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 the Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com*, click on the "eNews" link on the navigational menu and follow the prompts.The *FCSO eNews* is sent at least every week, more frequently as required.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

Routing Suggestions:

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

_____

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Medicare B Update!

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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. Monthly publications allow our team to better serve our customers by making valuable information available in a more timely manner.

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

Who Receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education 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 Form CMS-855.

Clear Identification of State-Specific Content

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

Publication Format

The *Update!* is arranged into distinct sections.

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

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

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

Educational resources. Important **addresses, phone numbers**, and **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.

Advance Beneficiary Notices

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

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

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

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

Patient Liability Notice

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

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users. Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found on CMS's BNI 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

INFORMATION FOR CONNECTICUT PROVIDERS

Avoid Delays—Check Your Enrollment Application Before Mailing!

Have you completed all required information? Is supporting documentation included?

Did you know that…

CMS provides Medicare contractors with guidelines on returning enrollment applications. For more detailed information regarding return of enrollment applications visit the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/*. The following is a list of common reasons why First Coast Service Options, Inc. (FCSO) returns provider enrollment applications to providers and suppliers:

1. **An outdated version of the CMS-855 application(s) was submitted.**

Effective May 1, 2006, CMS issued new application forms for providers enrolling with Medicare. All applications must be submitted using the April 2006 version or the June 2006 version.

2. **The CMS-855 and/or CMS-588 application was not signed and/or dated.**

The appropriate individual(s) must sign and date the application in ink. Signatures must not be copied or stamped.

3. **The reassignment package submitted was incomplete.**

CMS 855-R was submitted alone – If a new group with new practitioners submits only the CMS-855R for its group members, and does not include all required applications (CMS-855B and/or CMS-855I) necessary to process the enrollment package, the CMS-855R will be returned.

CMS-855B was submitted alone – If a new group wants to enroll and submits only the CMS-855B, without attaching the CMS-855I and CMS-855R for the group members not currently enrolled, the applications will be returned. CMS-855I and/or CMS-855R are necessary to process the enrollment package for the group.

4. **The CMS-855R application was signed by an unauthorized official** whose signature is not on file with Medicare.

Where to go for Help?

Enrollment applications, tips to facilitate the enrollment process and answers to commonly asked questions may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/*. Specific instructions for completing the enrollment applications are outlined within each section of the application. You may also find it helpful to contact your Medical Association or Society.

If you are experiencing difficulty accessing the appropriate forms or have general questions regarding the enrollment process, please contact our Provider Customer Service Department at 1-888-760-6950.

INFORMATION FOR FLORIDA PROVIDERS

Avoid Provider Enrollment Delays

Did you know incomplete applications result in significant delays?

First Coast Service Options, Inc. **pre-screens** enrollment applications to verify they include required data elements and supporting documentation. **Applications will be returned without further review if certain conditions exist.** The most common reasons for returned applications include:

- An outdated version of the CMS-855 application(s) was submitted. Only the 06/06 versions are accepted.
- The CMS-855 and/or CMS-588 EFT application was not signed in ink and/or dated.
- All required applications in the reassignment package were not submitted.
- The CMS-855R application was signed by an unauthorized official.

FCSO processes applications in the order they are received. Providers must correct and resubmit applications that are returned by FCSO. Resubmitted applications are considered a new receipt and will be processed in the order of receipt. The most common items missing from applications include:

- Medical or professional licenses, occupational licenses, certifications, and registrations required by Federal or State law.
- National Provider Identifier (NPI) notification letters from NPPES.
- Business licenses such as occupational licenses (business tax receipts).

Avoid Provider Enrollment Delays (FL), continued

- Internal Revenue Service (IRS) CP-575 documentation.
- Interim sales agreements.

If an application is missing at least one required data element or supporting document, FCSO will send you a letter (referred to as a pre-screening letter), via fax, requesting the information needed to continue processing your application. When a fax number is not available, FCSO will mail this letter to the correspondence address noted in the application.

Providers have 60 days from the date of the pre-screening letter to return all requested information. If all requested information is not returned in 60 days, FCSO will reject the application. Once rejected, the provider must resubmit the application, which will be processed in the order of receipt.

For More Information…

Enrollment applications, tips to facilitate the enrollment process and answers to commonly asked questions may be found at *http://www.floridamedicare.com/Reference/General_Topics/Provider_Enrollment/109011.pdf*.

You may also access Centers for Medicare & Medicaid Services (CMS) Internet–Only Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 10 at *http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf*.

EDUCATIONAL ACTIVITIES

Newly Enhanced Provider Enrollment Simulation Now Available

Not sure if you need to fill out a CMS-855I form, a CMS-855R form, or both? Be sure to explore the newly enhanced provider enrollment Web-Based Training (WBT) course, available now on our Learning Management System (LMS), which is located at *http://www.fcsomedicaretraining.com*. The course incorporates new information and enhancements that add to the overall learning experience.

If you have an account in the LMS, log in and click the course catalog tab. Once there, select catalog. From there, select the link to the Provider Enrollment WBT to launch the course.

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 "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 number may use 9999.)
- You will receive your logon information within 72 hours of requesting an account.

Provider Enrollment Educational Events

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

CLAIMS

Important Guidance on the New CMS-1500 and UB-04 Forms

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

Provider Types Affected

All providers using the new forms CMS-1500 or UB-04 to bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

What You Need to Know

This *MLN Matters* article, SE0729, provides you valuable information about the new CMS 1500 and UB-04 forms.

Background

CMS Form 1500 Version 08-05

In 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised CMS-1500 (08-05). This new version of the form, revised to accommodate the reporting of the national provider identifier (NPI), was developed through a collaborative effort headed up by the National Uniform Claim Committee (NUCC), which is chaired by the American Medical Association (AMA), in consultation with the CMS.

The committee includes representation from key provider and payer organizations, as well as standards setting organizations, one healthcare vendor, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

Although CMS prefers that you submit all claims to Medicare electronically, the Administrative Simplification Compliance Act Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 provide for exceptions to the mandatory electronic claim submission requirement. Therefore, Medicare will receive, and process, paper claims (using the new [08-05] version of the CMS-1500) only from physicians and suppliers who are excluded from the mandatory electronic claims submission requirements.

CMS began accepting the revised CMS-1500 in January 1, 2007, planning to discontinue the older version on April 1, 2007; however formatting issues forced CMS to extend this date to July 2, 2007. At that time, CMS began returning the 12-90 version of the form. While the Government Printing Office (GPO) is not yet in a position to accept and fill orders for the revised CMS-1500, CMS' research indicates the form is widely available for purchase from print vendors.

For assistance in locating the form, you can contact the NUCC at *http://www.nucc.org/*, or you might consider using local print media directories to search for print vendors, contacting other providers to inquire on their source for the form, or searching for "CMS-1500 (08-05)" or "CMS-1500 08/05" on the Internet to locate online print vendors. You should ask for samples before ordering to ensure that the formatting is correct.

Some important details in completing the new CMS-1500 are as follow:

- If you previously populated boxes 17a (referring provider), 24j (rendering provider), and 33 (billing provider) with your legacy number, you should now begin using your NPI also.
- The billing provider NPI goes in box 33a. In addition, if the billing provider is a group, then the rendering provider NPI must go in box 24j. If the billing provider is a solo practitioner, then box 24j is always left blank. A referring provider NPI goes in box 17b.
- If the information in block 33 (billing) is different than block 32 (service facility), you should populate block 32 with the address information.

You may learn more about the new version of the CMS-1500 by reading *MLN Matters* article MM5060 (Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500), released September 15, 2006. You may find that article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf*

UB-04 Information

At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. The UB-04, the basic form that CMS prescribes for the Medicare program, incorporates the National Provider Identifier (NPI) taxonomy, and additional codes; and is only accepted from institutional providers 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.

Effective March 1, 2007, institutional claim filers such as hospitals, SNFs, hospices, and others were to have begun using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007 (during which time either the UB-92 or the UB-04 may have been used). On and after May 23, 2007: 1) The UB-92 has become no longer acceptable (even as an adjustment claim) and 2) All institutional paper claims must be submitted on the UB-04.

You should note that while most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change. Some details of the form follow:

- The UB-04 (Form CMS-1450) is a uniform institutional provider bill suitable for billing multiple third party payers. A particular payer, therefore, may not need some of the data elements.
- When filing, you should retain the copy designated "Institution Copy" and submit the remaining copies to your Medicare contractor, managed care plan, or other insurer.
- Instructions for completing inpatient and outpatient claims are the same unless otherwise noted.
- If you omit any required data, your contractor will either ask you for them or obtain them from other sources and

Important Guidance on the New CMS-1500 and UB-04 Forms, continued

will maintain them on its history record. It will not obtain data that are not needed to process the claim.

- Data elements in the CMS uniform electronic billing specifications are consistent with the UB-04 data set to the extent that one processing system can handle both. The definitions are identical, although in some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Further, the revenue coding system is the same for both the CMS-1450 and the electronic specifications.
- For the UB-04, the billing provider's NPI is entered in form locator (FL) 56. The attending provider's NPI is entered in FL76. The operating provider 's NPI is entered in FL77. Up to 2 other provider NPIs can be entered in FL78 and FL79.

You may find more information about the UB-04 (CMS-1450) by reading *MLN Matters* article MM5072 (Uniform Billing (UB-04) Implementation – UB-92 Replacement), released November 3, 2006. You may find that article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf*. The change request, from which that article was taken, contains a copy of the UB-04 form (front and back) in PDF format, a crosswalk between the UB-04 and the UB-92, and the revised portion of the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the CMS 1450 Data Set), Sections 70 (Uniform Bill - Form CMS-1450 [UB-04]) and 71 (General Instructions for Completion of Form CMS-1450 [UB-04]). These sections contain very detailed instructions for completing the form.

For assistance in obtaining UB-04s you may contact the NUBC at *http://www.nubc.org/*.

Additional Information

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

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

MLN Matters Number: SE0729
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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AMBULANCE

Revision to Certification for Hospital Services Covered by the Supplementary Medical Insurance Program as It Pertains to Ambulance Services

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

Provider Types Affected

Physicians and hospitals billing Medicare fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MAC) for ambulance services for Medicare patients.

Background

Change request (CR) 5684 furnishes the revised certification for hospital services by the supplementary medical insurance program as those requirements pertain to physician certification of ambulance services in Chapter 4, Section 20 of the *Medicare General Information, Eligibility, and Entitlement Manual.*

Key Points of Change Request 5684

- Prior to the effective date of **September 17, 2007,** of CR 5684, certification by a physician in connection with ambulance services furnished by a participating hospital was required.
- As of the effective date of CR 5684, language requiring physician certification for ambulance services furnished by a participating hospital is deleted from the above-mentioned Medicare manual.
- Your Medicare FI, carrier or A/B MAC has been instructed to comply with this revision.

Additional Information

To view the official instruction (CR 5684) issued to your Medicare FI, Carrier or A/B MAC, visit the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R47GI.pdf*.

The revised manual section is attached to CR 5684. If you have questions, please contact your Medicare FI, carrier, or A/B MAC at their toll-free number which may be found on the CMS Web site at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: MM5684
Related Change Request (CR) Number: 5684
Related CR Release Date: August 17, 2007
Related CR Transmittal Number: R47GI
Effective Date: September 17, 2007
Implementation Date: September 17, 2007

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CONSOLIDATED BILLING

2008 Annual Update of HCPCS Codes for Skilled Nursing Facility Consolidated Billing

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], Part A/B MACs) and fiscal intermediaries [FIs]) for services provided to Medicare beneficiaries in a skilled nursing facility (SNFs).

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5696, which provides the 2008 annual update of HCPCS codes for SNF consolidated billing (CB) and how the updates affect edits in the Medicare claim processing systems.

CAUTION – What You Need to Know

CR 5696 provides updates to HCPCS codes that will be used to revise the common working file (CWF) edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manual*, Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

GO – What You Need to Do

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

Background

Medicare claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Physicians and providers are advised that, by the first week in December 2007, new code files will be posted to on the CMS Web site the at *http://www.cms.hhs.gov/SNFConsolidatedBilling/*.

Institutional providers note that this site will include new Excel® and PDF format files.

Note: It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed on the CMS Web site at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* in order to understand the major categories including additional exclusions not driven by HCPCS codes.

Additional Information

The official instruction, CR 5696, issued to your Medicare contractor regarding this change may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1317CP.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).

MLN Matters Number: MM5696
Related Change Request (CR) Number: 5696
Related CR Release Date: August 17, 2007
Related CR Transmittal Number: R1317CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

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DRUGS AND BIOLOGICALS

Important Notice Regarding Vaccine Administrations in 2008

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the August 2007 Medicare B Update! page 20.

Note: This article was revised on August 3, 2007, to correct the G code for the administration of vaccinations for Part D. The G code referenced was G3077 and it should have been G0377. Also, a reference to a related article (SE0727) was added in the *Additional Information* section. All other information is unchanged.

Provider Types Affected

Physicians and other providers who bill Medicare carriers or Medicare administrative contractors (A/B MACs) for the administration of Part D-covered vaccines to Medicare beneficiaries.

What Providers Need to Know

This article (SE0723) provides 2008 payment guidance for the administration of Part D-covered vaccines. This is not new policy guidance, just a reminder of the policy for 2008. **Remember that, effective January 1, 2008, physicians can no longer bill Medicare Part B for the administration of Medicare Part D-covered vaccines, using the special G code (G0377).** Instead, you will need to bill the patient for the vaccine and its administration, and the patient will need to submit the claim to their Part D plan for reimbursement

You should make sure that your billing staffs are aware of this Part D-covered vaccine administration guidance for 2008.

Background

Section 202(b) of the Tax Relief and Health Care Act of 2006 (TRHCA) established a permanent policy for payment by Medicare for administration of Part D-covered vaccines, beginning in 2008. Specifically, the policy states that, effective January 1, 2008, the administration of a Part D-covered vaccine is included in the definition of "covered Part D drug" under the Part D statute.

During 2007, in transition to this new policy, providers were permitted to bill Part B for the administration of a Part D vaccine using a special G code (G0377). SE0723 now reminds providers of the requirement that payment for the administration of Part D covered vaccines only during 2007.

Therefore, effective January 1, 2008, you can no longer bill the G code to Part B; rather you will need to bill the patient for the vaccine and its administration, and the patient will need to submit the claim to the Part D plan for reimbursement.

Important Note: This guidance does not affect Part B covered vaccines.

Additional Information

You might want to look at *MLN Matters* articles MM5486 (Payment by DME MACs and DMERCs for the Administration of Part D Vaccines), released December 29, 2006; and MM5459 (Emergency Update to the 2007 Medicare Physician Fee Schedule Database [MPFSDB]) released January 11, 2007. You may find these articles at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5486.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf*, respectively.

You may also want to review SE0727 (Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D), which may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0727.pdf* on the CMS Web site.

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*.

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: SE0723 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Response to Competitive Acquisition Program for Part B Drug and Biological Claims When the Medicare System Common Working File 69XD Error Code is Received

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

Provider Types Affected

Participating Competitive Acquisition Program (CAP) physicians and other providers billing Medicare carriers or Medicare administrative contractors (A/B MAC) for Part B drugs and biologicals under the CAP.

Provider Action Needed

STOP – Impact to You

If you submit the same prescription order number more than once on a single CAP claim, your carrier or A/B MAC will return the entire claim as unprocessable.

CAUTION – What You Need to Know

Change request 5658, from which this article is taken, instructs carriers and A/B MACs to return as unprocessable CAP claims received with duplicate prescription order numbers.

GO – What You Need to Do

Make sure that your billing staffs are aware that they should not submit the same prescription order number more than once on a CAP claim, nor should they use the JW modifier on CAP claims, per CR 5658.

Background

Carriers and A/B MACs receive an error code when the same prescription order number is submitted more than once on a CAP claim. This inclusion of duplicate prescription order numbers on a single claim can happen, for example, when:

- The provider is coding wastage of the drug using the JW modifier, and has repeated the prescription order number on the wastage line
- The units provided for the drug exceed 999 and the balance of the units are coded on an additional line with a repeat of the prescription order number
- The provider has submitted more than one line on the same claim with the same or different dates of service using the same prescription order number (even when the units do not exceed 999).

In response to this error code, carriers and A/B MACs will return the claims as unprocessable, using the following remittance advice claim adjustment reason code (CARC) and remittance advice remark code (RARC) messages:

- CARC 16: Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. This change to be effective April 1, 2007. At least one remark code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
- Message 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.
- New RARC N389: Duplicate prescription number submitted.
- RARC M16: Please see our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

In order to resolve the issue of units that exceed 999, the Centers for Medicare & Medicaid Services (CMS) will be working with the approved CAP vendor to issue additional prescription order numbers when the units of the drug exceed 999.

Finally, CR 5658 rescinds (from CR 4309, issued on February 17, 2006) the instructions that addressed applying the unused drug modifier JW to indicate billing for the unused portion of a single-use drug product under the CAP. Claims for drugs provided under CAP submitted with the modifier JW will be treated as unprocessable. This CR does not affect the use of the modifier JW for non-CAP claims.

Additional Information

You may find the official instruction, CR 5658, issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1313CP.pdf* on the CMS Web site

If you have any questions, please contact your carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* 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: MM5658	Related Change Request (CR) #: 5658
Related CR Release Date: July 23, 2007	Effective Date: August 23, 2007
Related CR Transmittal #: R1313CP	Implementation Date: August 23, 2007

LABORATORY

Date of Service for Laboratory Specimens

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs), for services provided to Medicare beneficiaries related to tests performed on laboratory specimens.

Provider Action Needed

This article is based on change request (CR) 5573 which implements revisions to the date of service (DOS) policy for tests performed on laboratory specimens, in accordance with updates to 42CFR414.510 that were published in the *Federal Register* on December 1, 2006. **Remember when submitting claims that the general rule is that the DOS is the date the specimen is collected. Where a specimen is collected over a period that spans two calendar days, the DOS is the date the collection period ended.**

Background

The general rule for the DOS of a test performed on a laboratory specimen is the date that the specimen is collected. If a specimen is collected over a period that spans two calendar days, then the DOS must be the date that the collection period ended.

The current DOS policy allows an exception to the general rule for tests performed on an archived specimen. If a specimen was stored for more than 30 calendar days before testing (otherwise known as "an archived specimen"), the DOS of the test must be the date that the specimen was obtained from storage.

In the final physician fee schedule regulation published in the *Federal Register* on December 1, 2006 (*http://www.access.gpo.gov/su_docs/fedreg/a061201c.html*), the Centers for Medicare & Medicaid Services (CMS) revised the DOS policy for laboratory specimens to allow additional exceptions to the general rule and the DOS rule for tests performed on an archived specimen.

CR 5573 implements the revisions to the DOS policy for tests performed on laboratory specimens specified in the final rule, in accordance with the updates to 42 CFR section 414.510 (*http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/06-9086.htm*).

As already mentioned, under the revised DOS policy for laboratory specimens, the general rule is that the DOS of the test must be the date the specimen was collected. However, there is a variation: If a specimen is collected over a period that spans two calendar days, then the DOS must be the date the collection ended.

Exceptions to the DOS Policy for Laboratory Tests

DOS for Tests Performed on Stored Specimens:

In the case of a test performed on a stored specimen, if a specimen was stored for less than or equal to 30 calendar days from the date it was collected, the DOS of the test must be the date the test was performed **only if:**

- The test is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital.
- The specimen was collected while the patient was undergoing a hospital surgical procedure.
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted.
- The results of the test do not guide treatment provided during the hospital stay.
- The test was reasonable and medically necessary for treatment of an illness.

Note: If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived, and the DOS of the test must be the date the specimen was obtained from storage.

DOS for Chemotherapy Sensitivity Tests Performed on Live Tissue:

In the case of a chemotherapy sensitivity test performed on live tissue, **the DOS of the test must be the date the test was performed only if**:

- The decision regarding the specific chemotherapeutic agents to test is made at least 14 days after discharge.
- The specimen was collected while the patient was undergoing a hospital surgical procedure.
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted.
- The results of the test do not guide treatment provided during the hospital stay.
- The test was reasonable and medically necessary for treatment of an illness.

Note: For purposes of applying the above exception, a "chemotherapy sensitivity test" is defined as a test that requires a fresh tissue sample to test the sensitivity of tumor cells to various chemotherapeutic agents.

Date of Service for Laboratory Specimens, continued

Additional Information

The official instruction, CR 5573, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1319CP.pdf* 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: MM5573
Related Change Request (CR) #: 5573
Related CR Release Date: August 17, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R1319CP
Implementation Date: January 1, 2008

PREVENTIVE SERVICES

Correct Reporting of Diagnosis Codes on Screening Mammography Claims

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2007 Medicare B Update! page 29.

Note: This article was revised on July 27, 2007 to add a reference to change request (CR) 5377. MM5050 erroneously removed TOB 12x as an applicable TOB for diagnostic mammography services supplied to Medicare inpatients and billable under Medicare Part B. CR 5377 announced that effective April 1, 2007, TOB 12x is acceptable by fiscal intermediaries (FIs) and A/B Medicare administrative contractors as an appropriate bill type for such services.

Provider Types Affected

All providers billing Medicare carriers and FIs for screening mammography claims

Providers Action Needed

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

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSI-X12 837) on claims that contain ONLY SCREENING mammography services.
- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSI-X12 837 and field 21 of CMS-1500 or Loop 2300 of the ANSI-X12 837) on claims that contain OTHER services in addition to a screening mammography.

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

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

Background

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

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

Implementation

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

Correct Reporting of Diagnosis Codes on Screening Mammography Claims, continued

Additional Information

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

To view the instruction (CR 5377) that reversed the removal of TOB 12x, visit *http://www.cms.hhs.gov/Transmittals/downloads/R1117CP.pdf* on the CMS Web site. The related *MLN Matters* article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5377.pdf* on the CMS Web site.

If you have questions, please contact your Medicare intermediary or carrier at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.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: MM5050 *Revised*
Related CR Release Date: April 28, 2006
Related CR Transmittal #: R916CP
Related Change Request (CR) #: 5050
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

RADIOLOGY

Revised Information on PET Scan Coding

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 contractors (carriers, fiscal intermediaries [FI], and Medicare administrative contractors [A/B MAC]) for positron emission tomography (PET) scan services for Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Effective for services on and after January 28, 2005, your carrier, FI, or A/B MAC will deny claims for PET scan services that contain *CPT* code *78609* and they will deny claims for PET scan services on or after January 1, 2008 that contain HCPCS code A4641.

CAUTION – What You Need to Know

Change request 5665, from which this article is taken, corrects erroneous information that was originally issued in CR 3741, transmittal 527 (New Coding for FDG PET Scans and Billing Requirements for Specific Indications of Cervical Cancer), dated April 15, 2005. CR 5665 updates *Medicare Claims Processing Manual*, Chapter 13, Sections 60.30.1 and 60.30.2 by removing HCPCS code *78609* from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans.

GO – What You Need to Do

Make sure that your billing staffs are aware of these code changes and submit only covered codes in your claims for PET scan services.

Background

The Centers for Medicare & Medicaid Services (CMS) recently learned that the *Medicare Claims Processing Manual*, Chapter 13 (Radiology Services), Sections 60.30.1 (Appropriate *CPT* Codes Effective for PET Scans for Services Performed on or After January 28, 2005) and 60.30.2 (Tracer Codes Required for PET Scans), and CR 3747 (transmittal 527, dated April 15, 2005), contain incorrect information regarding *CPT* code *78609* (PET for brain perfusion imaging) and HCPCS code A4641.

- In Section 60.3.1, *Medicare incorrectly lists CPT code 78609 as a covered service*, and in section 60.3.2 is incorrectly included in terms of the applicability of certain tracer codes. Similarly, section 60.30.2 incorrectly lists HCPCS code A4641as an applicable tracer for PET scans.

CR 5665, from which this article is taken, corrects these errors. It updates the manual by removing HCPCS code *78609* from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans. In so doing, it also corrects correct the erroneous information that was originally issued in CR 3747.

Note: All positron emission tomography (PET) scans services (codes *78459*, *78491*, *78492*, *78608*, and *78811-78816*) require the use of a radiopharmaceutical diagnostic imaging agent (tracer). Therefore, the applicable tracer code should always be used when billing for a PET scan service.

Note: The correct PET scan *CPT* codes and tracer HCPCS codes are listed below.

Key Points in CR 5665

- Effective January 28, 2005, *CPT 78609* became a noncovered service for Medicare.
- Carriers, FIs, and A/B MACS will deny claims submitted with *CPT* code *78609* (effective January 28, 2005).

Revised Information on PET Scan Coding, continued

- When denying these claims, they will use:
  - Medicare summary notice (MSN) 16.10 "Medicare does not pay for this item or service."
  - Claim adjustment reason code 96: "Non-covered charge."
  - Remittance advice remark codes N386: —"This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp.* If you do not have Web access, you may contact the contractor to request a copy of the NCD."
  - Effective January 1, 2008, HCPCS code A4641 is not an applicable tracer for PET scans;
    - You should not report HCPCS code A4641 when submitting claims for PET scans for services on or after January 1, 2008. Instead, as of that time, when submitting claims for PET scans containing CPT code *78491* or *78492* you should use only tracer code A9555 or A9526; and, when submitting claims for PET Scans containing *CPT* code *78459*, *78608*, or *78811-78816*, you should use only tracer code A9552 (see below).
    - Carriers, FIs, and A/B MACs will not search for, and adjust, claims that have been paid prior to the implementation date, but they will adjust claims brought to their attention.

The following list the currently covered PET scan *CPT* codes (on or after January 28, 2005) and tracer HCPCS codes, as of January 1, 2008).

Appropriate *CPT* Codes Effective for PET Scans for Services Performed on or After January 28, 2005

***CPT* Code**	**Description**
78459	*Myocardial imaging, positron emission tomography (PET), metabolic evaluation*
78491	*Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress*
78492	*Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress*
78608	*Brain imaging, positron emission tomography (PET); metabolic evaluation*
78811	*Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck)*
78812	*Tumor imaging, positron emission tomography (PET); skull base to mid thigh*
78813	*Tumor imaging, positron emission tomography (PET); whole body*
78814	*Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck)*
78815	*Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh*
78816	*Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body*

Note: All PET scan services require the use of a radiopharmaceutical diagnostic imaging agent (tracer). The applicable tracer code should be billed when billing for a PET scan service. See below, for applicable tracer codes.

Tracer Codes Required for PET Scans on or After January 1, 2008 (A4641 Is Allowed for Services on or Before December 31, 2007)

The following tracer codes are applicable only to *CPT 78491* and *78492*. They cannot be reported with any other code.

Institutional Providers Billing Fiscal Intermediaries or A/B MACs

HCPC	**Description**
A9555*	Supply of radiopharmaceutical diagnostic imaging agent, rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries
Q3000*	Supply of radiopharmaceutical diagnostic imaging agent, rubidium Rb-82 (deleted effective December 31, 2005)
A9526	Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13

***Note: For claims with dates of service prior to January 1, 2006, providers report Q3000 for supply of radiopharmaceutical diagnostic imaging agent, rubidium Rb-82. For claims with dates of service January 1, 2006, and later, providers report A9555 for radiopharmaceutical diagnostic imaging agent, rubidium Rb-82 in place of Q3000.**

Physicians/Practitioners Billing Carriers or A/B MACs

HCPC	**Description**
A4641*	Supply of radiopharmaceutical diagnostic imaging agent, *not otherwise classified*
A9526	Supply of radiopharmaceutical diagnostic imaging agent, ammonia N-13
A9555	Supply of radiopharmaceutical diagnostic imaging agent, rubidium Rb-82, diagnostic, per study dose, up to 60 millicuries

Revised Information on PET Scan Coding, continued

***Note: Effective January 1, 2008, tracer code A4641 is not applicable for PET scans.**

The following tracer codes are applicable only to *CPT 78459, 78608, 78811-78816*. They cannot be reported with any other code:

Institutional Providers Billing Fiscal Intermediaries or A/B MACs

HCPC	Description
A9552*	Supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18, FDG, diagnostic, per study dose, up to 45 millicuries
C1775*	Supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18 (deleted effective 12/31/05)
A4641**	Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified

***Note:** For claims with dates of service prior to January 1, 2006, OPPS *hospitals* report C1775 for supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose *F18*. For claims with dates of service January 1, 2006 and later, providers report A9552 for radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18 in place of C1775.

****Note:** Effective January 1, 2008, tracer code A4641 is not applicable for PET scans.

Physicians/Practitioners Billing Carriers or A/B MACs

HCPC	Description
A9552	Supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose F18, FDG, diagnostic, per study dose, up to 45 millicuries
A4641*	Supply of radiopharmaceutical diagnostic imaging agent, not otherwise classified

***Note:** Effective January 1, 2008, tracer code A4641 is not applicable for PET scans.

Additional Information

You may find more information about PET Scan codes by going to CR 5665, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1301CP.pdf* on the CMS Web site. You will find the updated *Medicare Claims Processing Manual*, Chapter 13 (Radiology Services), Sections 60.30.1 (Appropriate *CPT* Codes Effective for PET Scans for Services Performed on or After January 28, 2005) and 60.30.2 (Tracer Codes Required for PET Scans) as an attachment to that CR.

If you have any questions, please contact your 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: MM5665 *Revised*
Related Change Request (CR) #: 5665
Related CR Release Date: July 20, 2007
Effective Date: January 28, 2005 and January 1, 2008 (per article)
Related CR Transmittal #: R1301CP
Implementation Date: January 7, 2008

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GENERAL COVERAGE

Duplicate Claim Edit for the Technical Component of Radiology and Pathology Laboratory Services Provided to Hospital Patients

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

Provider Types Affected

Radiology suppliers, clinical diagnostic laboratories, and other providers billing Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for the technical component (TC) of **radiology and pathology** services provided to Medicare fee-for-service hospital inpatients.

Provider Action Needed

STOP – Impact to You

Previously the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5347 that established duplicate claims edits, which included consideration **of the admission and discharge dates of a hospital stay in identifying duplicate claims for radiology and pathology services.**

CAUTION – What You Need to Know

Effective with implementation of CR 5675 on October 1, 2007, claims with dates of service on or after April 1, 2007, **will be paid for** radiology and pathology services rendered to Medicare beneficiaries on **the day of admission and the day of discharge during an inpatient hospital stay**.

GO – What You Need to Do

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

Background

This CR is being implemented to avoid denying claims that were legitimately provided to beneficiaries on the admission and discharge dates. The general rule is that the TC of radiology services provided during an inpatient stay may be billed only by the admitting hospital. Radiology suppliers that render services to beneficiaries in an inpatient stay may not bill the Medicare carrier for the technical portion of the service.

Also, the TC of physician pathology services provided to a hospital inpatient may be billed only by the admitting hospital. Independent laboratories have been instructed that they may not bill for these services after December 31, 2007, per CR 5468 (Transmittal 1148, issued Jan 5, 2007). The **exception is that imaging and pathology services performed on the admission date and discharge date** by entities other than the admitting hospital **are separately payable.**

Also, note that carriers and A/B MACs will not reprocess claims already processed, but they will adjust previously processed claims if affected providers bring such claims to the attention of their carrier or A/B MAC.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5675) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1295CP.pdf* on the CMS Web site.

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).

CR 5347 implemented a process to prevent payments of the TC of radiology services furnished to an inpatient of a hospital by any entity other than the admitting hospital. This CR may be reviewed by clicking on *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5347.pdf* on the CMS website.

MLN Matters Number: MM5675
Related Change Request (CR) #: 5675
Related CR Release Date: July 13, 2007
Effective Date: April 1, 2007
Related CR Transmittal #: R1295CP
Implementation Date: October 1, 2007

New Remark Code for Denying Separately Billed Services

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

Provider Types Affected

Medicare providers who submit claims to Medicare Part A/B Medicare administrative contractors (A/B MACs) or carriers for ambulance services rendered to Medicare beneficiaries.

Provider Action Needed

Be aware that contractors will use a new remittance advice remark code (RARC) message when denying ambulance claims submitted with a code(s) that is not separately billable and already included in the base rate. For claims submitted by ambulance suppliers that Medicare processes on or after October 1, 2007, and which Medicare denies because the code for the service does not appear on the ambulance fee schedule (AFS), Medicare will return the RARC of N390 to show "This service cannot be billed separately." See the remainder of this article for further details.

Key Points of Change Request 5659

- Effective October 1, 2007, the new RARC N390 and N185 with claim adjustment reason code (CARC) 97, group code CO, will be used when denying any codes on the ambulance claims that does not appear on the AFS.
- For such claims processed and denied on or after October 1, 2007, the following Medicare summary notice (MSN) message will be sent to Medicare beneficiaries: "16.45 – You cannot be billed separately for this item or service. You do not have to pay this amount."

Background

CR 5659 is the official document that announces these changes in Medicare processes and states that effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when the Centers for Medicare & Medicaid Services (CMS) fully implemented the AFS. Therefore, payment is based solely on the AFS amount as cited in 42 CFR section 414.615 (e) and such payment represents payment in full for all services, supplies, and other costs for an ambulance service furnished to a Medicare beneficiary. CMS was made aware that some providers are submitting claims with ancillary services that are included in the base rate.

CMS decided that a clearer denial message was needed to explain the reason for the denial and that this service is not separately billable and as a result, these claims/services should not be resubmitted. This is true whether the primary transportation service is allowed or denied. Remember that when these services are denied, the services are not separately billable to the beneficiaries.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5659) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1318CP.pdf* on the CMS Web site.

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: MM5659
Related Change Request (CR) #: 5659
Related CR Release Date: August 17, 2007
Effective Date: October 1, 2007
Related CR Transmittal #: R1318CP
Implementation Date: October 1, 2007

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Nurse Practitioner Services and Clinical Nurse Specialist Services

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

Provider Types Affected

Nurse practitioners (NP) and clinical nurse specialist (CNS) who bill Medicare carriers and Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

What You Need to Know

In CR 5639, from which this article is taken, the Centers for Medicare & Medicaid Services (CMS) announces that their manuals are being updated by adding the National Board on Certification of Hospice and Palliative Nurses (NBCHPN) to the list of recognized national certifying bodies for NPs. This list will also provide the new name for the National Certification Board of Pediatric Nurse Practitioners and Nurses and provide the correct reference for the Critical Care Certification Corporation. This same list of recognized national certifying bodies for advanced practice nurses will be included under the manual instruction on CNS services.

Carriers and A/B MACs will enroll nurses, under the NP and CNS benefits, who meet all of the other NP or CNS qualifications; and are certified as advanced practice nurses by any of the recognized national certifying bodies listed below, effective November 19, 2007.

Background

Federal regulations that govern nurse practitioner (NP) services at 42 CFR 410.75 and those governing the clinical nurse specialists (CNS) services at 42 CFR 410.76 require that these advanced practice nurses be certified by a national certifying body that has established standards for NPs and CNSs.

CR 5639, from which this article is taken, announces that CMS is adding the National Board on Certification of Hospice and Palliative Nurses (NBCHPN) to the list of recognized national certifying bodies for NPs at the advanced practice level, located in the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 200 (Nurse Practitioner (NP) Services). CR5639 also announces the addition of this same list of recognized national certifying bodies for advanced practice CNSs in Section 210 (Clinical Nurse Specialist (CNS) Services) and in Chapter 10, Sections 12.4.5 and 12.4.8 of the *Medicare Program Integrity Manual*.

Effective November 19, 2007, the list of recognized national certifying bodies for NPs and CNSs at the advanced practice level is as follows:

- 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.

Additional Information

You may find more information about NP and CNS services by going to CR 5639, which is in two transmittals located on the CMS Web site. As an attachment to transmittal R75BP (*http://www.cms.hhs.gov/Transmittals/downloads/R75BP.pdf*), you will find updated *Medicare Benefit Policy* manual, Chapter 15 (Covered Medical and Other Health Services), Sections 200 (Nurse Practitioner (NP) Services) and 210 (Clinical Nurse Specialist (CNS) Services). As an attachment to transmittal R219PI (*http://www.cms.hhs.gov/Transmittals/downloads/R219PI.pdf*), you will find updated Chapter 10, Sections 12.4.5 and 12.4.8 of the *Medicare Program Integrity Manual*.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which is available at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5639
Related Change Request (CR) #: 5639
Related CR Release Date: August 17, 2007
Effective Date: November 19, 2007
Related CR Transmittal #: R75BP and R219PI
Implementation Date: November 19, 2007

Required Use of Tamper-Resistant Prescription Pads for Outpatient Drugs Prescribed to Medicaid Recipients

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

Provider Types Affected

This issue impacts all physicians, practitioners, and other providers who prescribe Medicaid outpatient drugs, including over-the-counter drugs, in states that reimburse for prescriptions for such items. Pharmacists and pharmacy staff especially should be aware of this requirement as it may affect reimbursement for prescriptions. The requirement is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

Background

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 was signed into law on May 25, 2007. Section 7002 (b) of that Act addresses the use of tamper-resistant prescription pads and offers guidance to state Medicaid agencies.

On August 17, 2007, the Centers for Medicare & Medicaid Services (CMS), issued a letter to state Medicaid directors with guidance on implementing the new requirement.

Key Points of the CMS Letter to Your State Medicaid Director

- As of October 1, 2007, in order for outpatient drugs to be reimbursable by Medicaid, all written, non-electronic prescriptions must be executed on tamper-resistant pads.
- CMS has outlined three baseline characteristics of tamper-resistant prescription pads, but each state will define which features it will require to meet those characteristics in order to be considered tamper-resistant. **To be considered tamper resistant on October 1, 2007, a prescription pad must have at least one of the following three characteristics:**
    - One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
    - One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
    - One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.
- **No later than October 1, 2008, to be considered tamper resistant, states will require that the prescription pad have all three characteristics.**
- Several states have laws and regulations concerning mandatory, tamper-resistant prescription pad programs, which were in effect prior to the passage of section 7002(b). CMS deems that the tamper-resistant prescription pad characteristics required by these states' laws and regulations meet or exceed the baseline standard, as set forth above.
- Your state is free to exceed the above baseline standard.
- Each state must decide whether they will accept prescriptions written in another state with different tamper proof standards.
- **CMS believes that both e-prescribing and use of tamper-resistant prescription pads will reduce the number of unauthorized, improperly altered, and counterfeit prescriptions.**

Situations in Which the New Requirement Does not Apply

The requirement does not apply:

- When the prescription is electronic, faxed, or verbal; (CMS encourages the use of e-prescribing as an effective means of communicating prescriptions to pharmacists.)
- When a managed care entity pays for the prescription;
- To refills of written prescriptions presented to a pharmacy before October 1, 2007; or
- In most situations when drugs are provided in nursing facilities, intermediate care facilities for the mentally retarded, institutions for mental disease, and certain other institutional and clinical facilities.

Note: The letter issued by CMS to state Medicaid directors states that emergency fills are allowed as long as a prescriber provides a verbal, faxed, electronic, or compliant prescription within 72 hours after the date on which the prescription is filled. **Please note** also that Drug Enforcement Administration (DEA) regulations regarding controlled substances may require a written prescription.

Additional Information

To review the letter from the Center for Medicaid and State Operations go to *http://www.cms.hhs.gov/SMDL/downloads/SMD081707.pdf* on the CMS Web site.

MLN Matters Number: SE0736	Related Change Request (CR) #: N/A
Related CR Release Date: N/A	Effective Date: October 1, 2007
Related CR Transmittal #: N/A	Implementation Date: N/A

ELECTRONIC DATA INTERCHANGE

Electronic Funds Transfer Standardizations and Revisions to the Medicare Claims Processing Manual

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5586 which revises the *Medicare Claims Processing Manual,* Chapter 24 (General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims).

CAUTION – What You Need to Know

Effective July 1, 2007, your Medicare contractor will conduct Administrative Simplification Compliance Act (ASCA) reviews annually of at least 20 percent of providers submitting CMS-1500 paper claims who were not already reviewed in the past two years and found to have fewer than 10 full-time employees employed by the practice. In addition, contractors will insure that the addenda record is sent with the Medicare claim payment when an ACH format is used to transmit an EFT payment to a financial institution but the remittance advice is separately transmitted to a provider. This will assist with reconciliation of the payment and the information that explains the payment. The EFT format will be the National Automated Clearinghouse Association (NACHA) format CCP - Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) as mentioned in the X12N 835 version 004010A1 implementation guide.

GO – What You Need to Do

See the "Background" and "Additional Information" sections of this article for further details regarding these changes.

Background

Change request (CR) 5586 provides the following revisions to the *Medicare Claims Processing Manual* (Chapter 24, Sections 40.7 and Section 90.5.3) regarding electronic funds transfer (EFT) and the identification of providers to be reviewed.

Contractor Roles in Administrative Simplification Compliance Act (ASCA) Reviews and Identification of Providers To Be Reviewed

Each carrier, DME MAC and B MAC (not FIs or RHHIs at this time) conducts an ASCA review annually of 20 percent of those providers still submitting CMS-1500 paper claims. Medicare contractors will not select a provider for a quarterly review if:

- A prior quarter review is underway and has not yet been completed for that provider;
- The provider has been reviewed within the past two years, determined to be a "small" provider as fewer than 10 FTEs are employed in that practice and there is no reason to expect the provider's "small" status will change within two years of the start of the prior review, or
- Fewer than 30 paper claims were submitted by the provider to Medicare during the prior quarter.

Electronic Funds Transfer (EFT)

Although EFT is not mandated by the Health Insurance Portability and Accountability Act (HIPAA), EFT is the required method of Medicare payment for all providers entering the Medicare program for the first time and any existing providers, not currently receiving payments by EFT, who are submitting a change to their existing enrollment data. Providers must submit a signed copy of CMS-588 (Electronic Funds Transfer Authorization Agreement) to their carriers, DME MACs, A/B MACs, FIs, and/or RHHIs. For changes of information, DME MACs will verify the authorized official on the CMS-855 form. In addition, Medicare contractors will not approve any requests to change the payment method from EFT to check.

Carriers, DME MACs, A/B MACs, FIs and RHHIs must use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an X12 835 transaction, then the NACHA format CCP (Cash Concentration/Disbursement plus Addenda –CCD+) is used to make sure that the addenda record is sent with the EFT, because providers need the addenda record to re-associate dollars with data. Carriers, DME MACs, A/B MACs, FIs, and RHHIs must:

- Transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim, and
- Designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

Note: Medicare contractors will not approve any requests to change payment method from EFT to check.

Additional Information

The official instruction, CR 5586, issued to your carrier, intermediary, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1284CP.pdf* on the CMS Web site.

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

Electronic Funds Transfer Standardizations and Revisions to the Medicare Claims Processing Manual, continued

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).
MLN Matters Number: MM5586
Related Change Request (CR) #: 5586
Related CR Release Date: July 9, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1284CP
Implementation Date: October 1, 2007

Healthcare Provider Taxonomy Code Update

Effective October 1, 2007, the Healthcare Provider Taxonomy Codes (HPTC) will be updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of the HPTC is available from the Washington Publishing Company Web site at: *http://www.wpc-edi.com/codes/taxonomy*. When an HPTC is reported to Medicare, it must be a valid code or a batch and/or claim level rejection will occur.

Provider Action

To avoid a batch or claim level rejection, verify the submitted HPTC is valid on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system, please contact your software support vendor.

Source: Publication 100-04, Transmittal 1300, Change Request 5673

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FRAUD AND ABUSE

Department of Health & Human Services and Department of Justice Fight Infusion Therapy Fraud

Strike Force Prosecutions and Demonstration Project Target Fraudulent Business Practices in South Florida

The Health & Human Services (HHS) Secretary Mike Leavitt has announced an initiative designed to protect Medicare beneficiaries from fraudulent providers of infusion therapy. This two-year project will focus on preventing deceptive providers from operating in South Florida. Providers there will be required to reapply to be a qualified Medicare infusion therapy provider.

"HHS continues to work with the Department of Justice to protect the public and Medicare by stopping fraud before it happens," Secretary Leavitt said. "This demonstration project works to bar unlawful infusion therapy providers from entering the Medicare billing system." The new infusion therapy demonstration follows similar demonstration projects previously announced by HHS.

The demonstrations target fraudulent billing by suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) in South Florida and Southern California, and home health agencies in the greater Los Angeles and Houston areas. These geographic areas have shown a high frequency of DMEPOS or home health care fraud. South Florida is also one of the high-risk areas for fraudulent billing by providers of infusion therapy.

The Department of Justice (DoJ) is supporting HHS's new controls through a surge in prosecutions for health care fraud in South Florida. In May, the DoJ and HHS announced the work of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing. Since implementing the "phase one" Strike Force in Miami last March, DoJ prosecutors working with Assistant U.S. Attorneys from the Southern District of Florida have filed 47 indictments charging 65 individuals and/or entities with health care fraud in schemes that collectively billed Medicare more than $345 million. The Strike Force has convicted 26 defendants to date; 23 by plea agreement and three have been convicted in jury trials.

"Through real-time access to Medicare billing data, the Medicare Fraud Strike Force has allowed us to move quickly to make arrests and bring prosecutions as rapidly as possible. The Department of Justice remains fully committed to vigorously protecting the financial integrity of the Medicare program," stated Attorney General Alberto Gonzales.

The Strike Force supplements the ongoing health care fraud enforcement efforts of the United States Attorney's Office in the Southern District of Florida, which has been among the leading offices in combating health care fraud nationwide, presently accounting for over 20 percent of all health care fraud defendants charged nationally. Since announcing a federal-state health care fraud initiative over 18 months ago, the United States Attorney's Office has filed at least 157 criminal cases charging at least 266 defendants with federal violations in various health care fraud schemes and significant civil cases and settlements. Collectively, defendants and subjects billed Medicare over $300 million and received more than $150 million in reimbursements in cases that preceded the announcement today. The vast majority of these cases involved fraudulent DME or human immunodeficiency virus (HIV) infusion fraud schemes.

The Centers for Medicare & Medicaid Services (CMS) will now require infusion providers who operate in several South Florida counties to immediately resubmit applications to be a qualified Medicare infusion therapy provider. Those who fail to reapply within 30 days of receiving a notice to reapply from CMS will have their Medicare billing privileges revoked. Infusion therapy providers that fail to report a change in ownership; have owners, partners, directors or managing employees who have committed a felony; or, no longer meet each and every provider enrollment requirement; will have their billing privileges revoked. Infusion providers that successfully complete the reapplication process may be subject to an enhanced review, including site visits, based on risk assessment.

CMS will also issue Medicare summary notices to beneficiaries in South Florida on a monthly basis, instead of quarterly, to support more frequent scrutiny of infusion provider billings.

"We want to test and compare different fraud prevention tools in these demonstration projects," explains CMS Acting Deputy Administrator Herb Kuhn. "Enhancing our review of these providers will go a long way toward eliminating those who do not meet the needs of beneficiaries and the promises of the program."

The Medicare infusion therapy scam includes recruitment of HIV/AIDS patients by paying them to come to clinics and receive non-rendered or medically unnecessary infusion services. In 2004, Florida had fewer reported AIDS cases than California and New York, yet its total submitted Medicare charges for these cases was three times higher than California and five times higher than New York. And the number of infusion services billed in Florida tripled from 2004 to 2005, jumping from 4.3 percent to 15 percent of national billing.

Steps have been implemented in Florida to control fraudulent activities including joint federal and state site visits, prepayment edits and automatic denial of clinically unbelievable dosages, payment suspensions, provider enrollment onsite visits and other activities. Corrective actions from these steps have resulted in denial of fraudulent and medically unnecessary Medicare infusion claims with charges in excess of $1.8 billion in 2005 and 2006.

Department of Health & Human Services and Department of Justice Fight Infusion Therapy Fraud, continued

"CMS has taken and will continue to take aggressive action to curb infusion therapy fraud and other organized fraud activities," Kuhn said.

This week, the Strike Force filed charges against a medical biller who submitted approximately $170 million in fraudulent medical bills on behalf of approximately 75 health clinics that purported to specialize in treating patients with HIV. From roughly October 2002 through April 2006, HIV clinics in South Florida serviced by this biller, Rita Campos and her company R and I Billing, allegedly provided bills to Medicare that indicated patients were being injected with excessive amounts of HIV medications. Based on the claims filed by Campos, Medicare paid more than $100 million for these fraudulent services. This investigation remains ongoing. Eight other defendants, including Eduardo Moreno, owner of RTC of Miami, an infusion clinic that billed Medicare for more than $5.2 million between August 2006 and March 2007, are fugitives. Moreno, who also owns multiple DME companies in addition to the infusion clinic, was arrested on April 7 after being named in a six-count indictment on fraud charges but fled following his release on bail.

The U.S. Marshals Service is launching a special project to track down Medicare fraud fugitives in South Florida.

HHS has several programs to help Medicare beneficiaries protect themselves against fraud. The Senior Medicare Patrol Program, established by the Administration on Aging, educates and assists beneficiaries in protecting their Medicare information, detecting Medicare billing errors and reporting potential health care fraud and abuse.

Instances of potential Medicare fraud also can be reported to the HHS Office of the Inspector General at 1-800-HHS-TIPS (800-447-8477) or *HHSTips@oig.hhs.gov*.

Note: All HHS press releases, fact sheets and other press materials are available at *http://www.hhs.gov/news*.

Source: Department of HHS Press Release, August 20, 2007, Provider Education Resources Listserv, Message 200708-14

Medicare Integrity Program Demonstration for Providers of Infusion Therapy in High-Risk Areas

The Department of Health & Human Services (HHS) announced a two-year demonstration project by the Centers for Medicare & Medicaid Services (CMS) under the authority of Section 402(a)(1)(J) of the Social Security Amendments of 1967 [42 U.S.C. Section 1395b-1(a)(1)(J)] which permits the Secretary to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.

The demonstration, which focuses on South Florida, seeks to develop and demonstrate improved methods for the investigation and prosecution of fraud occurring among infusion providers.

- Infusion providers: Clinics or solo practitioners located in South Florida, who provide intravenous infusion therapy and/or intramuscular and subcutaneous injections in the office setting, will be subject to the demonstration. Infusion providers shifting from infusion to other procedure codes to avoid detection and bypass administrative actions will also be included.
- Infused and injected drugs: Medicare's HealthCare Common Procedure Coding System (HCPCS) categorizes infused and injected medications as J codes and Q codes to specifically identify the medication, dosage and administration route. For example, J0881 is the HCPCS code for "Injection, darbepoetin alfa, 1 microgram (non-ESRD use)." Medicare also separately reimburses drug administration (i.e., injection or infusion). For example *96542* is the *CPT* code for "*Chemotherapy injection*," *90780* is the *CPT* code for "*IV infusion, 1 hour*;" and *90782* is the *CPT* code for "*injection, subcutaneous or intramuscular*."
- Geographic area: The demo focuses on infusion providers in South Florida and, if providers relocate to avoid detection, will expand to other Florida locales designated as high risk by CMS and federal law enforcement.

Background

In response to spikes in infusion billing detected in late 2003, CMS and its Miami Satellite Division, First Coast Service Options, Inc. (the Florida Medicare carrier), and TriCenturion (then Florida's Medicare program safeguard contractor), launched a multi-faceted initiative in 2004 to address widespread infusion fraud in South Florida. In March 2005, EDS took over as the program safeguard contractor (PSC). In 2005 and 2006, CMS and its contractors participated in Governor Jeb Bush's Federal/State Florida Infusion Task Force with the Department of Justice the Department of Health & Human Services' Office of Inspector General, the Federal Bureau of Investigation and Florida's Medicaid Fraud Control Unit, Department of Health, Agency for Health Care Administration, Office of the Attorney General, Office of Drug Control and the Governor's Office.

Medicare billing for infusion services in South Florida is disproportionately high. Although significant progress has been made, fraudulent billing practices of unscrupulous infusion providers continue to cost the Medicare program millions of dollars. The demonstration will provide additional tools for removal of fraudulent providers from the Medicare program and for more effective and efficient fraud detection and investigation.

Enormity of the Problem

The Medicare infusion scam began when for-profit clinics and doctors recruited HIV/AIDS patients and paid them to come to their clinics for non-rendered or medically unnecessary infusion services, which they billed to Medicare at clinically unbelievable frequencies and toxic dosages.

Medicare Integrity Program Demonstration for Providers of Infusion Therapy in High-Risk Areas, continued

Florida's 2004 average Medicare submitted charges per HIV/AIDS beneficiary ($16,389) were four times higher than California ($3,932) and nearly eight times higher than New York ($1,935).

Florida, with fewer AIDS cases in 2004 (94,725) than California (133,292) or New York (162,466), had total submitted Medicare charges for HIV/AIDS beneficiaries ($1,552,417,426) that were three times higher than California ($524,100,645) and five times higher than New York ($314,315,002).

Key Actions Taken by CMS and its Partners in 2005 and 2006:

Combinations of corrective actions have been implemented in Florida such as joint federal/state site visits, prepayment edits, autodenials of clinically unbelievable dosages, payment suspensions, provider enrollment on-site and activity checks, enrollment revocations and deactivations, data analysis, complaint investigations, prosecutions and plea agreements. In 2005 and 2006, carrier and PSC prepayment reviews and edits have directly resulted in denial of fraudulent and medically unnecessary Medicare infusion claims with charges in excess of $1.8 billion. The United States Attorney's Office for the Southern District of Florida has filed criminal charges in 20 infusion therapy health care fraud cases involving 42 defendants during 2006 and 2007, to date. (See case list below.)

Components of the Demonstration:

1. **Immediate submission of enrollment application.** Letters will be sent to targeted South Florida infusion providers asking that they resubmit Medicare provider enrollment applications within 30 days of CMS' notification.
2. **Revocation of billing privileges.** Medicare billing privileges will be revoked (and appropriate recoupment measures applied) if an infusion provider fails to reapply within 30 days of receipt of CMS' letter; fails to report a change in ownership or address; fails to report owners, partners, directors or managing employees who have committed a felony within the past 10 years; or fails to comply with all of the Medicare provider enrollment requirements.
1. **Enhanced review of infusion providers.** Infusion providers that successfully complete the reapplication process will be subject to enhanced review, including site visits driven by established risk factors.
1. **Consumer fraud prevention.** The infusion therapy demonstration will introduce two features to help consumers support this fraud prevention effort. A new toll-free Part B Florida beneficiary infusion fraud hotline will be established in the near future. CMS will also issue Medicare summary notices (MSNs) to beneficiaries in South Florida on a monthly basis instead of quarterly, to support more frequent and timely scrutiny of infusion provider billings.

Infusion Clinic Fraud Cases

United States Attorney's Office for the Southern District of Florida

In 2006 and 2007, the United States has filed 20 criminal cases against 42 defendants involved in infusion clinic health care fraud in the Southern District of Florida:

1. United States vs. Frantz Achille, No. 06-20496-CR
2. United States vs. Onelio Baez, et al., No. 05-20849-CR
3. United States vs. Gregory Delatour, No. 06-20029-CR
4. United States vs. Pedro Diaz, et al., No. 05-20869-CR
5. United States vs. Luis Manuel Fernandez, et al., No. 06-20322-CR
6. United States vs. Magda Lavin, No. 05-20814-CR
7. United States vs. Thaiz Parra, et al., No. 06-60167-CR
8. United States vs. Isaac Nosovsky, et al., No. 06-20178-CR
9. United States vs. Rafael Walled, No. 06-20030-CR
10. United States vs. Rosa Walled, No. 06-20031-CR
11. United States vs. Cesar Romero, No. 06-20740-CR
12. United States vs. Arnold Garcia, et al., No. 07-20057-CR
13. United States vs. Luis G. Henriquez Delgado, No. 07-20180-CR
14. United States vs. Jose Prieto, et al., No. 07-20177-CR
15. United States vs. Leider Alexis Munoz, No. 07-20225-CR
16. United States vs. Jorge Luis Mocega, et al., No. 07-20419-CR
17. United States vs. Orestes Alvarez-Jacinto, MD, No. 07-20420-CR
18. United States vs. Lester Miranda, et al., No. 07-20612-CR
19. United States vs. Rupert Francis, No. 07-20631-CR
20. United States vs. Rita Campos Ramirez, No 07-20633-CR.

Source: Department of HHS Fact Sheet, August 20, 2007, Provider Education Resources Listserv, Message 200708-14

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NATIONAL PROVIDER IDENTIFIER

Lifting the National Provider Identifier Crosswalk Bypass Logic

Since October 2, 2006, providers have been encouraged to submit both the national provider identifier (NPI) and Medicare legacy identifier, also know as the provider identifier number (PIN) on their claims. During this timeframe providers were not penalized for invalid NPI/legacy ID combinations.

Effective September 3, 2007, (Connecticut) and September 10, 2007, (Florida), First Coast Service Options, Inc. (FCSO) will begin editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. **Where a match cannot be located on the crosswalk, claims will be rejected or returned to the provider.**

When the claim is returned, a provider should first verify that the correct NPI was submitted. If correct, you will need to verify that your Medicare legacy identifier (PIN) corresponds with the information on file with the National Plan and Provider Enumeration System (NPPES).

NPPES data may be checked online at *https://nppes.cms.hhs.gov*.

What Can You Do to Minimize Impacts?

Verify the information submitted on NPI applications and ensure that NPPES is showing the correct information:

- In section C "Other Provider Identifier choose "PIN" as your identifier type code.
- The correct Identifier Type Code: 1 for individual and 2 for organization.
- Employer identification number (EIN), social security number (SSN) or the tax identification number (TIN).

Verify the data in NPPES and the CMS-855 enrollment application submitted to Medicare is correct and consistent. The provider must check the accuracy and consistency of the following fields in the NPPES record and the Medicare enrollment application:

- Employer identification number (EIN), social security number (SSN) or tax identification number (TIN).
- Practice address, business address, master address and other addresses (if applicable)
- Legal name or legal business name as reported to the internal revenue service (IRS).

Once you have verified your information is correct, test the systems by submitting a small number of claims. We encourage this process to detect problems early without affecting your cash flow.

Still Experiencing Processing Issues?

FCSO has developed additional instructions to assist with processing issues. Refer to articles "Claims Denied with CO-208 and N257 or N290" (for paper claim submitters) and "Medicare Part B—NPI Related Edits" (for electronic claim submitters) immediately following this article.

Note: If you are not currently receiving the EMC batch control listing, which identifies the NPI errors, please contact your clearinghouse.

If your NPPES information is correct and you have included and matched ALL Medicare legacy identifiers with a corresponding NPI in NPPES, but you are experiencing provider identifier problems with your claims that contain an NPI, you may need to contact your clearinghouse (if applicable).

If you are still experiencing claim processing issues after verifying your NPPES and clearinghouse information, you may need to submit a Medicare enrollment application (i.e., the CMS-855). Please contact your Medicare Part B Customer Service Center at 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

Additional Information

More information and education on the NPI can be found at the CMS NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand*. Also, providers can apply for an NPI online at *https://nppes.cms.hhs.gov*.

For more information regarding common enumeration errors in NPPES and using the NPI on Medicare claims, please refer to the Centers for Medicare & Medicaid Service *MLN Matters* Special Edition Article SE0725. This article may be found at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf*.

Source: CMS Joint Signature Memorandum 07508, August 13, 2007

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

Claims Denied With CO-208 and N257 or N290

Providers receiving claim denials with claim adjustment reason code CO-208 and remittance advice remark codes N257 or N290 should follow the steps below prior to contacting customer service.

Ensure Your Provider Identification Information was Submitted Correctly

If the billing provider is a group, Limited Liability Corporation (LLC), Professional Association (PA), or other incorporation, then:

- Verify the billing provider's NPI was entered in item 33A.
- Verify the billing provider's Medicare legacy number (also referred to as the Provider Identification Number [PIN]), if submitted, was entered in item 33B and corresponds with the NPI in item 33A.
- Verify the individual physician/non-physician practitioner's NPI was entered in the unshaded lower portion of item 24J.
- Verify the individual physician/non-physician practitioner's Medicare legacy number, if submitted, was entered in the shaded upper portion of item 24J and corresponds with the NPI in the lower portion of item 24J.

If the billing provider is an ambulatory surgical center (ASC), independent diagnostic testing facility (IDTF), independent lab, ambulance supplier, or solo practitioner, then:

- Verity the billing provider's NPI was entered in item 33A.
- Verify the provider's Medicare legacy number (also referred to as the Provider Identification Number [PIN]), if submitted, was entered in item 33B and corresponds with the NPI in item 33A.
- Item 24J should be left blank.

What Can You Do to Minimize Impacts?

Verify the information submitted on NPI applications and ensure that NPPES is showing the correct information:

- In section C "Other Provider Identifier", choose "PIN" as your identifier type code.
- The correct identifier type code: 1 for individual and 2 for organization
- Employer identification number (EIN), social security number (SSN) or tax identification (TIN)

Verify the data in NPPES and the CMS-855 enrollment application submitted to Medicare is correct and consistent. The provider must check the accuracy and consistency of the following fields in the NPPES record and the Medicare enrollment application:

- Employer identification number (EIN), social security number (SSN) or tax identification number (TIN)
- Practice address, business address, master address and other addresses (if applicable)
- Legal name or legal business name as reported to the Internal Revenue Service (IRS)

Once you have verified your information is correct, test the systems by submitting a small number of claims. We encourage this process to detect problems early without affecting your cash flow.

Medicare Part B – NPI Related Edits

Below are reject codes returned on the EMC batch control listing. If you submit your Medicare claims through a clearinghouse and do not receive the Batch control listing, please contact your clearinghouse. If you transmit your claims directly to Medicare and do not receive this report, please contact your vendor.

These edits will cause claim or batch level rejections as of September 3, 2007, (Connecticut) or September 10, 2007, (Florida)

M012	Either the Provider number (PIN) or the NPI submitted in the 2010AA Billing Provider loop is not valid in the Medicare Part B processing system (MCS), or not a valid provider for this loop. Entire batch will reject.
M013	The submitter/provider combination being sent (either billing provider or pay-to provider) is not a valid combination in the Medicare Part B processing system (MCS). Entire batch will reject.
M017	Either the Provider number (PIN) or the NPI submitted in the 2010AB Pay-to Provider loop is not valid in Medicare Part B processing system (MCS). Entire batch will reject.
M314 thru M339	Invalid NPI format. NPI number must be 10 digits with the first digit equal to 1, 2, 3 or 4 or NPI does not meet NPI algorithm.
M340	The 2010AA Billing Provider NPI submitted on the claim is not on the crosswalk (when only the NPI is submitted) or, the PIN/NPI combination submitted on the claim is not on the crosswalk (when both legacy and NPI are submitted).
M341	The 2010AB Pay-to Provider NPI submitted on the claim is not on the crosswalk (when only the NPI is submitted) or, the PIN/NPI combination submitted on the claim is not on the crosswalk (when both legacy and NPI are submitted).
M343	The 2310B Rendering Provider NPI submitted on the claim is not on the crosswalk (when only the NPI is submitted) or, the PIN/NPI combination submitted on the claim is not on the crosswalk (when both legacy and NPI are submitted).

Medicare Part B – NPI Related Edits, continued

M347	The 2420A Rendering Provider (line level) NPI submitted on the claim is not on the crosswalk (when only the NPI is submitted) or, the PIN/NPI combination submitted on the claim is not on the crosswalk (when both legacy and NPI are submitted.
M379	The 2010AA Billing Provider loop is submitted without a legacy PIN and either the EIN or SSN submitted is not a valid combination on the crosswalk.
M380	The 2010AB Pay-to Provider loop is submitted without a legacy PIN and either the EIN or SSN submitted is not a valid combination on the crosswalk.
M381	The 2310B Rendering Provider loop is submitted without a legacy PIN and either the EIN or SSN submitted is not a valid combination on the crosswalk.
M382	The 2420A Rendering Provider loop (line level) is submitted without a legacy PIN and either the EIN or SSN submitted is not a valid combination on the crosswalk.
M387	The contractor ID in the 1000B Receiver loop is not found on the crosswalk for the NPI submitted. (Contractor ID for FL [00050] or CT [00591]). Entire batch will reject.

The edits below are for secondary providers and will remain informational until May 2008.

M101	The NPI/PIN combination in the 2420C Service Facility loop is not valid on the NPI crosswalk.
M342	The 2310A Referring Provider NPI submitted on the claim is not on the crosswalk (when only the NPI is submitted) or, the PIN/NPI combination submitted on the claim is not on the crosswalk (when both legacy and NPI are submitted).
M344	The 2420A Rendering Provider (line level) NPI submitted on the claim is not on the crosswalk (when only the NPI is submitted) or, the PIN/NPI combination submitted on the claim is not on the crosswalk (when both legacy and NPI are submitted).
M345	The 2310D Service Facility Provider NPI submitted on the claim is not on the crosswalk (when only the NPI is submitted) or, the PIN/NPI combination submitted on the claim is not on the crosswalk (when both legacy and NPI are submitted).
M348	The 2420B Purchasing Service Provider NPI submitted on the claim is not on the crosswalk (when only the NPI is submitted) or, the PIN/NPI combination submitted on the claim is not on the crosswalk (when both legacy and NPI are submitted.
M351	The 2420F Referring Provider (line level) NPI submitted on the claim is not on the crosswalk (when only the NPI is submitted) or, the UPIN/NPI combination submitted on the claim is not on the crosswalk (when both UPIN and NPI are submitted.

Dissemination of Data from the National Plan and Provider Enumeration System to Begin September 4, 2007

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

The National Plan and Provider Enumeration System (NPPES) health care provider data that are disclosable under the Freedom of Information Act (FOIA) will be disclosed to the public by the Centers for Medicare & Medicaid Services (CMS). In accordance with the e-FOIA Amendments, CMS will be disclosing these data via the Internet. Data will be available in two forms:

1. A query-only database, known as the NPI registry.
2. A downloadable file.

CMS is extending the period of time in which enumerated health care providers may view their FOIA-disclosable NPPES data and make any edits they feel are necessary prior to our initial disclosure of the data.

CMS must build in time to resolve any errors or problems that may be encountered with edits that health care providers submit. Therefore, in order to ensure edits are reflected in the NPI registry when it first becomes operational and in the first downloadable file, health care providers need to submit their edits **no later than Monday, August 20, 2007.** Health care providers who submit edits on paper need to ensure that they are mailed in time for receipt by the NPI Enumerator by that date.

CMS will be making FOIA-disclosable NPPES health care provider data available beginning **Tuesday, September 4, 2007.** The NPI registry will become operational on September 4 and the downloadable file will be ready approximately one week later.

For assistance in making their edits health care providers should refer to the document entitled, "Information on FOIA-Disclosable Data Elements in NPPES," dated June 20, 2007, found on the CMS NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf*.

Dissemination of Data from the NPPES to Begin September 4, 2007, continued

Some of the key data elements that are FOIA-Disclosable are:

- NPI
- Entity Type Code (1-Individual or 2-Organization)
- Replacement NPI
- Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), OR the Legal Business Name for Organizations)
- Provider Other Name (First Name, Middle Name, Last Name, or 'Doing Business As' Name, Former Legal Business Name, Other Name. for Organizations)
- Provider Business Mailing Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Provider Business Location Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Healthcare Provider Taxonomy Code(s)
- Other Provider Identifier(s)
- Other Provider Identifier Type Code
- Provider Enumeration Date
- Last Update Date
- NPI Deactivation Reason Code
- NPI Deactivation Date
- NPI Reactivation Date
- Provider Gender Code
- Provider License Number
- Provider License Number State Code
- Authorized Official Contact Information (First Name, Middle Name, Last Name, Title or Position, Telephone Number).

The delay in the dissemination of NPPES data **does not alter** the requirement that HIPAA covered entities must comply with the requirements of the NPI final rule **no later than May 23, 2008.** All NPI contingencies that may be in place must be lifted by that date.

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 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.

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

Source: CMS Provider Education Resource 200708-06

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.

Implementation Delay for Transaction 835 and Standard Paper Remittance Advice

The Centers for Medicare & Medicaid Services (CMS) has advised contractors that the implementation of change request (CR) 5452 (*Stage 3 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice*) scheduled for October 1, 2007, has been delayed.

Until further notice is received by CMS, the electronic remittance advice (ERA), standard paper remittance advice (SPR), PC Print and MREP software will not report or insert the national provider identifier (NPI) information as directed in CR 5452. Providers will be notified when additional information becomes available.

The *MLN Matters* article MM5452 related to CR 5452 was published in the July 2007 *Medicare B Update!* (pages 47-48).

Source: CMS Pub. 100-04, Transmittal 1241, CR 5452

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The Second in the Series of Special Edition Articles on the National Provider Identifier Rescinded

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2007 Medicare B Update! pages 42-45.

Note: This article was rescinded on August 9, 2007, due to a number of factors affecting NPI implementation, especially the contingency plan announced in *MLN Matters* article MM5595. For the latest NPI information, you can view all NPI related *MLN Matters* articles by going to *http://www.cms.hhs.gov/NationalProvIdentStand/downloads/MMarticles_npi.pdf* on the Centers for Medicare & Medicaid Services website.

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

Processing Delays Due to NPI Issues

First Coast Service Options, Inc. (FCSO) is experiencing a high volume of pending claims as a result of National Provider Identifier (NPI) billing issues. The most common NPI billing errors are:

- Submitting the group NPI/PIN as the rendering provider
- Submitting an NPI with an invalid PIN (i.e. UPIN, NPI submitted as Medicare PIN, or invalid words such as "Pending")

These billing errors cause delays in claims processing and may result in additional development letters and/or returning the claim as unprocessable.

Provider Action Needed

Do not submit a group NPI for the rendering provider. When submitting the group NPI as the billing provider, the rendering provider's NPI must be submitted in item 24J on paper claims or in the 2310B loop on electronic claims.

Providers receiving development letters requesting a Medicare PIN **must** respond to each development letter and provide the appropriate Medicare PIN. Failure to respond will result in the claim(s) denying as unprocessable. The provider will then be required to resubmit the claim(s).

Providers **must** use the interactive voice response (IVR) unit to check claim status. If a claim has been received and is currently processing, providers should allow at least 30 days before contacting Provider Customer Service for additional assistance.

We apologize for any inconvenience this may cause.

Reporting Legacy Numbers in NPPES

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

The reporting of legacy numbers in the "Other Provider Identifier"/"Other Provider Identifier Type Code" fields in the National Plan and Provider Enumeration System (NPPES) will assist Medicare in successfully creating linkages between providers' NPIs and the identifiers that Medicare has assigned to them (such as PINs).

You should be aware that if you remove your legacy numbers from the "Other Provider Identifier"/"Other Provider Identifier Type Code" fields, linkages that Medicare has established using the reported Medicare legacy numbers will be broken and your Medicare claims **could be rejected.**

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.

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

Source: CMS Provider Education Resource 200708-09

Updated Information for Medicare Providers on National Provider Identifier

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

During this testing and implementation phase for the national provider identification (NPI), providers should pay close attention to information from health plans and clearinghouses to understand how claims are being processed and what providers should be doing to assure no disruption in payment. Providers should also ensure that the information they are submitting on a claim is what is being transmitted to each health plan by the billing vendors or clearinghouses that may be submitting the claims on their behalf.

National Plan and Provider Enumeration System (NPPES) FOIA-Disclosable Data to be Available on August 1, 2007

The NPI registry, a query-only database, will be operational on August 1, 2007. The NPI registry will operate in a real-time environment. This means that the Freedom of Information Act (FOIA)-disclosable data for newly enumerated providers, as well as updates and changes to enumerated provider FOIA-disclosable data, will be available in the NPI registry as that information is applied to the national plan and provider enumeration system (NPPES). The NPI registry will enable a user to query by, for example, NPI or provider name, and will return a list of all NPPES records that meet the query specifications. The user selects from that list the NPPES records he/she wants to see. The NPI registry will then display the FOIA-disclosable data for those records. About a week later, CMS will make available a file for downloading that will contain the FOIA-disclosable NPPES data of enumerated health care providers. Technical expertise will be required to download that file and to import that data into a relational database or to otherwise manipulate the data. CMS will be furnishing more information about data dissemination, including a "Read Me" file, header file, and code value document for the downloadable file, and will make that information available on the CMS NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp*.

Two New Educational Products Posted

Fact sheets:

- For providers who are organizations *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_FactSheet_Org_Provi_web_07-03-07.pdf*.
- For providers who are sole proprietors *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_FactSheet_Sole_Prop_web.pdf*.

Group Practices that Conduct Any HIPAA Standard Transactions MUST Have an NPI

A group practice that conducts any of the HIPAA standard transactions is a covered health care provider (a covered entity under HIPAA) and, as such, must obtain and use an NPI. The providers employed by the group practice, on the other hand, are only furnishing services at the group practice; they are not conducting any of the HIPAA standard transactions (such as submitting claims, checking eligibility and obtaining claim status electronically). Therefore, these employed providers are not covered health care providers and are not required by the NPI final rule to obtain NPIs. However, as a condition of employment, the group practice could require these providers to obtain NPIs so that the group practice can use them to identify the employed providers as the rendering providers in the claims that the group submits to health plans. If these physicians prescribe medications, the pharmacies may require their NPIs because the pharmacies may be required by health plans to include the NPIs of prescribers in their claims. Additionally, health plans may require enrolled physicians, or any other enrolled providers, to obtain NPIs in order to participate in those plans.

Important Information for Medicare Providers
Members of Group Practices Need NPIs for Medicare Purposes

Group practices that bill Medicare electronically are covered providers and are required by regulation to obtain and use NPIs to identify themselves as the billing and pay-to providers in Medicare claims. Medicare requires that providers who are identified as rendering providers in Medicare claims be identified by NPIs, whether or not they are covered providers. Therefore, group practices that are enrolled in Medicare will want to ensure that their members (physicians or other practitioners) obtain NPIs in order to ensure payments to the group practices by Medicare.

Issues with New CMS 1500 Form Version (08-05)

In 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised CMS-1500 (08- 05) to Medicare. This new version of the form was developed through a collaborative effort headed up by the National Uniform Claim Committee (NUCC). The American Medical Association (AMA) chairs the NUCC in consultation with the CMS. The committee includes representation from key provider and payer organizations, as well as standards setting organizations, one health care vendor, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

Although CMS prefers all claims be submitted to Medicare electronically, the Administrative Simplification Compliance Act (ASCA) provides for exceptions to the mandatory electronic claim submission requirement.

Therefore, Medicare must be prepared to receive and process paper claims. However, Medicare is not required to accept and process multiple versions of the CMS-1500 form.

Updated Information for Medicare Providers on National Provider Identifier, continued

CMS began accepting the revised CMS-1500 in January 1, 2007 with a planned cutoff of the old version Form CMS-1500 (12-90) on April 1, 2007. However, formatting issues, which were identified with CMS-1500 (08-05) printed stock and images sold by the Government Printing Office (GPO) forced CMS to extend the cut off date of the 12-90 version. CMS closely monitored the situation through our contractors and concluded that the formatting issue was solely limited to the GPO and, as such, moved forward with the planned phase out of the CMS-1500 (12-90) version. Beginning July 2, 2007, CMS began returning the 12-90 version of the form. However, it recently came to our attention that the GPO is still not in a position to accept and fill orders for the revised form. CMS recognizes that the ability to purchase the revised form is a critical factor in a provider's ability to comply with the July cut-off.

CMS research of the CMS-1500 has shown that the revised CMS-1500 (08-05) is widely available for purchase from print vendors. However, CMS is not able to recommend specific print vendors as this would be seen as creating a marketplace advantage. In order to assist providers in locating the CMS-1500 (08-05), CMS recommends:

- Use local print media directories to search for print vendors.
- Contact other providers to inquire on their source for the form.
- Search "CMS-1500 (08-05)" or "CMS-1500 08/05" via the Internet and locate online print vendors. Ask for samples before ordering to ensure that the formatting is correct.
- Contact the NUCC (*http://www.nucc.org*) for assistance.

Even though the CMS-1500 (08-05) experienced formatting difficulties, those issues were quickly resolved. Medicare contractors are currently receiving and processing the new CMS-1500 form without issue.

Therefore, CMS will continue to adhere to the July 2, 2007, mandatory cutoff of the CMS-1500 (12-90) version.

Note that in using the new CMS-1500 (08-05), if you previously populated boxes 17a (referring provider), 24j (rendering provider), and 33 (billing provider) with your legacy number, you should begin using your NPI also. If the information in block 33 (billing) is different than block 32 (service facility), you should populate block 32 with the address information.

Potential Issues Related to Clearinghouse Practices

It has come to CMS attention that some clearinghouses are stripping the NPI off the claim prior to its submission to Medicare. This could adversely affect Medicare providers in two ways. First, providers may be under the false impression that their claims are being successfully submitted to Medicare, through their clearinghouse, using an NPI. Second, without the NPI, these claims will not count toward PQRI participation for eligible professionals. Stripping of NPIs may also be occurring even though the NPI appears on remittance advice because some clearinghouses are adding the NPI to the remittance prior to sending to the provider. CMS urges Medicare providers that use clearinghouses to check with their clearinghouse to assure NPIs are not being stripped from claims. If the provider determines that their clearinghouse is stripping NPIs from the claim, the provider may wish to consider other billing options.

CMS has also become aware that some clearinghouses are not forwarding to providers NPI informational claim error messages being sent by Medicare carriers. Part B carriers currently use logic to bypass validating the NPI/legacy provider pair. While claims are being paid today based on the legacy identifier, these messages are designed to help the provider understand the problems Medicare is encountering in attempts to crosswalk the NPI to legacy identifiers. These informational messages are a critical measure of the extent to which a provider will experience rejected claims once the bypass logic is lifted. Providers who use clearinghouses should make sure they are in fact receiving NPI informational claim error messages so that issues can be addressed timely.

Reminder: Don't Miss This Important MLN Matters Article

A recent special edition *MLN Matters* article contains other important information for Medicare providers and suppliers, including how to use the NPI correctly on Part A and Part B claims. You may view this article by visiting the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf*.

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 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.

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

Source: CMS Provider Education Resource 200707-16

PREVENTIVE SERVICES

The Guide to Medicare Preventive Services Second Edition Is Now Available

The second edition of The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS), Medicare Learning Network (MLN). This comprehensive guide provides fee-for-services health care providers and suppliers with coverage, coding, billing and reimbursement information for preventive services and screenings covered by Medicare. This guide gives clinicians and their staffs the information they need to help them in recommending Medicare-covered preventive services and screenings that are right for their Medicare patients and provides information needed to bill Medicare effectively for services furnished.
To view this guide online, go to on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.

Source: CMS Provider Education Resource 200708-12 & 200708-13

Medicare Preventive Services—Quick Reference Information

The May 2007 *Quick Reference Information: Medicare Preventive Services* laminated chart is now available to order or download from the *Medicare Learning Network*. To order, go to the "*MLN* Product Ordering Page" located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* or to view online, go to *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf* on the CMS Web site.

Source: Provider Education Resources Listserv, Message 200707-19

GENERAL

August is National Immunization Awareness Month

Vaccines Aren't Just for Kids!

Too many adults become ill, disabled, and die each year from diseases that could have been prevented by vaccines. Everyone from the very young to senior citizens can benefit from immunizations. While many consider this to be a time to ensure that children are immunized for school, National Immunization Awareness month is the perfect time to remind patients, health care employees, family members, friends, co-workers, and others to take advantage of opportunities to get up-to date on their vaccinations.

Medicare covers both the cost of pneumococcal and influenza vaccine and their administration by recognized providers. No beneficiary coinsurance or copayment applies and a beneficiary does not have to meet his or her deductible to receive an influenza or pneumococcal immunization. Medicare also covers hepatitis B vaccination for persons at high or intermediate risk. The coinsurance or copayment applies for hepatitis B vaccination after the yearly deductible has been met.

Disease prevention is key to public health. It is always better to prevent a disease than to treat it. For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Medicare will cover a booster pneumococcal vaccine for high-risk persons if five years have passed since their last vaccination.

How Can You Help?

As a health care professional, you can help your Medicare patients and others understand the importance of disease prevention through immunizations. Your recommendation is the most important factor in increasing immunization rates among adults. You can help your Medicare patients take full advantage of the Medicare benefits that are right for them, including an annual influenza vaccination, a pneumococcal vaccination and the hepatitis B vaccination (for beneficiaries at high to intermediate risk for contracting the disease) by encouraging utilization of these benefits as appropriate.

For More Information

- For more information about Medicare's coverage of adult immunizations, including coverage, coding, billing and reimbursement, please visit the following CMS Web sites:
- The *MLN* Preventive Services Educational Products Web Page *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*
- Adult Immunizations *http://www.cms.hhs.gov/AdultImmunizations/01_Overview.asp#TopOfPage*
- For information to share with your Medicare patients, please visit *http://www.medicare.gov* on the Web.
- To learn more about National Immunization Awareness month, please visit *http://www.cdc.gov/vaccines/events/niam/default.htm#oview* on the Web.

Thank you for partnering with the Centers for Medicare & Medicaid Services as we strive to increase awareness and promote utilization of vaccines that can prevent infectious disease and save lives.

Source: Provider Education Resources Listserv, Message 200708-07

Claim Status Category Code and Claim Status Code Update

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 health care claim status transactions to Medicare contractors (carriers, Medicare administrative contractors [A/B MACs], durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and regional home health intermediaries [RHHIs]).

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5687, which provides the January 2008 updates of the claim status codes and claim status category codes for use by Medicare contractors (carriers, A/B MACs, DME MACs, FIs, and RHHIs).

CAUTION – What You Need to Know

Effective January 1, 2008, Medicare contractors are to use codes posted on July 9, 2007, at the *http://www.wpc-edi.com/codes* Web site. Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 – Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277 discusses these codes in more detail. You may review section 20.7 at: *http://www.cms.hhs.gov/manuals/downloads/clm104c31.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

GO – What You Need to Do

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

Background

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use claim status category and claim status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the version 004010X093A1 Health Care Claim Status Request and Response transaction. These codes indicate the general category of a claim status (accepted, rejected, additional information requested, and so on). The national code maintenance committee maintains the claim status category and claim status codes.

The national code maintenance committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at *http://www.wpc-edi.com/content/view/180/223/*. This page has previously been referenced by the following URL address: *http://www.wpc-edi.com/codes*. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2007 committee meeting were posted on that site on July 9, 2007. One of the decisions made during this June meeting by this maintenance committee was to allow the industry more lead time for implementation of code changes. At least six months lead-time will be allowed for industry implementation of all claim status-related code changes as well as claim adjustment reason code changes (the same committee maintains these code sets). As result, changes approved in June 2007 will be effective January 1, 2008.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5687) issued to your Medicare FI, carrier, DME MAC, RHHI or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1314CP.pdf* on the CMS Web site.

If you have questions, please contact your Medicare FI, carrier, DME MAC, RHHI 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: MM5687
Related Change Request (CR) #: 5687
Related CR Release Date: July 23, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1314CP
Implementation Date: January 7, 2008

Clarification About the Medical Privacy of Protected Health Information

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

Provider Types Affected

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

Provider Action Needed

The purpose of this special edition (SE) article, SE0726, is to be sure that heath care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health & Human Services (HHS) has published to clarify the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below. Remind individuals within your organization of:

- the privacy rule's protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
- that providers are permitted to disclose personal health information needed for patient care and other important purposes.

HHS Privacy Guidance

HHS' educational materials include a letter to healthcare providers with the following examples to clarify the privacy rule:

HIPAA Does Not Require Patients To Sign Consent Forms Before Doctors, Hospitals, or Ambulances Can Share Information for Treatment Purposes

Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization or jumping through other hoops. Clear guidance on this topic may be found in a number of places:

- Review the answers to frequently asked questions (FAQs) in the "Treatment/Payment/Health Care Operations" subcategory, or search the FAQs on a likely word or phrase such as "treatment." The link to the FAQs may be found at *http://www.hhs.gov/hipaafaq/* on the HHS Web site.
- Consult the Fact Sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," which is at *http://www.hhs.gov/ocr/hipaa/guidelines/sharingfortpo.pdf* on the HHS Web site.
- Review the "Summary of the HIPAA Privacy Rule" at *http://www.hhs.gov/ocr/privacysummary.pdf* on the HHS Web site.

HIPAA Does Not Require Providers to Eliminate All Incidental Disclosures

- The privacy rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that rule to clarify that incidental disclosures do not violate the privacy rule when providers and other covered entities have common sense policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.
- OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR Web site, see the FAQs in the "Incidental Uses and Disclosures" subcategory; search the FAQs on terms like "safeguards" or "disclosure"; or review the Fact Sheet on "Incidental Disclosures". The fact sheet is at *http://www.hhs.gov/ocr/hipaa/guidelines/incidentalud.pdf* on the HHS Web site.

HIPAA Does Not Cut off All Communications Between Providers and the Families and Friends of Patients

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.
- The privacy rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient's care, about the patient's location or general condition.
- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.
- Review the HHS/OCR Web site FAQs *http://www.hhs.gov/hipaafaq/notice/488.html* in the sub-category "Disclosures to Family and Friends."

HIPAA Does Not Stop Calls or Visits to Hospitals by Family, Friends, Clergy or Anyone Else

- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient's phone and room number, and general health condition.
- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.
- See the FAQs in the "Facility Directories" at *http://www.hhs.gov/hipaafaq/administrative/* on the HHS Web site.

HIPAA Does Not Prevent Child Abuse Reporting

Doctors can continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which may be found, for instance, by searching on the term "child abuse;" or review the fact sheet on "Public Health" that may be reviewed at *http://www.hhs.gov/ocr/hipaa/guidelines/publichealth.pdf* on the HHS Web site.

Clarification About the Medical Privacy of Protected Health Information, continued

HIPAA Is Not Anti-Electronic

Doctors can continue to use e-mail, the telephone, or fax machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the privacy rule went into effect. A helpful discussion on this topic may be found at *http://www.hhs.gov/hipaafaq/providers/smaller/482.html* on the HHS Web site.

Additional Information

The HHS complete listing of all HIPAA medical privacy resources is available at *http://www.hhs.gov/ocr/hipaa/* on the HHS Web site.

For a full list of educational materials, visit *http://www.hhs.gov/ocr/hipaa/assist.html* on the HHS Web site.

MLN Matters Number: SE0726
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

2007 Physician Quality Reporting Initiative Update

It's been one month since reporting quality data codes for the 2007 Physician Quality Reporting Initiative (PQRI) on claims for dates of service starting July 1 through December 31, 2007 began.

Eligible professionals participating in the 2007 PQRI indicate that the PQRI tool kit and data collection worksheets are an asset to successful reporting. Provider organizations report successful reporting by their members. Information about the 2008 PQRI was released in the *Notice of Proposed Rulemaking* for the 2008 Medicare physician fee schedule (MPFS).

To ensure successful reporting, the Centers for Medicare & Medicaid Services (CMS) brings to your attention the following items:

Use of Modifiers with PQRI Quality Data Codes

The PQRI quality data codes should only be reported with ***CPT* II modifier(s) 1P, 2P, 3P or 8P,** if applicable. If any other modifier, i.e., *CPT* I modifier or HCPCS Level II modifier, is placed on the same line as a PQRI code, it may cause the claim to be rejected or denied as an invalid procedure/modifier combination.

PQRI Letter to Medicare Beneficiaries

CMS has posted a letter to Medicare beneficiaries with important information about the PQRI on the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

The letter is from Medicare to the patient explaining what the program is, and the implications for the patient. Physicians may choose to provide a copy to their patients in support of their PQRI participation.

Question of the Week

Question: The 1.5 percent bonus is subject to a cap. How and when will CMS calculate the cap for an individual eligible professional?

Answer: The bonus cap calculation is defined as follows: the individual's instances of reporting quality data multiplied by 300 percent multiplied by the national average per measure payment. The third factor, the "national average per measure payment amount" may only be calculated after the reporting period ends (because it is equal to the total amount of allowed charges under the MPFS for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program) divided by the total number of instances (where data were reported by all participants in the program for all measures during the reporting period).

Because the "national average per measure payment amount" is not yet available, the following is a hypothetical example:

Example:

Dr. Smith had $400,000 in allowed charges during the PQRI reporting period.

The 1.5 % potential bonus is $6000.

Dr. Smith reported quality data codes in 500 instances.

The national average per measure payment amount for 2007 was calculated in calendar year (CY) 2008 and turned out to be $100 ($100 M total national allowed charges claims submitted from July through December, divided by, 1 million instances of PQRI quality data codes being reported in the same time period).

2007 Physician Quality Reporting Initiative Update, continued

The cap for Dr. Smith is $150,000 (500 x 3 x $100).

The bonus paid to Dr. Smith in early CY 2008 is $6,000.

How to View the Measures and Specifications

To view the entire list of 2007 PQRI quality measures and the associated measure specifications, visit the PQRI Web site at, *http://www.cms.hhs.gov/PQRI*, and click on the "Measures/Codes" section of the page.

How to View the List of Eligible Professionals

To see the complete list of eligible professionals who may choose to participate in the 2007 PQRI, visit the PQRI Web site at *http://www.cms.hhs.gov/PQRI*, and click on the "Eligible Professionals" section of the page.

PQRI Resources

New information is continually added to the most reliable source of information for the 2007 PQRI, the CMS Web site, *http://www.cms.hhs.gov/PQRI*. Here you will find new and revised *Frequently Asked Questions*, updates on issues related to both the 2007 and 2008 PQRI, new educational products, and access to the latest information you need to successfully participate in the 2007 PQRI.

General Information

Rejected Claims

Contractors can reject Medicare fee-for-service claims for a variety of reasons including:

- Incorrect billing information
- Terminated provider
- Beneficiary is not eligible for Medicare
- Claim was sent to the wrong contractor.

If a provider has questions about a claim rejected by a Medicare fiscal intermediary, carrier or administrative contractor, the provider should contact the contractor directly. It is never appropriate to direct the beneficiary who received the service billed on the claim to the 1-800-Medicare toll free line to resolve a claim rejection.

Source: CMS Provider Education Resource 200708-08

Reasons for Provider Notification of Medicare Claims Disputed/Rejected by Supplemental Payers/Insurers

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], Medicare administrative contractors [A/B MACs], and durable medical equipment MACs [DME MACs]).

Provider Action Needed

Effective for claims processed on or after July 1, 2007, when claims crossed over by Medicare to a supplemental payer/insurer are rejected or disputed by that insurer, Medicare will add a standardized message to the notification to the provider. That message will be in the form of a dispute reason code, which will explain why the supplemental insurer disputed the claim. Be sure your billing staff is aware of these codes, as described later in this article, and is ready to take corrective action, as appropriate.

Background

In *MLN Matters* article, MM3709, the Centers for Medicare & Medicaid Services (CMS) describes the notification process to Medicare providers when Medicare claims that should automatically cross to a supplemental payer/insurer-are not crossed over due to claim data errors. The notification is mailed to the correspondence address that is submitted by the provider, along with all other Medicare enrollment data, and is maintained by CMS' Medicare contractors. (MM3709 may be referenced at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3709.pdf* on the CMS Web site.)

There are also situations where provider notifications are sent after the claim has crossed to the supplemental payer/insurer. This occurs in situations where the insurer may not be able to process the Medicare claim for supplemental payment and, therefore, rejects or disputes the claim back to CMS' Coordination of Benefits Contractor (COBC). When these situations occur, the COBC transmits a report containing the "disputed" claims to the Medicare contractor, which then notifies the provider, through a special automated correspondence, that the claim was not crossed automatically.

Beginning in July 2007, provider notifications will include standardized language for claims that have been disputed by the supplemental payer/insurer and the dispute has been accepted by the COBC. The standardized language will read: "Claim rejected by other insurer," and it will include a reason code. The following is a list of the reason codes that may be contained in the standardized language and the definition of each.

Dispute Reason Codes

- 000100 – Duplicate Claim
- 000110 – Duplicate Claim (within the same ISA – IEA loop)
- 000120 – Duplicate claim (within the same ST-SE loop)
- 000200 – Claim for Provider ID/State should have been excluded
- 000300 – Beneficiary not on eligibility file
- 000400 – *Reserved for future use*
- 000500 – Incorrect claim count
- 000600 – Claim does not meet selection criteria
- 000700 – HIPAA Error
- 009999 – Other

When Medicare providers receive this notification, they may need to take appropriate action to obtain payment from the supplemental payer/insurer for all dispute reason codes **except** for 000100, 000110, 000120, and 000400.

Additional Information

If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number 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).

Reasons for Provider Notification of Medicare Claims Disputed/Rejected by Supplemental Payers/Insurers, continued

MLN Matters Number: SE0728
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

The 2007 Medicare Contractor Provider Satisfaction Survey Shows Positive Results for Medicare's Fee-for-Service Contractors

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

Provider Types Affected

All Medicare physicians, providers, and suppliers billing the Medicare program.

Provider Action Needed

No action is needed. This article is informational only and provides a summary of the findings from the second annual survey by Medicare to assess provider satisfaction with service from Medicare contractors (carriers, fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]).

Background

The Centers for Medicare & Medicaid Services (CMS) reports that most Medicare health care providers continue to find satisfaction with the services provided by Medicare contractors.

The Medicare Contractor Provider Satisfaction Survey (MCPSS), recently conducted by CMS for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The survey revealed that 85 percent of respondents rated their contractors between four and six on a six-point scale, with "one" representing "not at all satisfied" and "six" representing "completely satisfied." The national average score for 2007 is 4.56.

Contractors received an overall composite score for the seven business functions of the provider-contractor relationship: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. For all contractor types, a contractor's handling of provider inquiries surpassed claims processing as the key predictor of a provider's satisfaction. CMS has provided contractors information for process improvement based on individual MCPSS results.

The MCPSS was sent early this year to more than 36,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. The survey was expanded this year to include hospice locations and federally qualified health centers.

The full results of the 2007 survey are now available at *http://www.cms.hhs.gov/MCPSS* on the CMS Web site.

In January 2008, the next MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2008 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

Additional Information

Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, contact your contractor at their toll free number, which is available 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: SE0733
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

The Medicare Physician Guide July 2007 Version Is now Available

The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals (July 2007 version) may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf*.

This guide offers general information about the Medicare program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, fraud, abuse, inquiries, overpayments, and appeals. The Facilitator's Guide, companion to the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* that includes all the information and instructions necessary to prepare for and present a Medicare resident, practicing physician, and other health care professional training program, is also now available at *http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=facilitator&filterByDID=0&sortByDID=1&itemID=CMS061390&intNumPerPage=10*.

The *Medicare Billing Information for Rural Providers, Suppliers, and Physicians*, which consists of charts that provide billing information for rural health clinics, federally qualified health centers, skilled nursing facilities, home health agencies, and critical access hospitals, is available at *http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf*.

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

Source: CMS Provider Education Resource 200708-11

Unsolicited/Voluntary Refunds

All Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open accounts receivable). Intermediaries generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds. The Centers for Medicare & Medicaid Services reminds providers that:

> "The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

Source: CMS Pub 100-6 Transmittal 50, CR 3274

Use of Nine-Digit ZIP Codes for Establishing Payment Locality

Effective for dates of service **on or after October 1, 2007,** providers must submit a valid nine-digit ZIP code when billing for anesthesia services and services paid under the Medicare physician fee schedule when the services are provided in those ZIP code area that falls into more than one payment locality, except for services provided in place of service (POS) "Home," and for any other places of service that contractors currently consider to be the same as "Home." (Currently, there is no requirement for the submission of a ZIP code when the POS is "Home.") Failure to comply will result in the claim being returned unprocessable.

The affected nine-digit ZIP codes that cross payment localities in Florida are:

32948 33440 33917 33920 33955 33972 34141 34142 34972 34974

Connecticut is not impacted by this change.

For information about the use of nine-digit ZIP codes, payment determination and exceptions see the revised *MLN Matters* article related to change request CR 5208, published in the April 2007 *Medicare B Update!* (pages 60-62).

Source: CMS Pub. 100-04, Transmittal 1193, CR 5208

Sign up to our *eNews* electronic mailing list

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

LOCAL COVERAGE DETERMINATIONS

Unless otherwise indicated, articles apply to both Connecticut and Florida.

This section of the *Medicare B Update!* features summaries of new and revised local coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text LCDs on our provider education Web sites, *http://www.connecticutmedicare.com or http://www.floridamedicare.com*. Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new LCDs are posted to the Web site, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *http://www.connecticutmedicare.com or http://www.floridamedicare.com* , click on the "eNews" link on the navigational menu and follow the prompts.

More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Local Coverage Determinations - Table of Contents

Advance 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.

LCD Revision

Vagal Nerve Stimulation for Seizures and Resistant Depression

The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual System, Pub. 100-03 Medicare *National Coverage Determinations (NCD) Manual*, Chapter 1, Section 160.18 B and C indicates the following:

- *Effective for services performed on or after July 1, 1999, VNS is reasonable and necessary for patients with medically refractory partial onset seizures for whom surgery is not recommended or for whom surgery has failed.*
- *Effective for services performed on or after July 1, 1999, VNS is not reasonable and necessary for all other types of seizure disorders which are medically refractory and for whom surgery is not recommended or for whom surgery has failed.*
- *Effective for services performed on or after May 4, 2007, VNS is not reasonable and necessary for resistant depression.*

Based on the indications in the above NCD, only ICD-9-CM codes 345.41 (Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures with intractable epilepsy) and 345.51 (Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures with intractable epilepsy) will be covered for seizures. *CPT* codes *61885*, *61886*, *64573*, *64585*, *64590*, *64595*, *95970*, *95971*, *95974*, and *95975* billed for Vagal Nerve Stimulation (VNS) for all other types of seizure disorders are not considered reasonable and necessary.

In addition, based on the above NCD, VNS for resistant depression is not considered reasonable and necessary. The local coverage determination (LCD) for Vagal Nerve Stimulation (VNS) for Intractable Depression (*61885*) showing noncoverage of specific *CPT* codes and ICD-9-CM codes for depression is available through our provider education websites at *http://wwwconnecticutmedicare.com* or *http://www.floridamedicare.com*.

Additional Information

Descemet's Stripping Endothelial Keratoplasty—Coding and Billing

Keratoplasty is the general term for several variants of corneal transplant. A newer procedure is termed 'Descemet's stripping endothelial keratoplasty' (DSAEK), and is also known as deep lamellar endothelial keratoplasty. This procedure involves a small incision to allow intraocular placement of endothelium harvested from a donor cornea after the stripping off of diseased corneal endothelium. Microkeratome-based (automated) preparation of the donor endothelium may be used. This technique offers certain clinical advantages while achieving the goal of penetrating keratoplasty in patients with disease largely related to endothelial dysfunction. The beneficiary should be thoroughly educated about the benefits and risks of this modality.

The new Descemet's stripping procedure should be billed using *CPT* code *66999* (*Unlisted procedure, anterior segment of eye*), as a unique *CPT* code does not currently exist which describes this service. Please enter 'DSAEK' in Item 19 of the CMS-1500 or its electronic equivalent. Also, remember to use the appropriate modifiers when performing the service on both eyes.

Documentation in the medical record must include the following: patient's history and physical, office/progress notes and operative report. This documentation must also support the medical necessity of the procedure performed. Please note, the assignment of an unlisted code does not guarantee Medicare coverage or payment for services billed. In addition, providers should not submit this information with the claim. First Coast Service Options, Inc. (FCSO) may request it separately with an additional documentation request (ADR) letter.

Note that keratoplasty procedures primarily for refractive correction and radial keratotomy are **not** covered by Medicare. (See Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual System, Pub. 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 1, Section 80.7).

Anytime there is a question whether Medicare's medical reasonableness and necessity criteria would be met, we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed *CPT* codes. For further details about CMS' Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*. Please note that services that lead up to or are associated with noncovered services are not covered as well.

CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

September 2007

Hot Topics Teleconference

Topics based on data analysis; session includes discussion of changes in the Medicare program

When: September 12, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Provider Outreach & Education Advisory Group Meeting

For membership information, visit the POE AG page on *http://www.connecticutmedicare.com*

When: September 18, 2007
Location: CT Hospital Association, Wallingford, CT
Time: 8:30 a.m. – 10:30 a.m.
Type of Event: In-person

Two Easy Ways To Register!

Online - To register for this seminar, please visit our new training website 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 - Providers without Internet access can leave a message on our Registration Hotline at 203-634-5527 requesting a fax registration form.

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: _____

FLORIDA EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

September 2007

Hot Topics Teleconference – Topics to be determined

When: September 13, 2007
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.

Hearings

If you believe that your redetermination was incorrect and want it reviewed by a Hearing Officer, send your inquiry to the attention of the Hearing Department. A request for a hearing must be made within six months of the date of the Review Department determination and at least $100.00 must remain in controversy from this decision.

Post Office Box for Appeals/Hearings:

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

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:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and Abuse
First Coast Service Options, Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Florida Medicare Phone Numbers

PROVIDERS

Toll-Free
Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992

BENEFICIARY

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

For Education Event Registration (*not* toll-free)**:**
1-904-791-8103

EMC

Format Issues & Testing:
1-904-354-5977 option 4
Start-Up & Front-End Edits/Rejects:
1-904-791-8767 option 1
Electronic Funds Transfer
1-904-791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
PC-ACE Support:
1-904-355-0313
Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
Help Desk:
(Confirmation/Transmission):
1-904-905-8880 option 1

DME, ORTHOTIC OR PROSTHETIC CLAIMS

Cigna Government Services
1-866-270-4909

MEDICARE PART A

Toll-Free:
1-866-270-4909

Medicare Web sites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com

Centers for Medicare & Medicaid Services
www.cms.hhs.gov

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

ORDER FORM — 2008 PART B MATERIALS

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO with the designated account number indicated below.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *http://www.fcso.com*. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2007 through September 2008.	700395	Hardcopy $60.00		
		CD-ROM $20.00		
2008 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2008 through December 31, 2008, is available free of charge online at *http://www.fcso.com*. Additional copies or a CD-ROM is available for purchase. The Fee Schedule contains calendar year 2008 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare Part B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	Hardcopy: FL $12.00		
		Hardcopy: CT $12.00		
		CD-ROM: FL $6.00		
		CD-ROM CT $6.00		
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

First Coast Service Options, Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Please make check/money order payable to: FCSO Account # (fill in from above)
(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

Medicare B Update!

First Coast Service Options, Inc.
P.O. Box 2078 Jacksonville, FL 32231-0048 (Florida)
P.O. Box 44234 Jacksonville, FL 32231-4234 (Connecticut)

*** ATTENTION BILLING MANAGER ***