Guide – A Resource for Residents, Practicing Physicians, and Other Health Care Professionals: Includes all the information and instructions necessary to prepare for and present a Medicare resident, practicing physician, and other health care professional training program, including instructions for facilitators, a customization guide, two PowerPoint presentations with speaker notes, pre- and post-assessments, master assessment answer keys, and evaluation tools (January 2007). Available in hard copy, CD ROM, and downloadable formats.

Physicians' Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services – Explains how Medicare helps pay for kidney dialysis and kidney transplant services under the fee-for-service program (June 2007). Available in hard copy and downloadable formats.

Key Medicare News for 2008 for Physicians and Other Health Care Professionals, continued

Other Educational Tools

Medicare Learning Network Guidance Tool – Now available in CD ROM format and can be ordered through the *Medicare Learning Network* product ordering page. This playable CD will streamline your search to find the most relevant and up-to-date links or URLs for national provider educational materials. A tutorial will show you how to use the Guidance Tool to locate a new link (URL), refine your search, view, download and order educational articles, brochures, fact sheets, web-based training courses, worksheets and videos. Additionally, the *MLN* Guidance Tool will demonstrate by example how to navigate through sections of CMS' *Medicare Learning Network* (January 2007). Available in CD ROM format.

Medicare Preventive Services Bookmark – Lists the preventive services and screenings covered by Medicare and provides a message that encourages health care professionals to talk with their Medicare patients about these preventive services and encourage them to take advantage of these potentially life saving benefits. This product is appropriate for distribution at health care professional conferences, provider outreach and education activities, and other appropriate types of provider/supplier events (January 2007). Available in hard copy and downloadable formats.

Quick Reference Information: Medicare Preventive Services – A two-sided laminated reference chart that gives Medicare fee-for- service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services (May 2007). Available in hard copy and downloadable formats.

Quick Reference Information: Medicare Immunization Billing (Flu, PPV, and HBV) – A two-sided laminated reference chart that gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare billing information for the influenza, pneumococcal, and hepatitis B vaccines and their administration (October 2006). Available in hardcopy and downloadable formats.

An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – An educational video program that provides an overview of coverage criteria for Medicare preventive benefits. This program can be viewed individually or as part of an education session at a conference or other provider meeting. (The program is 75 minutes in length and approved by CMS for continuing education credits for successful completion.)

Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart – Provides Medicare claims processing information related to SNF spells of illness (January 2007). Available in downloadable format only.

Brochures

Changes in Medicare Coverage of Power Mobility Devices (PMDs): Power Wheelchairs and Power Operated Vehicles (POVs) – Addresses the CMS multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them (May 2007).

Diabetes-Related Services – This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes (August 2007)

Fact Sheets

Critical Access Hospital Program – Covers information related to the critical access hospital program (March 2007).

Federally Qualified Health Center Fact Sheet – Covers the federally qualified health center (FQHC) benefit under Medicare (March 2007).

Implementation of the UB-04 – Reviews the new UB-04 paper claim form, which is only accepted from institutional providers excluded from the mandatory electronic claims submission. It includes background information, the transition period and a crosswalk (May 2007). Available in downloadable format only.

Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet – This fact sheet provides information about inpatient rehabilitation facility prospective payment system rates and classification criterion (March 2007).

Medicare Disproportionate Share Hospital Fact Sheet – Covers the basics of the Medicare disproportionate share hospital (DSH) (August 2007).

Medicare Physician Fee Schedule Fact Sheet – Provides general information about the Medicare physician fee schedule (January 2007).

Medicare Secondary Payer Fact Sheet – Provides a general overview of the Medicare secondary payer provision for individuals involved in the admission and billing procedures at provider, physician and other supplier settings (June 2007).

Rural Health Clinic Fact Sheet – Covers the basics of the rural health clinic (RHC) program (June 2007).

Rural Referral Center Fact Sheet – Covers the basics of the rural referral center (RRC) program (March 2007).

Web Based Training Programs

CMS-1450 – Provides information that will allow you to file Medicare Part A claims accurately and reduce your chances of receiving unprocessable rejections (January 2007).

CMS-1500 – Provides information that will allow you to file Medicare Part B claims accurately and reduce your chances of receiving unprocessable rejections (May 2007).

Diagnosis Coding: Using the ICD-9-CM – Teaches you how to select accurate diagnosis codes from the ICD-9-CM volumes and how to use diagnosis codes correctly on Medicare claim forms (May 2007).

Medicare Fraud and Abuse – Teaches you how to identify Medicare fraud and abuse. You will also learn what safeguards to use to protect yourself against fraud and abuse and what liability and penalties you could face if you commit fraud or abuse (April 2004).

Outpatient Code Editor (OCE) – Useful for physicians and other health care professionals. This course addresses the OCE in Medicare's Fiscal Intermediary Standard System, which processes outpatient claims (January 2007).

Key Medicare News for 2008 for Physicians and Other Health Care Professionals, continued

Medicare Preventive Services Series: Part 1 Adult Immunizations: This web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for influenza, pneumococcal, and hepatitis B vaccines and their administration (Updated September 2007).

National Provider Identifier
Health Care Providers – Who are Sole Proprietors? – A sole proprietor/sole proprietorship is an individual and, as such, is eligible for a single NPI. Read more about sole proprietors and the NPI (July 2007).

Health Care Providers – Who are Organizations? – Organization health care providers apply for NPIs as organizations (entity type 2). Read more about organization providers and the NPI (July 2007).

Tip Sheets – What the "Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule" Means for Health Care Providers – Interprets the recently released contingency guidance into helpful steps for providers (May 2007).

National Provider Identifier Training Package – CMS has developed a training package for NPI that will assist providers with self-education, as well as education of staff. This package is also useful to national and local medical societies for group presentations and training. The entire package will consist of five modules: General Information, Electronic File Interchange (EFI), Subparts, Data Dissemination and Medicare Implementation. Each Module consists of a PowerPoint presentation (with speaker's notes) and is designed to stand-alone or can be combined with other modules for a training session tailored to the particular audience.

Enrolling in Medicare – CMS has posted a document that will assist physicians in completing the CMS-855I, Medicare Provider Enrollment Application for Physicians and Non-Physician Practitioners. The document is available at *http://www.cms.hhs.gov/Medicareprovidersupenroll/downloads/EnrollmentNPI.pdf* on the CMS Web site.

Physician Quality Reporting Initiative (PQRI) Tool Kit
CMS has developed a "PQRI Tool Kit ~ Six Steps for Success" that will assist eligible professionals with successful reporting, as well as education of staff. This tool kit is also useful for group presentations and training programs. Currently, the tool kit consists of six educational resources (listed below). Each resource in the tool kit is designed to stand-alone or can be combined with other resource for a training session tailored to the particular audience. The tool kit includes:

2007 PQRI Physician Quality Measures – A numerical listing of all measures included in 2007 PQRI .

***MLN Matters* Article 5640 – Coding & Reporting Principles –** A publication that introduces the coding and reporting principles underlying successful PQRI reporting.

2007 PQRI Code Master – A numerical listing of all codes included in PQRI intended for incorporation into billing software.

2007 Coding for Quality Handbook – A handbook that delineates coding and reporting principles and provides implementation guidelines for how to successfully report measures using clinical scenarios.

2007 Data Collection Worksheets – Measure-specific worksheets that walk the user step-by-step through reporting for each quality measure.

2007 PQRI Measure Finder Tool and User Guide – A tool designed to assist eligible professionals and their practice staff to quickly search for applicable measures and their detailed specifications.

Physician Quality Reporting Initiative (PQRI) PowerPoint Presentations – CMS has developed PowerPoint presentation modules that will assist eligible professionals with successful reporting, as well as education of staff. These PowerPoint presentation modules are also useful for group presentations and training programs.

Beneficiary Related News

MyMedicare.com

As announced in last year's article, Medicare beneficiaries can access Medicare's free secure online service to view their Medicare information by registering for **MyMedicare.com**. At this site, they can access their personalized information about their Medicare benefits and services, and can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare summary notice (MSN) or replacement Medicare card
- View eligibility, entitlement, and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications, and messages sent by CMS.

Registration is simple. Medicare beneficiaries should go to *http://www.medicare.gov* and click on the box in the upper left of the screen to sign up for **MyMedicare.gov.**

Additional Information

If you have any questions, please contact your carrier 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: SE0730
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

ELECTRONIC DATA INTERCHANGE

Rejection of Electronic Claim Status Requests that Lack National Provider Identifiers

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims status requests using the electronic data interchange (EDI) standard Health Insurance Portability and Accountability Act (HIPAA) transactions to Medicare contractors (carriers, fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]).

Provider Action Needed

STOP – Impact to You

This article is based on CR 5726, which describes policy changes that are a result of HIPAA requirements that prohibit the acceptance of EDI transactions that contain legacy provider numbers. CR 5726 specifically address changes around the processing of electronic claim status requests and the responses to such requests.

CAUTION – What You Need to Know

Beginning May 23, 2008, Medicare will return to sender any electronic claim status request (X12 276 transactions) that contain legacy provider numbers instead of or in addition to the national provider identifier (NPI) number. This policy also applies to direct data entry claim status inquiries and to Internet claim status screens operated as demonstration projects by some contractors.

GO – What You Need to Do

No later than May 23, 2008, providers should ensure that all electronic claim status requests sent to Medicare contractors contain only NPI numbers (no legacy provider numbers.)

Background

All electronics claim status requests submitted using the EDI standards (X12 276) adopted under HIPAA for national use must use the HIPAA-mandated NPI exclusively for provider identification no later than May 23, 2008. Those that do not are to be returned to the sender beginning May 23, 2008. All claims status responses (X12 277 transactions) will also contain only NPIs as of May 23, 2008. The same policy applies to direct data entry claim status inquiries and to those Internet claim status screens some contractors are permitted to operate under an Internet demonstration program. The absence of an NPI or the presence of a legacy number as of May 23, 2008, will result in rejection of the inquiry by these direct data entry processes.

Providers are advised that Medicare will return an NPI on the claims status response on or after May 23, 2008, even if the claim status request is received prior to May 23, 2008, using a legacy number. In returning the NPI, Medicare will use a crosswalk file that relates the legacy number to the provider's NPI. If the legacy number maps to more than one NPI, Medicare will return the first active NPI in the 277 response.

To avoid confusion, Medicare encourages providers to begin including their NPIs in their X12 276 inquiries as soon as possible prior to May 23, 2008, particularly if the provider has more than one NPI, but was assigned only one legacy number by Medicare for claims submission purposes.

Additional Information

The official instruction, CR 5726, issued to your Medicare contractor may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R302OTN.pdf* on the CMS Web site.

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5726
Related Change Request (CR) #5726
Related CR Release Date: November 2, 2007
Effective Date: May 23, 2008
Related CR Transmittal #: R302OTN
Implementation Dates: January 7,2008, and April 7, 2008

GENERAL INFORMATION

"Dark day" Scheduled for Florida Part B EDC Transition 1/21/08

The Centers for Medicare & Medicaid Services (CMS) recently awarded several contracts for Enterprise Data Centers (EDC) for Medicare fee-for-service claims processing. As a result, First Coast Service Options, Inc., (FCSO) will transition its Florida Part B data center from Infocrossing to Companion Data Services (CDS) on Monday, January 21, 2008.

How This Affects Our Customers

Because FCSO's offices are scheduled to be closed in observance of Dr. Martin Luther King, Jr. Day, we expect impacts to you to be minimal. You should continue to submit claims and correspondence as usual. However, due to the EDC transition, the Part B interactive voice response unit (IVR) will not be available on January 21.

At this time, we anticipate all system function availability to resume on Tuesday, January 22, 2008. In the event there is a delay that extends beyond the planned January 21 outage, we will provide a revised estimate on our Web site. This will become more apparent as we get closer to the transition date.

Individuals Authorized Access to CMS Computer Services—Provider Community

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

The First in a Series of Articles

These articles will help providers to register for future access to CMS online computer services. This article contains:

- Ten questions and answers to get you started
- Overview of the registration process for IACS-PC defined provider organization users.

Provider Types Affected

Physicians, providers, and suppliers who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Note: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS-PC at this time. DMEPOS suppliers may want to review question # 10 below.

What Providers Need to Know

In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available.

Provider Action Needed

Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider Community (IACS-PC). See the following section for key questions and answers about the registration process.

Ten Questions and Answers to Get You Started

1. **What Is IACS-PC?**
   IACS-PC is a security system CMS uses to control issuance of electronic identities and access to new CMS provider Web-based applications. Through IACS-PC, provider organizations, as defined by IACS-PC (see question # 7 below), and their staff, as well as individual practitioners, will be able to access new CMS applications. Provider organizations will also be able to manage users who they authorize to conduct transactions on their behalf, which may include staff and contractors.

Note: This release of IACS-PC will not impact access to FI/Carrier/MAC Internet applications or the DME Competitive Bidding System (DBidS) application. New enterprise CMS systems will not offer the Internet services FIs/carriers/MACs are providing in the near future.

2. **Who Can Use this System?**
   Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, the soon-to-be-announced online applications under IACS-PC do not include services to DMEPOS suppliers. (See question # 10 below).

3. **Why Register Now?**
   Since the new applications have not been announced at the time of this notice, it may be hard to decide if you should register to use the system. However, because IACS-PC registration must precede use, we recommend that individual

Individuals Authorized Access to CMS Computer Services—Provider Community, continued

practitioners and provider organizations (with the exception of DMEPOS suppliers) register now. Even if the IACS-PC registration process goes well and all documentation is in order, it may still take several weeks to finalize registration. Since the system is new, registering now gives you a "cushion" so that if there are delays in processing your registration, you will have the registration process complete in time to request access to the various CMS provider related computer services as soon as they are available early next year.

4. If I Register Now, How Long Is my Password Valid?
Passwords expire in 60 days. After that point, when you log into IACS-PC, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically to IACS-PC to keep your current password active.

5. How Do I Register as an IACS-PC User?
IACS-PC uses a self-registration process. The self-registration process that you will follow will depend on the type of IACS-PC user you are. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

Note: The CMS Web site contains links to IACS user guides for other communities of users. Only use instruction links for the IACS-PC community as directed by CMS.

The External User Services (EUS) Help Desk will support this process for IACS-PC. It may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

6. When Would I Register as an Individual Practitioner?
An individual practitioner is defined by IACS-PC as a physician or non- physician practitioner. This is intended for practitioners who will be conducting transactions with online applications personally and have **no staff** who will be accessing the applications.

More details can be found in the Individual Practitioner Registration- Quick Reference Guide, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Individual_Practitioner_Registration_QRG_111607.pdf*.

7. When Would I Register as an IACS-PC Provider Organization?
The term "organization," as defined by IACS-PC, should not be confused with the term organization as it applies to provider enrollment or the NPI. For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers and physician group practices.
It also includes individual physicians and nonphysician practitioners who want to delegate staff to conduct transactions on their behalf. In this case, for IACS-PC registration purposes, registration must be as an organization.
IACS-PC provider organizations require security officials (see question # 9 below) that establish the provider organization in IACS-PC. All users will then be grouped together within IACS-PC under the provider organization security official.

8. What Should I Have in Hand Before I Register?
For an individual practitioner (who will be conducting transactions with online applications personally and have no additional staff that will be accessing the applications) they will need to know their:

- Social security number
- Correspondence information.

For an IACS-PC provider organization, the security official (SO) of that organization will be the first person to register within IACS and create their organization. The SO should have the following organizational information available before they sign on to register:

- Taxpayer identification number (TIN)
- Legal business name
- Corporate address
- Internal Revenue Service (IRS) issued CP-575 hard copy form.

9 How Do I Register my IACS-PC Provider Organization?
IACS-PC is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS-PC and then be accountable for users in the organization. Using information supplied via the IACS-PC registration as well as a mailed-in copy of the organization's CP-575 form, CMS will verify the SO's role in the organization, the TIN and the Legal Business Name of the organization. This can take several weeks. Once approved, the SO then has the ability to approve other registrants under the provider organization. For more detail, please read the Overview section, which follows question #10.
Once you understand IACS-PC user roles, and have designated an SO, the SO should register using the instructions in the Security Official Registration – *Quick Reference Guide*, which is available on the CMS website at: *http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf*.

The next *MLN Matters* article in this series of articles will provide instructions for additional users to register in IACS-PC.

10. Why Are you Excluding DMEPOS Suppliers from IACS-PC?
DMEPOS suppliers should not register in IACS-PC at this time because we do not expect any new online services will be available to them in 2008. DMEPOS suppliers interested in the second round of DMEPOS competitive bidding should follow CMS DMEPOS competitive bid instructions which will be released closer to the 2008 bid window.

Individuals Authorized Access to CMS Computer Services—Provider Community, continued

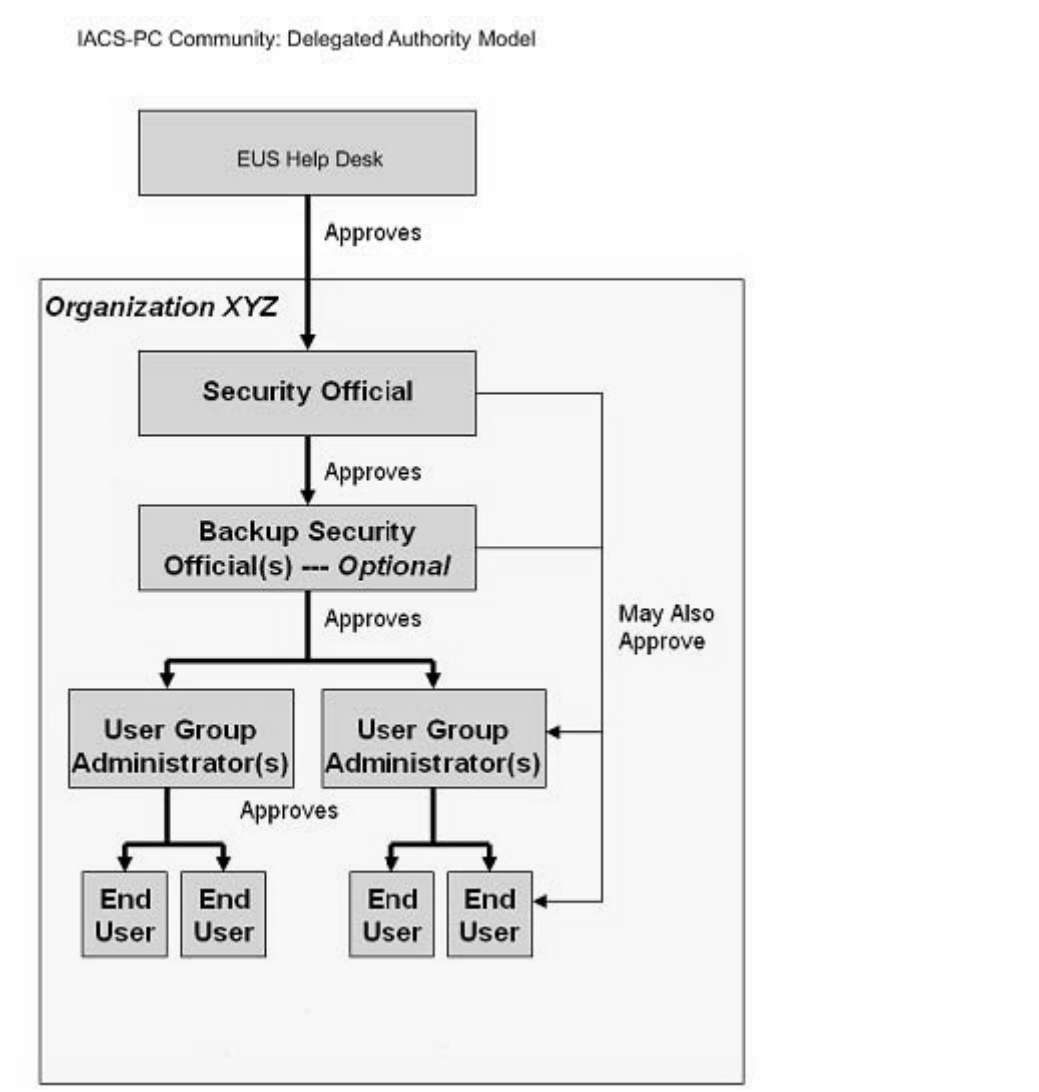
Overview: Registering in IACS-PC as a Provider Organization or a Provider Organization User

For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers, and physician group practices. It also includes individual physicians and nonphysician practitioners who want to delegate employees to conduct transactions on their behalf.

I. The Registration Process

IACS-PC is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. At this time, a provider organization must have at least two users, one of whom will be able to access IACS-PC applications.

The "delegated authority model" previously described is below. The EUS help desk will be responsible for approving the organization's security official. Then the security official may approve the backup security official(s) etc.



Individuals Authorized Access to CMS Computer Services—Provider Community, continued

II. Registration Roles

1. **The First Person to Register Must Be the Security Official**
   The security official is the person who registers their organization in IACS-PC and updates the organization profile information in IACS-PC. There may be only one security official for an organization. The security official is trusted to approve the access request of backup security official(s) and can approve the access requests of user group administrators and end users. The security official will be approved by CMS through its EUS help desk. The security official is held accountable by CMS for the behavior of those they approve including the end users for the organization.
   The Security Official Registration – *Quick Reference Guide* may be found on the CMS Web site at: *http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf.*

Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS help desk.

2. **An Organization May Choose To Have One or More Backup Security Officials (Optional)**
   This is an optional role. You need not have a backup security official. The security official approves the backup security official. A backup security official performs the same functions as a security official in an organization, with the exception of approving other backup security officials. There can be one or more backup security officials in an organization. The backup security official can approve the access requests of user group administrators and end users and may aid the security official with the administration of user groups and user group administrators' accounts.

3. **The Next Registrant Must Be a User Group Administrator**
   The security official or backup security official approves the user group administrator (UGA). The UGA is trusted to approve the access requests of end users for that user group.
   Organizations with 2-9 IACS-PC users must, at a minimum, have a security official and one or more UGAs. If there will be only one user in a group, that user must register as a UGA.
   A UGA registers the user group within an organization in IACS-PC and updates the user group profile information in IACS-PC. There can be multiple UGAs for the same user group within an organization.

4. **Organizations with Ten or more IACS-PC Users Must also Have End Users**
   An end user is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An end user is part of a user group within the provider organization. An end user may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An end user may belong to multiple groups in one or more organizations. The end user is approved by the UGA.

Note: End user requests cannot be approved until after the user group administrator has been approved.

III. Surrogate User Groups

This applies to provider organizations that want to delegate online work to individuals or a company outside of the provider organization. Under this scenario, those working on behalf of the provider organization register as a **surrogate user group**. Examples include clearinghouses, credentialing departments, independent contractors. A surrogate user group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A surrogate user group may be associated with multiple provider organizations.

1. **The First Contractor Employee To Register in a Surrogate User Group Must Be the UGA**
   If there will be only one user in a surrogate group, that user must register as a UGA. The UGA for the surrogate user group will register the surrogate user group and update the user group profile information in IACS-PC. There can be multiple UGAs within the same surrogate user group. The UGA is trusted to approve the access requests of end users for their user group.
   The UGA of the surrogate user group must be approved by the security official or backup security official in the provider organization on whose behalf it performs work. Once approved, the UGA of a surrogate group may request to associate with other provider organizations for which it performs work without registering again.

2. **A Contractor Employee May also Register as an End User**
   An end user is approved to perform Medicare business for a surrogate or provider user group by their UGA. An end user may belong to multiple groups in one or more organizations.

Additional Help

The EUS help desk will support this process for IACS-PC. It may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

MLN Matters Number: SE0747
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Registration to Access the CMS Online Computer Services Is Now Available

In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available. Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider Community (IACS-PC).

A recent *MLN Matters* article, the first in a new series on IACS-PC, addresses key questions and answers about the registration process and may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Source: CMS Provider Education Resource 200711-17

Crossover of Assignment of Benefits Indicator (CLM08) From Paper Claim Input

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

Provider Types Affected

Physicians and suppliers submitting paper claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], and 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) 5780 that makes system changes to the manner in which the Medicare sets the Crossover of Assignment of Benefits Indicator (CLM08) value in the coordination of benefits (COB) flat file for transmission of claims to COB partners.

CAUTION – What You Need to Know

CR 5780 will result in changes to Medicare systems to appropriately set the correct indicator in CLM08 based on the presence of or lack of a patient signature in box/item 13 of the CMS-1500.

GO – What You Need to Do

See the *Background* and *Additional Information* sections of this article for further details regarding these changes and be sure billing personnel complete box/item 13 of the CMS-1500 in accordance with the revised instructions.

Background

The basic claims form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program is the CMS-1500. It answers the needs of many health insurers, and it is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 (*http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr424_02.html*).

Coordination of benefits (COB) trading partners requested that CMS change the current process of automatically setting a "Y" value in the CLM08 segment of the 837 Professional Coordination of Benefits (COB) claim crossover file. Trading partners may use the CLM08 value to determine where the claim reimbursement is to go and have, in some cases, reimbursed the provider instead of the beneficiary.

Note: CLM08 is the assignment of benefits indicator, and a "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

CR 5780 initiates system changes to appropriately set the correct indicator in CLM08 based on the presence of or lack of a signature in box/item 13 of the CMS-1500. In addition, CR 5780 revises the CMS-1500 claim completion instructions in order to inform providers regarding how the presence or lack of a signature in box 13 will affect downstream patient assignment of benefits. Specifically, the *Medicare Claims Processing Manual* (chapter 26, section 10.3 – Items 11a-13 – Patient and Insured Information) is revised (***changes are bolded and italicized***) as follows:

"Item 13 - The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream COB trading partners (supplemental insurers) with whom we have a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may or may not affect supplemental payments to providers and/or their patients.

Crossover of Assignment of Benefits Indicator (CLM08) From Paper Claim Input, continued

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked."

Note: This may be a "Signature on File" signature and/or a computer generated signature."

The business requirements in CR 5780 do not affect inbound claims or current Medicare claims processing guidelines. They specifically address COB claims only which are sent to trading partners.

Additional Information

The official instruction, CR 5680, issued to your carrier, DME MAC, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1369CP.pdf* on the CMS Web site.

If you have any questions, please contact your Medicare carrier, DME MAC, 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: MM5780
Related Change Request (CR) #: 5780
Related CR Release Date: November 2, 2007
Effective Date: April 1, 2008
Related CR Transmittal #: R1369CP
Implementation Date: April 7, 2008

2008 Open Enrollment for Medicare Part D Coverage and Medicare Advantage Plans

Campaign Features Major Outreach to Beneficiaries Eligible for Low Income Subsidies, Enhanced Publications and Online Tools

The U.S. Department of Health & Human Services (HHS) announced that, beginning November 15, 2007, Medicare beneficiaries can begin making enrollment changes in their health and prescription drug coverage for 2008, if necessary. The Medicare annual open enrollment period for prescription drug plan runs **from November 15 through December 31, 2007.**

In addition, for Medicare Advantage (MA) plans only, beneficiaries can make one change in enrollment – enrolling in a new plan, changing plans or canceling a plan – between **January 1 and March 31, 2008.**

"Now is the time for beneficiaries to prepare and compare their health and prescription drug coverage options and choose the plan that best meets their needs," said HHS Secretary Mike Leavitt. "We intend to keep building on the success the program has achieved thus far. The most recent satisfaction rate stands at 86 percent, the estimated average premium is 40 percent lower than originally estimated and total estimated costs are running $188 billion below initial projections. Part D is a program that is working well and is helping Medicare beneficiaries with their prescription drug costs."

HHS' Centers for Medicare & Medicaid Services (CMS) encourages all beneficiaries to act soon to compare their current plan with other plan options. If they are satisfied with their current plan, they do not need to do anything in order to maintain their coverage. CMS wants eligible beneficiaries who do not have prescription drug coverage to know that, if they wait, they may pay a penalty on their premium.

During this coordinated election period, beneficiaries are encouraged to review their prescriptions and other health needs when assessing the plan options described in the *"Medicare & You"* handbook or on *www.medicare.gov*. In addition, CMS recommends that beneficiaries gather any Medicare or Social Security mailings they received and materials made available by local counselors to use as a reference when speaking with a 1-800-Medicare representative or entering information on *www.medicare.gov*.

CMS also encourages people to take advantage of the enhanced online Medicare Prescription Drug Plan Finder options available on *www.medicare.gov*. This feature offers information on available drug plans, including out-of-pocket costs and pharmacy networks. The enhanced online *Medicare Prescription Drug Plan Finder* and *Medicare Options Compare* tools enable beneficiaries to compare drug plan options for prescription drug plans and Medicare Advantage plans in their area. CMS continues to refine its educational tools, so beneficiaries will find it easier to locate information about available health and drug plans.

Starting today, *www.medicare.gov* also provides beneficiaries with the five-star ratings of the quality and performance of plans that offer Part C and Part D services. These plan ratings allow consumers to compare items such as customer service, complaints, managing chronic conditions and ease in obtaining prescriptions.

To read more about the plan ratings within Medicare Web compare tools, check out the CMS publication available in the Medicare Web site at *http://www.medicare.gov/Publications/Pubs/pdf/11226.pdf*.

To read more of the HHS press release issued on November 15, 2007, click here: *http://www.hhs.gov/news/press/2007pres/11/pr20071115a.html*.

Visit the Medicare Learning Network – It's Free!

Source: CMS Provider Education Resource 200711-15

November Was American Diabetes Month

Diabetes continues to be a prevalent health concern in the United States. Approximately 20.8 million Americans, or 7.0 percent of the population, have diabetes. Of these, 10.3 million people are age 60 and over. Left undiagnosed, diabetes can lead to serious complications such as heart disease, stroke, blindness, kidney damage, lower-limb amputations and premature death. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes.

Covered diabetes screening tests include the following:

- A fasting blood glucose test.
- A post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults).
- A 2-hour post-glucose challenge test alone.

We Need Your Help!

CMS needs your help to ensure that people with Medicare are assessed for and informed about their risk factors for diabetes or pre-diabetes, and that those who are eligible take advantage of the diabetes screening tests.

In addition to providing coverage for diabetes screenings, Medicare also provides coverage for a variety of preventive care and other services for people with diabetes, such as the initial preventive physical examination (must be received within the first six months of the beneficiary's initial Medicare Part B coverage period), cardiovascular screening blood tests, diabetes self-management training, medical nutrition therapy, diabetes supplies, glaucoma screening, and influenza and pneumococcal immunizations. These services can help beneficiaries manage the disease and lower the risk of complications. Talk with your Medicare patients about the preventive services that are right for them and encourage utilization by providing referrals for appropriate services for which they may be eligible. Working together, we can help people with diabetes take steps to reduce the occurrence of serious complications through early detection and treatment, controlling the levels of blood glucose, blood pressure, and blood lipids, life style modifications (diet and exercise), and by receiving other preventive care practices as appropriate.

For More Information

- For more information about Medicare's coverage of diabetes screening services, initial preventive physical examination, cardiovascular screening blood tests, diabetes self management training, medical nutrition therapy, diabetes supplies, influenza and pneumococcal immunizations, and glaucoma screening services, including coverage, coding, billing, and reimbursement guidelines, please visit the CMS *Medicare Learning Network* (*MLN*) Preventive Services Educational Products Web page *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp.*
- For literature to share with your Medicare patients, please visit *http://www.medicare.gov.*
- For more information about American Diabetes Month, please visit *http://www.diabetes.org/communityprograms-and-localevents/americandiabetesmonth.jsp.*

Thank you for partnering with CMS during American Diabetes Month as we strive to make sure that people with Medicare learn more about diabetes and their risk factors for the disease and that they take full advantage of the diabetes screening tests and other Medicare-covered preventive services for which they may be eligible.

November Flu Shot Reminder

"Flu season is here! Medicare patients give many reasons for not getting their annual flu shot, including—"It causes the flu"; "I don't need it"; "It has side effects"; "It's not effective"; "I didn't think about it"; "I don't like needles!" The fact is that every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting their annual flu shot—and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu. Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf* on the CMS Web site."

Source: Provider Education Resources Listserv, Message 200711-01

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

New Brochure—Diabetes-Related Services

November was American Diabetes Month – The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes, as well as other covered services for people with diabetes. CMS has published a new provider brochure titled "Diabetes-Related Services". This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. You may download, view and print this new brochure by visiting the Medicare Learning Network (MLN) at *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf* on the CMS Web site. Print copies of the brochure may be ordered, free of charge, from the MLN Product Ordering Page by visiting *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS Web site.

For More Information

- For more information about Medicare's coverage of preventive services and screenings for people with diabetes, including the diabetes screening services, diabetes self management training, medical nutrition therapy, diabetes supplies, initial preventive physical examination, cardiovascular screening blood tests, influenza and pneumococcal immunizations, and glaucoma screening services, please visit the CMS Medicare Learning Network (MLN) Preventive Services Educational Products Web page *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- For literature to share with your Medicare patients, please visit *http://www.medicare.gov*.
- National Diabetes Education Program (NDEP) *http://ndep.nih.gov/* – NDEP provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.
- For more information about American Diabetes Month, please visit *http://www.diabetes.org/communityprograms-and-localevents/americandiabetesmonth.jsp*.

Source: Provider Education Resources Listserv, Message 200711-10

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.*

2007 – 2008 Influenza Season Resources for Health Care Professionals

The Centers for Medicare & Medicaid Services (CMS) has released the following special edition *MLN Matters* article, SE0748 – *2007-2008 Influenza (Flu) Season Resources for Health Care Professionals*, located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf*.

This article provides fee-for-service Medicare providers and their staff with access to a variety of seasonal flu related educational resources that they can use during the 2007-2008 flu season.

Visit the Medicare Learning Network – It's Free!

Source: CMS Provider Education Resource 200711-18

Physician Quality Reporting Initiative Update

Important Information About the Use of the National Provider Identifier

Physician Quality Reporting Initiative (PQRI) participants must use their national provider identifiers (NPIs) correctly for their quality-data submissions to count toward successful reporting.

In recent NPI related communications, CMS indicated that since October 15, 2007, Medicare is sending informational warnings that indicate there was no NPI shown in the primary provider fields on your claim(s). Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

Medicare informational warnings called "Provider Identification Code Qualifier Invalid Value" messages will be labeled M389, M390, M391, and/or M392, but, again, these are only reminders. If you receive one of these messages, your claim did not include an NPI as required for PQRI reporting. If you are certain that your claim was submitted with an NPI, you may want to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

PQRI Participation and Coding Tips

The Centers for Medicare & Medicaid Services has developed a tip sheet to assist eligible professionals participating in PQRI with reporting accuracy. Successful participation in PQRI is dependent on accurate submission of information provided on Medicare claims. This new resource provides helpful tips on the PQRI reporting process and is available on the PQRI Web page at: *http://www.cms.hhs.gov/PQRI/Downloads/2007PQRITipSheet.pdf*.

Other PQRI Resources

New information is continually added to the most reliable source of information about PQRI, the CMS Web site: *http://www.cms.hhs.gov/PQRI*. Here you will find new and revised Frequently Asked Questions (FAQ), updates on issues

Physician Quality Reporting Initiative Update, continued

related to both the 2007 and 2008 PQRI, new educational products, and access to the latest information you need to successfully participate in PQRI. Many of the FAQs have been recently updated, so be sure to check the Web site if you have any questions.

Two of the newest FAQs are:

8691 – Question: Where do I place the Physician Quality Reporting Initiative (PQRI) quality data codes on the CMS-1500 claim form?
Answer: The 2007 PQRI quality-data codes are HCPCS codes and reporting requirements for these codes follow current rules for reporting other HCPCS codes (e.g. CPT Category I codes). For additional information, see FAQ #8255.

8687 – Question: Are Medicare patients who are covered under Railroad Retirement Benefits and Postal Worker benefits included in the Physician Quality Reporting Initiative (PQRI)?

Answer: Yes.

Source: Provider Education Resources Listserv, Message 200711-07

2008 PQRI Provisions Announced in the Medicare Physician Fee Schedule Final Rule

The 2008 Medicare physician fee schedule (MPFS) final rule, effective for services on or after January 1, 2008, is on display in the *Federal Register* and will be published on November 27, 2007. The rule identifies 119 measures the Centers for Medicare & Medicaid Services has selected for eligible professionals to use to report quality-of-care information under the 2008 Physician Quality Reporting Initiative (PQRI). The rule may be found at: *http://www.cms.hhs.gov/center/physician.asp*. The PQRI provisions begin on page 653. A summary of these provisions is available at: *http://www.cms.hhs.gov/PQRI/35_2008PQRIInformation.asp*, in the 2008 PQRI information section of the PQRI Web page. Click on the "PQRI Provisions of the 2008 Physician Fee Schedule Proposed Rule" file in the Downloads section to view the summary.

Source: Provider Education Resources Listserv, Message 200711-10

Revisions to Change Request 4294—Low Vision Rehabilitation Demonstration

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

Provider Types Affected

Providers who bill Medicare fiscal intermediaries (FI), carriers, or Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries under the Medicare Low Vision Rehabilitation Demonstration.

What You Need to Know

CR 5756, from which this article is taken, revises some of the Medicare Low Vision Rehabilitation Demonstration coverage limitations described in CR 4294 (released January 20, 2006). Specifically, it changes the limitation of services from 9 hours of rehabilitation services in one consecutive 90-day period (once in a lifetime) to 12 hours of rehabilitation services ***per calendar year.*** You should make sure that your billing staffs are aware of these Medicare Low Vision Rehabilitation Demonstration coverage changes, which are effective for services supplied under the demonstration on or after April 1, 2008.

Background

To improve participation among eye care physicians in the Low Vision Rehabilitation Demonstration and to correct unnecessary limitations in level of low vision rehabilitation coverage, CR 5756, from which this article is taken, revises CR 4294 (Revisions to CR 3816 – Low Vision Rehabilitation Demonstration), released January 20, 2006. Specifically, it changes the 90-day, once in a lifetime limitation for vision rehabilitation services to *a calendar year basis*; and increases the number of hours of covered vision rehabilitation services to which a participating beneficiary is entitled from 36 units of 15 minutes each (9 hours), to 48 units of 15 minutes each (12 hours).

Additional Information

You may find the official instruction conveying the revisions to the Medicare Low Vision Rehabilitation Demonstration coverage limitations by going to CR 5756, located at *http://www.cms.hhs.gov/Transmittals/downloads/R54DEMO.pdf* on the CMS Web site.

If you have any questions, please contact your FI, carrier, 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: MM5756
Related Change Request (CR) #: 5756
Related CR Release Date: November 2, 2007
Effective Date: April 1, 2008
Related CR Transmittal #: R54DEMO
Implementation Date: April 7, 2008

Competitive Acquisition Program 2008 Physician Election and Impact on Carriers

The 2008 Physician Election Period for the Medicare Part B Drug Competitive Acquisition Program (CAP) began on October 1, 2007, and will conclude on November 15, 2007. The CAP is a voluntary program that offers physicians the option to acquire many drugs they use in their practice from an approved CAP vendor, thus reducing the time they spend buying and billing for drugs. The 2008 CAP program period will run from January 1 to December 31, 2008.

Physicians are instructed to submit their CAP election forms to their local carrier. As per change request (CR) 4064, local carriers are required to forward a list to the CAP designated carrier of all physicians and practitioners who have elected to participate in the CAP. This list is due on November 22, 2007.

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

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*.

To view and download the billing instructions for CAP physicians, see "CAP Physician Billing Tips" in the Downloads section of the "Information for Physicians" page: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp*.

Source: Provider Education Resources Listserv, Message 200711-13

Update to Requirement to Submit National Provider Identifier Notification

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

Provider Types Affected

Physicians, providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier, (hereinafter collectively referred to as "providers") who bill Medicare contractors (carriers, fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs] and regional home health intermediaries [RHHIs]) for claims for services provided to Medicare beneficiaries.

What Providers Need to Know

Providers, except DMEPOS suppliers, are no longer required to submit to the Medicare contractor a copy of the national provider identifier (NPI) notification received from the National Plan and Provider Enumeration System (NPPES), unless requested to do so by the contractor. Similarly, if the provider, except DMEPOS supplier, obtained the NPI via the electronic file interchange (EFI) mechanism, the provider need not submit a copy of the notification received from the EFI Organization (EFIO), unless requested to do so by the contractor. If paper documentation of a provider's NPI is requested by the contractor, the contractor may accept a copy of the provider's NPI Registry's Details Page in lieu of a copy of the NPI notification.

Additional Information

If you have questions, please contact your Medicare A/B MAC, FI, 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).

You may see the official instruction (CR5795) issued to your Medicare A/B MAC, FI, RHHI, or carrier by going to *http://www.cms.hhs.gov/Transmittals/downloads/R227PI.pdf* on the CMS Web site.

MLN Matters Number: MM5795
Related Change Request (CR) #: 5795
Related CR Release Date: November 2, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R227PI
Implementation Date: January 7, 2008

Mandatory Reporting of the National Provider Identifier on All Part B Claims

Effective March 1, 2008, your Medicare fee-for-service claims must include a national provider identifier (NPI) in the primary provider fields on the claim (i.e., the billing, pay-to provider, and rendering provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., referring, ordering and supervising) may continue to include only your legacy number, if you choose.

Failure to submit an NPI in the primary provider fields will result in your claim being rejected, beginning March 1, 2008.

In addition, if you already bill using the NPI/legacy pair in the primary provider fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI in the primary provider fields. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims.

Source: CMS Joint Signature Memorandum 08048, November 14, 2007

National Provider Identifier for Ordering/Referring and Attending/ Operating/Other/Service Facility

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

Provider Types Affected

Physicians and providers who bill Medicare carriers, fiscal intermediaries (FI), and Medicare administrative contractors (A/B MAC) for claims for services provided to Medicare beneficiaries.

What Providers Need to Know

Be cognizant of the fact that in accordance with the NPI final rule, when an identifier is reported on a claim for ordering/referring/attending provider, operating/other/ service facility provider, or for any provider that is not a billing, pay-to or rendering provider, that identifier **must be an NPI**. **For Medicare purposes this means that submission of an NPI for an ordering/referring provider is mandatory effective May 23, 2008. Legacy numbers cannot be reported on any claims sent to Medicare on or after May 23, 2008.**

Medicare has always required that a provider identifier be reported for ordering/referring providers. Effective May 23, 2008, that number **must be an NPI,** regardless of whether that referring or ordering provider participates in the Medicare program or not or is a covered entity.

Key Points

- Medicare will not pay for referred/ordered services or items unless the name and NPI number of the referring/ ordering/attending/operating/other/service facility provider is on the claim.
- It is the responsibility of the claim/bill submitter to obtain the ordering/referring/attending/operating/other/ service facility NPI for health care providers.
- Providers whose business is largely based upon provision of services or items referred/ordered by other providers must be careful furnishing such services/ items unless they first obtain the NPI of the referring/ ordering individual. If they furnish services/items and do not obtain that person's NPI prior to billing Medicare, their claim will be denied.
- If the NPI is not directly furnished by the ordering/ referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/her NPI prior to delivery of the services/items.
- Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries.
- Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.
- Physicians and the following nonphysician practitioners are the only types of providers allowed to refer/order services or items for beneficiaries:
  - Nurse practitioners (NP)
  - Clinical nurse specialists (CNS)
  - Physician assistants (PA)
  - Certified nurse midwives (CNM)
- Established NPI business requirements for beneficiary submitted (change request [CR] 5328), deceased physician (CR 5416), adjustments (CR 5416), beneficiary submitted (CR 4169), flu claims (CR 4169), foreign claims (CR 4169) and pandemic flu claims (CR 4169) remain as written.

Background

This article is based on CR 5674. Please note that 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. The (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS-045-F). All entities covered under HIPAA must comply with the requirements of the NPI final rule.

Additional Information

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

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

You may see the official instruction (CR 5674) issued to your Medicare A/B MAC, FI, or carrier by going to *http:// www.cms.hhs.gov/Transmittals/downloads/R225PI.pdf* on the CMS Web site.

MLN Matters Number: MM5674
Related Change Request (CR) #: 5674
Related CR Release Date: October 26, 2007
Effective Date: May 23, 2008
Related CR Transmittal #: R225PI
Implementation Date: April 7, 2008

Update About the National Provider Identifier Initiative

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

Requirement to Update Information in the National Plan and Provider Enumeration System

Health care providers who are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) are required by the national provider identifier (NPI) final rule to update their National Plan and Provider Enumeration System (NPPES) data. The final rule [at (162.410(a)(4)] states that covered health care providers must notify the NPPES of changes in their required NPPES data elements within 30 days of the changes. Failure to provide updated information may be considered an act of noncompliance with the NPI regulation, and a complaint may be filed against covered health care providers who do not comply with this provision, or any other provisions of the rule.

Health care providers can make most updates and changes over the Web, using the user IDs and passwords they selected when they first applied for their NPIs. If they applied on paper, most health care providers can submit updates or changes over the Web and may select user IDs and passwords at the time of the update. Certain changes or updates, however, must be made on paper (CMS-10114), as they require the original signature of the health care provider or, for an organization health care provider, the signature of the authorized official. Such changes include:

1. Applications for NPIs, and all updates/changes, from individuals who do not have social security numbers (SSN) or who do not want to report their SSNs to NPPES.
2. All requests to deactivate NPIs.
3. All requests to reactivate NPIs.
4. All changes to incorrectly submitted SSNs.
5. All changes to incorrectly submitted dates of birth.
6. All changes to incorrectly submitted employer identifier numbers (EINs).
7. All changes of EINs.
8. Password resetting changes due to changes to the contact person or authorized official.

When to Contact the NPI Enumerator for Assistance

Your health plans cannot assist you with NPI questions that should be directed to the NPI enumerator. However, the issues with which the NPI Enumerator can assist you are also limited to the following topics:

- Status of an NPI application, update, or deactivation.
- Forgotten/lost NPI.
- Lost NPI notification.
- Trouble accessing NPPES.
- Forgotten password/User ID.
- Need to request a paper application.

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

The NPI application is also a good source of information. Please refer to the NPI application instructions for clarification on information to be submitted in order to obtain an NPI or update your record. You can also refer to the "Application Help" tab located on the NPPES Web site for additional assistance while you are online.

Resources for other kinds of questions may be found at the end of this document. Please note that the NPI Enumerator's operation is closed on federal holidays.

Important Information for Medicare Providers
Medicare Announces a New "Key" NPI Date

This is an important message for physicians, other practitioners, providers, and suppliers that bill Medicare carriers, A/B Medicare administrative contractors (MACs), and DME MACs using an electronic claim form (ASC X12 837P) or paper claim form (CMS-1500).

The Centers for Medicare & Medicaid Services (CMS) is pleased to report that the vast majority of Medicare claims are being sent to Medicare with a national provider identifier (NPI). Moreover, the Medicare NPI crosswalk is successfully cross walking NPIs to legacy numbers for most claims. Given these favorable results, we are taking the next step towards full implementation of the NPI in Medicare.

Effective March 1, 2008, your Medicare fee-for-service claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim.

You may not submit claims containing only a legacy identifier in the primary fields.

Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable beginning March 1, 2008. Until further notice, you may continue to include legacy identifiers only for the secondary fields.

Medicare Informational Warnings to Those Who Are Not Submitting NPIs on Claims

Since October 15, 2007, Medicare physicians, nonphysician practitioners and other providers and suppliers who bill carriers and Medicare administrative contractors (MACs) using the ASC X12 837P or CMS-1500 receive informational warnings that indicate there was no NPI shown in the primary provider fields on your claim(s).

Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

Many Medicare physicians, nonphysician practitioners, and other providers and suppliers are not using NPIs in their Medicare claims, even in the primary provider fields (Billing/pay-to and Rendering). While, until March 1, you may continue to submit legacy identifiers in these fields, we strongly encourage you to begin using your NPI as well. You may use the NPI/PIN pair or the NPI-only to identify the Billing/pay-to and Rendering Providers.

Medicare informational warnings, called "Provider Identification Code Qualifier Invalid Value" messages, will be labeled M389, M390, M391, and/or M392, but, again, these are only reminders. If you receive one of these messages

Update About the National Provider Identifier Initiative, continued

and you are certain that your claim was submitted with an NPI, you may wish to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

The informational warnings consist of one or more of the following messages:

M389 2010AA NM108 Billing Provider Identification Code Qualifier Invalid Value
The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M390 2010AB NM108 Pay To Provider Identification Code Qualifier Invalid Value
The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M391 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid Value
The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M392 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid Value
The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

Testing Claims With Only the NPI

If you already bill using the NPI/legacy pair in the primary fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI. This test will serve to assure your claims will successfully process when only the NPI alone is mandated on all claims. If the results are positive, begin increasing the number of claims in the batch. If your claims reject, first go into the NPPES Web site located at *https://nppes.cms.hhs.gov/* and validate that your information is correct and that you reported your Medicare legacy identifier(s) in the Other Provider Identification Numbers section. Your Medicare legacy identifier(s) would be the number(s) that you used—prior to using the NPI—as the Billing/Pay-to and Rendering Providers. If the NPPES information is correct and you reported your Medicare legacy identifier(s), call your contractor and ask that they validate what is in their system.

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI may be found at the CMS NPI Web 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

Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your Web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" on the Web site in the left column of the *http://www.cms.hhs.gov/NationalProvIdentStand*.

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

Visit the Medicare Learning Network – it's Free!

Source: CMS Provider Education Resource 200711-05

Key Medicare Dates for National Provider Identifier

The NPI is here. The NPI is now. Are you using it?

As we get closer to May 23, 2008, be sure to pay attention to information from Medicare and other health plans regarding NPI implementation timelines.

Important Message for Residents at Teaching Hospitals and Academic Medical Centers: Why get your NPI now?

- If the hospitals' residents want to enroll in Medicare, you need to obtain NPIs before applying (enrolling) as a Medicare provider.
- Other health plans may require you to obtain NPIs as a condition of enrollment.
- If you prescribe medication, the pharmacies may need to know your NPI before dispensing the medications and submitting claims to health plans.
- If you order or refer services, your NPI may be required on the claims from providers who actually furnished the services.
- Future employers may require you to obtain NPIs as a condition of employment.

Key Medicare Dates for National Provider Identifier, continued

Important Information for Medicare Providers
Summary of Key Medicare Dates
October 29, 2007 – By this date, all carriers, A/B MACs and DME MACs will be rejecting claims where the NPI/legacy identifier combination used in claims cannot be validated against the NPI crosswalk. Informational edits will no longer be issued once this happens, but will be replaced by reject reports that will assist providers in determining why the claim is being rejected.

January 1, 2008 – As of this date, 837I electronic claims and UB04 paper claims without an NPI in fields identifying the primary provider (billing and pay-to) will be rejected. Legacy identifiers paired with NPIs in the primary provider fields on the claim will still be acceptable as will legacy-only numbers in secondary provider fields (see clarification below). **CMS has not yet announced the date by which an NPI will be required for primary provider fields on 837 professional electronic claims and 1500 paper claims processed by carriers, A/B MACs and DME MACs. This will occur prior to May 23, 2008; a specific date will be announced once available.**

May 23, 2008 – In keeping with the contingency guidance issued on April 3, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims, and SPR remittance advice. This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction. CMS will also stop sending legacy identifiers on COB crossover claims at this time.

Common Claims Problems/Errors Causing Rejections

The following problems/errors are due to providers billing with incompatible NPI/legacy pairs:

- The type of NPI you use (Entity Type 1 or Entity Type 2) must match your Medicare enrollment PIN (individual or organization). When compatible NPI/legacy pairs are submitted on a claim, there is a much higher success rate for finding a match on the NPI crosswalk, thus further ensuring timely and accurate processing of your claim.
- Those who are enrolled with Medicare as individuals but obtained an organization (Entity type 2) NPI through NPPES (or vice versa) need to ensure their enrollment records are correct and their NPIs were obtained appropriately.
- On professional claims (837P and CMS-1500), the NPI/PIN combination should identify the Billing, Pay-to, and Rendering Provider (the Pay-to Provider is identified only if it is different from the Billing Provider). This includes claims submitted by corporations that physicians and non-physician practitioners have formed or by physicians and nonphysician practitioners who bill Medicare directly. For more information, please refer to *MLN Matters* article SE0744 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0744.pdf* on the CMS Web site.

Other problems identified include:

- Providers are not taking proactive action based on the Part B informational edits and reject reports, despite extensive outreach and educational activities designed to make providers aware of the need to take action. Don't let this happen to you. Pay attention to the informational edits prior to October 30 and the reject messages thereafter.
- CMS has received reports of clearinghouses and billing services that may be stripping the NPI from the claim and later adding the NPI back on the remittance advice. Make sure this is not unknowingly happening to your claims. If you suspect your clearinghouse or billing service is stripping your NPI from claims, please contact your contractor to confirm that an NPI was not received.

Clarification: NPI Requirement on Medicare Institutional Claims for January 1, 2008

At the beginning of October, CMS issued a notice that referred to institutional claims. We are further clarifying that effective January 1, 2008, NPIs will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e., 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on January 1, 2008. (Pay-to Provider is identified only if it is different from the Billing Provider.)

You may continue to use only legacy identifiers for the secondary provider fields in the 837I and UB-04 claims, until May 23, 2008, if you choose.

Test Your Claims Now

Medicare encourages submitters to send a small number of claims using NPIs only (no legacy identifiers). If no claims are rejected, the submitter may gradually increase the volume. And remember, Medicare will require the NPI on paper claims – be sure to begin the testing process now even if you bill paper.

Upcoming WEDI NPI Audiocast on Using the NPI Registry and the NPPES Downloadable File

The Workgroup for Electronic Data Interchange will host an NPI audiocast on October 31. Visit *http://www.wedi.org/npioi/index.shtml*, on the WEDI Web site to learn more. Please note; there is a cost to participate in WEDI events.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI may be found through the CMS NPI page *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. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

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

Source: Provider Education Resources Listserv, Message 200710-16

Latest NPI News Relative to SSNs, Legacy IDs and Much More

The NPI is here. The NPI is now. Are you using it?

Social Security Numbers (SSNs) Should Not Be Reported in FOIA-disclosable NPPES Fields

As the Centers for Medicare & Medicaid Services (CMS) has mentioned in previous outreach messages and on the CMS NPI Web site, some health care providers have reported their SSNs, or the SSNs of other health care providers, in their NPPES records in fields that the Freedom of Information Act (FOIA) requires that CMS make publicly available. For example, there are instances where SSNs are reported in the "Other Provider Identification Numbers," "License Number," and "Employer Identification Number (EIN)" fields in providers' NPPES records. The information that providers report in these (and certain other) fields is fully disclosable by CMS to the public and, therefore, **SSNs should never be reported in any of these fields**.

Because SSNs are 9-digit numbers, CMS has been suppressing all 9-digit numbers found in any FOIA-disclosable field except for ZIP code and telephone/fax number fields. This means that these 9-digit numbers—whether or not they are SSNs—are not displayed in the NPI Registry and cannot be found in the monthly NPPES downloadable file. If these 9-digit numbers are legitimate EINs, "Other Provider Identification Numbers," or "License Numbers," health plans and others who are using the NPI Registry and the downloadable file are not able to see them, which means that they cannot see all of the NPPES data they may need in order to accurately match providers in NPPES to the providers in their own files, thus making it more difficult to link NPIs to legacy identifiers. In some cases, this may adversely affect payments to providers by health plans.

It is imperative that providers immediately look at their NPPES records to ensure that they did not inadvertently report their, or someone else's, SSN in a FOIA-disclosable field; if they did, they need to delete that SSN immediately and, if appropriate, replace it with the correct information (e.g., an EIN). Providers must look in their NPPES records (*https://nppes.cms.hhs.gov/*) in order to view all of the information they reported. If they need assistance in deleting inappropriately reported SSNs, they may contact the NPI Enumerator at 1-800-465-3203. If they need assistance in knowing which NPPES fields are disclosable under FOIA, they should review the document entitled, "National Plan and Provider Enumeration System (NPPES) Data Elements Data Dissemination – Information for Providers," dated June 20, 2007, and found at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf* on the CMS NPI Web page.

Providers cannot rely on the information disclosed in the NPI Registry or in the downloadable file in trying to determine if they inappropriately reported SSNs in FOIA-disclosable fields because CMS suppresses these numbers, as explained above; these numbers will not be seen in the NPI Registry or the downloadable file.

In order to protect your personal information from public disclosure, please correct this information immediately if this situation pertains to you.

When to Contact the NPI Enumerator for Assistance

The topics with which the NPI Enumerator can assist providers are listed as follows:

- Status of an NPI application, update, or deactivation
- How to apply, update, or deactivate
- Forgotten/lost NPI
- Lost NPI notification
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application

Health care providers needing assistance on any of the above topics may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at CustomerService@NPIenumerator.com.

The NPI application form, itself, is also a good source of information. Please refer to the NPI application instructions for clarification on information to be submitted in order to obtain an NPI or update an NPPES record. Refer to the 'Application Help' tab located on the NPPES Web site for additional assistance while online.

Important Information for Medicare Providers

As of October 29, 2007, all Medicare contractors have lifted the bypass logic and are editing against the Medicare crosswalk. As a result, claims that include non-matching NPIs and legacy identifiers are now rejecting. The following table is a review of the next set of dates, which are crucial for compliance with the NPI regulations.

Medicare's Key Dates

January 1, 2008

- 837I electronic claims and UB-04 paper claims without an NPI in fields identifying the primary provider (billing and pay-to) will be rejected.
- Legacy identifiers paired with NPIs in the primary provider fields on the claim will still be acceptable as will legacy-only numbers in secondary provider fields.

March 1, 2008

- Medicare FFS 837P and CMS-1500 claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields).
- You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields.
- Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable.
- Until further notice, you may continue to include legacy identifiers only for the provider secondary fields.

May 23, 2008

- In keeping with the Contingency Guidance issued on April 3, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims and SPR remittance advice.
- This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction.
- CMS will also stop sending legacy identifiers on COB crossover claims at this time.

Latest NPI News Relative to SSNs, Legacy IDs and Much More, continued

Be Sure to List Medicare Legacy Identifiers in the Appropriate Fields in NPPES

It is important for Medicare providers to note that the Medicare crosswalk only uses numbers listed in the Medicare fields within the "Other Provider Identification Numbers" section of the NPPES application; this section has fields for Medicare UPIN, Medicare OSCAR/Certification, Medicare PIN and Medicare NSC as noted in the following sample of the section:

Issuer	Number	State	Issuer (for Other NumberType only)
Medicare UPIN			
Medicare			
Oscar/Certification			
Medicare PIN			
Medicare NSC			
Medicaid		State is required if Medicaid number is furnished	
Other, Specify:			

If claims are rejecting, providers should review their NPPES records (not their NPI Registry records), to confirm that Medicare legacy identifiers are reported in the appropriate fields of the "Other Provider Identification Numbers" section.

Correct Way to List a Railroad Retirement (RR) Number in NPPES

It has come to our attention that certain clearinghouses are incorrectly instructing Medicare providers who bill as part of the Railroad Retirement (RR) Board program to list their Medicare RR PIN in the "Other" section in the "Other Provider Identification Numbers" field of NPPES (see the diagram in the above paragraph to view a sample of this NPPES field). An RR PIN is a Medicare PIN, and, therefore, should be listed in the Medicare PIN section within this field of NPPES. RR providers should double check their NPPES records and update their information, if necessary. Because Medicare RR PINs are 9-digit numbers, they are temporarily being suppressed and will not be displayed in the NPI Registry or the downloadable file. Providers should review their NPPES records, not their NPI Registry records, to determine if corrections are needed.

What is meant by the Term "Billing Provider"?

The term "Billing Provider" means the provider that is identified in the following loops, field locators, or items in the 837I/UB-04 and the 837P/CMS-1500 claim formats, respectively. Although the name of this loop/segment is "Billing Provider", the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop.

Institutional Claims
837I (electronic claim)
Billing Provider 2010AA
UB-04 (paper claim)
Form Locator (FL) 01

Professional Claims
837P (electronic claim)
Billing Provider 2010AA
CMS-1500 (paper claim)
Field 33

Test Your Claims Now!

Medicare also continues to urge providers to send a small batch of claims now with only the NPI. If the results are positive, begin increasing the number of claims in the batch.

If claims are rejecting, first go into the NPPES Web site located at *https://nppes.cms.hhs.gov/* and validate that your NPPES information is correct and that you reported your Medicare legacy identifier(s) in the appropriate Medicare sections of the "Other Provider Identification Numbers" field. Your Medicare legacy identifier(s) would be the number(s) that you used—prior to using the NPI—as the Billing/Pay-to and Rendering Providers. If the information in your NPPES record is correct and you reported your Medicare legacy identifier(s), print the screen (so you have a copy of your NPPES record on paper), call your contractor and ask they validate what is in their system.

Reminder: Medicare Is Issuing Informational Warnings to Those Who Are Not Submitting NPIs On Part B Claims

As stated in an earlier November NPI message, since October 15, 2007, Medicare physicians, nonphysician practitioners and other providers and suppliers who bill carriers and Medicare Administrative Contractors (MACs) using the ASC X12N 837P receive informational warnings that indicate if there was no NPI shown in the primary provider fields in those claim(s). Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

The informational warnings consist of one or more of the following messages:

M389 2010AA NM108 Billing Provider Identification Code Qualifier Invalid value
The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M390 2010AB NM108 Pay To Provider Identification Code Qualifier Invalid value
The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

Latest NPI News Relative to SSNs, Legacy IDs and Much More, continued

M391 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid value
The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M392 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid value
The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

Medicare informational warnings, called "Provider Identification Code Qualifier Invalid Value" messages, will be labeled M389, M390, M391, and/or M392, but, again, these are only reminders. If you receive one of these messages and you are certain that your claim was submitted with an NPI, you may wish to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

Many Medicare physicians, nonphysician practitioners, and other providers and suppliers are not using NPIs in their Medicare claims, even in the primary provider fields (Billing/pay-to and Rendering). While, until March 1, 2008, you may continue to submit legacy identifiers in these fields, we strongly encourage you to begin using your NPI as well. You may use the NPI/PIN pair or the NPI-only to identify the billing/pay-to and rendering providers. By doing so, you should have sufficient time to correct any problems that came about prior to the requirement to use only the NPI in claims.

Need More Information?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI may be found through the CMS NPI page *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. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your Web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the *www.cms.hhs.gov/NationalProvIdentStand* CMS Web page.

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

Source: Provider Education Resources Listserv, Message 200711-22

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page 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 (LCDs) 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 LCDs 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.fcso.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 LCD, and are based on the date of service (unless otherwise noted in the LCD). 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 our Web site *http://www.fcso.com* , select Medicare Providers, Connecticut or Florida,, click on the "eNews" link located on the upper-righ-hand corner of the page 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 Beneficiary Notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

REVISIONS TO THE LCDs

J0129: Abatacept—Revision to the LCD

The local coverage determination (LCD) for abatacept became effective June 30, 2007. Since that time, the verbiage in the Food and Drug Administration (FDA) approved product label has changed. Therefore, under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the phrase "…slowing the progression of structural damage…" was changed to " …inhibiting the progression of structural damage."

This revision to the LCD is effective for services rendered on or after June 30, 2007. The full text of this LCD is available through our provider education Web site at *http://www.fcso.com* on or after this effective date.

0145T: Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries—Revision to the LCD

The local coverage determination (LCD) for computed tomographic angiography of the chest, heart and coronary arteries was last updated on October 1, 2007. Since that time, a revision was made to add additional diagnosis codes based on two separate reconsiderations for this LCD.

The following ICD-9-CM codes were added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD for CT angiography of the chest for non-cardiac indications (*CPT* code *71275*):

337.9	Unspecified disorder of autonomic nervous system (Horner's syndrome)
441.1	Thoracic aneurysm, ruptured
441.6	Thoracoabdominal aneurysm, ruptured
441.7	Thoracoabdominal aneurysm, without mention of rupture
458.9	Hypotension, unspecified
729.5	Pain in limb
729.81	Swelling of limb
785.0	Tachycardia, unspecified
786.06	Tachypnea
786.09	Other dyspnea and respiratory abnormalities

In addition to the above, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision is effective for services rendered on or after November 21, 2007. The full text of this LCD is available through our provider education Web site at *http://www.fcso.com* on or after this effective date.

ADDITIONAL INFORMATION

Diagnostic Breath Analysis—Coverage Guidelines

Diagnostic breath analyses are tests performed to measure either the hydrogen or carbon dioxide content of the breath after ingestion of certain compounds. The analyses are performed to diagnose certain gastrointestinal diseases.

Indications

A lactose breath hydrogen test to detect lactose malabsorption is eligible for coverage.

CPT code *91065* (*Breath hydrogen test (eg, for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit*) should be used to report this service.

ICD-9 Codes that Support Medical Necessity

271.3	Intestinal disaccharidase deficiencies and disaccharide malabsorption
787.91	Diarrhea

Limitations

The following breath tests are excluded from coverage:

Lactulose breath hydrogen for diagnosing small bowel bacterial overgrowth and measuring small bowel transit time.

Diagnostic Breath Analysis—Coverage Guidelines, continued

- CO_2 for diagnosing bile acid malabsorption
- CO_2 for diagnosing fat malabsorption

Screening tests, in the absence of associated signs, symptoms or complaints are denied under 1862(a)(7).

It is understood that any diagnosis information submitted must have (in the patient record) medical justification of the tests. Subsequent determination that the medical record is lacking such justification will result in a retroactive denial under 1862(a)(1)(A).

Documentation Requirements

The ordering physician should retain in the patient's medical record, history and physical, examination notes documenting evaluation and management of one of the Medicare covered conditions/diagnoses, with relevant clinical signs/symptoms or abnormal laboratory test results, appropriate to one of the covered indications. The patient's clinical record should further indicate changes/alterations in medications prescribed for the treatment of the patient's condition. There must be an attending/treating physician's order for each test documented in the patient's medical/clinical record. Documentation must be available to Medicare upon request.

Effective Date

This coverage guideline is effective for services provided **on or after January 18, 2008.** The full text of the Centers for Medicare & Medicaid Services (CMS) national coverage determination regarding this service (Pub 100-03, Chapter 1, Part 2, Section 100.5) may be viewed on the CMS Internet-Only Manual System, *Medicare National Coverage Determinations (NCD)* manual at *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part2.pdf*.

55876: Implanted Fiducial Markers—Coding and Billing Guidelines

Both fiducial artificial markers and implanted markers are used as a guide to provide a clear and accurate reference point(s) for any type of imaging modality, image guided surgery, or radiation therapy. If the precise location of the target organ is known, dose escalation becomes more feasible for radiation therapy. An Interventional Radiologist generally performs these procedures. The marker(s) can be implanted with or without general anesthesia and the procedure requires 45 to 60 minutes to perform.

CPT code *55876* was established to report the placement of interstitial device(s) in the prostate for radiation therapy guidance. This procedure is performed in men with malignant neoplasms of the prostate. The following *CPT* codes for image guidance may be paid in addition to *CPT* code *55876* based on the type of procedure utilized:

- *76942* for Ultrasonic Guidance
- *77002* for Fluoroscopic Guidance
- *77012* for Computed Tomography Guidance
- *77021* for Magnetic Resonance Guidance

Unlisted *CPT* codes *19499, 32999,* or *47399* could be used when placing fiducial markers in the breast, lung or liver. Providers should not submit any medical record documentation with these claims. First Coast Service Options, Inc. will request this by means of an additional development request (ADR) letter. All applicable supporting documentation should be submitted for review with this request for the unlisted codes *19499*, *32999*, or *47399*. Only one image guidance code is expected per episode of fiducial marker placement. Unlisted codes are not allowable by an ambulatory surgical center (ASC). In addition, *CPT* code *55876* (fiducial marker placed in prostate) cannot be billed by an ASC prior to January 1, 2008.

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CONNECTICUT ONLY - ADDITIONAL INFORMATION

Adjustment of Gastric Band after Laparoscopic Gastric Banding Procedure

Laparoscopic placement of an adjustable gastric band (LAGB) (*CPT* code *43770*) is a covered procedure for morbid obesity, when appropriate, based on the *Medicare National Coverage Determination (NCD) Manual*. National coverage guidelines may be viewed at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* in Pub. 100-03, *Medicare National Coverage Determinations (NCD) Manual*, chapter 1, part 2, section 100.1. Adjustment of the gastric band after LAGB consists of an injection or withdrawal of saline. Adjustments to the LAGB should not be billed during the 90-day global period after the procedure, as it is included in the primary procedure and not separately payable during the global period.

Currently, adjustment of the LAGB does not have a unique *CPT* code. After the 90-day global period, it should be billed using *CPT* code *43659* (*Unlisted laparoscopy procedure, stomach*) with the statement "adjustment of gastric band" in Item 19 of the CMS-1500 or its electronic equivalent.

An evaluation and management (E&M) code and adjustment of LAGB will only be allowed if a significant separately identifiable and medically necessary service is provided. Modifier 25 should be appended to the E&M code only if it does not apply to the evaluation and adjustment of the LAGB.

CONNECTICUT ONLY - WIDESPREAD PROBE REVIEW

Widespread Probe Review Results: *99211 & 85610*

First Coast Service Options, Inc. (FCSO) conducted a widespread probe (WSP) review on services billed with *CPT* code *99211* (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician), and *85610* (Prothrombin time) by the same provider on the same date of service.

One hundred and two (102) beneficiary claims were reviewed for twenty (20) providers. These claims encompassed two hundred and four (204) services:

- 102 services billed with *CPT* code *85610*
- 102 services billed with *CPT* code *99211*

Results and notable findings of the widespread probe review were as follows:

- Twelve (12) providers were allowed all services as billed. Documentation submitted supported E&M services (*99211*) and the laboratory services billed on the same date of service.
- Three (3) providers were denied all services billed with *CPT* code *99211*. Documentation submitted did not support that a face-to-face visit occurred on the same date of service as the laboratory service. The laboratory services were allowed as billed.
- One (1) provider was denied five out of six services billed with *CPT* code *99211*. All laboratory services were allowed as billed.
- Three (3) providers were denied one out of five services billed with *CPT* code *99211*. All laboratory services were allowed as billed.
- One (1) provider was denied one claim for both services billed. The date of service requested for review was not submitted. All other claims and services were allowed as billed.

In cases where *CPT* code *99211* was billed in conjunction with *85610*, it is not enough to only document activities related to drawing a blood sample, recording the results, and in some cases a change in the dosage of medication. The documentation must contain evidence of a face-to-face encounter for the purpose of evaluating the patient. Due to the absence of such documentation, services billed with *CPT* code *99211* were denied. Additionally, services were denied when the provider failed to submit documentation for the requested date of service under review.

FLORIDA ONLY - ADDITIONAL INFORMATION

Adjustment of Gastric Band after Laparoscopic Gastric Banding Procedure

Laparoscopic placement of an adjustable gastric band (LAGB) (*CPT* code *43770*) is a covered procedure for morbid obesity, when appropriate, based on the *Medicare National Coverage Determination (NCD) Manual* and local coverage determination (LCD) guidelines. National coverage guidelines may be viewed at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* in Pub. 100-03, *Medicare National Coverage Determinations (NCD) Manual*, chapter 1, part 2, section 100.1. The local coverage guidelines may be viewed at *http://www.floridamedicare.com/Part_B/Local_Medical_Coverage/Final_LCDs/107117.asp*.

Adjustment of the gastric band after LAGB consists of an injection or withdrawal of saline. Adjustments to the LAGB should not be billed during the 90-day global period after the procedure, as it is included in the primary procedure and not separately payable during the global period.

Currently, adjustment of the LAGB does not have a unique *CPT* code. After the 90-day global period, it should be billed using *CPT* code *43659* (*Unlisted laparoscopy procedure, stomach*) with the statement "adjustment of gastric band" in Item 19 of the CMS-1500 or its electronic equivalent.

An evaluation and management (E&M) code and adjustment of LAGB will only be allowed if a significant separately identifiable and medically necessary service is provided. Modifier 25 should be appended to the E&M code only if it does not apply to the evaluation and adjustment of the LAGB.

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GENERAL EDUCATIONAL RESOURCES

Articles in this section apply to both Connecticut and Florida.

2007 – 2008 Influenza Season Resources for Health Care Professionals

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare for influenza (flu) vaccines and vaccine administration provided to Medicare beneficiaries.

Provider Action Needed

- Keep this Special Edition *MLN Matters* article and refer to it throughout the 2007 - 2008 flu season.
- Talk with your patients about their risk of contracting the flu virus and complications arising from the virus and encourage them to get the flu shot. (Medicare provides coverage of the flu vaccine and its administration without any out-of-pocket costs to the Medicare beneficiaries, (i.e., no deductible or copayment/coinsurance.)
- Stay abreast of the latest flu information and inform your patients.
- Order appropriate provider resources for yourself and your staff.
- Have appropriate literature on hand about seasonal flu that can be handed out to your patients during the flu season.
- Don't forget to immunize yourself and your staff – **Get the Flu Shot – Not the Flu!**

Introduction

Historically the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

Prevention is Key to Public Health!

- While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by recommending that they take advantage of the annual flu shot covered by Medicare.
- Medicare Part B reimburses health care professionals who accept the Medicare-approved payment amount for the flu vaccine and its administration. There is no beneficiary coinsurance or copayment and beneficiaries do not have to meet their deductible to receive the flu shot.
- Health care providers and their staff are also at risk for contracting the flu, so do not forget to immunize yourself and your staff. Protect yourself, your patients, your staff, and your family and friends. **Get Your Flu Shot – Not the Flu!**

Helping You Stay Informed

CMS has developed a variety of educational resources to help promote increased awareness and utilization of the flu vaccine among beneficiaries, providers, and their staff and to ensure that Medicare FFS health care professionals have the information they need to bill Medicare correctly for the flu vaccines and their administration.

Products

1. MLN Matters Articles

- MM5744: Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price (AWP) located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5744.pdf* on the CMS Web site.
- MM5511: Update to Medicare Claims Processing Manual (Publication 100-04), Chapter 18, Section 10 For Part B Influenza Billing located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf* on the CMS Web site.
- MM4240: Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf* on the CMS Web site.
- MM5037: Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf* on the CMS Web site.

2. MLN Influenza Related Products for Health Care Professionals

- *Quick Reference Information: Medicare Immunization Billing* - This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file at

2007 – 2008 Influenza Season Resources for Health Care Professionals, continued

http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf on the CMS Web site.

- The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Second Edition - This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file. Updated August 2007 at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf* on the CMS Web site.
- *Medicare Preventive Services Adult Immunizations Brochure* - This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Updated August 2007. Available in print and as a downloadable PDF file at *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf* on the CMS Web site.
- *Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course* - This WBT course contains four modules that include information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion. This course can be accessed through the MLN Product Ordering Web page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS Web site.
- An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals video program - This educational video program provides health care professionals with an overview of Medicare-covered preventive services. The program includes a segment on Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Included in the segment are strategies that providers may use to increase the use of these vaccines in their practices and tips for setting up a flu clinic. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered through the MLN Product Ordering Web page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS Web site.
- *Quick Reference Information: Medicare Preventive Services* - This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B. Available in print or as a downloadable PDF file at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf* on the CMS Web site.
- *Medicare Preventive Services Bookmark* - This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder to health care professionals about the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file at *http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf* on the CMS Web site.

MLN Preventive Services Educational Products Web Page

This *Medicare Learning Network* (*MLN*) Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS providers. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This Web page is updated as new product information becomes available. Bookmark this page (*http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage)* for easy access.

3. Other CMS Resources

- CMS Adult Immunizations Web Page located at *http://www.cms.hhs.gov/AdultImmunizations/* on the CMS Web site.
- CMS Frequently Asked Questions located at *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi* on the CMS Web site.
- *Medicare Benefit Policy Manual* - Chapter 15, Section 50.4.4.2 – Immunizations located at *http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf* on the CMS Web site.
- *Medicare Claims Processing Manual* – Chapter 18, Preventive and Screening Services located at *http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf* on the CMS Web site.

4. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2007 – 2008 flu season:

- Advisory Committee on Immunization Practices located at *http://www.cdc.gov/vaccines/recs/acip/default.htm* on the Internet.
- American Lung Association's Influenza (Flu) Center located at *http://www.lungusa.org* on the Internet. – This site provides a flu clinic locator at *http://www.fluclinicslocator.org* on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- Centers for Disease Control and Prevention – *http://www.cdc.gov/flu*.

2*007 – 2008 Influenza Season Resources for Health Care Professionals, continued*

- Immunization Action Coalition – *http://www.immunize.org*
- Immunization: Promoting Prevention for a Healthier Life – *http://www.nfid.org/pdf/publications/naiaw06.pdf*
- Medicare Quality Improvement Community – *http://www.medqic.org*
- National Alliance for Hispanic Health – *http://www.hispanichealth.org/*
- The National Center for Immunization and Respiratory Diseases (NCIRD) (established spring 2007) replaces the name National Immunization Program (NIP) – *http://www.cdc.gov/vaccines/about/*
- National Foundation For Infectious Diseases – *http://www.nfid.org/influenza*
- National Network for Immunization Information – *http:/www.immunizationinfo.org*
- National Vaccine Program – *http://www.hhs.gov/nvpo*
- Office of Disease Prevention and Promotion – *http://odphp.osophs.dhhs.gov*
- Partnership for Prevention – *http://www.prevent.org*
- World Health Organization – *http://www.who.int/csr/disease/influenza/en/*

Additional Information

For information to share with your Medicare patients, please visit, *http://www.medicare.gov* on the Web.

***Note:** The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. The authors of the video program and web-based training course have no conflicts of interest to disclose. The video program and Web-based training course were developed without any commercial support.

MLN Matters Number: SE0748
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

Medicare Preventive Services Series

The Centers for Medicare & Medicaid Services (CMS) has updated the following Web-based training (WBT) course: Medicare Preventive Services Series: Part 3 Expanded Benefits. This Web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for the following services: the initial preventive physical exam (also known as, the "Welcome to Medicare" physical exam), diabetes screenings, diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as colorectal, prostate, and glaucoma screenings, and bone mass measurements.

Note: CMS has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102.

Participants who successfully complete this course may receive .2 IACET CEU. To register, free of charge for this course, please visit, *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS Web site.

Visit the Medicare Learning Network ~ it's free!

Source: Provider Education Resources Listserv, Message 200711-20

Updated Women's Health Web-Based Training Course

The Centers for Medicare & Medicaid Services (CMS) has updated the following Web-based training (WBT) course: *Medicare Preventive Services Series: Part 2 Women's Health*. This WBT course provides information to help fee-for-services providers understand Medicare's coverage and billing guidelines for mammography services, Pap tests, pelvic exams, colorectal cancer screenings, and bone mass measurements.

CMS has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET), (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. Participants who successfully complete this course may receive .2 IACET CEU. To register, free of charge for this course, please visit the CMS Web site at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

Visit the Medicare Learning Network – It's Free!

Source: CMS Provider Education Resource 200711-08

Guidelines for Teaching Physicians, Interns and Residents Fact Sheet

The Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet (July 2007 version), which provides information about payment for physician services in teaching settings and general documentation guidelines, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf*.

Source: Provider Education Resources Listserv, Message 200711-06

Medicare Learning Network Publications

The following publications may now be ordered from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network* by visiting *http://www.cms.hhs.gov/mlngeninfo*; scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page":

- The Rural Health Bookmark, which offers Medicare providers, suppliers, and physicians information about rural educational resources.
- Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program Bookmark, which provides information about the Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program.

The revised Skilled Nursing Facility Prospective Payment System Fact Sheet (October 2007), which provides the elements of the skilled nursing facility prospective payment system, is now available in downloadable format on the CMS *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/snfprospaymtfctsht.pdf*.

Visit the *Medicare Learning Network* – It's Free!

Source: Provider Education Resources Listserv, Message 200710-20

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Florida Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

December 2007 – January 2008

Ask-the-Contractor Teleconference (ACT)

Topic: Provider Enrollment.

When: December 12, 2007
Time: 12:00 Noon – 1:00 p.m.
Type of Event: Teleconference

Ask-the-Contractor Teleconference (ACT)/Webcast

Topic: Evaluation and Management – Consultations and Subsequent Hospital Care.

When: December 13, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Hot Topics Webcast

When: January 9, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Preventive Services Webcast

When: January 16, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Note: *Dates and times are subject to change prior to event advertisement.*

Two Easy Ways To Register!

Online - Simply log on to your account on our provider training Web site at *www.fcsomedicaretraining.com* and select the course you wish to register for. Class materials will be available under "My Courses" no later than one day before the event. If you need assistance, please contact our FCSO Medicare training help desk by calling 866-756-9160 or sending an email to *fcsohelp@geolearning.com*.

- To locate this course on the provider training Web site, click on the following links/buttons in this order:
  - "Course Catalog" from the top navigation bar, then "Catalog" in the middle of the page;
  - "Browse Catalog" on the right of the search box, then "CT Part B" from list in the middle of the page;
  - Select the specific session you're interested in and then click the "Preview Schedule" button at the bottom of the page;
  - On the Instructor-Led Training (ILT) Schedule page, locate the line that has the course you are interested in and click the "Register" link in the Options column.
- First-time user? Please set up an account using the instructions located at *www.connecticutmedicare.com/*

Fax - If you would like to participate in any of these events and do not have access to the Internet, please complete the registration section, circle your selection(s) and fax to (904) 361-0407.

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

December 2007 – January 2008

Ask-the-Contractor Teleconference/Webcast

When: December 13, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Preventive Services Webcast

When: January 16, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Hot Topics Teleconference/Updates Webcast

When: January 17, 2008
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

Two Easy Ways To Register

Online – To register for this seminar, please visit our new training Web site at *http://www.fcsomedicaretraining.com*.

- If you are already a registered user of FCSO's Learning Management System (LMS), simply log on, select the specific session you are interested in, and click the "Register" button.
- If you are a **first-time user** of the LMS, you will need to set up an account. To do so, follow these steps:
  - From the welcome page, click on "I need to request an account" just above the log on button.
  - Complete the Request User Account form. (**Note:** Providers who do not yet have an NPI may use 9999.) You will receive your log on information within 72 hours of requesting an account.
  - Once your registration is complete, log on and select "Course Catalog," then select "Catalog." Select the specific session you are interested in, and then click the "Register" button.

Fax – If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to (904) 361-0407. Keep 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.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

More educational events (teleconferences, webcasts, etc.) will be planned to help providers with hot issues. Keep checking our Web site, *http://www.floridamedicare.com* or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events!

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.

Post Office Box for Appeals:

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

Post Office Box for EDI:

Electronic Media Claims/EDI

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

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

Appeals
1-866-535-6790, option 1

Medicare Secondary Payer
1-866-535-6790, option 2

Provider Enrollment
1-866-535-6790, option 4

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
National Government Services
Medicare Part A
1-888-855-4356

Durable Medical Equipment
NHIC
DME MAC Medicare Part B
1-866-419-9458

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

Quality of Care
Qualidign (Peer Review Organization)
1-800-553-7590

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

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

Health Insurance Counseling Program (CHOICES)/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 or 1-860-832-9265 (Hartford area or from out of state)

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 32231-0018

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:
Palmetto GBA
Railroad Medicare Part B
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
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