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 websites, subscribe to our *FCSO eNews* mailing list. It's very easy to do. Simply go to the website 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.
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The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider education websites: *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*.

Routing Suggestions:

- ❑ Physician/Provider
- ❑ Office Manager
- ❑ Billing/Vendor
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_____

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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://wwwfloridamedicare.com*. It's very easy to do. Simply go to the Web site, click on the "eNews" link on the navigational menu and follow the prompts.

Medicare B Update!

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

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

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

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

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

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education 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 website(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM.

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

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

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

Clear Identification of State-Specific Content

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

Publication Format

The *Update!* is arranged into distinct sections.

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

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

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

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

Advance Beneficiary Notices

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

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

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

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

Patient Liability Notice

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

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

Tips to Expedite your Medicare Enrollment Process

Medicare Enrollment Applications/Forms (**CMS-855A, CMS-855B, CMS-855I, CMS-855R and CMS-855S, 06/06 versions**) submitted to First Coast Service Options, Inc. (FCSO) must be completed with accurate information and must have all supporting documentation attached. FCSO Provider Enrollment staff will review all submitted applications, and as necessary, will send a letter asking for additional information and/or documentation. The following tips regard the most common reasons for which FCSO **must** request additional information and/or documentation.

1. **Ensure the name reflected on your National Provider Identifier (NPI) application form identically matches your legal business name.**

   Access the following Web site address or phone number to validate that the legal business name the Internal Revenue Service (IRS) has for you (CP-575) matches the business name registered with the National Plan & Provider Enumeration System (NPPES): *https://nppes.cms.hhs.gov/NPPES/Welcome.do*, 1-800-465-3203 or 1-800-692-2326 for TTY services.

   Applying for an NPI is a separate process from requesting provider enrollment in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) **requires** that providers and suppliers obtain their NPI prior to enrolling for, or updating, their Medicare enrollment information. Based on this regulation, **each** enrollment application form (initial applications and changes/updates) **must** include your NPI and a copy of the NPI notification from the NPI contractor. If your NPI and the NPI notification letter are not submitted, your enrollment into the Medicare program will be delayed.

   FCSO will send a letter to the c**ontact person** you named in Section 13 of the enrollment application, **or** if there is no contact person listed, the letter will be sent to your **correspondence address.**

2. **Attach a copy of your Internal Revenue Service (IRS) CP-575 form.**

   The IRS CP-575 is a letter you receive from the IRS granting your employer identification number (EIN). This IRS form reflects your legal business name. It also provides proof of your employer tax identification number (TIN), which is required for FCSO's Medicare records.

   Medicare records **must** have a written confirmation from the IRS validating your TIN with your legal business name. Acceptable tax documents **must be generated or pre-printed by the IRS**. Examples of acceptable documentation are IRS CP-575, IRS Form 8109 and IRS substitute letter 147C. A W-9 **is not** acceptable documentation.

3. **Attach a copy of your Electronic Funds Transfer (EFT) Authorization Agreement (CMS-588 – not to be confused with CMS-855 enrollment forms).**

   FCSO requires this form if you are submitting an initial Provider Enrollment Application **or** a change to an existing Medicare provider number that has not previously been set up for EFT. Remember to **also include** a copy of a voided check and/or a deposit slip. Be aware that with the EFT authorization, Medicare can send payments directly to your financial institution whether claims are filed electronically or on paper.

   Note: FCSO has determined that some banks may not use the routing number located at the bottom of your pre-printed check or deposit ticket for direct deposits but may use the automated clearing house (ACH) number located elsewhere on the check or deposit ticket. Please check with your bank for the proper number to report as the routing number on your EFT form.

4. **Read each section of the application form(s)**

   For each section of the Provider Enrollment forms, CMS has provided detailed instructions. Ensure that, where applicable, boxes are checked, signatures (in ink) are provided and all required fields have been completed.

5. **Include copies of all professional and business licenses.**

   Examples include but are not limited to:

   - Licenses, certifications and registrations required by state, city and/or county boards (i.e., State of Connecticut Professional License, CRNA Recertification, FDA Mammography Certification, CLIA, Diabetes Education Certificate)
   - Certified Registered Nurse Anesthetists Licenses (*http://www.aana.com*)
   - Provisional licenses

6. **Obtain other helpful information**

   - Within the instructions in the "Medicare Enrollment Application" itself. See "Tips," and Section 17 "Supporting Documents."
   - From your Medical Association or Medical Society.
   - At the CMS Web site (*http://www.cms.hhs.gov/*).

7. **Send all Provider Enrollment Applications to the following address:**

   First Coast Service Options, Inc.
   P.O. Box 45010
   Jacksonville, Florida 32232-5010

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.*

Step-By-Step Directions To Completing CMS-855R Application

Section 1

Did you check **only one box** on Page 3 (Basic Information)?

o Yes

Did you fill in the **"required sections"** denoted to the right side of the box you checked?

o Yes

Section 2

Did you provide the requested information for the supplier to whom benefits are being reassigned, or reassignment is being terminated.

o Yes

Did you denote "pending" in the Medicare identification number block on your application **if** the supplier's initial enrollment application was submitted concurrently with this application?

o Yes

Note: The supplier's name as reported to the IRS must match what was reported on the supplier's CMS-855B when it enrolled. The NPI in this section is the NPI associated with the group.

Section 3

Did you complete all portions of this section?

o Yes

Did you denote "pending" in the Medicare Identification Number block on your application **if** your initial enrollment application is being submitted concurrently with this reassignment application?

o Yes

Note: The NPI in this section is the NPI associated with the **individual** who is reassigning benefits.

Section 4

Did the individual practitioner complete and sign (in ink) Section 4A on Page 5?

o Yes

Note: All signatures **must** be originals.

Did the authorized or delegated official complete and sign (in ink) Section 4B on Page 5?

o Yes

Note: All individuals who allow another supplier to receive payment for their services must sign the Reassignment of Benefits Statement. **All signatures must be originals.**

Section 7

Did you complete Section 7 (on page 6), with the Contact Person information?

o Yes

Your Application Contact Information

The following chart describes when and how FCSO will contact providers based on the contact information provided in your enrollment application.

Contact Type	During the Enrollment Process	Once Provider/Supplier Is Enrolled
Contact Address	Used as a first contact for all for additional information requests.	
Correspondence Address	Used for additional information requests if the contact information on the application is incomplete.	
Pay-to Address	Used to send remittance to providers and or to notify groups and individual practitioner of approval/denial into the Medicare program.	Used to request additional claim information and or to send remittance advices and checks to providers. **Note:** Upon request from the provider/supplier, requests for additional claim information may be sent to the practice address.

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Step-By-Step Directions To Completing CMS-855I Application

Section 1

If you are a **physician's assistant**, did you fill in **both** your Medicare Identification Number (if issued) and your National Provider Identifier (NPI) on Page 4, Section 1A, in the two spaces provided within the first paragraph at the top of the page?

o Yes

If you are reassigning all of your Medicare benefits (per section 4B1 of this application), did you furnish **both** your Medicare Identification Number (if issued) and your National Provider Identifier (NPI) on Page 4, Section 1A, in the two spaces provided within the second paragraph at the top of the page?

o Yes

Did you check **only one box** on pages 4 & 5, Section 1A (Basic Information)?

o Yes

Did you fill in the **"required sections"** denoted to the right side **of the box** you checked?

o Yes

Did you check **one or more** boxes on Page 5, Section 1B (Basic Information)?

o Yes

Did you fill in the **"required sections"** denoted to the right side of **each** box you checked?

o Yes

Section 2

Did you fill in your personal information on Page 6 in Section 2A, (Identifying Information), relative to yourself as well as to your license and certification information?

Types of Licenses required are:

- CRNA (*http://www.aana.com*)
- Professional License

o Yes

Did you provide your correspondence address (**not** a billing agency's address) for Section 2B, on Page 6?

o Yes

Note**:** **This address** cannot **be your billing agency address.**

Did you complete questions 1-4 in Section 2C (Resident/Fellow Status) on Page 7, if you are currently in an approved training program as a **Resident** or are in a **Fellowship** program?

o Yes

If you are **not** in an approved training program, did you answer **"no"** to questions 1a and 1b?

o Yes

Did you designate your primary specialty (**only one**) and your secondary specialties (**one or more**) on Page 8, Section 2D (Medical Specialties), Question 1.

o Yes

If applicable, did you designate your nonphysician specialty on Page 9, Section 2D, Question 2.

o Yes

Note: **An additional CMS-855I** must **be completed for** each **nonphysician specialty type.**

If you are, or were, a **physician's assistant**, did you fill in the required information on Page 10, Sections E, F and G?

o Yes

Note: In Section 2E the employer's and physician's NPI must be listed. Additionally, ensure that the name corresponding with your NPI is your legal business name as reported to the IRS and that it matches exactly. This includes any spacing or punctuation. If not, contact NPPES (*https://nppes.cms.hhs.gov/NPPES/Welcome.do*) and request the update.

Did you respond "yes" or "no" regarding whether or not you hold a doctoral degree in **Psychology** in Section 2H on Page 11?

o Yes

If you checked "yes," did you provide a copy of your degree with this application?

o Yes

Step-By-Step Directions To Completing CMS-855I Application, continued

Did you complete Section 2I (questions 1-4) on Page 11, if you are a **psychologist** billing independently.

o Yes

Did you complete Section 2J (questions 1-5) on Page 11, if you are a **physical** or **occupational therapist** in private practice?

o Yes

If you responded "yes" to any question numbered 2-5, did you attach a copy of the lease agreement for your facility usage?

o Yes

Did you respond "yes" or "no" regarding whether or not you are an employee of a Medicare **skilled nursing facility** (SNF) or an employee of another entity that has an agreement to provide **nursing services** to a SNF in Section 2K on Page 11?

o Yes

If you answered "yes," did you provide the name and address of the applicable SNF?

o Yes

Section 3

Did you report any adverse legal actions that have been imposed against you in Section 3 (Adverse Legal Actions/ Convictions) Page 13?

o Yes

If yes, did you attach a copy of the adverse legal documentation and its resolution?

o Yes

Note: Your application will be considered incomplete if the information is missing or you enter "not applicable."

Section 4

Did you complete Section 4A on Page 14, if you are the **Sole Owner** of a **Professional Corporation**, a **Professional Association**, or a **Limited Liability Company** intending to bill Medicare through this business entity?

o Yes

Note: **Section 4A** – Ensure that the name corresponding with your NPI is your legal business name as reported to the IRS and that it matches exactly. If not, contact NPPES (*https://nppes.cms.hhs.gov/NPPES/Welcome.do*) and request the update.

Has your organization, under any **current or former** name or business identity ever had any adverse legal actions that have been imposed against it (Page 14, Section 4 under "Adverse Legal History," Questions 1 & 2)?

o Yes

If yes, did you attach a copy of the adverse legal documentation and its resolution?

o Yes

On Page 15, Section 4B, Questions 1 & 2, did you indicate (yes or no) that your services (all/any) will be rendered as part of a group or organization to which you will reassign your benefits?

o Yes

If **any** or **all** of the services you render will be as part of a group or organization to which you will reassign your benefits, did you furnish the name(s), Medicare Identification Number(s) and NPIs of each group or organization?

o Yes

Note: If **all** of your services will be rendered as part of a group and you will reassign your benefits, check yes in this section and proceed to section 13. If you check no, proceed with the application.

If **any** (meaning you work for a group and have an individual practice location) of your services will be rendered as part of a group and you will reassign your benefits, complete this section and proceed to section 4C.

Did you fill in the appropriate spaces in Section 4C (changes/additions/deletions) on Page 16 regarding your solo practice or your organization's practice location(s)?

o Yes

Note: If you as a sole practitioner or your organization sees patients in more than one location, complete this section for each location. **The NPI in this section will be the NPI associated with you individual name and social security number.**

Did you fill in the requested information on Page 17, Section 4D, for all locations where health care services are rendered in patients' homes?

o Yes

Step-By-Step Directions To Completing CMS-855I Application, continued

Did you fill in Section 4E on Page 18 regarding your option to have your special payment address mirror your practice location address, or to be different from that?

o Yes

Note: For electronic fund transfer (EFT), include CMS-588 for initial enrollments and/or if you are making changes to an existing Medicare provider number that has not already been set up for EFT. **Remember to include a voided check and/or deposit slip.**

Did you provide your employer identification number (EIN) in Section 4F (Employer ID Number Information), Page 18 in order for your Medicare payments to be reported under your EIN?

o Yes

Did you provide the storage facilities address where you maintain your medical records on Pages 19, Section 4G (if it's different than your practice/physical location)?

o Yes

Did you explain any unique circumstances concerning your practice locations or the method by which you render health care services in Section 4H on Page 19?

o Yes

Section 6

Did you include the name(s) of **all** managing employees at **any** of your practice locations (practice locations were indicated previously in Section 4) on Page 20, Section 6A?

o Yes

Note: If you have more than one managing employee, this section must be completed for each.

Did you identify any adverse legal actions that have been imposed against any managing employees indicated above (Section 6B, Page 20)?

o Yes

If yes, did you attach a copy of the adverse legal action documentation and resolution?

o Yes

Section 8

Did you complete Section 8 on Page 21 with information specific to the billing agency you utilize?

o Yes

Note: If you do **not** use a billing agency, you can continue with Section 13 on Page 22). **Make sure** that you have first checked the box stating, "check here if this section does not apply."

Section 13

Did you complete Section 13 on page 22, with the contact person information?

o Yes

Section 14

Did you read Section 14 on pages 23 & 24 to ensure your understanding of the penalties for falsifying Medicare information?

o Yes

Section 15

Did you complete the Certification Statement in Section 15 (Page 26)?

o Yes

Note: All signatures must be original. The use of blue ink is preferred.

Section 17

Did you read Section 17 on page 27 to ensure that you have submitted correct and complete supporting documentation?

o Yes

Your Application Contact Information

The following chart describes when and how FCSO will contact providers based on the contact information provided in your enrollment application.

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Pay-to Address	Used to send remittance to providers and or to notify groups and individual practitioner of approval/denial into the Medicare program.	Used to request additional claim information and or to send remittance advices and checks to providers. **Note:** Upon request from the provider/supplier, requests for additional claim information may be sent to the practice address.

INFORMATION FOR FLORIDA PROVIDERS

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1. **Ensure the name reflected on your National Provider Identifier (NPI) application form identically matches your legal business name.**

   Access the following Web site address or phone number to validate that the legal business name the Internal Revenue Service (IRS) has for you (CP-575) matches the business name registered with the National Plan & Provider Enumeration System (NPPES): *https://nppes.cms.hhs.gov/NPPES/Welcome.do*, 1-800-465-3203 or 1-800-692-2326 for TTY services.

   Applying for an NPI is a separate process from requesting provider enrollment in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) **requires** that providers and suppliers obtain their NPI prior to enrolling for, or updating, their Medicare enrollment information. Based on this regulation, **each** enrollment application form (initial applications and changes/updates) **must** include your NPI and a copy of the NPI notification from the NPI contractor. If your NPI and the NPI notification letter are not submitted, your enrollment into the Medicare program will be delayed.

   FCSO will send a letter to the c**ontact person** you named in Section 13 of the enrollment application, **or** if there is no contact person listed, the letter will be sent to your **correspondence address.**

2. **Attach a copy of your Internal Revenue Service (IRS) CP-575 form.**

   The IRS CP-575 is a letter you receive from the IRS granting your employer identification number (EIN). This IRS form reflects your legal business name. It also provides proof of your employer tax identification number (TIN), which is required for FCSO's Medicare records.

   Medicare records **must** have a written confirmation from the IRS validating your TIN with your legal business name. Acceptable tax documents **must be generated or pre-printed by the IRS**. Examples of acceptable documentation are IRS CP-575, IRS Form 8109 and IRS substitute letter 147C. A W-9 **is not** acceptable documentation.

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   FCSO requires this form if you are submitting an initial Provider Enrollment Application **or** a change to an existing Medicare provider number that has not previously been set up for EFT. Remember to **also include** a copy of a voided check and/or a deposit slip. Be aware that with the EFT authorization, Medicare can send payments directly to your financial institution whether claims are filed electronically or on paper.

   Note: FCSO has determined that some banks may not use the routing number located at the bottom of your pre-printed check or deposit ticket for direct deposits but may use the automated clearing house (ACH) number located elsewhere on the check or deposit ticket. Please check with your bank for the proper number to report as the routing number on your EFT form.

4. **Read each section of the application form(s)**

   For each section of the Provider Enrollment forms, CMS has provided detailed instructions. Ensure that, where applicable, boxes are checked, signatures (in ink) are provided and all required fields have been completed.

5. **Include copies of all professional and business licenses.**

   Examples include, but are not limited to:

   - Occupational licenses – Check with your city and county for applicable licensure requirements
   - Licenses, certifications and registrations required by your state, city and/or county boards (e.g., State of Florida Professional License, CRNA Recertification, Health Care Clinic Licenses, Radiation Control License, FDA Mammography Certification, CLIA, Diabetes Education Certificate)
   - Certifications and/or registrations required to operate a health care facility
   - Health care clinic licenses (*http://www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/HealthCareClinic/index.shtml*)
   - Certified registered nurse anesthetists licenses (*http://www.aana.com*)
   - Provisional licenses

6. **Obtain other helpful information**

   - Within the instructions in the "Medicare Enrollment Application" itself. See "Tips," and Section 17 "Supporting Documents."
   - From your Medical Association or Medical Society.

Tips to Expedite your Medicare Enrollment Process!, continued

- At the CMS Web site (*http://www.cms.hhs.gov/*).
- At the Florida State Requirements Web site (*http://www.doh-mqaservices.com/*).
- At the Florida Department of Business and Professional Regulations Web site (*http://www.myflorida.com/*)

7. Send all Provider Enrollment Applications to the following address:

First Coast Service Options, Inc.
P.O. Box 44021
Jacksonville, Florida 32231-4021

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.*

Step-By-Step Directions To Completing CMS-855R Application

Section 1

Did you check **only one box** on Page 3 (Basic Information)?

o Yes

Did you fill in the **"required sections"** denoted to the right side of the box you checked?

o Yes

Section 2

Did you provide the requested information for the supplier to whom benefits are being reassigned, or reassignment is being terminated.

o Yes

Did you denote "pending" in the Medicare identification number block on your application **if** the supplier's initial enrollment application was submitted concurrently with this application?

o Yes

Note: The supplier's name as reported to the IRS **must match** what was reported on the supplier's CMS-855B when it enrolled. **The NPI in this section is the NPI associated with the group.**

Section 3

Did you complete all portions of this section?

o Yes

Did you denote "pending" in the Medicare Identification Number block on your application **if** your initial enrollment application is being submitted concurrently with this reassignment application?

o Yes

Note: The NPI in this section is the NPI associated with the **individual** who is reassigning benefits.

Section 4

Did the individual practitioner complete and sign (in ink) Section 4A on Page 5?

o Yes

Note: **All signatures** must **be originals.**

Did the authorized or delegated official complete and sign (in ink) Section 4B on Page 5?

o Yes

Note: All individuals who allow another supplier to receive payment for their services must sign the Reassignment of Benefits Statement. **All signatures must be originals.**

Section 7

Did you complete Section 7 (on page 6), with the Contact Person information?

o Yes

Your Application Contact Information

The following chart describes when and how FCSO will contact providers based on the contact information provided in your enrollment application.

Contact Type	During the Enrollment Process	Once Provider/Supplier Is Enrolled
Contact Address	Used as a first contact for all for additional information requests.	
Correspondence Address	Used for additional information requests if the contact information on the application is incomplete.	
Pay-to Address	Used to send remittance to providers and or to notify groups and individual practitioner of approval/denial into the Medicare program.	Used to request additional claim information and or to send remittance advices and checks to providers. **Note:** Upon request from the provider/supplier, requests for additional claim information may be sent to the practice address.

Step-By-Step Directions To Completing CMS-855I Application

Section 1

If you are a **physician's assistant**, did you fill in **both** your Medicare Identification Number (if issued) and your National Provider Identifier (NPI) on Page 4, Section 1A, in the two spaces provided within the first paragraph at the top of the page?

o Yes

If you are reassigning all of your Medicare benefits (per section 4B1 of this application), did you furnish **both** your Medicare Identification Number (if issued) and your National Provider Identifier (NPI) on Page 4, Section 1A, in the two spaces provided within the second paragraph at the top of the page?

o Yes

Did you check **only one box** on pages 4 & 5, Section 1A (Basic Information)?

o Yes

Did you fill in the **"required sections"** denoted to the right side **of the box** you checked?

o Yes

Did you check **one or more** boxes on Page 5, Section 1B (Basic Information)?

o Yes

Did you fill in the **"required sections"** denoted to the right side of **each** box you checked?

o Yes

Section 2

Did you fill in your personal information on Page 6 in Section 2A, (Identifying Information), relative to yourself as well as to your license and certification information?

Types of Licenses required are:

- HCCL
- CRNA
- Professional license
- City and county license
  - Check with city, town or county tax office

o Yes

Did you provide your correspondence address (**not** a billing agency's address) for Section 2B, on Page 6?

o Yes

Note: This address **cannot** be your billing agency address.

Did you complete questions 1-4 in Section 2C (Resident/Fellow Status) on Page 7, if you are currently in an approved training program as a **Resident** or are in a **Fellowship** program?

o Yes

If you are **not** in an approved training program, did you answer **"no"** to questions 1a and 1b?

o Yes

Did you designate your primary specialty (**only one**) and your secondary specialties (**one or more**) on Page 8, Section 2D (Medical Specialties), Question 1.

o Yes

If you checked **Diagnostic Radiology** as your specialty, and you will be billing Medicare for the technical component of the diagnostic tests, did you **also** complete a CMS-855B enrollment form as an **Independent Diagnostic Testing Facility** (IDTF)?

o Yes

If applicable, did you designate your nonphysician specialty on Page 9, Section 2D, Question 2.

o Yes

Note: An additional CMS-855I **must** be completed for **each** nonphysician specialty type.

If you are, or were, a **physician's assistant**, did you fill in the required information on Page 10, Sections E, F and G?

o Yes

Note: In Section 2E the employer's and physician's NPI must be listed. Additionally, ensure that the name corresponding with your NPI is your legal business name as reported to the IRS and that it matches exactly. This includes any spacing or punctuation. If not, contact NPPES (*https://nppes.cms.hhs.gov/NPPES/Welcome.do*) and request the update.

Did you respond "yes" or "no" regarding whether or not you hold a doctoral degree in **Psychology** in Section 2H on Page 11?

o Yes

If you checked "yes," did you provide a copy of your degree with this application?

o Yes

Did you complete Section 2I (questions 1-4) on Page 11, if you are a **psychologist** billing independently.

o Yes

Did you complete Section 2J (questions 1-5) on Page 11, if you are a **physical** or **occupational therapist** in private practice?

o Yes

If you responded "yes" to any question numbered 2-5, did you attach a copy of the lease agreement for your facility usage?

o Yes

Did you respond "yes" or "no" regarding whether or not you are an employee of a Medicare **skilled nursing facility** (SNF) or an employee of another entity that has an agreement to provide **nursing services** to a SNF in Section 2K on Page 11?

o Yes

If you answered "yes," did you provide the name and address of the applicable SNF?

o Yes

Step-By-Step Directions To Completing CMS-855I Application, continued

Section 3

Did you report any adverse legal actions that have been imposed against you in Section 3 (Adverse Legal Actions/ Convictions) Page 13?

o Yes

If yes, did you attach a copy of the adverse legal documentation and its resolution?

o Yes

Note: Your application will be considered incomplete if the information is missing or you enter "not applicable."

Section 4

Did you complete Section 4A on Page 14, if you are the **Sole Owner** of a **Professional Corporation**, a **Professional Association**, or a **Limited Liability Company** intending to bill Medicare through this business entity?

o Yes

Note: **Section 4A** – Ensure that the name corresponding with your NPI is your legal business name as reported to the IRS and that it matches exactly. If not, contact NPPES (*https://nppes.cms.hhs.gov/NPPES/Welcome.do*) and request the update.

Has your organization, under any **current or former** name or business identity ever had any adverse legal actions that have been imposed against it (Page 14, Section 4 under "Adverse Legal History," Questions 1 & 2)?

o Yes

If yes, did you attach a copy of the adverse legal documentation and its resolution?

o Yes

On Page 15, Section 4B, Questions 1 & 2, did you indicate (yes or no) that your services (all/any) will be rendered as part of a group or organization to which you will reassign your benefits?

o Yes

If **any** or **all** of the services you render will be as part of a group or organization to which you will reassign your benefits, did you furnish the name(s), Medicare Identification Number(s) and NPIs of each group or organization?

o Yes

Note: If **all** of your services will be rendered as part of a group and you will reassign your benefits, check yes in this section and proceed to section 13. If you check no, proceed with the application.

If **any** (meaning you work for a group and have an individual practice location) of your services will be rendered as part of a group and you will reassign your benefits, complete this section and proceed to section 4C.

Did you fill in the appropriate spaces in Section 4C (changes/additions/deletions) on Page 16 regarding your solo practice or your organization's practice location(s)?

o Yes

Note: If you as a sole practitioner or your organization sees patients in more than one location, complete this section for each location. **The NPI in this section will be the NPI associated with you individual name and social security number.**

Did you fill in the requested information on Page 17, Section 4D, for all locations where health care services are rendered in patients' homes?

o Yes

Did you fill in Section 4E on Page 18 regarding your option to have your special payment address mirror your practice location address, or to be different from that?

o Yes

Note: For electronic fund transfer (EFT), include CMS-588 for initial enrollments and/or if you are making changes to an existing Medicare provider number that has not already been set up for EFT. **Remember to include a voided check and/or deposit slip.**

Did you provide your employer identification number (EIN) in Section 4F (Employer ID Number Information), Page 18 in order for your Medicare payments to be reported under your EIN?

o Yes

Did you provide the storage facilities address where you maintain your medical records on Pages 19, Section 4G (if it's different than your practice/physical location)?

o Yes

Did you explain any unique circumstances concerning your practice locations or the method by which you render health care services in Section 4H on Page 19?

o Yes

Section 6

Did you include the name(s) of **all** managing employees at **any** of your practice locations (practice locations were indicated previously in Section 4) on Page 20, Section 6A?

o Yes

Note: If you have more than one managing employee, this section must be completed for each.

Did you identify any adverse legal actions that have been imposed against any managing employees indicated above (Section 6B, Page 20)?

o Yes

If yes, did you attach a copy of the adverse legal action documentation and resolution?

o Yes

Section 8

Did you complete Section 8 on Page 21 with information specific to the billing agency you utilize?

o Yes

Note: If you do **not** use a billing agency, you can continue with Section 13 on Page 22). **Make sure** that you have first checked the box stating, "check here if this section does not apply."

Step-By-Step Directions To Completing CMS-855I Application, continued

Section 13

Did you complete Section 13 on page 22, with the contact person information?

o Yes

Section 14

Did you read Section 14 on pages 23 & 24 to ensure your understanding of the penalties for falsifying Medicare information?

o Yes

Section 15

Did you complete the Certification Statement in Section 15 (Page 26)?

o Yes

Note: All signatures **must** be original. The use of blue ink is preferred**.**

Section 17

Did you read Section 17 on page 27 to ensure that you have submitted correct and complete supporting documentation?

o Yes

Your Application Contact Information

The following chart describes when and how FCSO will contact providers based on the contact information provided in your enrollment application.

Contact Type	During the Enrollment Process	Once Provider/Supplier Is Enrolled
Contact Address	Used as a first contact for all for additional information requests.	
Correspondence Address	Used for additional information requests if the contact information on the application is incomplete.	
Pay-to Address	Used to send remittance to providers and or to notify groups and individual practitioner of approval/denial into the Medicare program.	Used to request additional claim information and or to send remittance advices and checks to providers. **Note:** Upon request from the provider/supplier, requests for additional claim information may be sent to the practice address.

Ask The Contractor Teleconference (ACT)

Thursday, August 16, 2007
11:30 A.M.–1:00 P.M.

Do you have questions on the changes the Centers for Medicare & Medicaid Services (CMS) has implemented for Provider Enrollment?

- Should you or shouldn't you complete the CMS-855 enrollment form?
- What is required to start submitting claims with the National Provider Identifier (NPI)?

If you have questions, this conference call is for you. Get answers to your questions by Medicare subject matter experts.

Don't miss out on this opportunity to interact directly with your Medicare Contractor.

CLAIMS

Claim Processing Change for Services Submitted with the Health Professional Shortage Area Modifiers QB or QU for Claims with Dates of Service on or After January 1, 2006

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

Provider Types Affected

Physicians submitting claims to Medicare Part A/B Medicare administrative contractors (A/B MACs), or carriers for services rendered to Medicare beneficiaries in a health professional shortage area (HPSA).

Provider Action Needed

STOP – Impact to You

For dates of service on or after January 1, 2006, when a modifier is required to bill for the HPSA bonus, use modifier AQ for physician services provided in HPSAs. **Claims will be returned as unprocessable if submitted with the modifiers QB or QU**, for dates of service on or after January 1, 2006.

CAUTION – What You Need to Know

Make certain that services eligible to receive a HPSA bonus for dates of service on or after January 1, 2006, are billed with the **modifier AQ, when a modifier is required.**

GO – What You Need to Do

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

Background

Under certain circumstances, it is necessary to include a modifier on a claim in order to receive a HPSA bonus payment. The modifiers QB and QU are appropriate to be submitted for claims with dates of service prior to January 1, 2006. **The modifier AQ is appropriate to be used for dates of service on or after January 1, 2006.** Per direction from the Centers for Medicare & Medicaid Services (CMS), some Medicare contractors allow claims submitted with the modifiers QB and QU with dates of service on or after January 1, 2006 to be submitted and processed, though no bonus payment is made as the correct modifier has not been submitted. According to the Health Insurance Portability and Accountability Act (HIPAA) regulations for transactions and code sets, as found in 45 code of federal regulations (CFR) 160, providers must include valid codes and modifiers, as derived from the standard transaction code sets, on their incoming claims submitted to Medicare. Therefore, allowing claims with inappropriate modifiers to be accepted into the Medicare claims processing system constitutes a violation of the HIPAA standard transaction code sets.

In order to comply with HIPPA regulations and allow claims to be forwarded successfully to supplemental payers, **as of October 1, 2007**, **Medicare will no longer accept claims submitted with the QB or QU modifiers for invalid dates of service.** Claims must be submitted with the correct modifiers for the correct dates of service in order to be processed.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5629) issued to your Medicare carrier, or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1275CP.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).

Additional information on the HPSA bonus and the physician scarcity area bonus may be found at *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/01_overview.asp* on the CMS Web site.

The Guide for Using the HPSA/PSA Web page may be viewed by going to *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf* on the CMS Web site.

MLN Matters Number: MM5629
Related Change Request (CR) #: 5629
Related CR Release Date: June 29, 2007
Effective Date: January 1, 2006
Related CR Transmittal #: R1275CP
Implementation Date: October 1, 2007

Billing and Payment in a Health Professional Shortage Area—Revision to Claims Processing Manual

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

Provider Types Affected

Physicians who bill Medicare carriers and Medicare administrative contractors (A/B MACs) for services rendered in Health Professional Shortage Area (HPSA).

What Physicians Need to Know

CR 5625, from which this article is taken, informs carriers and A/B MACs that they no longer have to maintain a separate Web site of HPSA designated areas for you to use concerning claims for the HPSA bonus payment. Rather, your contractor's Web site will have links to a Center for Medicare & Medicaid Services (CMS) Web site (*http://www.cms.hhs.gov/hpsapsaphysicianbonuses/*) and a HRSA Web site (*http://www.bhpr.hrsa.gov/shortage/*). These sites will be available to help you when filing HPSA bonus payment claims.

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

Background

CMS is simplifying the process of determining designations that are eligible to receive the HPSA bonus payment; in order to ensure a more accurate method of 1) paying claims in areas that are designated for the HPSA bonus payment, and 2) reducing the risk of overpayments in area that are not designated as HPSA bonus payment areas.

To reflect these changes, *Medicare Claims Processing Manual* (100-04) Chapter 12 (Physician/Practitioner Billing), section 90.4 (Billing and Payment in a Health Professional Shortage Area [HPSA]) is being updated; and CR 5625, from which this article is taken, revises how Medicare contractors will disseminate information about HPSA bonus payment to the provider community.

Per these revisions, carriers will no longer maintain an updated Web site of HPSA designations for physicians to use when filing HPSA bonus payment claims. The carriers, instead, will be required to provide two direct links for you to use when filing HPSA bonus payment claims. Those links are:

- To the CMS Web site, to verify automated HPSA bonus designation status, which you can access at *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/*; and
- To the HRSA Web site, to verify HPSA bonus designation status, which you may access at *http://www.bhpr.hrsa.gov/shortage/*,

You should be aware that CMS will continue to automatically pay a bonus for those ZIP codes that are considered to fully fall in the county based on a determination of dominance made by the United States Postal Service (USPS) and for those ZIP codes that fully fall within a partial county HPSA (effective for services rendered on or after the date of designation by HRSA)

However, for those ZIP codes that do not fully fall within a full county HPSA or fully within a non-full county HPSA, you must continue to enter the AQ modifier on the claim in order to receive the bonus.

Additional Information

You may find the official instruction, CR 5625, issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1273CP.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: MM5625
Related Change Request (CR) #: 5625
Related CR Release Date: June 29, 2007
Effective Date: October 1, 2007
Related CR Transmittal #: R1273CP
Implementation Date: October 1, 2007

Health Professional Shortage Area Listing For Primary Care, Mental Health—Florida Only

The following are counties (all census tracts) designated as geographic HPSAs (and therefore eligible for the HPSA bonus payment) for primary care for Florida, as of May 11, 2007. There have been no changes communicated for Connecticut.

Primary Care

County/Area Name	Census Tracts (C.T.)	Type
Clay/Keystone Heights		Rural
Collier/Imokalee/Everglades		Rural
Columbia		Rural
Dixie		Rural
Escambia/Atmore (AL/FL)	0038.00, 0039.00, 0040.00	Rural
Franklin		Rural
Gadsden		Urban
Glades		Rural
Hamilton		Rural
Hardee		Rural
Hendry		Rural
Jefferson		Rural
Lafayette		Rural
Liberty		Rural
Madison		Rural
Martin/Indiantown		Rural
Okeechobee		Rural
Palm Beach	0080.01, 0080.02, 0081.01, 0081.02, 0082.01, 0082.02, 0082.03, 0083.01, 0083.02	Rural
Sumter		Rural
Suwannee		Rural
Wakulla		Rural

Mental Health

The following are counties (all census tracts) designated as geographic HPSAs (and therefore eligible for the HPSA bonus payment) for mental health for Florida, as of May 11, 2007. There have been no changes communicated for Connecticut.

County	Type
Bradford	Rural
Calhoun	Rural
Columbia	Rural
Dixie	Rural
Franklin	Rural
Gilchrist	Rural
Glades/Hendry CA	Rural
Gulf	Rural
Hamilton	Rural
Hendry CA/Glades	Rural
Hillsborough/Ruskin CCD/Wimauma-Lithia CCD	Urban
Holmes	Rural
Indian River/Fellsmere	Rural
Jackson	Rural
Jefferson	Rural

County	Type
Lafayette	Rural
Lake	Rural
Liberty	Rural
Madison	Rural
Martin/Indiantown Service Area/Indiantown	Rural
Monroe/Upper Keys	Rural
Putnam	Rural
St Johns	Urban
Sumter	Rural
Suwannee	Rural
Taylor	Rural
Union	Rural
Wakulla	Rural
Walton	Rural
Washington	Rural

Source: CMS Atlanta Regional Office Memorandum, dated June 29, 2007

CONSOLIDATED BILLING

Additional Common Working File Editing for Skilled Nursing Facility Consolidated Billing

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

Note: This article was revised on July 17, 2007, to reflect a correction made to change request (CR) 5624. The implementation date was changed to January 7, 2008. All other information remains the same.

Provider Types Affected

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

What Providers Need to Know

Effective for dates of service on or after April 1, 2001, CR 5624, from which this article is taken, instructs Medicare carriers, A/B MACs, and DME MACs to bypass certain current SNF consolidated billing (CB) Part B and Part B/DMEMAC edits in order to enable the identification of periods when SNF CB edits should not be applied.

Background

CR 5624 instructs Medicare carriers, A/B MACs, and DME MACs (effective April 1, 2001) to bypass SNF CB Part B and Part B/DMEMAC edits when certain inpatient claims are present on Medicare's history. These revisions will allow Medicare SNF CB editing to take into account periods of SNF stays that are noncovered by Medicare Part A when services should be payable outside of CB by the Medicare Part B contractor.

Note: CR 5624 does not change the policy for SNF CB. It adjusts Medicare claim systems to be in line with current policy.

Medicare contractors (carrier, A/B MAC, or DME MAC) will re-open and re-process inappropriately denied claims for dates of service on or after April 1, 2001 through January 1, 2008 when you bring such claims to their attention. You should contact your Medicare contractor to have claims re-processed that you feel were erroneously subject to these consolidated billing edits, and denied. The change will be implemented on January 7, 2008 and claims will be processed correctly as of that date.

Additional Information

You may find the official instruction, CR 5624, issued to your carrier, A/B MAC, or DME MAC on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1289CP.pdf*. As an attachment to CR 5624, you will find updated *Medicare Claims Processing Manual* (100-04), Chapter 6 (SNF Inpatient Part A Billing), Sections 110.2.2 (A/B Crossover Edits), 110.2.4 (Edit for Ambulance Services), and 110.2.5 (Edit for Clinical Social Workers [CSWs]).

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

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

MLN Matters Number: MM5624 *Revised*
Related Change Request (CR) #: 5624
Related CR Release Date: July 13, 2007
Effective Date: April 1, 2001
Related CR Transmittal #: R1289CP
Implementation Date: January 7, 2008

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.

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 special edition 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 (G3077). 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.

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
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

Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D

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

Provider Types Affected

Physicians, pharmacists, health care professionals, suppliers, and their staff.

Provider Action Needed

This special edition *MLN Matters* article describes the Centers for Medicare & Medicaid Services (CMS) policy regarding provider reimbursement for Part D vaccines and vaccine administration in 2007 and 2008 under the Medicare Prescription Drug Benefit (Part D). In addition, the article outlines various approaches that Part D plans may implement to ensure beneficiaries have adequate access to Part D vaccines.

Background

With the advent of the Medicare Part D program, there is now broader reimbursement available to providers for vaccines administered to Medicare beneficiaries. Some vaccines are covered under Medicare Part B and others under Part D. The Part B program covers most of the vaccines indicated for the Medicare population, with the immunizer administering the vaccine and billing the Part B contractor (Medicare carrier or Part A/B Medicare administrative contractor or A/B MAC) for both the vaccine and its associated administration. The Part D program generally covers those vaccines not available under Part B; however, unlike Part B, the immunizer may or may not be able to directly bill the Part D sponsor for the vaccine and its adminis-

Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D, continued

tration, but instead may need to work with the beneficiary and his/her Part D plan to facilitate reimbursement. The first step is for the provider to understand which vaccines are available under the two different programs so he/she can assist the beneficiary in obtaining the vaccines needed to maintain and improve his/her health.

Coverage of Vaccines Under the Part B Program

Medicare Part B currently covers the following immunizations:

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

If a vaccine is covered under Part B, it will continue to be covered under Part B regardless of the changes to Part D vaccine administration reimbursement in 2007 and 2008 discussed later in this article.

Coverage of Vaccines Under the Part D Program

The Part D program will generally cover those vaccines not available for reimbursement under Medicare Parts A or B when administration is reasonable and necessary for the prevention of illness.

Part D plans identify covered drugs and vaccines through the use of formularies. However, a new preventative vaccine may not be specifically listed on the Part D plan's formulary. This does not mean the vaccine is not available for reimbursement. The provider can contact the Part D plan about coverage and any supporting information that might be necessary to facilitate vaccine coverage for the beneficiary (Part D plan contact information is located at the end of this article).

To facilitate greater access to Part D vaccines, CMS has directed that starting in 2008 all Part D plans' formularies must contain all commercially available vaccines (unless excluded due to available reimbursement under Part B, e.g., influenza or pneumococcal vaccines as discussed above).

Example of Identifying Vaccines Covered Under Part B or Part D

Hepatitis B vaccine provides a useful illustration of how a provider could approach vaccine reimbursement under Medicare Part B or D. **Part B covers Hepatitis B vaccine for intermediate and high-risk patients.** A beneficiary meeting the intermediate or high-risk coverage criteria could obtain the hepatitis B vaccination series from their physician and the physician would submit a claim to the Medicare Part B contractor. For the beneficiary who did not satisfy the appropriate Part B risk criteria, he or she could still obtain the hepatitis B vaccine from their physician; however, any potential reimbursement would be available from the beneficiary's Part D plan instead of the Part B contractor. Facilitation of Part D vaccine reimbursement is discussed later in this article.

Coverage of Vaccine Administration Under the Part B Program

The Tax Relief and Health Care Act (TRHCA), effective January 1, 2007, provided for reimbursement of vaccine administration associated with Part D vaccines. Pharmacies and physicians can use a newly instituted G code (G0377) to bill Part D vaccine administration to local Medicare Part B contractors. Normal Part B beneficiary deductible and coinsurance requirements apply and **reimbursement for this code is only effective for calendar year 2007.**

Payment for the actual Part D covered vaccine is the responsibility of the beneficiary's Part D plan. In other words, in 2007 Medicare Part B will not pay for the Part D vaccine (i.e. low-risk hepatitis B vaccine), just the Part D vaccine administration.

For additional information on Part B reimbursement of Part D vaccine administration in 2007 see the *MLN Matters* articles MM5443 and MM5459, published in December 2006:

- MM5443 is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5443.pdf* and
- MM5459 is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf*.

Coverage of Vaccine Administration Under the Part D Program

TRHCA modified the definition of a Part D drug to include "for [Part D] vaccines administered on or after January 1, 2008, **its administration**." Consequently, beginning on January 1, 2008, the Part D program will cover vaccine administration costs associated with Part D vaccines. **Thus, the coverage available in 2007 under Part B will cease and reimbursement will be available solely under Part D.** CMS interprets this new statutory requirement to mean that the Part D vaccine administration costs are a component of the negotiated price for a Part D-covered vaccine. In other words, the negotiated price for a Part D vaccine will be comprised of the vaccine ingredient cost, a dispensing fee (if applicable), sales tax (if applicable) and a vaccine administration fee. This interpretation recognizes the intrinsic linkage that exists between the vaccine and its corresponding administration, since a beneficiary would never purchase a vaccine without the expectation that it would be administered.

In general, CMS believes that Part D vaccines, including the associated administration costs, should be billed on one claim for both in- and out-of-network situations. For example, if an in-network pharmacy dispenses and administers the vaccine in accordance with state law, the pharmacy would process a single claim to the Part D sponsor and collect from the enrollee any applicable cost sharing on the vaccine and its administration. Alternatively, if a vaccine is administered out-of-network in a physician's office, the physician would administer the vaccine and then bill the beneficiary for the entire charge, including both components. The beneficiary would, in turn, submit a paper claim to the Part D sponsor for reimbursement of plan allowable costs for both the vaccine cost and the administration fee.

Cost-Sharing Considerations

In general, a Part D plan should not charge separate copays for the vaccine and its administration since CMS views the vaccine and its administration as intrinsically linked. If a Part D plan charges coinsurance, it should be applied relative to the entire price of both components. Low income subsidy eligible individuals with copays set by statue (see section 1860D-14(a)(1)(D) of the Social Security Act) will always pay only one copay for a vaccine and all related charges. Thus, for example, a low income subsidy eligible individual entitled to $1.05/$3.10 copays in 2008 would pay only $3.10 for both the vaccine and its administra-

Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D, continued

tion (and any applicable dispensing fee) even if the components are billed separately.

Elements of Vaccine Administration

CMS expects that Part D plans will take into consideration the elements reflected in existing 2007 Part B vaccine administration fees when establishing their own vaccine administration fees for 2008. Part D plans will have the discretion to implement either a single vaccine administration fee for all vaccines or multiple administration fees based on type of vaccine, variance in provider type, and product administration complexity. Providers should contact Part D plans regarding specific vaccine administration fees for 2008. (Part D plan contact information is listed at the end of this article.)

Part D Reimbursement for Vaccines in Provider Settings

As stated earlier, Part D plans are required to provide access to vaccines not covered under Parts A or B. During initial Part D rulemaking, CMS described use of standard out-of-network requirements to ensure adequate access to the small number of vaccines covered under Part D that are administered in a physician's office. CMS' approach was based on the fact that most vaccines of interest for the Medicare population (influenza, pneumococcal, and hepatitis B for intermediate and high risk patients) were covered and remain covered under Part B. For those that are not covered under Part B, the beneficiary would pay the physician and then submit a paper claim to his or her Part D plan for reimbursement up to the plan's allowable charge. In the absence of communication with the plan prior to vaccine administration, the amount the physician charges may be different from the plan's allowable charge, and a differential may remain that the beneficiary will be responsible for paying.

As newer vaccines have entered the market with indications for use in the Medicare population, Part D vaccine in-network access has become more imperative. Requiring the beneficiary to pay the physician's full charge for a vaccine out of pocket first and be reimbursed by the plan later is not an optimal solution, and CMS has urged Part D plans to implement cost-effective, real-time billing options at the time of administration. CMS issued guidance to Part D plans to investigate alternative approaches to improve access to vaccines under the drug benefit without requiring up-front beneficiary payment and to ensure adequate access to Part D vaccines.

CMS outlined the following options to Part D plans for their consideration. Physicians should expect to see various models develop and should be aware of both their potential existence and use by Medicare beneficiaries.

Options to Ensure Adequate Access Under Part D to Covered Vaccines
In-Network Distribution Approaches

In-Network Access to Retail Pharmacies: Enrollees could obtain a prescription from the physician and bring it to their local network retail pharmacy for filling. In some states, it will already be possible for the vaccine to be administered by the pharmacist. Forty-six states currently allow pharmacists to provide some type of vaccinations. When it is safe to dispense and administer these vaccines in the pharmacy, plans will be exploring utilization of their network pharmacists as a provider of adult Medicare Part D vaccines.

In-Network Pharmacy Distribution: A Part D plan's local pharmacy or specialty pharmacy could provide vaccines directly to physician offices. Under this scenario, the physician could call in a prescription, or the beneficiary could deliver or mail a prescription for the vaccine to the pharmacy. The pharmacy would fill the prescription for the vaccine, ship or deliver to the physician's office, and bill the Part D plan for the vaccine. (This model resembles the competitive acquisition program (CAP) for Medicare Part B drugs in that the drug is shipped to the physician, but the physician never purchases or gets reimbursed for the drug.)

Out-of-Network Approaches: Facilitated Out-of-Network Access Approaches

Web-Assisted Out-of-Network Billing: Under this approach, physicians would electronically submit beneficiary out-of-network claims to Part D plans for vaccines dispensed and administered in the physician's office through a web-assisted portal (vendor). This approach would allow the beneficiary to pay out of pocket only the appropriate deductible and copay or cost sharing directly to the physician, thus avoiding any up-front payment and repayment for the full cost of the vaccine. The physician would assume responsibility for submitting the claim on behalf of the beneficiary and would agree to accept Part D plan payment as payment in full.

Model Vaccine Notice for Physicians (Paper Claim Enhancement): Part D plans would provide all enrollees with a vaccine-specific notice that the enrollees could bring to their physicians. This notice would provide information necessary for a physician to contact the enrollee's Part D plan to receive authorization of coverage for a particular vaccine, reimbursement rates, enrollee cost-sharing to be collected by the physician, and instructions on how to submit the out-of-network claim on the beneficiary's behalf.

It is important to emphasize for either out-of-network approach, the physician does not become a network provider, but is assisting the beneficiary in the submission of his or her out-of-network claim.

CMS is working with Part D Sponsors to facilitate these various approaches. CMS encourages additional exploration of other possible means to coordinate the billing of vaccines in the real-time environment of the Part D benefit. CMS expects significant development in this area over the next year.

Frequently Asked Questions

- If I need to immunize a beneficiary with a Part D vaccine, what do I need to do?
  The beneficiary or physician can call the Part D Plan to discuss what the cost sharing and allowable charges would be for the vaccine as part of the Part D plan's out-of-network access or inquire as to the availability of any alternative vaccine access options. Plan contact information is available at the following Web site: *http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/MPDPFIntro.asp* and then follow the directions on the section "Learn More About Plans in Your Area." You may also obtain plan contact information by calling 1-800-MEDICARE.

- Do I need to provide advanced beneficiary notice (ABN)?
  No. Unlike traditional Medicare, Part D does not require ABNs.

- Can I charge an administration fee?
  Yes. Administration fees for vaccines could be handled in the following manner:

Reimbursement for Vaccines and Vaccine Administration Under Medicare Part D, continued

- Before January 1, 2008: When a physician administers a Part D vaccine, the physician should use HCPCS code G0377 (linked to *CPT* code *90471*) to bill the Part B local carrier for the administration fee of the vaccine.
- January 1, 2008 and after: Part D vaccines, including the associated administration costs could be billed on one claim to the beneficiary or to the Part D plan, as stated in the preceding examples.
- Is the Herpes zoster vaccine (Zostavax™) covered under Medicare Part B or D?
  Since the Herpes zoster vaccine is a preventive vaccine, it will be available for reimbursement under Part D. Beneficiaries and providers should contact the Part D plans for more information about costs and reimbursement for this and other preventive vaccines.

Additional Information

More information about Part D for physicians is available on the CMS prescription drug Web page for physicians, which is at *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp#TopOfPage*.

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Implementation Date: N/A

Update to Medicare Claims Processing Manual for Part B Influenza Billing

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

Provider Types Affected

Physicians, nonphysician practitioners, and providers who bill Medicare contractors (carriers, Part A/B Medicare administrative contractors [A/B MAC]), and use CMS-1500 (08-05) for submitting vaccine and roster claims, especially those who wish to participate in the centralized billing program offered by the Centers for Medicare & Medicaid Services (CMS).

Key Points

It is important that providers who want to participate in centralized billing programs understand and follow the rules governing the program. Specifically, approval to participate in the CMS centralized billing program is a two-part approval process. Individuals and corporations who wish to enroll as a CMS mass immunizer centralized biller must send their request to participate as a centralized biller in writing by June 1 of the year they wish to begin centralized billing. These written requests should be sent to the following address:

Center for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop *C4-10-07*
Baltimore, Maryland 21244

The CMS central office (CO) will complete part 1 of the approval process by reviewing preliminary demographic information included in the request for participation letter. **Completion of part 1 is not approval to set up flu clinics, vaccinate beneficiaries, and bill Medicare for reimbursement.**

All new participants must complete part 2 of the approval process (Form CMS-855 application) before they may set up flu clinics, vaccinate Medicare beneficiaries, and bill Medicare for reimbursement. **If an individual or entity's request is approved for centralized billing, the approval is limited to 12 months from September to August 31 of the next year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year.** The designated Medicare carrier for centralized billing will provide, in writing, to CMS CO and to approved centralized billers notification of completion and approval of part 2 of the approval process. The designated carrier may not process claims for any centralized biller who has not completed parts 1 and 2 of the approval process. If claims are submitted by a provider who has not received approval of parts 1 and 2 of the approval process to participate as a centralized biller, the carrier must return the claims to the provider to submit to the local carrier for payment.

Before September 1 of every year, CMS CO provides the designated carrier with the names of the entities that are authorized to participate in centralized billing for the 12-month period beginning September 1 and ending August 31 of the next year.

Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the processing carrier for centralized billing through completion of the Form CMS-855 (Provider Enrollment Application). **Providers/suppliers are encouraged to apply to enroll as a centralized biller early as the enrollment process takes 8 -12 weeks to complete. Applicants who have not completed the entire enrollment process and received approval from CMS CO and the designated carrier to participate as a Medicare mass immunizer centralized biller will not be allowed to submit claims to Medicare for reimbursement.**

Update to Medicare Claims Processing Manual for Part B Influenza Billing, continued

In addition to the centralized billing processes, the following are revised portions of chapter 18, section 10, of the *Medicare Claims Processing Manual*, which is attached to CR 5511 (the Web address for CR 5511 is provided in the *Additional Information* section of this article):

Chapter 18/Section 10.2.5 – Claims Submitted to Carriers

- The administration of the influenza virus vaccine is covered in the flu vaccine benefit under section 1861(s)(10)(A) of the Act, rather than under the physicians' services benefit. Therefore, it is not eligible for the 10 percent health professional shortage area (HPSA) incentive payment *or the 5 percent physician scarcity area (PSA) incentive payment.*
- Medicare still requires that the hepatitis B vaccine be administered under a physician's order with supervision.

Chapter 18/Section 10.3.1 – Roster Claims Submitted to Carriers for Mass Immunization

- If a public health center (PHC) or other individual or entity qualifies to submit roster claims, it may use a preprinted CMS-1500 *(08-05)*

Chapter 18/Section 10.3.1.1 – Centralized Billing for Flu and Pneumococcal (PPV) Vaccines to Medicare Carriers

Format Clarifications for Roster Cover Document

Providers submitting roster claims must complete a cover CMS-1500 (08-05) and are reminded that:

- Item 32 must be completed to report the name, address, and ZIP code of the location where the service was provided (including centralized billers).
- Item 32a must be completed to report the NPI of the service facility (e.g., hospitals) if it is available. The carrier will use the ZIP code in Item 32 to determine the payment locality for the claim. (The NPI can be reported on the CMS-1500 (08-05) as of January 1, 2007.)
- Once Medicare requires NPI reporting, the NPI of the billing provider or group must be reported in item 33a. (The NPI can be reported on the CMS-1500 (08-05) as of January 1, 2007.)

Format Clarifications for Roster Claims

- Item 33 must be completed to report the provider of service/supplier's billing name, address, ZIP code, and telephone number. Once Medicare requires NPI submissions, the NPI of the billing provider or group must be reported.
- For electronic claims, the name, address, **and ZIP code** of the facility is reported in:
- The HIPAA compliant ANSI X12N 837: Claim level loop 2310D NM101=FA. When implemented, the facility (e.g., hospital's) NPI will be reported in the loop 2310D NM109 (NM108=XX) if one is available. Prior to NPI, enter the tax information in loop 2310D NM109 (NM108=24 or 34) and enter the Medicare legacy facility identifier in loop 2310D REF02 (REF01=1C). Report the address, city, state, and ZIP code in loop 2310d N301 and N401, N402, and N403. Facility data is not required to be reported at the line level for centralized billing.
- Providers note that if a claim is received with an invalid ZIP code, carriers will return the claims as unprocessable.
- If a claim is received with a ZIP code that is not valid for the street address given, carriers will return the claim as unprocessable.

Chapter 18/Section 10.4.2

In your annual request to participate in centralized billing, you must also:

- Include the names and addresses of all entities operating under the corporation's application; and
- Include contact information for a designated contact person for your centralized billing program.

Providers should note that the practice of requiring a beneficiary to pay for the vaccination upfront and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per section 1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment upfront.

Additional Information

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.

For complete details regarding this change request (CR) please see the official instruction (CR 5511) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1278CP.pdf* 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: MM5511
Related Change Request (CR) #: 5511
Related CR Release Date: June 29, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1278CP
Implementation Date: July 30, 2007

Medicare Payment for Preadministration-Related Services Associated with IVIG Administration—Payment Extended through CY 2007

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the January 2007 Medicare B Update! pages 58-59.

Note: This article was changed on July 9, 2007, to reference MM5635. MM5635 implemented HCPCS coding changes for immune globulin. On and after July 1, 2007, HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized [e.g. liquid], 500 mg) will no longer be payable by Medicare. To view the new HCPCS codes, please go to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5635.pdf* on the CMS Web site.

Provider Types Affected

Physicians and hospitals that bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for intravenous immune globulin (IVIG) administration.

Provider Action Needed

STOP – Impact to You

You may bill for preadministration-related services associated with IVIG administration (HCPCS code G0332) during calendar year 2007. The preadministration-related service must be billed on the same claim and have the same date of service, as the claim for the IVIG itself (codes J1566 and/or J1567) and the drug administration service. **(See note above regarding J1567.)**

CAUTION – What You Need to Know

CR 5428, from which this article was taken, extends payment of the pre-administration-related service for IVIG through CY 2007 **but only when submitted on the same claim as the IVIG and its administration**.

GO – What You Need to Do

Make sure that your billing staff is aware that they must include your claim for the IVIG pre-administration-related services on the same claim (and with the same date of service) as the IVIG and its administration.

Background

Under section 1861(s)(1) and 1861(s)(2), Medicare Part B covers IVIG administered by physicians in physician offices and by hospital outpatient departments. More specifically, when you administer IVIG to a Medicare beneficiary in the physician office or hospital outpatient department, Medicare makes separate payments to the physician or hospital for both the IVIG product itself and for its administration via intravenous infusion.

In addition, for 2006, CMS established a temporary pre-administration-related service payment, for physicians and hospital outpatient departments that administer IVIG to Medicare beneficiaries, to cover the effort required to locate and acquire adequate IVIG product and to prepare for an infusion of IVIG during this current period where there may be potential market issues. **CR 5428, from which this article was taken, announces the extension of this temporary payment for the IVIG pre-administration-related service through CY 2007.**

As a reminder, here are some important details that you should know:

- The policy and billing requirements concerning the IVIG preadministration-related services payment are the same in 2007 as they were in 2006.
- This IVIG pre-administration service payment is in addition to Medicare's payments to the physician or hospital for the IVIG product itself and for its administration by intravenous infusion.
- Medicare carriers, FIs, or A/B MACs will pay for these services, that are provided in a physician office, under the physician fee schedule; and FIs or A/B MACs will pay for them under the outpatient prospective payment system (OPPS), for hospitals subject to OPPS (bill types: 12x, 13x) or under current payment methodologies for all non-OPPS hospitals (bill types: 12x, 13x, 85x).
- You need to use HCPCS code G0332 –Services for intravenous infusion of immunoglobulin prior to administration (this service is to be billed in conjunction with administration of immunoglobulin) to bill for this service.
- You can bill for this only one IVIG pre-administration per patient per day of IVIG administration.
- The service must be billed on the same claim form as the IVIG product (HCPCS codes J1566 (Injection, immune globulin, intravenous, lyophilized [e.g., powder], 500 mg) and/or J1567 (Injection, immune globulin, intravenous, non-lyophilized [e.g., liquid], 500 mg), and have the same date of service as the IVIG product and a drug administration service. **(See note above regarding J1567.)**
- Your claims for preadministration-related services will be returned/rejected by your FI, carrier, or A/B MAC if more than 1 unit of service of G0332 is indicated on the same claim for the same date of service. They will use the appropriate reason/ remark code such as:

  M80 – "Not covered when performed during the same session/date as a previously processed service for the patient"

  B5 – "Payment adjusted because coverage/program guidelines were not met or were exceeded"

  M67 – "Missing other procedure codes"

  16 – "Claim/service lacks information which is needed for adjudication."

Medicare Payment for Services Associated with IVIG—Payment Extended through CY 2007, continued

Additional Information

You may find the official instruction, CR 5428, issued to your FI, carrier, or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1140CP.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: MM5428 *Revised*
Related CR Release Date: December 22, 2006
Related CR Transmittal #: R1140CP
Related Change Request (CR) #: 5428
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

HOSPICE

Hospice Benefits Under Medicare Part B

Background

Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for professional services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an **"**attending physician," who is not an employee of the designated hospice nor receives compensation from the hospice for those services.

Billing Requirements and Use of Required Modifiers

When a Medicare beneficiary elects hospice coverage he/she may designate an attending physician, who may be a nurse practitioner, not employed by the hospice, in addition to receiving care from hospice-employed physicians. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient's terminal illness are **not** considered "hospice services." These attending physician services are billed to Medicare Part B, provided they were not furnished under a payment arrangement with the hospice. The attending physician codes services using the appropriate modifier.

GV Attending physician not employed or paid under agreement by the patient's hospice provider.

The attending physician codes services furnished for the treatment and management of a hospice patient's terminal condition with the modifier GV.

GW Service not related to the hospice patient's terminal condition.

The rendering provider codes any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period with the modifier GW.

If another physician covers for a hospice patient's designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or locum tenens billing instructions. In such instances, the attending physician bills using the modifier GV **in conjunction with** either the modifier Q5 or Q6.

Q5 – Service furnished by a substitute physician under a reciprocal billing arrangement.
Q6 – Service furnished by a locum tenens physician.

Additional Information

Refer to Chapter 11 of the *Medicare Claims Processing Manual* at *http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf* for the complete instruction.

Source: CMS Internet Only Manual, Publication 100-04, Chapter 11, Sections 40 & 120

NERVOUS SYSTEM

Vagus Nerve Stimulation for Resistant Depression

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

Provider Types Affected

Physicians, hospitals, and other providers who bill Medicare carriers, fiscal intermediaries (FI), and Medicare administrative contractors (A/B MAC) for vagus nerve stimulation procedures.

Provider Action Needed

Change request (CR) 5612, from which this article is taken, announces that CMS is issuing a national (non) coverage determination (NCD) stating that vagus nerve stimulation (VNS) is not reasonable and necessary for the treatment of resistant depression.

Therefore, effective May 4, 2007, CMS will deny VNS claims when resistant depression is the indication for the procedure.

Background

VNS utilizes a battery-powered pulse generator (similar to a pacemaker), that is surgically implanted under the skin of the left chest and an electrical lead (wire) connected from the generator to the left vagus nerve; through which electrical signals are sent to the brain.

In 1999, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) that (effective for services performed on or after July 1, 1999) VNS is reasonable and necessary for patients with medically refractory partial onset seizures when surgery is not recommended or has failed.

On August 7, 2006, a formal request to reconsider resistant depression as an additional indication initiated a national coverage analysis, and CR 5612, from which this article is taken, communicates the findings of that analysis. Specifically in CR 5612, CMS announces that it has reviewed the evidence and has concluded that vagus nerve stimulation (VNS) is not reasonable and necessary for the treatment of resistant depression under section 1862(a)(1)(A) of the Social Security Act, and has issued a national noncoverage determination for this indication.

Therefore, effective May 4, 2007, CMS will deny or reject, as appropriate, VNS claims for resistant depression, as specified in the *Medicare National Coverage Determinations Manual*, Chapter 1, Part 2 (Sections 90 – 160.25 [Coverage Determinations]), Section 160.18 (Vagus Nerve Stimulation (VNS), Subsection C (Nationally Non-Covered Indications).

CR 5612 contains some specifics about VNS coverage that you should be aware of:

- Carriers, FIs, and A/B MACs will continue to pay VNS claims for medically refractory partial onset seizures as specified in section 160.18.B of the *Medicare National Coverage Determination Manual*, identified when any of the following ICD-9-CM diagnosis codes appear on the claim:
  - 345.41 (Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures with intractable epilepsy),
  - 345.51 (Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures with intractable epilepsy), or
- Carriers, FIs, and A/B MACs will continue to deny/reject VNS claims for all other types of seizures as specified in section 160.18.C of the *Medicare National Coverage Determination Manual*.
- Physicians and hospitals will be liable for noncovered VNS procedures unless they issue an appropriate advance beneficiary notice (ABN), which should include the following language:

  Items or Service Section: "Vagus Nerve Stimulation".

  Because Section: **"**As specified in section 160.18 of Pub.100-03, *Medicare National Coverage Determination Manual*, Medicare will not pay for this procedure as it is not a reasonable and necessary treatment for (select either "your type of seizure disorder" or "resistant depression.)"
- When denying noncovered VNS services carriers, FIs, and A/B MACs will use the following messages:
  - Medicare summary notice (MSN) 16.10 "Medicare does not pay for this item or service;"
- Claim adjustment reason code (CARC) 50: "These are noncovered services because this is not deemed a "medical necessity" by the payer;" and
- One of the following remittance advice remark code (RARC) messages, depending on liability:
  - M27 Alert: **"**The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

Vagus Nerve Stimulation for Resistant Depression, continued

You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office;" **or**

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

- Medicare carriers, FIs, and A/B MACs will also include group code CO (contractual obligation) or PR (patient responsibility) depending on liability.
- Carrier, FIs, and A/B MACs will not search their files to retract payment for claims already paid, but will adjust claims brought to their attention.

Finally, you should remember that this addition/revision of section 160.18 of the *Medicare National Coverage Determination Manual* is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869[f][1][A][i] of the Social Security Act.)

Additional Information

You may find the official instruction issued to your carrier, FI, or A/B MAC about the VNS NCD by looking at the two transmittals for CR 5612. The first transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R70NCD.pdf* on the CMS Web site. That transmittal contains the amended *Medicare National Coverage Determinations Manual*, Chapter 1, Part 2 (Sections 90 – 160.25 – Coverage Determinations), Section 160.18 (Vagus Nerve Stimulation (VNS), Subsection C (Nationally Non-Covered Indications). The second transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R1271CP.pdf* and it contains the amended *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 200 (Billing Requirements for Vagus Nerve Stimulation (VNS).

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*

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: MM5612
Related Change Request (CR) #: 5612
Related CR Release Date: June 22, 2007
Effective Date: May 4, 2007
Related CR Transmittal #: R1271CP and R70NCD
Implementation Date: July 23, 2007

MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

Update to the 2007 Medicare Physician Fee Schedule Database

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2007 Medicare B Update! pages 18-19.

Note: This article was changed on July 9, 2007, to reference MM5635. MM5635 implemented HCPCS coding changes for immune globulin. On and after July 1, 2007, HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized ([e.g. liquid], 500 mg) will no longer be payable by Medicare. There is a reference to J1567 on page three of this article. To view the new HCPCS codes for immune globulin, please go to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5635.pdf* on the CMS Web site.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

Update to the 2007 Medicare Physician Fee Schedule Database, continued

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

GO – What You Need to Do

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

Background

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

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

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

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

Additional Information

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

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

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

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

2007 Carrier-Priced Fee Schedule Services

Reimbursement for most procedures paid on the basis of the Medicare physician fee schedule database (MPFSDB) is calculated by CMS and provided to carriers annually. These are listed on the MPFSDB with a code status of "A" (Active code). Each carrier calculates reimbursement for other procedures, known as "C" status or carrier-priced codes. Per CMS, status "C" equals carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report."

In many instances, however, enough historical data has been collected to allow FCSO to develop a consistent allowance for some C status codes. These codes and allowances below are effective for services rendered on or after January 1, 2007.

Connecticut Fees

Proc	Mod	Par	Nonpar	Ltg Chg	Note
G0186		639.23	607.27	698.36	
G0186		619.08	588.13	676.34	#
R0070		162.83	154.69	177.89	
R0075		162.83	154.69	177.89	
0145T		640.70	608.66	699.96	
0145T	TC	356.28	338.47	389.24	C
0145T	26	98.17	93.26	107.25	
0146T		640.70	608.66	699.96	
0146T	TC	356.28	338.47	389.24	C
0146T	26	98.17	93.26	107.25	
0147T		640.70	608.66	699.96	
0147T	TC	356.28	338.47	389.24	C
0147T	26	98.17	93.26	107.25	
0148T		640.70	608.66	699.96	
0148T	TC	464.78	441.54	507.77	C
0148T	26	98.17	93.26	107.25	
0149T		640.70	608.66	699.96	
0149T	TC	464.78	441.54	507.77	C
0149T	26	98.17	93.26	107.25	
0150T		640.70	608.66	699.96	
0150T	TC	294.97	280.22	322.25	C
0150T	26	98.17	93.26	107.25	
0151T		150.00	142.50	163.88	
0151T	TC	100.00	95.00	109.25	
0151T	26	50.00	47.50	54.62	
70170		59.61	56.63	65.12	
70170	TC	44.21	42.00	48.30	
70557		402.90	382.75	440.17	
70557	TC	241.74	229.65	264.10	
70558		445.46	423.19	486.67	
70558	TC	267.28	253.92	292.00	
70559		447.24	424.88	488.61	
70559	TC	268.35	254.93	293.17	
71090		107.43	102.06	117.37	
71090	TC	78.31	74.39	85.55	
72291		207.23	196.87	226.40	
72291	TC	124.34	118.12	135.84	
72292		240.35	228.33	262.58	
72292	TC	144.21	137.00	157.55	
73530		38.81	36.87	42.40	
73530	TC	23.77	22.58	25.97	
74190		85.31	81.04	93.20	
74190	TC	60.54	57.51	66.14	
74300		50.79	48.25	55.49	
74300	TC	30.47	28.95	33.29	
74301		29.47	28.00	32.20	
74301	TC	17.68	16.80	19.32	
74305		58.08	55.18	63.45	
74305	TC	36.32	34.50	39.68	
74328		182.07	172.97	198.91	
74328	TC	146.06	138.76	159.57	
74330		192.15	182.54	209.92	
74330	TC	146.06	138.76	159.57	
74340		118.93	112.98	129.93	C
74340	TC	90.99	86.44	99.41	C
74355		158.07	150.17	172.69	C
74355	TC	119.65	113.67	130.72	C
74360		106.26	100.95	116.09	C
74360	TC	77.43	73.56	84.59	C
74420		140.26	133.25	153.23	
74420	TC	121.51	115.43	132.75	
74425		79.28	75.32	86.61	
74425	TC	60.54	57.51	66.14	
74445		111.35	105.78	121.65	
74445	TC	52.20	49.59	57.03	
74450		84.77	80.53	92.61	
74450	TC	67.53	64.15	73.78	
74470		85.65	81.37	93.57	
74470	TC	57.87	54.98	63.22	
74775		99.82	94.83	109.05	
74775	TC	67.53	64.15	73.78	
75801		254.74	242.00	278.30	C
75801	TC	211.79	201.20	231.38	C
75803		270.76	257.22	295.81	C
75803	TC	211.79	201.20	231.38	C
75805		253.73	241.04	277.20	C
75805	TC	211.79	201.20	231.38	C
75810		641.71	609.62	701.07	
75810	TC	583.24	554.08	637.19	
75894		641.26	609.20	700.58	C
75894	TC	573.50	544.82	626.55	C
75896		642.03	609.93	701.42	C
75896	TC	573.50	544.82	626.55	C

– These amounts apply when service is performed in a facility setting.
C – The payment for the technical component is capped at the OPPS amount.

2007 Carrier-Priced Fee Schedule Services, continued

Proc	Mod	Par	Nonpar	Ltg Chg	Note
75898		133.85	127.16	146.23	
75898	TC	48.65	46.22	53.15	
75940		611.00	580.45	667.52	C
75940	TC	582.39	553.27	636.26	C
75945		192.44	182.82	210.24	C
75945	TC	170.72	162.18	186.51	C
75952		701.56	666.48	766.45	
75952	TC	420.94	399.89	459.88	
75953		255.58	242.80	279.22	
75953	TC	153.35	145.68	167.53	
75954		625.29	594.03	683.13	
75954	TC	375.17	356.41	409.87	
75960		477.13	453.27	521.26	C
75960	TC	433.46	411.79	473.56	C
75970		469.05	445.60	512.44	C
75970	TC	425.76	404.47	465.14	C
75980		321.55	305.47	351.29	C
75980	TC	247.96	235.56	270.90	C
75992		473.57	449.89	517.38	C
75992	TC	444.41	422.19	485.52	C
76001		156.69	148.86	171.18	
76001	TC	121.51	115.43	132.75	
76125		50.22	47.71	54.87	
76125	TC	36.32	34.50	39.68	
76350		18.67	17.74	20.40	
76932		106.37	101.05	116.21	
76932	TC	70.87	67.33	77.43	
76940		187.34	177.97	204.67	
76940	TC	77.25	73.39	84.40	
76941		141.31	134.24	154.38	
76941	TC	70.64	67.11	77.17	
76945		105.14	99.88	114.87	
76945	TC	70.64	67.11	77.17	
76975		113.33	107.66	123.81	
76975	TC	70.87	67.33	77.43	
78282		54.96	52.21	60.04	
78282	TC	32.98	31.33	36.03	
78414		64.13	60.92	70.06	
78414	TC	38.48	36.56	42.04	
78459		922.14	876.03	1,007.44	C
78459	TC	842.49	800.37	920.42	C
78491		923.81	877.62	1,009.26	C
78491	TC	842.49	800.37	920.42	C
78492		945.57	898.29	1,033.04	C
78492	TC	842.49	800.37	920.42	C
78608		1,062.23	1,009.12	1,160.49	C
78608	TC	985.34	936.07	1,076.48	C
78609		1,988.66	1,889.23	2,172.61	
78609	TC	1,904.79	1,809.55	2,080.98	
78811		1,066.37	1,013.05	1,165.01	C
78811	TC	985.34	936.07	1,076.48	C
78812		1,085.91	1,031.61	1,186.36	C
78812	TC	985.34	936.07	1,076.48	C
78813		1,089.16	1,034.70	1,189.91	C
78813	TC	985.34	936.07	1,076.48	C
78814		1,208.44	1,148.02	1,320.22	C
78814	TC	1,094.43	1,039.71	1,195.66	C
78815		1,220.25	1,159.24	1,333.12	C
78815	TC	1,094.43	1,039.71	1,195.66	C
78816		1,223.50	1,162.33	1,336.67	C
78816	TC	1,094.43	1,039.71	1,195.66	C
79300		230.20	218.69	251.49	
79300	TC	138.12	131.21	150.90	
86485		21.00	19.95	22.94	
91132		75.29	71.53	82.25	
91132	TC	45.18	42.92	49.36	
91133		94.68	89.95	103.44	
91133	TC	56.81	53.97	62.06	
92978		308.32	292.90	336.84	
92978	TC	211.04	200.49	230.56	
92979		184.39	175.17	201.45	
92979	TC	106.52	101.19	116.37	
93235		145.22	137.96	158.65	
93236		121.51	115.43	132.75	
93315		398.52	378.59	435.38	
93315	TC	239.11	227.15	261.23	
93317		263.12	249.96	287.46	
93317	TC	157.87	149.98	172.47	
93318		278.01	264.11	303.73	
93318	TC	166.81	158.47	182.24	
93501		957.84	909.95	1,046.44	
93501	TC	787.38	748.01	860.21	
93505		340.53	323.50	372.03	
93505	TC	93.69	89.01	102.36	
93508		831.40	789.83	908.30	
93508	TC	582.63	553.50	636.52	
93510		1,983.73	1,884.54	2,167.23	
93510	TC	1,722.03	1,635.93	1,881.32	
93511		1,975.95	1,877.15	2,158.73	
93511	TC	1,675.75	1,591.96	1,830.76	
93524		2,600.30	2,470.28	2,840.83	
93524	TC	2,190.81	2,081.27	2,393.46	
93526		2,606.96	2,476.61	2,848.10	
93526	TC	2,251.08	2,138.53	2,459.30	
93527		2,620.21	2,489.20	2,862.58	
93527	TC	2,190.81	2,081.27	2,393.46	
93528		2,715.97	2,580.17	2,967.20	
93528	TC	2,190.81	2,081.27	2,393.46	

– These amounts apply when service is performed in a facility setting.
C – The payment for the technical component is capped at the OPPS amount.

2007 Carrier-Priced Fee Schedule Services, continued

Proc	Mod	Par	Nonpar	Ltg Chg	Note
93529		2,476.26	2,352.45	2,705.31	
93529	TC	2,190.81	2,081.27	2,393.46	
93530		1,031.88	980.29	1,127.33	
93530	TC	787.38	748.01	860.21	
93531		2,726.82	2,590.48	2,979.05	
93531	TC	2,251.08	2,138.53	2,459.30	
93555		335.77	318.98	366.83	
93555	TC	290.50	275.97	317.37	
93556		503.75	478.56	550.35	
93556	TC	457.25	434.39	499.55	
93561		50.58	48.05	55.26	
93561	TC	25.10	23.84	27.42	
93562		23.61	22.43	25.79	
93562	TC	15.55	14.77	16.99	
93571		310.32	294.80	339.02	
93571	TC	210.82	200.28	230.32	
93602		168.84	160.40	184.46	
93602	TC	51.65	49.07	56.43	
93603		195.39	185.62	213.46	
93603	TC	78.31	74.39	85.55	
93609		402.44	382.32	439.67	
93609	TC	126.96	120.61	138.70	
93610		229.82	218.33	251.08	
93610	TC	63.32	60.15	69.18	
93612		242.04	229.94	264.43	
93612	TC	75.20	71.44	82.16	
93615		62.93	59.78	68.75	
93615	TC	14.88	14.14	16.26	
93618		419.10	398.14	457.87	
93618	TC	184.39	175.17	201.45	
93619		776.28	737.47	848.09	
93619	TC	358.67	340.74	391.85	
93620		1,713.88	1,628.19	1,872.41	
93620	TC	1,028.33	976.91	1,123.45	
93621		314.63	298.90	343.73	
93621	TC	188.78	179.34	206.24	
93622		504.42	479.20	551.08	
93622	TC	302.66	287.53	330.66	
93623		421.00	399.95	459.94	
93623	TC	252.60	239.97	275.97	
93624		371.49	352.92	405.85	
93624	TC	92.75	88.11	101.33	
93640		526.18	499.87	574.85	
93640	TC	333.45	316.78	364.29	
93641		659.85	626.86	720.89	
93641	TC	333.45	316.78	364.29	
93662		434.37	412.65	474.55	
93662	TC	260.62	247.59	284.73	
94642		31.40	29.83	34.30	
95824		113.25	107.59	123.73	
95824	TC	67.95	64.55	74.24	
95951		902.15	857.04	985.60	
95951	TC	541.29	514.23	591.36	
95965		1,164.82	1,106.58	1,272.57	
95965	TC	698.90	663.95	763.55	
95966		581.41	552.34	635.19	
95966	TC	348.85	331.41	381.12	
95967		509.03	483.58	556.12	
95967	TC	305.42	290.15	333.67	

Florida Fees

		Participating			Nonparticipating			Limiting Charge			Note
Proc	Mod	Loc 03	Loc 04	Loc 99	Loc 03	Loc 04	Loc 99	Loc 03	Loc 04	Loc 99	
G0186		603.49	626.24	578.12	573.32	594.93	549.21	659.31	684.17	631.60	
G0186		585.75	607.90	561.64	556.46	577.51	533.56	639.93	664.13	613.59	#
R0070		105.22	105.22	105.22	99.96	99.96	99.96	114.95	114.95	114.95	
R0075		105.22	105.22	105.22	99.96	99.96	99.96	114.95	114.95	114.95	
0145T		566.14	603.83	532.78	537.83	573.64	506.14	618.51	659.68	582.06	
0145T	TC	309.38	331.69	289.48	293.91	315.11	275.01	338.00	362.37	316.26	C
0145T	26	94.16	97.41	91.47	89.45	92.54	86.90	102.87	106.42	99.93	
0146T		566.14	603.83	532.78	537.83	573.64	506.14	618.51	659.68	582.06	
0146T	TC	309.38	331.69	289.48	293.91	315.11	275.01	338.00	362.37	316.26	C
0146T	26	94.16	97.41	91.47	89.45	92.54	86.90	102.87	106.42	99.93	
0147T		566.14	603.83	532.78	537.83	573.64	506.14	618.51	659.68	582.06	
0147T	TC	309.38	331.69	289.48	293.91	315.11	275.01	338.00	362.37	316.26	C
0147T	26	94.16	97.41	91.47	89.45	92.54	86.90	102.87	106.42	99.93	
0148T		566.14	603.83	532.78	537.83	573.64	506.14	618.51	659.68	582.06	
0148T	TC	403.49	432.53	377.58	383.32	410.90	358.70	440.81	472.54	412.51	C

– These amounts apply when service is performed in a facility setting.
C – The payment for the technical component is capped at the OPPS amount.

2007 Carrier-Priced Fee Schedule Services, continued

Proc	Mod	Par	Nonpar	Ltg Chg	Note		Proc	Mod	Par	Nonpar	Ltg Chg	Note	
0148T	26	94.16	97.41	91.47	89.45		92.54	86.90	102.87	106.42	99.93		
0149T		566.14	603.83	532.78	537.83		573.64	506.14	618.51	659.68	582.06		
0149T	TC	403.49	432.53	377.58	383.32		410.90	358.70	440.81	472.54	412.51	C	
0149T	26	94.16	97.41	91.47	89.45		92.54	86.90	102.87	106.42	99.93		
0150T		566.14	603.83	532.78	537.83		573.64	506.14	618.51	659.68	582.06		
0150T	TC	256.19	274.69	239.70	243.38		260.96	227.71	279.89	300.10	261.87	C	
0150T	26	94.16	97.41	91.47	89.45		92.54	86.90	102.87	106.42	99.93		
0151T		150.00	150.00	150.00	142.50		142.50	142.50	163.88	163.88	163.88		
0151T	TC	95.24	100.00	89.16	90.48		95.00	84.70	104.05	109.25	97.41	C	
0151T	26	50.00	50.00	50.00	47.50		47.50	47.50	54.62	54.62	54.62		
21088		6,360.07	6,360.07	6,360.07	6,042.07		6,042.07	6,042.07	6,948.38	6,948.38	6,948.38		
21088		4,070.45	4,070.45	4,070.45	3,866.93		3,866.93	3,866.93	4,446.97	4,446.97	4,446.97	#	
70170		54.07	57.86	50.80	51.37		54.97	48.26	59.07	63.21	55.50		
70170	TC	39.45	42.81	36.54	37.48		40.67	34.71	43.10	46.77	39.92		
70557		382.84	394.73	372.20	363.70		374.99	353.59	418.25	431.24	406.63		
70557	TC	229.70	236.84	223.32	218.21		225.00	212.15	250.95	258.75	243.98		
70558		424.30	438.10	411.99	403.08		416.19	391.39	463.55	478.62	450.10		
70558	TC	254.58	262.86	247.19	241.85		249.72	234.83	278.13	287.17	270.06		
70559		427.70	442.64	414.40	406.32		420.51	393.68	467.26	483.58	452.73		
70559	TC	256.62	265.58	248.64	243.79		252.30	236.21	280.36	290.15	271.64		
71090		97.58	104.48	91.62	92.70		99.26	87.04	106.61	114.14	100.09		
71090	TC	70.01	76.03	64.81	66.51		72.23	61.57	76.49	83.06	70.80		
72291		214.67	232.88	195.17	203.94		221.24	185.41	234.53	254.42	213.22		
72291	TC	128.80	139.72	117.11	122.36		132.73	111.25	140.71	152.64	127.94		
72292		268.64	302.48	234.30	255.21		287.36	222.59	293.49	330.46	255.97		
72292	TC	161.18	181.49	140.59	153.12		172.42	133.56	176.09	198.28	153.59		
73530		35.06	37.05	33.31	33.31		35.20	31.64	38.30	40.48	36.39		
73530	TC	20.78	22.34	19.41	19.74		21.22	18.44	22.70	24.41	21.21		
74190		77.24	82.37	72.78	73.38		78.25	69.14	84.38	89.99	79.51		
74190	TC	53.59	57.95	49.79	50.91		55.05	47.30	58.55	63.31	54.40		
74300		50.07	52.37	47.30	47.57		49.75	44.93	54.70	57.21	51.68		
74300	TC	30.04	31.43	28.38	28.54		29.86	26.96	32.82	34.34	31.01		
74301		28.35	29.58	26.89	26.93		28.10	25.55	30.97	32.32	29.38		
74301	TC	17.01	17.74	16.13	16.16		16.85	15.32	18.58	19.38	17.62		
74305		53.29	56.79	50.28	50.63		53.95	47.77	58.22	62.04	54.93		
74305	TC	32.44	35.21	30.04	30.82		33.45	28.54	35.44	38.47	32.82		
74328		163.76	175.44	153.61	155.57		166.67	145.93	178.91	191.67	167.82		
74328	TC	129.35	139.89	120.15	122.88		132.90	114.14	141.31	152.83	131.26		
74330		173.47	185.49	163.03	164.80		176.22	154.88	189.52	202.65	178.11		
74330	TC	129.35	139.89	120.15	122.88		132.90	114.14	141.31	152.83	131.26		
74340		109.42	118.05	102.07	103.95		112.15	96.97	119.54	128.97	111.51	C	
74340	TC	82.83	90.64	76.17	78.69		86.11	72.36	90.49	99.02	83.22	C	
74355		144.77	154.69	136.00	137.53		146.96	129.20	158.16	169.00	148.58		
74355	TC	107.56	116.30	99.93	102.18		110.48	94.93	117.51	127.06	109.17		
74360		98.02	105.64	91.54	93.12		100.36	86.96	107.09	115.41	100.01	C	
74360	TC	70.68	77.43	64.93	67.15		73.56	61.68	77.22	84.59	70.94	C	
74420		125.61	135.04	117.41	119.33		128.29	111.54	137.23	147.53	128.27		
74420	TC	107.56	116.30	99.93	102.18		110.48	94.93	117.51	127.06	109.17		
74425		71.64	76.69	67.27	68.06		72.86	63.91	78.27	83.78	73.49		

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2007 Carrier-Priced Fee Schedule Services, continued

		Participating			Nonparticipating			Limiting Charge			Note
Proc	**Mod**	**Loc 03**	**Loc 04**	**Loc 99**	**Loc 03**	**Loc 04**	**Loc 99**	**Loc 03**	**Loc 04**	**Loc 99**	
74425	TC	53.59	57.95	49.79	50.91	55.05	47.30	58.55	63.31	54.40	
74445		103.41	109.46	98.25	98.24	103.99	93.34	112.98	119.59	107.34	
74445	TC	46.20	49.96	42.93	43.89	47.46	40.78	50.47	54.58	46.90	
74450		76.51	82.07	71.69	72.68	77.97	68.11	83.59	89.66	78.32	
74450	TC	59.86	64.76	55.58	56.87	61.52	52.80	65.40	70.75	60.72	
74470		77.78	82.83	73.41	73.89	78.69	69.74	84.97	90.49	80.20	
74470	TC	51.34	55.57	47.66	48.77	52.79	45.28	56.09	60.71	52.07	
74775		90.79	96.78	85.60	86.25	91.94	81.32	99.19	105.73	93.52	
74775	TC	59.86	64.76	55.58	56.87	61.52	52.80	65.40	70.75	60.72	
75801		225.96	241.24	212.50	214.66	229.18	201.88	246.86	263.55	232.16	C
75801	TC	183.46	196.48	171.82	174.29	186.66	163.23	200.43	214.65	187.71	C
75803		239.94	254.80	226.75	227.94	242.06	215.41	262.13	278.37	247.72	C
75803	TC	183.46	196.48	171.82	174.29	186.66	163.23	200.43	214.65	187.71	C
75805		224.06	238.70	211.08	212.86	226.76	200.53	244.79	260.78	230.60	C
75805	TC	183.46	196.48	171.82	174.29	186.66	163.23	200.43	214.65	187.71	C
75810		571.43	614.83	533.56	542.86	584.09	506.88	624.29	671.70	582.91	
75810	TC	515.50	557.02	479.18	489.72	529.17	455.22	563.18	608.54	523.50	
75894		650.43	737.15	580.33	617.91	700.29	551.31	710.59	805.34	634.01	C
75894	TC	584.87	668.98	516.92	555.63	635.53	491.07	638.97	730.86	564.74	C
75896		650.02	736.20	580.32	617.52	699.39	551.30	710.15	804.30	634.00	C
75896	TC	584.87	668.98	516.92	555.63	635.53	491.07	638.97	730.86	564.74	C
75898		124.56	130.83	119.20	118.33	124.29	113.24	136.08	142.93	130.23	
75898	TC	43.20	46.78	40.09	41.04	44.44	38.09	47.20	51.11	43.80	
75940		543.21	585.98	505.88	516.05	556.68	480.59	593.46	640.18	552.67	
75940	TC	515.50	557.02	479.18	489.72	529.17	455.22	563.18	608.54	523.50	
75945		186.71	208.00	169.20	177.37	197.60	160.74	203.98	227.24	184.85	C
75945	TC	165.27	185.41	148.70	157.01	176.14	141.26	180.56	202.56	162.45	C
75952		719.18	775.00	658.51	683.22	736.25	625.58	785.70	846.69	719.42	
75952	TC	431.51	465.01	395.10	409.93	441.76	375.35	471.42	508.02	431.65	
75953		301.35	347.48	255.53	286.28	330.11	242.75	329.22	379.62	279.17	
75953	TC	180.81	208.49	153.32	171.77	198.07	145.65	197.53	227.78	167.50	
75954		738.88	853.75	625.35	701.94	811.06	594.08	807.23	932.72	683.19	
75954	TC	443.32	512.25	375.20	421.15	486.64	356.44	484.33	559.63	409.91	
75960		461.62	514.38	418.18	438.54	488.66	397.27	504.32	561.96	456.86	C
75960	TC	419.52	470.59	377.48	398.54	447.06	358.61	458.33	514.12	412.40	C
75970		479.42	545.40	426.20	455.45	518.13	404.89	523.77	595.85	465.62	C
75970	TC	437.95	502.47	385.95	416.05	477.35	366.65	478.46	548.95	421.65	C
75980		292.69	313.06	274.99	278.06	297.41	261.24	319.76	342.02	300.43	
75980	TC	222.13	240.20	206.36	211.02	228.19	196.04	242.68	262.42	225.45	
75992		421.28	454.28	392.51	400.22	431.57	372.88	460.25	496.30	428.82	C
75992	TC	393.30	425.23	365.42	373.63	403.97	347.15	429.68	464.56	399.22	C
76001		141.84	152.12	132.96	134.75	144.51	126.31	154.96	166.19	145.26	
76001	TC	107.56	116.30	99.93	102.18	110.48	94.93	117.51	127.06	109.17	
76125		45.66	48.84	42.91	43.38	46.40	40.76	49.88	53.36	46.88	
76125	TC	32.44	35.21	30.04	30.82	33.45	28.54	35.44	38.47	32.82	
76350		16.46	17.46	14.94	15.64	16.59	14.19	17.98	19.08	16.32	
76932		96.88	103.31	91.33	92.04	98.14	86.76	105.84	112.87	99.78	
76932	TC	63.38	68.83	58.66	60.21	65.39	55.73	69.24	75.20	64.09	

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2007 Carrier-Priced Fee Schedule Services, continued

		Participating			Nonparticipating			Limiting Charge			Note
Proc	**Mod**	**Loc 03**	**Loc 04**	**Loc 99**	**Loc 03**	**Loc 04**	**Loc 99**	**Loc 03**	**Loc 04**	**Loc 99**	
76940		187.06	201.51	173.64	177.71	191.43	164.96	204.36	220.15	189.70	C
76940	TC	75.44	82.04	67.67	71.67	77.94	64.29	82.42	89.63	73.93	
76941		130.26	137.83	123.76	123.75	130.94	117.57	142.31	150.58	135.21	
76941	TC	62.48	67.54	58.07	59.36	64.16	55.17	68.26	73.79	63.44	
76945		95.49	101.66	90.14	90.72	96.58	85.63	104.32	111.06	98.48	
76945	TC	62.48	67.54	58.07	59.36	64.16	55.17	68.26	73.79	63.44	
76975		104.05	110.96	98.11	98.85	105.41	93.20	113.67	121.22	107.19	
76975	TC	63.38	68.83	58.66	60.21	65.39	55.73	69.24	75.20	64.09	
77520		900.75	900.75	900.75	855.71	855.71	855.71	984.07	984.07	984.07	
77522		932.27	932.27	932.27	885.66	885.66	885.66	1,018.50	1,018.50	1,018.50	
77523		968.30	968.30	968.30	919.88	919.88	919.88	1,057.87	1,057.87	1,057.87	
77525		1,080.90	1,080.90	1,080.90	1,026.86	1,026.86	1,026.86	1,180.88	1,180.88	1,180.88	
78282		51.96	54.28	49.16	49.36	51.57	46.70	56.77	59.30	53.71	
78282	TC	31.17	32.56	29.50	29.61	30.93	28.02	34.05	35.57	32.23	
78414		61.45	64.02	58.31	58.38	60.82	55.39	67.13	69.94	63.70	
78414	TC	36.87	38.41	34.99	35.03	36.49	33.24	40.28	41.96	38.23	
78459		834.76	905.24	774.24	793.02	859.98	735.53	911.98	988.97	845.86	C
78459	TC	759.41	827.61	700.85	721.44	786.23	665.81	829.66	904.16	765.68	C
78491		836.52	907.28	775.78	794.69	861.92	736.99	913.90	991.20	847.54	C
78491	TC	759.41	827.61	700.85	721.44	786.23	665.81	829.66	904.16	765.68	C
78492		856.79	928.18	795.50	813.95	881.77	755.72	936.04	1,014.04	869.08	C
78492	TC	759.41	827.61	700.85	721.44	786.23	665.81	829.66	904.16	765.68	C
78608		961.16	1,043.06	890.85	913.10	990.91	846.31	1,050.07	1,139.54	973.25	C
78608	TC	887.81	967.36	819.47	843.42	918.99	778.50	969.93	1,056.84	895.27	C
78609		1,815.15	1,908.78	1,663.33	1,724.39	1,813.34	1,580.16	1,983.05	2,085.34	1,817.19	
78609	TC	1,735.05	1,826.04	1,585.42	1,648.30	1,734.74	1,506.15	1,895.54	1,994.95	1,732.07	
78811		966.60	1,049.60	895.45	918.27	997.12	850.68	1,056.01	1,146.69	978.28	C
78811	TC	887.81	967.36	819.47	843.42	918.99	778.50	969.93	1,056.84	895.27	C
78812		984.75	1,068.03	913.32	935.51	1,014.63	867.65	1,075.84	1,166.82	997.80	C
78812	TC	887.81	967.36	819.47	843.42	918.99	778.50	969.93	1,056.84	895.27	C
78813		987.77	1,071.10	916.31	938.38	1,017.54	870.49	1,079.14	1,170.18	1,001.07	C
78813	TC	887.81	967.36	819.47	843.42	918.99	778.50	969.93	1,056.84	895.27	C
78814		1,095.69	1,188.07	1,016.44	1,040.91	1,128.67	965.62	1,197.04	1,297.97	1,110.46	C
78814	TC	986.28	1,074.73	910.29	936.97	1,020.99	864.78	1,077.51	1,174.14	994.49	C
78815		1,106.65	1,199.21	1,027.24	1,051.32	1,139.25	975.88	1,209.02	1,310.14	1,122.26	C
78815	TC	986.28	1,074.73	910.29	936.97	1,020.99	864.78	1,077.51	1,174.14	994.49	C
78816		1,109.67	1,202.28	1,030.22	1,054.19	1,142.17	978.71	1,212.31	1,313.49	1,125.52	C
78816	TC	986.28	1,074.73	910.29	936.97	1,020.99	864.78	1,077.51	1,174.14	994.49	C
79300		229.00	238.41	217.13	217.55	226.49	206.27	250.18	260.46	237.21	
79300	TC	137.41	143.04	130.29	130.54	135.89	123.78	150.12	156.27	142.34	
86485		17.92	18.95	16.26	17.02	18.00	15.45	19.58	20.70	17.76	
91132		71.25	74.55	67.23	67.69	70.82	63.87	77.84	81.45	73.45	
91132	TC	42.75	44.80	40.34	40.61	42.56	38.32	46.70	48.94	44.07	
91133		88.46	92.15	83.85	84.04	87.54	79.66	96.64	100.67	91.61	
91133	TC	53.07	55.30	50.30	50.42	52.53	47.78	57.98	60.42	54.95	
92978		278.54	296.49	262.91	264.61	281.67	249.76	304.30	323.92	287.23	
92978	TC	186.69	201.81	173.49	177.36	191.72	164.82	203.96	220.48	189.54	
92979		168.48	178.78	159.57	160.06	169.84	151.59	184.06	195.32	174.33	

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2007 Carrier-Priced Fee Schedule Services, continued

		Participating			Nonparticipating			Limiting Charge			Note
Proc	**Mod**	**Loc 03**	**Loc 04**	**Loc 99**	**Loc 03**	**Loc 04**	**Loc 99**	**Loc 03**	**Loc 04**	**Loc 99**	
92979	TC	94.54	102.35	87.75	89.81	97.23	83.36	103.28	111.82	95.87	
93235		130.18	139.70	121.90	123.67	132.71	115.81	142.22	152.62	133.18	
93236		107.56	116.30	99.93	102.18	110.48	94.93	117.51	127.06	109.17	
93315		379.46	393.96	361.10	360.49	374.26	343.05	414.56	430.40	394.50	
93315	TC	227.68	236.37	216.65	216.30	224.55	205.82	248.74	258.23	236.69	
93317		249.91	259.13	238.09	237.41	246.17	226.19	273.03	283.10	260.11	
93317	TC	149.95	155.48	142.85	142.45	147.71	135.71	163.82	169.86	156.06	
93318		303.16	313.66	289.30	288.00	297.98	274.83	331.20	342.67	316.06	
93318	TC	181.90	188.19	173.59	172.81	178.78	164.91	198.73	205.60	189.65	
93501		866.48	933.49	808.67	823.16	886.82	768.24	946.63	1,019.84	883.47	
93501	TC	702.42	762.20	650.58	667.30	724.09	618.05	767.39	832.70	710.76	
93505		322.23	340.44	306.93	306.12	323.42	291.58	352.04	371.93	335.32	
93505	TC	84.84	92.64	78.15	80.60	88.01	74.24	92.69	101.21	85.38	
93508		752.38	804.70	707.03	714.76	764.47	671.68	821.98	879.13	772.43	
93508	TC	515.23	556.95	478.74	489.47	529.10	454.80	562.89	608.47	523.02	
93510		1,786.47	1,928.70	1,663.53	1,697.15	1,832.26	1,580.35	1,951.72	2,107.10	1,817.41	
93510	TC	1,536.71	1,667.72	1,423.14	1,459.87	1,584.33	1,351.98	1,678.86	1,821.98	1,554.78	
93511		1,782.06	1,922.29	1,660.91	1,692.96	1,826.18	1,577.86	1,946.90	2,100.10	1,814.54	
93511	TC	1,495.13	1,622.46	1,384.72	1,420.37	1,541.34	1,315.48	1,633.43	1,772.54	1,512.81	
93524		2,347.33	2,531.70	2,188.15	2,229.96	2,405.11	2,078.74	2,564.46	2,765.88	2,390.55	
93524	TC	1,955.44	2,122.34	1,810.79	1,857.67	2,016.22	1,720.25	2,136.32	2,318.66	1,978.29	
93526		2,350.03	2,537.01	2,188.52	2,232.53	2,410.16	2,079.09	2,567.41	2,771.68	2,390.96	
93526	TC	2,009.55	2,181.21	1,860.79	1,909.07	2,072.15	1,767.75	2,195.43	2,382.97	2,032.91	
93527		2,366.60	2,551.96	2,206.62	2,248.27	2,424.36	2,096.29	2,585.51	2,788.02	2,410.73	
93527	TC	1,955.44	2,122.34	1,810.79	1,857.67	2,016.22	1,720.25	2,136.32	2,318.66	1,978.29	
93528		2,458.59	2,647.81	2,295.40	2,335.66	2,515.42	2,180.63	2,686.01	2,892.73	2,507.72	
93528	TC	1,955.44	2,122.34	1,810.79	1,857.67	2,016.22	1,720.25	2,136.32	2,318.66	1,978.29	
93529		2,228.27	2,407.34	2,073.49	2,116.86	2,286.97	1,969.82	2,434.38	2,630.02	2,265.29	
93529	TC	1,955.44	2,122.34	1,810.79	1,857.67	2,016.22	1,720.25	2,136.32	2,318.66	1,978.29	
93530		936.87	1,007.01	876.45	890.03	956.66	832.63	1,023.53	1,100.16	957.52	
93530	TC	702.42	762.20	650.58	667.30	724.09	618.05	767.39	832.70	710.76	
93531		2,466.79	2,658.70	2,301.28	2,343.45	2,525.76	2,186.22	2,694.97	2,904.63	2,514.15	
93531	TC	2,009.55	2,181.21	1,860.79	1,909.07	2,072.15	1,767.75	2,195.43	2,382.97	2,032.91	
93555		300.16	322.68	280.53	285.15	306.55	266.50	327.92	352.53	306.48	
93555	TC	257.46	278.58	239.03	244.59	264.65	227.08	281.28	304.35	261.14	
93556		448.18	482.35	418.34	425.77	458.23	397.42	489.64	526.97	457.04	
93556	TC	404.35	437.09	375.72	384.13	415.24	356.93	441.75	477.52	410.47	
93561		47.67	50.87	44.98	45.29	48.33	42.73	52.08	55.58	49.14	
93561	TC	23.34	25.77	21.30	22.17	24.48	20.23	25.50	28.15	23.27	
93562		22.38	24.26	20.81	21.26	23.05	19.77	24.45	26.50	22.73	
93562	TC	14.56	16.12	13.26	13.83	15.31	12.60	15.91	17.61	14.49	
93571		280.32	298.46	264.53	266.30	283.54	251.30	306.25	326.07	289.00	
93571	TC	186.60	201.80	173.33	177.27	191.71	164.66	203.86	220.47	189.36	
93602		159.95	169.27	152.15	151.95	160.81	144.54	174.75	184.93	166.22	
93602	TC	46.09	50.01	42.69	43.79	47.51	40.56	50.35	54.64	46.64	
93603		184.14	195.74	174.38	174.93	185.95	165.66	201.17	213.85	190.51	
93603	TC	70.01	76.03	64.81	66.51	72.23	61.57	76.49	83.06	70.80	
93609		379.17	400.47	361.21	360.21	380.45	343.15	414.24	437.51	394.62	

– These amounts apply when service is performed in a facility setting.
C – The payment for the technical component is capped at the OPPS amount.

2007 Carrier-Priced Fee Schedule Services, continued

		Participating			Nonparticipating			Limiting Charge			Note
Proc	**Mod**	**Loc 03**	**Loc 04**	**Loc 99**	**Loc 03**	**Loc 04**	**Loc 99**	**Loc 03**	**Loc 04**	**Loc 99**	
93609	TC	113.22	122.81	104.90	107.56	116.67	99.66	123.69	134.17	114.60	
93610		218.76	231.47	208.16	207.82	219.90	197.75	239.00	252.88	227.41	
93610	TC	57.00	62.08	52.63	54.15	58.98	50.00	62.27	67.82	57.50	
93612		229.78	243.49	218.33	218.29	231.32	207.41	251.03	266.01	238.53	
93612	TC	67.39	73.25	62.33	64.02	69.59	59.21	73.62	80.03	68.10	
93615		59.08	61.43	57.07	56.13	58.36	54.22	64.54	67.11	62.35	
93615	TC	13.28	14.40	12.30	12.62	13.68	11.69	14.51	15.73	13.44	
93618		390.84	414.66	370.62	371.30	393.93	352.09	426.99	453.02	404.90	
93618	TC	164.18	177.98	152.20	155.97	169.08	144.59	179.37	194.44	166.28	
93619		720.86	765.57	682.79	684.82	727.29	648.65	787.54	836.39	745.95	
93619	TC	319.48	346.39	296.13	303.51	329.07	281.32	349.03	378.43	323.52	
93620		1,646.00	1,718.72	1,556.61	1,563.70	1,632.78	1,478.78	1,798.25	1,877.70	1,700.60	
93620	TC	987.60	1,031.23	933.97	938.22	979.67	887.27	1,078.95	1,126.62	1,020.36	
93621		309.71	325.59	290.83	294.22	309.31	276.29	338.36	355.71	317.73	
93621	TC	185.84	195.35	174.50	176.55	185.58	165.78	203.03	213.42	190.64	
93622		537.07	588.15	483.19	510.22	558.74	459.03	586.75	642.55	527.89	
93622	TC	322.24	352.90	289.91	306.13	335.25	275.41	352.05	385.54	316.73	
93623		410.39	428.60	387.91	389.87	407.17	368.51	448.35	468.25	423.79	
93623	TC	246.24	257.16	232.75	233.93	244.30	221.11	269.02	280.95	254.28	
93624		350.12	369.06	334.15	332.61	350.61	317.44	382.51	403.20	365.06	
93624	TC	82.91	90.04	76.75	78.76	85.54	72.91	90.58	98.37	83.85	
93640		482.40	515.15	454.29	458.28	489.39	431.58	527.02	562.80	496.31	
93640	TC	296.42	321.10	274.96	281.60	305.05	261.21	323.84	350.80	300.39	
93641		611.41	649.86	578.61	580.84	617.37	549.68	667.97	709.97	632.13	
93641	TC	296.42	321.10	274.96	281.60	305.05	261.21	323.84	350.80	300.39	
93662		445.15	479.10	408.17	422.89	455.14	387.76	486.33	523.42	445.93	
93662	TC	267.09	287.47	244.91	253.74	273.10	232.66	291.80	314.06	267.56	
94642		29.97	31.42	27.50	28.47	29.85	26.13	32.74	34.33	30.04	
95824		102.73	107.86	91.60	97.59	102.47	87.02	112.23	117.84	100.07	
95824	TC	61.63	64.72	54.96	58.55	61.48	52.21	67.33	70.71	60.04	
95951		854.45	886.02	813.06	811.73	841.72	772.41	933.49	967.98	888.27	
95951	TC	512.67	531.62	487.83	487.04	505.04	463.44	560.09	580.79	532.95	
95965		1,098.16	1,135.18	1,048.88	1,043.25	1,078.42	996.44	1,199.74	1,240.18	1,145.90	
95965	TC	658.90	681.11	629.33	625.95	647.05	597.86	719.85	744.11	687.54	
95966		563.79	587.25	534.48	535.60	557.89	507.76	615.94	641.57	583.92	
95966	TC	338.28	352.34	320.69	321.37	334.72	304.66	369.57	384.93	350.35	
95967		495.54	516.85	469.17	470.76	491.01	445.71	541.38	564.66	512.57	
95967	TC	297.32	310.11	281.51	282.45	294.60	267.43	324.82	338.80	307.55	
99082		1.99	1.99	1.99	1.89	1.89	1.89	2.17	2.17	2.17	

– These amounts apply when service is performed in a facility setting.
C – The payment for the technical component is capped at the OPPS amount.

RADIOLOGY

Allowance Revision to HCPCS Code A9552

First Coast Service Options, Inc. (FCSO) has identified an overpayment in the Medicare allowance involving HCPCS code A9552 affecting claims for date of services **on of after January 1, 2007,** with a processed date of **January 1, 2007, through May 11, 2007.**

The correct allowance for HCPCS code A9552 is $220.80 per study dose.
Claims processed **on or after May 12, 2007,** are being paid correctly.

Action Required by Providers

If you were overpaid for HCPCS code A9552 for date of services **on of after January 1, 2007**, with a processed date of **January 1, 2007, through May 11, 2007,** please return the overpaid amount, along with a completed Overpayment Refund Form to:

Connecticut
Medicare Part B Correspondence
Attention: Financial Services
P.O. Box 45010
Jacksonville, FL 32232-5010

Florida
Medicare Part B Financial Services
P.O. Box 44141
Jacksonville, FL 32231-4141

If you fail to refund any payments made in error, you will be sent a letter requesting the refund. We apologize for any inconvenience this has caused.

SURGERY

Percutaneous Transluminal Angioplasty

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

Provider Types Affected

Physicians and hospitals that submit claims to Medicare contractors (Part A/B Medicare administrative contractors [A/B MACs], fiscal intermediaries [FI] or carriers) for PTA services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

On August 02, 2006, a request to reconsider the national coverage determination (NCD) for PTA and stenting of the carotid arteries initiated a national coverage analysis. Change request (CR) 5660 communicates the findings resulting from that analysis.

CAUTION – What You Need to Know

Effective for dates of service performed on and after April 30, 2007, be aware of

- Clarifications regarding the use of PTA and stenting of the carotid arteries for patients at high risk for carotid endarterectomy (CEA) and
- **Note the process that facilities must follow for certification and recertification** that is specified in section 20.7 of Publication100-03, the *Medicare National Coverage Determinations Manual*.

GO – What You Need to Do

If you are a provider of PTA and stenting of the carotid arteries services be aware that CMS has reviewed the evidence and determined that **coverage for this NCD is unchanged** and that **facilities should follow the certification/recertification guidelines in CR 5660.** See the *Background and Additional Information* sections of this Medicare Modernization Act (MMA) update.

Background

On April 22, 2005, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 3811 providing Medicare coverage for PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent when beneficiaries are at high risk for carotid endarterectomy (CEA). This national coverage determination (NCD) is contained in section 20.7 of the *Medicare National Coverage Determinations Manual* and the **changes in the NCD are listed below.** To read more about this NCD, click on the article issued with this change request that may be found in *the Additional Information* section of this article.

Percutaneous Transluminal Angioplasty, continued

PTA is covered when used under the following conditions:

- Treatment of atherosclerotic obstructive lesions.
  - In the lower extremities, i.e. the iliac, femoral, and popliteal arteries.
  - In the upper extremities, i.e. the innominate, subclavian, axillary, and brachial arteries, but not head or neck vessels.
  - Of a single coronary artery.
- Concurrent with carotid stent placement.
  - Food and Drug Administration (FDA)-approved category B investigational device exemption (IDE) clinical trials – effective July 1, 2001.
  - FDA-approved post approval studies – effective October 12, 2004.
  - Patients at high risk for carotid endarterectomy (CEA) – effective March 17, 2005.

Note: Coverage is limited to procedures performed using FDA approved carotid artery stents and embolic protection devices.

The use of a distal embolic protection device is required. If deployment of the distal embolic protection device is not technically possible, then the procedure should be aborted given the risks of carotid artery stenting (CAS) without distal embolic protection.

- Concurrent with intracranial stent placement
- FDA-approved category B IDE clinical trials – effective November 6, 2006.

CAS for patients who are not at high risk for CEA remains covered only in FDA-approved Category B IDE clinical trials under 42 CFR 405.201.

CMS has determined that PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent is not reasonable and necessary for all other patients.

Facilities Certification

Facilities must be certified for Medicare to cover the CAS procedures and must recertify every two (2) years in order to maintain Medicare coverage of CAS procedures. Recertification will occur when the facility documents that and describes how it continues to meet the CMS standards. The new recertification guidelines are as follows:

At 23 Months After Initial Certification

Submission of a letter to CMS stating how the facility continues to meet the minimum facility standards as listed in section 20.7 of the *Medicare National Coverage Determinations Manual*. (See the *Additional Information* section of this article for the Web link to the NCD within CR 5660)

At 27 Months After Initial Certification

- Submission of required data elements for all CAS procedures performed on patients during the previous two years of certification.
- Required data elements:

  Patients' Medicare identification number if a Medicare beneficiary

  Patients' date of birth

  Date of procedure

Does the patient meet high surgical risk criteria (defined below)?

- Age =80
- Recent (< 30 days) myocardial infarction (MI)
- Left ventricle ejection fraction (LVEF) < 30%
- Contralateral carotid occlusion
- New York Heart Association (NYHA) class III or IV congestive heart failure
- Unstable angina: Canadian cardiovascular society (CCS) class III/IV
- Renal failure: end stage renal disease on dialysis
- Common carotid artery (CCA) lesion(s) below clavicle
- Severe chronic lung disease
- Previous neck radiation
- High cervical internal carotid artery (ICA) lesion(s)
- Restenosis of prior carotid endarterectomy (CEA);
- Tracheostomy;
- Contralateral laryngeal nerve palsy.

Is the patient symptomatic (defined below)?

- Carotid transient ischemic attack (TIA) persisting less than 24 hours;
- Non-disabling stroke: Modified rankin scale <3 with symptoms for 24 hours or more;
- Transient monocular blindness:amaurosis fugax;

Modified Rankin Scale score if the patient experienced a stroke

Percent stenosis of stented lesion(s) by angiography

Was embolic protection used?

Were there any complications during hospitalization (defined below)?

- Stroke: an ischemic neurologic deficit that persisted more than 24 hours
- MI
- Death

Recertification is effective for two (2) additional years during which facilities will be required to submit the requested data every April 1 and October 1.

CMS will consider the approval of national carotid artery stenting registries that provide CMS with a comprehensive overview of the registry and its capabilities, and the manner in which the registry meets CMS data collection and evaluation requirements. Specific standards for CMS approval are listed below. Facilities enrolled in a CMS approved national CAS registry will automatically meet the data collection standards required for initial and continued facility certification. Hospitals' contracts with an approved registry may include authority for the registry to submit required data to CMS for the hospital. A list of approved registries will be made available on the CMS coverage Web site. In addition, CMS will publish a list of approved facilities in the *Federal Register*.

National Registries

As noted above, CMS will approve national registries developed by professional societies and other organizations

Percutaneous Transluminal Angioplasty, continued

and allow these entities to collect and submit data to CMS on behalf of participating facilities to meet facility certification and recertification requirements. To be eligible to perform these functions and become a CMS approved registry, the national registry, at a minimum, must be able to:

1. Enroll facilities in every US state and territory.
2. Assure data confidentiality and compliance with HIPAA.
3. Collect the required CMS data elements as listed above.
4. Assure data quality and data completeness.
5. Address deficiencies in the facility data collection, quality, and submission.
6. Validate the data submitted by facilities, as needed.
7. Track long term outcomes such as stroke and death.
8. Conduct data analyses and produce facility specific data reports and summaries.
9. Submit data to CMS on behalf of the individual facilities.
10. Provide quarterly reports to CMS on facilities that do not meet or no longer meet the CMS facility certification and recertification requirements pertaining to data collection and analysis.

Registries wishing to receive this designation from CMS must submit evidence that they meet or exceed these 10 requirements. Though the registry requirements pertain to CAS, CMS strongly encourages all national registries to establish a similar mechanism to collect comparable data on CEA. Having both CAS and CEA data will help answer questions about carotid revascularization, in general, in the Medicare population.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5660) issued to your Medicare carrier, or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R71NCD.pdf* on the CMS Web site.

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

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

The *MLN Matters* article related to CR 3811, which is referenced in the *Background Section* of this article may be reviewed by clicking on the following link *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf* on the CMS Web site.

MLN Matters Number: MM5660
Related Change Request (CR) #: 5660
Related CR Release Date: June 29, 2007
Effective Date: April 30, 2007
Related CR Transmittal #: R71NCD
Implementation Date: July 30, 2007

Overpayment on Multiple Surgery Claims

First Coast Service Options, Inc. (FCSO) has identified overpayments affecting multiple surgery services when the services have been submitted on more than one claim. As a result of this identification, FCSO will pursue overpayments on claims paid incorrectly.

Providers submitting claims for multiple surgical procedures need to include all the procedures performed on the same day on a single claim. This action will help prevent manual intervention and will also expedite the claim processing time.

Action Required by Providers

If you received overpayments for multiple surgery procedures performed on the same date of service, please return the overpaid amount, along with a completed Overpayment Refund Form to:

Connecticut
Medicare Part B Correspondence
Attention: Financial Services
P.O. Box 45010
Jacksonville, FL 32232-5010

Florida
Medicare Part B Financial Services
P.O. Box 44141
Jacksonville, FL 32231-4141

If you fail to refund any payments made in error, you will be sent a letter requesting the refund. We apologize for any inconvenience this has caused.

Astigmatism-Correcting Intraocular Lens Implementation

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the June 2007 Medicare B Update! pages 19-22.

Note: This article was revised on July 18, 2007, to correct a typo and to provide new Web addresses for accessing the Notices of Exclusion from Medicare Benefits. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5527, which discusses a recent administrator ruling from the Centers for Medicare & Medicaid Services (CMS) regarding astigmatism-correcting intraocular lenses (A-C IOLs) following cataract surgery (CMS-1536-R). **The new policy is effective for dates of service on and after January 22, 2007. Physicians and providers need to be aware that effective January 22, 2007:**

- Medicare will pay the same amount for cataract extraction with A-C IOL insertion that it pays for cataract extraction with conventional IOL insertion.
- **The beneficiary is responsible for payment of that portion of the hospital or ambulatory surgery center (ASC) charge for the procedure that exceeds the facility's usual charge for cataract extraction and insertion of a conventional IOL following cataract surgery, as well as any fees that exceed the physician's usual charge to perform a cataract extraction with insertion of a conventional IOL.**

In addition, CMS reminds physicians that they can be reimbursed for the conventional or A-C IOL (V2632) only when the service is performed in a physician's office. Also, when physicians perform cataract surgery in an ASC or hospital outpatient setting, the physician may only bill for the professional service because payment for the lens is bundled into the facility payment for the cataract extraction.

Background

The Centers for Medicare & Medicaid Services (CMS) Administrator rulings serve as 1) precedent final opinions and orders and 2) statements of policy and interpretation. The Administrator rulings provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to Medicare, Medicaid, utilization and peer review by Quality Improvement Organizations, private health insurance, and related matters. These rulings also promote consistency in interpretation of policy and adjudication of disputes, and they are binding on all CMS components, Medicare contractors, the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, and administrative law judges who hear Medicare appeals.

CR 5527 discusses a recent CMS administrator ruling concerning requirements for determining payment for insertion of intraocular lenses (IOLs) that replace beneficiaries' natural lenses and correct pre-existing astigmatism following cataract surgery under the Social Security Act:

Note that CR 5527 basically restates CMS policy provided in CR3927 (*MLN Matters* article MM3927), except that CR 3927 focused on presbyopia-correcting IOLs and this article focuses on A-C IOLs.

Coverage Policy

In general, an item or service covered by Medicare must satisfy the following three basic requirements:

- Fall within a statutorily-defined benefit category;
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part;
- Not be excluded from coverage.

The Social Security Act specifically excludes eyeglasses and contact lenses from coverage, with an exception for one pair of eyeglasses or contact lenses covered as a prosthetic device furnished after each cataract surgery with insertion of an IOL. In addition, there is no Medicare benefit category to allow payment for the surgical correction or cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for the imperfect curvature of the cornea (astigmatism).

An A-C IOL is intended to provide what two separate items otherwise achieve:

- An implantable conventional IOL (one that is not astigmatism -correcting) that is covered by Medicare, and
- The surgical correction, eyeglasses, or contact lenses that are not covered by Medicare.

Although A-C IOLs may serve the same function as eyeglasses or contact lenses furnished following removal of a

Astigmatism-Correcting Intraocular Lens Implementation, continued

cataract, A-C IOLs are neither eyeglasses nor contact lenses. The following table is a summary of benefits for which Medicare makes payment, and services for which Medicare does not pay (no benefit category):

Benefits for Which Medicare Makes Payment	Services for Which Medicare Does NOT Pay – No Benefit Category
A conventional intraocular lens (IOL) implanted following cataract surgery.	The astigmatism-correcting functionality of an IOL implanted following cataract surgery.
Facility or physician services and supplies required to insert a conventional IOL following cataract surgery.	Facility or physician services and resources required to insert and adjust an AC-IOL following cataract surgery that exceeds the services and resources furnished for insertion of a conventional IOL.
One pair of eyeglasses or contact lenses as a prosthetic device furnished after each cataract surgery with insertion of an IOL.	The surgical correction of cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for imperfect curvature of the cornea (astigmatism) Eye examinations performed to determine the refractive state of the eyes specifically associated with insertion of an AC-IOL (including subsequent monitoring services), that exceed the one-time eye examination following cataract surgery with insertion of a conventional IOL.

Currently, there is one NTIOL class approved for special payment when furnished by an ASC, and this currently active NTIOL category for "Reduced Spherical Aberration" was established on February 27, 2006 and expires on February 26, 2011.

Effective for services furnished on or after January 22, 2007, CMS now recognizes the following as A-C IOLs:

- Acrysof® Toric IOL (models: SN60T3, SN60T4, and SN60T5), manufactured by Alcon Laboratories, Inc; and
- Silicon 1P Toric IOL (models: AA4203TF and AA4203TL), manufactured by STAAR Surgical.

Payment Policy for Facility Services and Supplies

The following applies to an IOL inserted following removal of a cataract in a hospital (on either an outpatient or inpatient basis) that is paid under 1) the hospital outpatient prospective payment system (OPPS) or 2) the inpatient prospective payment system (IPPS), respectively (or in a Medicare-approved ASC that is paid under the ASC fee schedule):

- Medicare does not make separate payment to the hospital or the ASC for an IOL inserted subsequent to extraction of a cataract. Payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure; and
- Any person or ASC, who presents or causes to be presented a bill or request for payment for an IOL inserted during or subsequent to cataract surgery for which payment is made under the ASC fee schedule, is subject to a civil money penalty.

For an A-C IOL inserted subsequent to removal of a cataract in a hospital (on either an outpatient or inpatient basis) that is paid under the OPPS or the IPPS, respectively (or in a Medicare-approved ASC that is paid under the ASC fee schedule):

- The facility should bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional or A-C IOL is inserted. When a beneficiary receives an A-C IOL following removal of a cataract, hospitals and ASCs should report the same *CPT* code that is used to report removal of a cataract with insertion of a conventional IOL (see "Coding" below);
- There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL; and
- There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services and supplies required to examine and monitor the beneficiary who receives an AC-IOL following removal of a cataract that exceed the facility charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary after cataract surgery followed by insertion of a conventional IOL.

Payment Policy for Physician Services and Supplies

For an IOL inserted following removal of a cataract in a physician's office Medicare makes separate payment, based on reasonable charges, for an IOL inserted subsequent to extraction of a cataract that is performed at a physician's office.

For an A-C IOL inserted following removal of a cataract in a physician's office:

Astigmatism-Correcting Intraocular Lens Implementation, continued

- A physician should bill for a conventional IOL, regardless of whether a conventional or A-C IOL is inserted (see "Coding," below);
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed the physician charges for services and supplies for the insertion and adjustment of a conventional IOL; and
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of an AC-IOL that exceed the physician charges for services and supplies to examine and monitor a beneficiary following removal of a cataract with insertion of a conventional IOL.

For an A-C IOL inserted following removal of a cataract in a hospital or ASC:

- A physician may not bill Medicare for the A-C IOL inserted during a cataract procedure performed in those settings because payment for the lens is included in the payment made to the facility for the entire procedure;
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed physician charges for services and supplies required for the insertion of a conventional IOL; and
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of an A-C IOL that exceed the physician charges for services and supplies required to examine and monitor a beneficiary following cataract surgery with insertion of a conventional IOL.

Coding

No new codes are being established at this time to identify an A-C IOL or procedures and services related to an A-C IOL, and hospitals, ASCs, and physicians should report one of the following *CPT* codes to bill Medicare for removal of a cataract with IOL insertion:

66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage,

66983 Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure), or

66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification).

Physicians inserting an IOL or an A-C IOL in an office setting may bill code V2632 (posterior chamber intraocular lens) for the IOL or the A-C IOL, which is paid on a reasonable charge basis.

If appropriate, hospitals and physicians may use the proper *CPT* code(s) to bill Medicare for evaluation and management services usually associated with services following cataract extraction surgery, if appropriate.

Beneficiary Liability

When a beneficiary requests insertion of an A-C IOL instead of a conventional IOL following removal of a cataract and that procedure is performed, the beneficiary is responsible for payment of facility charges for services and supplies attributable to the astigmatism-correcting functionality of the A-C IOL:

- In determining the beneficiary's liability, the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the AC-IOL that exceeds the work and resources attributable to insertion of a conventional IOL;
- The physician and the facility may not charge for cataract extraction with insertion of an A-C IOL unless the beneficiary requests this service; and
- The physician and the facility may not require the beneficiary to request an A-C IOL as a condition of performing a cataract extraction with IOL insertion.

Provider Notification Requirements

When a beneficiary requests insertion of an A-C IOL instead of a conventional IOL following removal of a cataract:

- Prior to the procedure to remove a cataractous lens and insert an A-C IOL, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment, or other subsequent treatments related to the astigmatism-correcting functionality of the IOL.
- The correcting functionality of an A-C IOL does not fall into a Medicare benefit category and, therefore, is not covered. Therefore, the facility and physician are not required to provide an advanced beneficiary notice to beneficiaries who request an A-C IOL.
- Although not required, CMS strongly encourages facilities and physicians to issue a **Notice of Exclusion from Medicare Benefits** to beneficiaries in order to identify clearly the nonpayable aspects of an A-C IOL insertion. This notice may be found on the CMS Web site at: *http://www.cms.hhs.gov/BNI/downloads/CMS20007English.pdf* for the English language version and *http://www.cms.hhs.gov/BNI/downloads/CMS20007Spanish.pdf* for the Spanish language version.

Astigmatism-Correcting Intraocular Lens—Implementation of CMS 1536 Ruling, continued

Additional Information

The official instruction, CR 5527, issued to your Medicare carrier, intermediary, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1228CP.pdf* on the CMS Web site.

If you have any questions, please contact your Medicare carrier, intermediary, 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* 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: MM5527 *Revised*
Related Change Request (CR) #: 5527
Related CR Release Date: April 27, 2007
Effective Date: January 22, 2007
Related CR Transmittal #: R1228CP
Implementation Date: May 29, 2007

GENERAL COVERAGE

Incorrect Denial of Claims with Payable ICD-9-CM Codes

As a result of a processing issue, claims with payable ICD-9-CM codes may have been denied in error. The result is an underpayment situation for claims processed between July 1, 2007, and July 22, 2007. The problem was corrected on July 23, 2007.

No Action is Required by Providers at This Time

First Coast Service Options, Inc. requests that providers do not submit appeal or reopening requests, and to refrain from calling the customer services lines in regards to these incorrect denials. Adjustments will be performed systematically. Requesting appeals, reopenings and or telephone inquiries will not expedite payments.

FCSO, on behalf of CMS, apologizes for any inconvenience this may cause.

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.

ELECTRONIC DATA INTERCHANGE

National Provider Identifier Required to Enroll in Electronic Data Interchange, and Update of Telecommunication and Transmission Protocols

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

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], including regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC], or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

If not already enrolled for use of electronic billing & other electronic data interchange (EDI) transactions, you will not be able to enroll to begin use if you have not yet obtained a national provider identifier (NPI).

CAUTION – What You Need to Know

CR 5637, from which this article is taken, announces that providers must obtain an NPI, as a condition for initial enrollment, for the use of EDI. Your Medicare contractor will not issue you an EDI access number and password until you obtain an NPI.

GO – What You Need to Do

If you have not already obtained your NPI, you should apply now. You can apply online by going to *https://nppes.cms.hhs.gov/*.

Background

Since May 2006, providers have been required to obtain an NPI prior to initial Medicare enrollment, or before updating their enrollment records, but were not required to have an NPI, as a condition for enrollment, in order to begin using EDI transactions.

CR 5637, from which this article is taken, announces that (effective October 1, 2007) providers will need to obtain an NPI, as a condition for initial enrollment, for the use of EDI.

This is being implemented to further support efforts by the Centers for Medicare & Medicaid Services (CMS) to have all providers obtain NPIs as soon as possible. Moreover, as indicated in *MLN Matters* article MM5595 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf*), Medicare is monitoring claims to determine the level of NPI reporting. This is being done to determine when it will be reasonable for Medicare to begin rejecting claims that lack an NPI for billing, pay-to or rendering providers.

CR 5637 also updates EDI connectivity information in the *Medicare Claims Processing Manual*, section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), sections 20 (EDI Enrollment) and 30.3 (Telecommunications and Transmission Protocols) because some of the information in the manual is obsolete due to technology changes.

In summary, these changes are:

- Medicare contractors will use V.90 56K modems for EDI transactions submitted via dial-in connections.
- Medicare contractors will offer data compression in a means that an EDI transaction sender/receiver requests, using the V.90 56 K modem, PK ZIP version 2.04x or higher, WinZIP or V.42 bis data compression.
- DME MACs will reject standard National Council for Prescription Drug Programs (NCPDP) transactions that do not use the standard NCPDP electronic envelope.
- Medicare contractors may, but are not required to, accommodate other types of data compression that an EDI submitter/receiver requests.

Additional Information

You may find more information about the requirement for an NPI in order to be able to use EDI transactions, by going to CR 5637, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1283CP.pdf* on the CMS Web site. As an attachment to CR 5637, you will find updated *Medicare Claims Processing Manual*, Section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), Sections 20 (EDI Enrollment) and 30.3 (Telecommunications and Transmission Protocols). You can find more information about EDI on the CMS Web site at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/*, and more information about the NPI at *http://www.cms.hhs.gov/NationalProvIdentstand/* on the CMS Web site.

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

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

MLN Matters Number: MM5637
Related Change Request (CR) #: 5637
Related CR Release Date: July 6, 2007
Effective Date: October 1, 2007
Related CR Transmittal #: R1283CP
Implementation Date: October 1, 2007

Update of Claim Adjustment Reason Codes and Remittance Advice Remark Codes and Enhancement of Medicare Remit Easy Print

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5634, which instructs Medicare contractors that a remittance advice remark code (RARC) must be used with claim adjustment reason codes (CARCs) 16, 17, 96, 125, and A1. CR 5634 also instructs that updated Medicare Remit Easy Print (MREP) software will be provided which incorporates enhancements approved by the Centers for Medicare & Medicaid Services (CMS) and the currently valid CARCS and and RARCS.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions (submission of claims, claims inquiries, electronic remittance advice, etc.) adopted under HIPAA using valid standard codes. The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 transactions are part of the transactions and code sets rule selected by HIPAA, and the ANSI X12 subcommittee 'N' covers standards in the insurance industry, including health insurance (hence these are X12N standards). The ANSI ASC X12N transaction number 835 (ANSI ASC X12N-835) is the ANSI standard electronic remittance advice (ERA) transaction that provides payment information on a submitted claim.

CARC and RARC Update

As a reminder, Medicare policy states that:

- Claim adjustment reason codes (CARCs) are required in the remittance advice and coordination of benefits transactions
- Remittance advice remark codes (RARCs) are **required in the remittance advice for both paper and electronic formats**.

When the payment differs from the amount being billed, Payers communicate the reason for any adjustment using:

- **Group Codes** (which identify who is financially responsible for the amount that the payer is not reimbursing)
- **CARCs** (which provide an explanation why an amount is being adjusted)
- **RARCs** (which provide a supplemental explanation about the adjustment) Any RARC that has the word "Alert" is an informational remark code that does not provide any supplemental explanation for a specific adjustment but provides general information related to adjudication

The following table includes group codes currently being used by CMS:

Group Code	Definition
CO	Contractual Obligation (Provider is financially responsible)
PR	Patient responsibility (Provider can collect the amount from patient)
OA	Other Adjustment (Generally used to report bundling/unbundling situation, predetermination of benefits, and secondary payments)
CR	Correction (Used with reversal and correction)

The ANSI ASC X12N-835 Implementation Guide (version 004010A1) requires CARCs (if needed) but does not require use of RARCs. A HIPAA compliant version of the Implementation Guide for transaction 835 (Health Care Claim Payment & Remittance Advice) is available at: *http://www.wpc-edi.com/HIPAA*.

The code committee that maintains the CARC code set recently modified five CARCs (16, 17, 96, 125, and A1). These CARCs were selected for modification because they were very generic, and they were used most frequently. Of these 5 CARCs, the following four now require the use of at least one appropriate RARC, and they are **effective April 1, 2007**:

CARC	Definition
16	Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Update of CARC and RARC and Enhancement of Medicare Remit Easy Print, continued

CARC	Definition
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

The remaining one CARC (which follows) also requires at least one RARC, but it is **effective June 1, 2007**.

A1 – Claim denied charges

CMS instructed your Medicare contractor(s) to analyze their current use of RARCs with CARCs 16, 17, 96, and 125, and determine if any existing RARCs (that are not currently being used) may be appropriate to explain an adjustment. Your Medicare contractor(s) may start using any of the currently existing RARCs with CARCs 16, 17, 96, 125, and A1.

Note: The most current list of RARCs may be found at: *http://www.wpc-edi.com/codes*.

In addition, the committee that maintains reason codes approved the following CARC effective February 28, 2007:

204 – This service/equipment/drug is not covered under the patient's current benefit plan

Your Medicare contractor(s) may use CARC 204 instead of CARC 96 and an appropriate remark code, e.g., N130.

N130 – Consult plan benefit documents for information about restrictions for this service

RARC N130 will be used with CARC 96 as a default combination to be reported on all DME claims if:

- No code has been assigned by your Medicare contractor, and
- Medicare does not cover the service.

Medicare Remit Easy Print Enhancement

CMS developed MREP software that gives providers a tool to read and print an electronic remittance advice (RA) in a readable format. Providers who use the MREP software have the ability to print paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that may be included with claims submissions to secondary/tertiary payers for coordination of benefits. Information regarding MREP and instructions on obtaining MREP are available through your Medicare contractor.

In a continuing effort to improve MREP, CMS established a process to receive suggestions to enhance the functionality and effectiveness of MREP from providers, contractors, and CMS staff. The next updated version of MREP that incorporates improvements approved by CMS will be available in July 2007. Note that the timeline for the annual MREP enhancement update has changed from October to July.

Additional Information

The official instruction, CR 5634, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1267CP.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM5634
Related Change Request (CR) #: 5634
Related CR Release Date: June 15, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1267CP
Implementation Date: July 2, 2007

FRAUD AND ABUSE

Health & Human Services Fights Durable Medical Equipment Fraud

Demonstration Project Targets Fraudulent Business Practices in South Florida and Southern California

Health & Human Services (HHS) Secretary Mike Leavitt announced a two-year effort designed to further protect Medicare beneficiaries from fraudulent suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). This initiative is focused on preventing deceptive companies from operating in south Florida and southern California.

This new initiative will have an immediate effect in two regions of the country where there are high concentration of suppliers, south Florida and southern California. Based on the results, it could be expanded nationwide.

Miami and Los Angeles have been identified as high-risk areas when it comes to fraudulent billing by DMEPOS suppliers. HHS, working with the Department of Justice (DOJ), formed a Medicare fraud strike force to combat fraud through the use of real-time analysis of Medicare billing data. In just three months, 56 individuals have been charged in the southern district of Florida with fraudulently billing Medicare for more than $258 million. The strike force is made up of federal, state and local investigators.

For your convenience, copies of the HHS press release and fact sheet on this topic are available on the HHS Web site at *http://www.hhs.gov/news*.

Source: Provider Education Resources Listserv, Message 200707-04

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APPEALS TRANSITION

Appeals Transition—BIPA Section 521 Appeals

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

This article is based on change request (CR) 5460, which notifies Medicare contractors about their need to comply with changes to provisions in chapter 29 of the *Medicare Claims Processing Manual* (Publication 100-04) that address the appointment of representatives, fraud and abuse, guidelines for writing appeals correspondence, and the disclosure of information.

Background

The Medicare claims appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) and the Medicare Prescription Drug Improvement and Modernization Act (MMA). The Social Security Act (section 1869[c]), as amended by BIPA and MMA, requires changes to the Code of Federal Regulations (CFR; Title 42) regarding:

- Appointment of representatives,
- Fraud and abuse,
- Guidelines for writing appeals correspondence, and
- The disclosure of information.

Therefore, the Centers for Medicare & Medicaid Services (CMS) is revising provisions in Chapter 29 of the *Medicare Claims Processing Manual* that address these changes.

The purpose of CR 5460 is to notify Medicare contractors about their need to comply with these revised *Medicare Claims Processing Manual* provisions, which are included as an attachment to CR 5460.

Some of the key changes to the manual direct Medicare contractors to:

- Follow the procedures that define who may be a representative and how a representative is appointed via the Appointment of Representative [AOR] form (CMS-1696).
- Do not accept an appointment if the contractor has evidence that the appointment should not be honored.
- Send notice only to the representative when the contractor takes action or issues a redetermination (if there is an appointed representative).
- Provide assistance in completing the CMS-1696 form, as needed.
- Do not release beneficiary-specific information to a representative before the beneficiary or appellant and the prospective representative have completed and signed the CMS-1696 or other conforming written instrument.

Appeals Transition—BIPA Section 521 Appeals, continued

Please note that the **AOR** applies to all services, claims and appeals submitted on behalf of the beneficiary for the duration of the AOR.

- Follow the procedures that describe the process a beneficiary must use to assign their appeal rights to a provider via the Transfer of Appeal Rights form (CMS-20031).
- For each new appeal request, a form needs to be submitted, this form is valid for all levels of the appeal process including judicial review, even in the event of the death of the beneficiary.
- If a provider furnishes the service, he/she would be a party to the initial determinations, only providers or suppliers who are not a party may accept assignment of appeal rights from a beneficiary. That is assignment of appeal rights applies only to providers and suppliers who are never a party to an appeal because they do not participate in Medicare and have not taken the claim on assignment.
- The provider or supplier who accepts the appeal rights to collect payment from the beneficiary for the item or service that is the subject of the appeal. The provider or supplier may collect any applicable deductible or coinsurance. The provider or supplier agrees to this waiver by completing and signing Section II of the Transfer of Appeal Rights form.
- Provide redetermination letters that are understandable to beneficiaries.

Please note that an **Assignment of Appeal Rights** is valid for the duration of an appeal unless the beneficiary revokes it.

Additional Information

The official instruction, CR 5460, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1274CP.pdf* on the CMS Web site. The revised portions of the *Medicare Claims Processing Manual* are attached to that CR.

If you have any 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* on the CMS Web site.

MLN Matters Number: MM5460
Related Change Request (CR) #: 5460
Related CR Release Date: June 29, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1274CP
Implementation Date: October 1, 2007

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

COMPETITIVE ACQUISITION PROGRAM

Participating Competitive Acquisition Program Physician Training

Noridian Administrative Services (NAS), the designated carrier for the Competitive Acquisition Program (CAP), offers interactive, online workshops about the CAP for Part B drugs and biologicals. These workshops train participating CAP physicians on a variety of CAP topics, and NAS staff can also answer questions. Interested parties may view additional information about and register for these workshops at *https://www.noridianmedicare.com/cap_drug/train/workshops/index.html*.

Upcoming workshops will be held on the following dates:

August 8, 2007, at 2:00 p.m. Central Time

September 12, 2007, at 2:00 p.m. Central Time

October 18, 2007 at 12:00 p.m. Central Time

Source: CMS Provider Education Resource 200707-08

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DURABLE MEDICAL EQUIPMENT

Deadlines Extended for the DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) is extending the registration and bid submission deadlines for the first round of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) Competitive Bidding Program.

Please note: *All bids were due by 9:00 p.m. prevailing Eastern Time on July 20, 2007, and the registration deadline is July 7, 2007.*

- On May 15, 2007, CMS issued a request for bids for the first round of the Medicare DMEPOS Competitive Bidding Program. The original due date was 9:00 p.m. prevailing Eastern Time on July 13, 2007. *All bids were due by 9:00 p.m. prevailing Eastern Time on July 20, 2007.*
- Suppliers interested in bidding must first register and receive a user ID and password before they can access the internet-based bid submission system. Suppliers should register immediately to avoid a delay in being able to submit bids. Registration opened on April 9, 2007. The original registration deadline was June 30, 2007. ***The registration deadline is now July 7, 2007.***
- Suppliers must be accredited or be pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. For a list of the CMS-approved Deemed Accreditation Organizations, visit: *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/*

For more information on the program, please visit *http://www.dmecompetitivebid.com*

Source: Provider Education Resources Listserv, Message 200706-40

Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the June 2007 Medicare B Update! pages 26-27.

Note: This article was changed on July 9, 2007 to add a link to a related durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Bidding article SE0717 on page 3. All other information remains the same.

Provider Types Affected

All suppliers of durable medical equipment (DME) that wish to participate in the Medicare DMEPOS competitive bidding program.

Provider Action Needed

This special edition article, SE0714, outlines the pre-bidding activities that DME suppliers need to follow in order to participate in the Medicare DMEPOS Competitive Bidding Program.

Background

Providers and suppliers that furnish certain DMEPOS to Medicare beneficiaries under Medicare Part B will have an opportunity to participate in a competitive acquisition program (the "Medicare DMEPOS Competitive Bidding Program"). This program will improve the accuracy of Medicare's payments for certain DMEPOS, reduce beneficiary out-of-pocket expenses, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services.

To assist with the DMEPOS Competitive Bidding Program, CMS awarded a contract to Palmetto GBA to serve as the competitive bidding implementation contractor (CBIC) for program implementation and monitoring.

As the DMEPOS Competitive Bidding Program progresses, suppliers may want to view the final rule governing the program, which is available at *http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1270f.pdf* on the CMS Web site. In addition, you may want to visit *http://www.cms.hhs.gov/competitiveacqfordmepos* for more complete information on the program and the process whereby suppliers can bid and participate.

There are other *MLN Matters* articles on the program. These articles are discussed briefly in the "Additional Information" section of this article.

Basic Instructions

All suppliers submitting a bid must:

- Be in good standing and have an active national supplier clearinghouse number (NSC#)
- Meet any local or state licensure requirements, if any, for the item being bid
- Be accredited or be pending accreditation. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. (For a listing of CMS-approved accrediting organizations, please visit

Pre-Bidding Activities for the Medicare DMEPOS Competitive Bidding Program, continued

http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf on the CMS Web site. *MLN Matters* article SE0713 provides additional information on accreditation and is located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf*

- Complete initial registration in the Internet application (Individuals Authorized Access CMS computer Services, IACS) to get a USER ID and password. Suppliers need to complete this initial registration process early to avoid delays in being able to submit bids. The initial registration process requires the **authorized official**, as identified in Section 15 of the CMS-855S, to complete the information required in the Internet application. The authorized official's information must match the information on file at the national supplier clearinghouse. To complete this initial registration and obtain a USER ID and password, please go to *https://applications.cms.hhs.gov*.

All suppliers submitting a bid should:

- Review *MLN Matters* article SE0717, Initial Supplier Registration for Competitive Bidding Program is Now Open, which provides important information about the registration process. SE0717 may be viewed at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0717.pdf* on the CMS Web site.
- Review the information in the Bid Application Tool Kit to facilitate a better understanding of the bidding process and rules. This information is located on the CBIC Web site at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersBid%20Application%20Tool%20Kit*.
- View the educational webcast to learn more about the Medicare DMEPOS Competitive Bidding Program and detailed information on the bid application process. This information is located on the CBIC Web site at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersEducational%20Tools*.
- CMS encourages you to register to receive updates on the Competitive Bidding Program. You may do so by going to *http://www.cms.hhs.gov/apps/mailinglists/* on the Web.

Additional Information

The CMS complete listing of all DME resources is available at *http://www.cms.hhs.gov/center/dme.asp* on the CMS Web site. A background review of the rationale for this program is at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DME_sum.pdf* on the CMS Web site.

MLN Matters article SE0713, Accreditation Information for Suppliers of Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS), **relates to** this article and provides an overview of the Medicare Modernization Act legislation and how it impacts this competitive bidding program. It also outlines the quality standards for suppliers, describes the status of accreditation, and provides the web addresses of the ten accrediting organizations. SE0713 may be viewed at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf* on the CMS website.

Another article, MM5574, provides more overview information regarding the DMEPOS Competitive Bidding Program and that article is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf* on the CMS site.

MLN Matters Number: SE0714 *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

NATIONAL PROVIDER IDENTIFIER

New National Provider Identifier Educational Products Available

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

New *MLN Matters* Article Available

A new special edition *MLN Matters* article is now posted on the CMS Web site with important information for Medicare providers and suppliers. Some of the topics include:

- Common Enumeration Errors in NPPES.
- Dos and Don'ts when Reporting "Other Provider Identification Numbers" in NPPES.
- How To Use your NPI when Billing Medicare Part A (Institutional) Claims to a Fiscal Intermediary (FI) or A/B MAC.
- How To Use Your NPI When Billing Medicare Part B (Professional) Claims to Carriers and A/B MACs.
- Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007, for DME Suppliers Submitting Claims to DME MACS Only.

New NPI Educational Products Available, continued

You may view this article by visiting the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf*.

June 14, 2007 NPI Data Dissemination Roundtable Transcript Available Now

The transcript for the June 14, 2007, NPI data dissemination roundtable may be found on the CMS website at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/6-14NPITranscript.pdf*.

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 may 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 200707-08

Provider Education for Handling Issues Related to Deceased Providers

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the June 2007 Medicare B Update! pages 29-30.

Note: This article was revised on May 7, 2007, to add this statement that Medicare fee-for-service (FFS) has announced a contingency plan regarding the May 23, 2007 implementation of the national provider identifier (NPI). For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf* on the CMS Web site. Also, on June 28, 2007, the article was revised to delete one sentence that should not have been in the article.

Provider Types Affected

Those submitting claims on behalf of physicians and providers who died before obtaining a NPI, where such submitted claims that were received by a Medicare contractor (carrier, Part A/B Medicare administrative contractors [A/B MAC], durable medical equipment [DMERC] and/or DME Medicare administrative contractors, [DME/MAC]) after May 23, 2007.

Background

This article and related change request (CR) 5508 addresses NPI issues related to deceased providers. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that the Secretary of the Department of Health & Human Services adopt standards providing for a standard unique health identifier for each health care provider for use in the healthcare system and to specify the purpose for which the identifiers may be used.

All entities covered under HIPAA must comply with the requirements of the NPI final rule no later than May 23, 2007. Among these requirements are the following:

- Any health care provider who is an entity covered under HIPAA must obtain an NPI.
- Health care providers meeting the definition of health care provider referenced in the NPI final rule but not covered entities are eligible to obtain NPIs as well.
- Health care providers covered under HIPAA must use NPIs to identify themselves and their subparts (if applicable) on all standard transactions adopted under HIPAA.

Because deceased providers may not have NPIs, this article discusses what representatives of those providers need to do in order to submit claims that need to be paid.

Key Points

If an individual provider dies before obtaining an NPI, the following apply:

- If a provider dies before obtaining an NPI and claims for that provider are received by a Medicare contractor after May 23, 2007, and Medicare (the Medicare contractor, the Medicare online survey and certification reporting system [OSCAR], of the national supplier clearinghouse [NSC]) has not been notified of the death, the claims will reject when received by Medicare due to the absence of the provider's NPI.
- At that point, the claim submitter would be expected to contact the Medicare contractor to which the claims were submitted to discuss payment of the claims and report the provider's death. Toll free numbers of the Medicare contractors are available at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.
- The state in which a provider furnishes care will continue to be responsible for notification of Medicare of the death of a provider following existing procedures. Since some states send such notifications on a quarterly basis, CMS is implementing the following procedures to enable affected claims to be paid more promptly:

Provider Education for Handling Issues Related to Deceased Providers, continued

- Because Medicare will reject an electronic claim received without an NPI after May 23, 2007, in cases where the provider died prior to obtaining an NPI, the provider's representative will need to submit the claim on paper.
- A representative of the estate should then contact the claims processing contractor, who will notify the provider that they must submit the claims on paper and that they must annotate the claim to state that the provider is deceased in Item 19.

Additional Information

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

You may view the official instruction (CR 5508) issued to your Medicare carrier, DME/MAC, DMERC and/or A/B MAC by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1216CP.pdf* on the CMS Web site.

MLN Matters Number: MM5508 *Revised*
Related Change Request (CR) #: 5508
Related CR Release Date: March 30, 2007
Effective Date: May 23, 2007
Related CR Transmittal #: R1216CP
Implementation Date: April 30, 2007

Deadline For NPI Updates/Changes/Deletions

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

CMS Announces the Date by which Updates/Changes/Deletions Must Be Submitted to NPPES in Order to be Reflected in Initial Downloadable File

The Centers for Medicare & Medicaid Services (CMS) will be disseminating provider information contained in the National Plan and Provider Enumeration System (NPPES) that is required to be disclosed under the Freedom of Information Act (FOIA), in accordance with the NPPES Data Dissemination Notice (CMS-6060-N) that was published in the *Federal Register* on May 30, 2007. The notice encouraged providers who have been assigned national provider identifiers (NPIs) to view their NPPES data and to update, change, or delete (where permitted) the data that will be disclosed under the FOIA.

NPPES FOIA-disclosable data will be made available in an initial file that can be downloaded from the Internet, as well as in a query-only database known as the NPI Registry. There will be monthly update files that will also be downloadable from the Internet. CMS will begin disseminating data on August 1, 2007.

CMS has made available a document that will assist providers in making updates, changes, and deletions to the FOIA-disclosable NPPES provider data. The document is entitled, "National Plan and Provider Enumeration System (NPPES) Data Elements – Data Dissemination – Information for Providers" available at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf* on the NPI Web site. We strongly recommend that providers read this document as soon as possible.

The initial downloadable file will be created using a "snapshot" of the NPPES FOIA-disclosable provider data as of a specific date. Because the initial downloadable file will be the foundation containing the FOIA-disclosable data for more than 2.2 million providers, it is important that the information in that file be as accurate as possible.

In order for providers' updates, changes, and deletions to be reflected in the initial downloadable file, providers must ensure that their updates, changes, and deletions are submitted to NPPES **no later than July 16, 2007**. To ensure the inclusion of updates, changes, and deletions in the initial downloadable file, July 16 is the last date on which they may be submitted via the Web-based process, and is the last date by which the NPI Enumerator can receive them on the paper NPI Application/ Update form (CMS-10114).**

There will undoubtedly be some updates, changes, and deletions that will require action on the part of the NPI Enumerator. For example, a change may be missing some required data. As a result, the change cannot be made until the NPI Enumerator has contacted the provider and obtained the missing data, enabling the change to be successfully processed and reflected in NPPES and then in the initial downloadable file. The July 16 date allows a period of time for this type of NPI Enumerator intervention, if necessary.

Updates, changes, and deletions that are submitted after July 16 will be reflected in the appropriate monthly update file, also downloadable from the Internet. For example, an update submitted on July 26 would be effective after the creation of the initial downloadable file and thus would be reflected in the first update file (to be created 1 month after the creation of the initial downloadable file); an update submitted on August 30 would be effective after the creation of the first update file and thus would be reflected in the second update file (to be created one month after the creation of the first monthly update file).

After the initial downloadable file is made available, an update file will be available each month thereafter at the same Internet location. All of the files (the initial file and the update files) will remain available for download at that Internet location.

Deadline For NPI Updates/Changes/Deletions, continued

The NPI Registry will operate in a real-time environment. Updates, changes, and deletions will be reflected in the NPI Registry at the same time they are reflected in NPPES. Therefore, the July 16 date is insignificant with respect to the data in the NPI Registry.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? More information and education on the NPI may be found at the CMS NPI page *http://www.cms.hhs.gov/NationalProvIdentStand* on the CMS website.

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

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

****NOTE**: If submitting the paper NPI Application/Update form, you may use the old version until July 10, 2007. Do not submit old versions of the CMS-10114 to the NPI Enumerator after that date. Submit the revised CMS-10114. The revised CMS-10114 is available from the NPI Enumerator (1-800-465-3203) or from the CMS forms page (*http://www.cms.hhs.gov/cmsforms*).

Source: Provider Education Resources Listserv, Message 200706-40

Date to Submit Changes to NPPES for the Initial Downloadable File

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

The Centers for Medicare & Medicaid Services (CMS) will be disseminating provider information contained in the National Plan and Provider Enumeration System (NPPES) that is required to be disclosed under the Freedom of Information Act (FOIA), in accordance with the NPPES Data Dissemination Notice (CMS-6060-N) that was published in the *Federal Register* on May 30, 2007. The notice encouraged providers who have been assigned national provider identifiers (NPIs) to view their NPPES data and to update, change, or delete (where permitted) the data that will be disclosed under the FOIA.

NPPES FOIA-disclosable data will be made available in an initial file that may be downloaded from the Internet, as well as in a query-only database known as the NPI registry. There will be monthly update files that will also be downloadable from the Internet. CMS will begin disseminating data on August 1, 2007.

CMS has made available a document that will assist providers in making updates, changes, and deletions to the FOIA-disclosable NPPES provider data. The document is entitled, "National Plan and Provider Enumeration System (NPPES) Data Elements – Data Dissemination – Information for Providers" available on the NPI Web site at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf*.

We strongly recommend that providers read this document as soon as possible.

The initial downloadable file will be created using a "snapshot" of the NPPES FOIA-disclosable provider data as of a specific date. Because the initial downloadable file will be the foundation containing the FOIA-disclosable data for more than 2.2 million providers, it is important that the information in that file be as accurate as possible. **In order for providers' updates, changes, and deletions to be reflected in the initial downloadable file, providers must ensure that their updates, changes, and deletions are submitted to NPPES no later than July 16, 2007. To ensure the inclusion of updates, changes, and deletions in the initial downloadable file, July 16 is the last date on which they may be submitted via the web-based process, and is the last date by which the NPI Enumerator can receive them on the paper NPI Application/Update form (CMS-10114).[1]**

There will undoubtedly be some updates, changes, and deletions that will require action on the part of the NPI Enumerator. For example, a change may be missing some required data. As a result, the change cannot be made until the NPI enumerator has contacted the provider and obtained the missing data, enabling the change to be successfully processed and reflected in NPPES and then in the initial downloadable file. The July 16 date allows a period of time for this type of NPI enumerator intervention, if necessary.

Updates, changes, and deletions that are submitted after July 16 will be reflected in the appropriate monthly update file, also downloadable from the Internet. For example, an update submitted on July 26 would be effective after the creation of the initial downloadable file and thus would be reflected in the first update file (to be created one month after the creation of the initial downloadable file); an update submitted on August 30 would be effective after the creation of the first update file and thus would be reflected in the second update file (to be created one month after the creation of the first monthly update file).

After the initial downloadable file is made available, an update file will be available each month thereafter at the same Internet location. All of the files (the initial file and the update files) will remain available for download at that Internet location.

The NPI registry will operate in a real-time environment. Updates, changes, and deletions will be reflected in the NPI registry at the same time they are reflected in NPPES. Therefore, the July 16 date is insignificant with respect to the data in the NPI registry.

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*.

Date to Submit Changes to NPPES for the Initial Downloadable File, continued

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

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.

Source: CMS Provider Education Resource 200706-37

New National Provider Identifier Educational Products Available

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

Approximately 98 percent of the estimated 2.3 million covered health care providers now have national provider identifiers (NPIs). Health plans, health care clearinghouses and health care providers are now transitioning to the implementation phase for NPI compliance.

CMS Delays Dissemination of National Plan and Provider Enumeration System Data

The National Plan and Provider Enumeration System (NPPES) Data Dissemination Notice (CMS-6060-N) was published on May 30, 2007. NPPES health care provider data that are required to be disclosed under the Freedom of Information Act (FOIA) will be made publicly available. The FOIA-disclosable data will be made available in an initial file downloadable from the Internet, with monthly update files also downloadable from the Internet, and in a query-only database (the NPI registry) whereby users can query by NPI or provider name. The notice stated that these data will be available 30 days after the publication date, and the Centers for Medicare & Medicaid Services (CMS) had previously stated that they would be available on June 28, 2007.

CMS believes that health care providers need additional time, beyond what was afforded in the Data Dissemination Notice, in which to view their FOIA-disclosable NPPES data and make any updates or deletions (where permitted) that they feel are necessary. **Therefore, CMS has decided to delay the dissemination of FOIA-disclosable NPPES health care provider data until August 1, 2007, 60 days after the publication date of the notice.**

CMS will provide additional information in the near future with respect to the date by which changes would have to be submitted in order to be reflected in the initial downloadable file. CMS understands that the health care industry is in urgent need of the FOIA-disclosable NPPES health care provider data; however, CMS believes it is in the best interests of the industry, and the health care providers in particular, that the NPPES data we will be disclosing be as accurate as possible.

For the latest information on Data Dissemination, as well as a list of the FOIA-disclosable data elements, visit *http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp* on the NPI Web site.

Revised NPI Application/Update Form

The NPI Application/Update form (CMS-10114, 05-07) has been revised and is now available for download on the CMS Web site. More information on the revisions to the form, as well as a link to the revised form, is available at *http://www.cms.hhs.gov/NationalProvIdentStand/03_apply.asp* on the CMS NPI Web site.

The Importance of Up-to-Date Billing Software

Providers that use billing software should make sure they are using the most current version. Software vendors have made changes to accommodate the NPI. Running an outdated software version could contribute to claim rejections or the inability to send your NPI.

National Uniform Billing Committee (NUBC) Response Regarding Printing Problems with the UB-04 Form

It has come to the attention of the NUBC that some laser printers are having difficulty meeting the print specification of the UB-04 form. The UB-04 form and the UB-92 contain identical margin specifications. Both forms are 82 characters across. To accommodate the 80-character limitation of some laser printers, many users of the UB-92 form developed workarounds that basically "cheated" on the printing layout. This was commonly accomplished by starting in the second position and ending in the 80th position; basically ignoring the first column on the left and the last column on the right. The UB-92 had no critical data elements in these fields. In order to meet the UB-04 print specifications, users should utilize laser printers that have "edge-to-edge" print capability (four mm margins on the left and right) or wide carriage impact printers (dot-matrix or line printers).

More information may be found at *http://www.nubc.org/UB-04_Printing_Requirements.pdf* on the NUBC Web site.

Important Information for Medicare Providers

Testing Your NPI on Medicare Claims

To date, Medicare has encouraged providers to submit both an NPI and a legacy identifier on claims.

At this time, only fiscal intermediaries and the CIGNA Idaho and Tennessee carrier are editing the NPI against the Medicare NPI crosswalk file when the NPI/legacy identifier is submitted. If you are billing these contractors and claims are not rejecting, your reporting of the NPI is successful.

Other carriers (including CIGNA North Carolina) and durable medical equipment Medicare administrative contractors (DME MACs) are not validating the NPI/legacy pair against the Medicare crosswalk. If a provider is submitting claims to these

New National Provider Identifier Educational Products Available, continued

contractors your claims have not, and will not reject because the system is bypassing the NPI crosswalk validation and simply processing on the legacy provider number. Although carrier submitters may be receiving informational edits when the problem occurs, DME MAC submitters are not.

To fully understand if your provider information is valid on both the crosswalk and the contractors provider file, Medicare is now asking providers who submit claims to the other carriers and DME MACs to send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume. If any claim is rejected due to provider identifier issues, first verify your NPI to make sure it was entered correctly. If the NPI is correct, then data in either NPPES or Medicare provider files is incorrect. You must check the accuracy of the following fields in your NPPES record and/or 855 provider enrollment record:

- Employee identification number (EIN) (for organization providers), social security number (SSN) (for individual providers)
- Other provider identification numbers (in NPPES where type = Medicare. This is where providers, when they apply for their NPIs, may, as an option, list the Medicare legacy identifier(s) that needs to be linked to the NPI.)
- Business location (practice location) address (from NPPES and provider enrollment records)
- Master address (from provider enrollment records)
- Other address (from provider enrollment records)
- Legal name or legal business name

Once data is corrected, please wait a few days for the systems to update, and test again with a small number of claims. This process will help establish confidence that your claims will be paid. It is critical that you start testing with your NPI now.

Note that for claims submitted with the NPI only (no legacy identifier) to any contractor (carrier, FI, DME MAC); the NPI has been and will be edited against the NPI crosswalk.

While Medicare fee-for-schedule (FFS) has announced its contingency plan, it is committed to ending the contingency plan as soon as possible.

Common Errors that May Result in Claim Rejections

- Errors in the EIN, or Tax ID (TIN). As a reminder, providers that are organizations are required to report the EIN when they apply for an NPI (on-line, paper, and EFI). That EIN might or might not also be the TIN. With the revised CMS-10114 (to be used beginning July 10, for on-line, paper, and EFI), organizations that are subparts will be required to report the LBN of their "parent" and the "parent's" TIN. The applicant will continue to be required to report its EIN. If the EIN error is on the Medicare record, the provider should submit a CMS-855 to correct.
- Invalid or incomplete data within the 'Other Provider Identifiers' section of the NPPES online application, such as:
  - The absence of the Medicare identification number/provider number,
  - Not having the 'Type' listed as Medicare for a Medicare identification number/provider number, and or
  - Having extra Medicare identification numbers/provider numbers that shouldn't be linked to the NPI of the applicant.
  - Delays in reporting change of ownership. Whenever there is a change of ownership, the provider is responsible for reporting that change to the appropriate Medicare contractor within 30 days. Providers are supposed to report that change on the CMS-855.

CMS is currently working on a special edition *MLN Matters* article regarding verifying NPPES data and correct billing for Medicare claims. This article will be announced as soon as it is available.

835 Electronic Remittance Advice Changes Effective on July 2, 2007

A recent *MLN Matters* article discusses the changes currently scheduled for the implementation into the Medicare DMERC processing system July 2, 2007. Visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf* on the CMS Web site.

How do I Share my NPI with Medicare?

Please share your NPI with Medicare by submitting it on Medicare claims. Unlike some health plans, there is no fax number, phone number or special Web site you need to use to communicate your NPI to Medicare. As stated previously, Medicare is now asking that submitters send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume.

NPIs and the Physician Quality Reporting Initiative (PQRI)

Please note that individual NPIs will be required on claims from those providers who will be participating in the 2007 PQRI. Please visit *http://www.cms.hhs.gov/pqri* for more details.

CMS Discontinues the Assignment of Unique Physician Identification Numbers

Effective June 29, 2007, CMS will discontinue assigning unique physician identification numbers (UPINs) to Medicare providers. CMS is considering extending access to the UPIN Registry until May 23, 2008. For further details, visit the change request (CR 5584) on this subject at *http://www.cms.hhs.gov/transmittals/downloads/R207PI.pdf* and the associated *MLN Matters* article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5584.pdf* on the CMS Web site.

New National Provider Identifier Educational Products Available, continued

Upcoming WEDI NPI Industry Forum

The Workgroup for Electronic Data Interchange (WEDI) will host its 7th NPI Industry Forum July 18-19, 2007 in Fairfax, VA. Please visit *http://www.wedi.org/npioi/index.shtml* for more details and to register. Please note that there is a charge to participate in WEDI events.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? More information and education on the NPI may be found at the CMS NPI page *http://www.cms.hhs.gov/NationalProvIdentStand* on the CMS Web site. Providers may apply for an NPI online at *https://nppes.cms.hhs.gov* or may call the NPI enumerator to request a paper application at 1-800-465-3203.

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

Source: Provider Education Resources Listserv, Message 200706-33

Information Regarding National Plan and Provider Enumeration System Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

Certain information you enter into the National Plan and Provider Enumeration System (NPPES) in order to obtain and maintain your national provider identifier (NPI) is used by Medicare in processing claims.

CAUTION – What You Need to Know

If the information you entered in NPPES is not correct, your claims may reject. It is important to verify that information was entered correctly. Other guidance in this article will also help assure your claims are processed timely and correctly.

GO – What You Need to Do

The Centers for Medicare & Medicaid Services (CMS) recommends that physicians, providers, and suppliers validate their NPPES data and be sure their staff are aware of the key elements that need to be correct as explained in this article. Also, you may want to be sure your staff are aware of the important billing tips in this article.

Background

As Medicare begins to implement the NPI into its systems, several enumeration and billing errors have been identified that may result in claim rejections.

Common Enumeration Errors in NPPES

Below are some of the more frequent errors providers have been making when applying for NPIs:

- **Errors in employer identification number (EIN):** As a reminder, providers that are organizations are required to report the EIN when they apply for an NPI (on-line, paper, and electronic file interchange (EFI)). That EIN may also be the taxpayer identification number (TIN). With the revised NPI application/update form (CMS-10114) (to be used beginning July 10, 2007, for online, paper, and EFI), organizations that are subparts will be required to report the legal business name (LBN) of their "parent" and the "parent's" TIN. The applicant will continue to be required to report its EIN. **If the EIN error is on the Medicare provider enrollment record, the provider should submit a CMS-855 to the Medicare contractor to correct it.**
- **Invalid or incomplete data within the 'Other Provider Identifiers' section of the NPPES online application, such as:**
  - The absence of the Medicare legacy number
  - Not having the '*Type*' listed as Medicare for a Medicare provider number, and/or
  - Reporting Medicare provider numbers that do not belong to the provider applying for the NPI and, therefore, should not be linked to the assigned NPI.
- **Reporting an incomplete identifier:** Medicare providers/suppliers need to ensure that, if reporting their Medicare legacy identifiers to NPPES, they report the full identifier. This means that suffixes to the OSCAR/ certification numbers are to be reported. If the full identifier is not reported, it will be impossible for Medicare to establish the linkage from the NPI to that particular Medicare legacy identifier when using NPPES data and the NPI crosswalk.
- **Having more than the allowable number of legacy numbers:** At the present time, the NPPES can capture a grand total of 20 "Other Provider Identification Numbers." While this adequately accommodates the majority of providers/suppliers, it does not accommodate all of them. NPPES will be expanded to capture more than 20 "Other Provider Identification Numbers" at a future date. Medicare providers/suppliers who have more than 20 Medicare legacy identifiers that need to be linked directly to the NPI to be assigned should contact their Medicare fee-for-service contractors to determine how best to inform those contractors of all of the Medicare legacy identifiers.

Information Regarding NPPES Errors, Using the NPI on Medicare Claims and 835 RA Changes, continued

- **Listing legacy numbers that do not belong to the applicant:** The provider/supplier should make sure that any Medicare legacy identifier(s) (OSCAR/certification number, provider identification number (PIN), unique physician identification number (UPIN), and national supplier clearinghouse (NSC) number) entered in that field in NPPES are those that will need to be linked directly to the NPI to be assigned. That is, do not list in the "Other Provider Identification Numbers" section identifiers that belong to providers other than the one that is applying for the NPI. Specific examples follow in the "Do and Don't" section below.

Do and Don't When Reporting "Other Provider Identification Numbers" in NPPES

- **For a Medicare physician or other practitioner applying for an NPI:**

  Do include your UPIN (if one was assigned) and your PIN when applying for an NPI.

  Do not include the PIN of your group practice or clinic if you are affiliated with a group practice or clinic.

- **For a Medicare group practice or clinic applying for an NPI:**

  Do include your PIN.

  Do not include the PINs or UPINs of any of the members of the group practice or clinic.

- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy/DME supplier:**

  Do include both NSC numbers (pharmacy and DME supplier).

- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy:**

  Do include the NSC number assigned to the pharmacy.

  Do not include the NSC number assigned to the DME supplier.

- **For a Medicare pharmacy that is applying for an NPI as a DME supplier:**

  Do include the NSC number assigned to the DME supplier.

  Do not include the NSC number assigned to the pharmacy.

- **For a Medicare hospital swing bed unit that is applying for an NPI as a swing bed unit:**

  Do include the OSCAR/certification number assigned to the swing bed unit.
  Do not include the OSCAR/certification number assigned to the hospital.

- **For a Medicare hospital that is applying for an NPI but does not want swing bed units or rehabilitation units (if they have these units) to have their own NPIs:**

  Do include the OSCAR/certification number assigned to the hospital **and** the OSCAR/certification numbers assigned to both the swing bed unit and the rehabilitation unit.

If Medicare providers/suppliers determine that they should make changes to their NPPES records, they may do so by going to NPPES at *https://nppes.cms.hhs.gov/* at any time and updating their information. Or, if they prefer, they may send updates on the paper NPI Application/Update Form (CMS-10114). Forms may be requested by calling the NPI enumerator at their toll-free number, which is 1-800-465-3203, TTY 1-800-692-2326.

The revised CMS-10114 is to be used beginning July 10, 2007.

These forms may be obtained from the enumerator, as outlined above, or you may download the form from the CMS Web site forms page at *http://www.cms.hhs.gov/cmsforms*.

CMS recommends that Medicare providers/suppliers make a copy of their NPPES information by doing a "print screen" of their NPPES record or make a photocopy of the completed paper NPI Application/Update form and keep it on hand for reference if they encounter problems.

Common Error in Reporting Change of Ownership to Medicare

Delays in reporting Change of Ownership

Whenever there is a change of ownership, the provider is responsible for reporting that change to the appropriate Medicare contractor within 30 days. Providers are supposed to report that change on the CMS-855.

How To Use Your NPI when Billing Medicare Part A (Institutional) Claims to a Fiscal Intermediary or A/B MAC

For providers who submit electronic Part A institutional claims to Medicare FIs or A/B MACs, a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Failure to properly submit the NPI in the correct loops may cause the claim to reject. Organization providers should utilize their NPI in the 2010AA or 2010AB loop. The attending, operating or other physicians should be identified in the 2310A, B and C loops respectively. If 2420A loop is used, the Attending Physician NPI must be submitted.

Below is a guide to use when submitting primary NPIs:

Name/Loop	Legacy Information	NPI Information
Billing Provider 2010AA Loop	OSCAR	Provider NPI
Pay to Provider 2010AB Loop	OSCAR	Provider NPI
Attending Physician 2310A Loop	PIN, UPIN	Physician NPI
Operating Physician 2310B Loop	PIN, UPIN	Physician NPI
Other Physician 2310C	PIN, UPIN	Physician NPI
Attending Physician 2420A	PIN, UPIN	Physician NPI

Information Regarding NPPES Errors, Using the NPI on Medicare Claims and 835 RA Changes, continued

Some Medicare FIs and A/B MACs have developed front-end reason codes that will return claims to the providers when the NPI and Legacy combination submitted does not match the NPI crosswalk.

If a reject or RTP (Return to Provider) is received, providers are encouraged to verify that their NPI/Legacy combination is valid in NPPES first at *https://nppes.cms.hhs.gov*.

The following is a listing of front-end processing reason codes:

Code **Description**

32000 This claim has been rejected because the intermediary has no record of the Medicare provider number submitted.

32102 The claim contains an NPI but the first digit of the NPI is not equal to "1", "2", "3","4" or the 10th digit of the NPI does not follow the check digit validation routine. Please verify billing and, if appropriate, correct.

**Online providers – press PF9 to store the claim.
**Other providers – return to the intermediary.

32103 NPI/OSCAR pair on the claim is not present in the Medicare NPI crosswalk file.
This edit applies to the NPI associated with the OSCAR number. Please verify provider-billing number and, if appropriate, please correct either NPPES or your CMS-855 information.
Please verify all of your information in NPPES. You should validate that the NPI/OSCAR pair you are using on the claim reflects the OSCAR number that you reported to NPPES. You may view/correct your NPPES information by going to *https://nppes.cms.hhs.gov*.

If your NPPES information is correct, and you have included all Medicare legacy identifiers (OSCARs) in NPPES, but you are still experiencing problems with your claims that contain a valid NPI, you may need to submit a Medicare enrollment application (i.e., the CMS-855). Please contact your contractor prior to submitting a CMS-855 form.
The NPI and the legacy (OSCAR) number are present on the claim and the NPI is present in the crosswalk file, but the associated legacy (OSCAR) number in the crosswalk file does not match the legacy (OSCAR) number on the claim.
Please verify billing number and, if appropriate, correct.

***Online providers – Press PF9 to store the claim.
***Other Providers – Return to the intermediary.

32105 The NPI is present in the Crosswalk File but the NPI corresponds to more than one legacy (OSCAR) number.
Enter the OSCAR number associated with the NPI submitted. Please verify billing number and, if appropriate, correct.

***Online providers – Press PF9 to store the claim.
***Other providers – Return to the intermediary.

32107 The NPI for the attending physician on the claim is not present in the crosswalk file.
Please verify billing number and, if appropriate, correct.

***Online providers – Press PF9 to store the claim.
***Other providers – Return to the intermediary.

32108 The attending physician's NPI and UPIN are present on the claim and the attending physician's NPI is present in the Crosswalk File, but the attending physician's UPIN in the Crosswalk File does not match the attending physician's UPIN on the claim.
Please verify the UPIN and, if appropriate, correct.

***Online providers – Press PF9 to store the claim.
***Other providers – Return to the intermediary.

32109 The operating physician's NPI on the claim is not present in the Crosswalk File.
Please verify billing number and, if appropriate, correct.

***Online providers – Press PF9 to store the claim.
***Other providers – Return to the intermediary.

32110 The operating physician's NPI and UPIN are present on the claim and the operating physician's NPI is present in the Crosswalk File, but the operating physician's UPIN in the Crosswalk File does not match the operating physician's UPIN on the claim.
Please verify the UPIN and, if appropriate, correct.

***Online providers – Press PF9 to store the claim.
***Other providers – Return to the intermediary.

32111 The other physician NPI on the claim is not present in the Crosswalk File.
Please verify the billing number and, if appropriate, correct.

***Online providers – Press PF9 to store the claim.
***Other providers – Return to the intermediary.

32112 The other physician's NPI and UPIN are present on the claim and the other physician's NPI is present in the Crosswalk File, but the other physician's UPIN in the Crosswalk File does not match the other physician's UPIN on the claim.
Please verify the UPIN and, if appropriate, correct.

***Online providers – Press PF9 to store the claim.
***Other providers – Return to the intermediary.

32113 The taxonomy code entered is invalid.
Or, a taxonomy code is required when the NPI is present in the Crosswalk File and the NPI corresponds to more than one legacy (OSCAR) number.
Please verify the billing number and, if appropriate, correct.

***Online providers – Press PF9 to store the claim.
***Other providers – Return to the intermediary.

Information Regarding NPPES Errors, Using the NPI on Medicare Claims and 835 RA Changes, continued

If your FI or A/B MAC is using the MEDATRAN claims translator, below is a list of EDI Inbound Reject codes you may receive:

Edit Number	Loop	Edit Description
99	2010AA	The NPI/Legacy combination does not match the NPI crosswalk.
99	2010AB	The NPI/Legacy combination does not match the NPI crosswalk.
99	2310A,B,C	The NPI/Legacy combination does not match the NPI crosswalk.
99	2420A	The NPI/Legacy combination does not match the NPI crosswalk.

How To Use Your NPI when Billing Medicare Part B (Professional) Claims to Carriers and A/B MACs

For providers who submit electronic professional claims to Medicare Part B carriers and A/B MACs, CMS test data indicates that a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Even if you have validated your NPPES data, failure to properly submit the NPI in the correct loops may cause the claim to reject. Group providers should utilize the GROUP NPI in the 2010AA or 2010AB loop. The INDIVIDUAL or MEMBER OF GROUP NPI should only be submitted in the 2310B or 2420A loops.

Below is a guide to use when submitting primary NPIs:

Name/Loop	Legacy Information	NPI Information
Billing Provider 2010AA Loop	Group PIN Individual PIN	Group NPI
Individual NPI Pay to Provider 2010AB Loop (this should only be submitted if different from billing provider)	Group PIN Individual PIN	Group NPI Individual NPI
Rendering Provider 2310B Loop (this should only be submitted if a group practice)	Individual / Member of Group PIN	Individual/ Member of Group NPI
Rendering Provider 2420A Loop (this should only be submitted if a group practice)	Individual / Member of Group PIN	Individual/ Member of Group NPI

Some carriers and A/B MACs will return the informational messages or edits below when the NPI and legacy identifier combination submitted does not match the NPI crosswalk. As of the date of this article, claims with NPI/legacy identifiers are not rejecting because Part B contractors (except CIGNA Tennessee and Idaho), have "crosswalk bypass" logic in their system that will allow invalid pairs to process on the legacy number. The informational edits you are receiving are a warning that your claims will reject when the logic is removed. Providers are encouraged to verify that the NPI/legacy identifier combination is valid on NPPES prior to submission of Medicare claims at *https://nppes.cms.hhs.gov*.

Following is a listing of the edits you may receive when billing professional Part B claims:

Edit Number	Loop	Edit Description
M340	2010AA	The NPI/Legacy combination does not match the NPI crosswalk.
M341	2010AB	The NPI/Legacy combination does not match the NPI crosswalk.
M343	2310B	The NPI/Legacy combination does not match the NPI crosswalk.
M347	2420A	The NPI/Legacy combination does not match the NPI crosswalk.

Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007 for DME Suppliers Submitting Claims to DME MACS Only

DME suppliers are reminded that important changes will occur on your electronic remittance advice and your standard paper remittance actions, effective July 2, 2007. As of that date when you have submitted an NPI on your claim, your DME MAC will report on the 835 (or via the Medicare remit easy print [MREP])]software) as follows:

- The billing/pay-to NPI will be reported at the payee level (Loop 1000B in N104 with the XX qualifier in N103 of the 835).
- The TIN (EIN/SSN) will be reported in the REF segment (Loop 1000B, data field REF 02 with qualifier TJ in REF 01 of the 835) as payee additional ID.
- Any relevant rendering provider NPI will be reported at the claim level (Loop 2100, data field NM 109 with qualifier XX in NM 108 on the 835) if different from the payee NPI.
- Any relevant rendering NPI(s) will be reported at the service line level (Loop 2110, data field REF 02 with qualifier HPI in REF 01 on the 835) when different from the claim level rendering NPI.

When you do not report your NPI, but report your legacy national supplier clearinghouse (NSC) number on a claim, Medicare will continue to report legacy numbers in generating your remittance advice. Further information regarding the remittance changes may be found in CR 5452,

Information Regarding NPPES Errors, Using the NPI on Medicare Claims and 835 RA Changes, continued

which is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf* or in the related *MLN Matters* article, MM5452, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf*.

Note: The 835 remittance advice changes listed above will be effective for other providers submitting Part A institutional claims and Part B professional claims, at a later date. Medicare will notify submitters when a date is determined.

Additional Information

You may also want to review *MLN Matters* article SE0679, which has additional information on the overall NPI activity. This article is on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf*.

Important information regarding current NPI implementation contingency plan is in article MM5595, which is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf*.

If you have any 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: SE0725
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

PROVIDER QUALITY REPORTING INITIATIVE

Physician Quality Reporting Initiative Letter to Medicare Beneficiaries

The Centers for Medicare & Medicaid Services has posted a letter to Medicare beneficiaries with important information about the Physician Quality Reporting Initiative (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. To access the letter, visit the CMS Web site at *http://www.cms.hhs.gov/PQRI*. Once on the *Overview page*, scroll down to the "**Downloads**" section.

PQRI Questions of the Week

Q: If a PQRI quality-data code is not listed on a line adjacent to the correct *Current Procedural Terminology (CPT)* category I code, will the quality data code be accepted?

A: Yes, the PQRI analyses will match PQRI quality-data codes to the CPT category I codes that appear on any nondenied service line on the claim, regardless of the order in which the various line items appear.

Q: If I report a modifier to a PQRI quality-data code on a claim, when use of that modifier is not specifically allowed per the PQRI measure specifications document, will I get credit for reporting?

A: No. In order to be considered an instance of appropriate quality data submission, PQRI quality-data codes should be accurate and reflect valid modifiers as in the measure specifications. Invalid codes will not be included in reporting or performance rate calculations.

Q: I have questions about which PQRI measures are most applicable to my specialty and practice, and how best to implement PQRI in my practice. Where can I get more information and advice on these topics?

A: For specialty or practice-specific questions, please contact your professional organization or specialty association for guidance. In many cases, these organizations have information and tools to enable successful reporting of PQRI measures available on their Web sites.

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

A: 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 physician fee schedule 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.)

Physician Quality Reporting Initiative Letter to Medicare Beneficiaries, continued

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 percent 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 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).

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.

For a complete listing of all questions and answers about the 2007 PQRI, visit the CMS Web site at *http://www.cms.hhs.gov/PQRI*, and click on "All PQRI FAQs" available on any page.

Source: CMS Provider Education Resource 200707-10

2007 Physician Quality Reporting Initiative Alert

It has come to the attention of Centers for Medicare & Medicaid Services (CMS) that some clearinghouses are stripping the national provider identifier (NPI) prior to submission of the claim to Medicare. This will adversely affect eligible professionals in that these claims will not count toward Physician Quality Reporting Initiative (PQRI) participation. CMS urges eligible professionals that use clearinghouses to check with their clearinghouse to assure NPIs are not being stripped from claims. If the eligible professional determines that their clearinghouse is stripping NPIs from the claim, the eligible professional may want to consider other billing options.

A recent special edition *MLN Matters* article contains 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 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf* on the CMS Web site.

Source: Provider Education Resources Listserv, Message 200707-12

Reporting on the 2007 Physician Quality Reporting Initiative Begins

The Centers for Medicare and Medicaid Services (CMS) is pleased to announce that reporting for the 2007 Physician Quality Reporting Initiative (PQRI) on claims for dates of service as of July 1, 2007, has begun. Eligible professionals may now start participating in the PQRI by simply reporting the appropriate quality measure data on claims submitted to their Medicare claims processing contractor.

Remember, all your informational needs can be met by visiting the PQRI Web site at *http://www.cms.hhs.gov/PQRI*. Here you will find educational resources, including the PQRI Tool Kit, and links to our most frequently asked questions (FAQs).

CMS also announced the proposed rule that would establish new policies and payment rates for physicians and other providers who are paid under the Medicare physician fee schedule. Included in the proposed rule is important information directly related to 2008 PQRI. To view or download the proposed rule, visit *http://www.cms.hhs.gov/center/physician.asp*, click on CMS-1385-P, then go to page 402 of the document.

Source: Provider Education Resources Listserv, Message 200707-05

2007 Physician Quality Reporting Initiative Update

The Testing Opportunity for the 2007 Physician Quality Reporting Initiative Has Ended

Effective June 30, 2007, Physician Quality Reporting Initiative (PQRI) testing with the G8300 test code ended. Carriers and A/B MACs will no longer accept the test code G8300 on claims.

Reminder: For dates of service beginning July 1, 2007, when 2007 PQRI line items are included on claims, the PQRI line item will be denied and remittance advice (RA) remark code message N365, "This procedure code is not payable. It is for reporting/information purposes only" will appear on the RA.

Updated 2007 Physician Quality Reporting Initiative Educational Resource

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the updated version of The Measure Finder Tool (version 1.1) and user guide are now available as part of the 2007 PQRI Tool Kit – Six Steps to Success.

The Measure Finder Tool (version 1.1) is a slightly modified version of the tool to address a technical problem in Measure Finder Tool (version 1.0). Please delete the previous version of the tool from your computer.

The Measure Finder Tool (version 1.1) is designed to help eligible professionals and their coding/billing staff to quickly search for applicable measures and their detailed specifications. This tool will allow users to search for applicable measures based on a single code or a combination of codes.

The user guide provides instruction on how to use the PQRI Measure Finder Tool (version 1.1).

To access the Tool Kit, visit, *http://www.cms.hhs.gov/PQRI*, on the CMS Web site in the PQRI Tool Kit section. Once on the PQRI Tool Kit page, scroll down to the "Downloads" section.

Source: Provider Education Resources Listserv, Message 200706-39 & 200706-40

Updated 2007 Physician Quality Reporting Initiative Educational Resource

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the updated version of The Measure Finder Tool (Version 1.1) and *User Guide* is now available as part of the 2007 PQRI Tool Kit – Six Steps to Success.

The Measure Finder Tool (Version 1.1) is a slightly modified version of the tool to address a technical problem in Measure Finder Tool (Version 1.0). Please delete the previous version of the tool from your computer.

The Measure Finder Tool (Version 1.1) is designed to help eligible professionals and their coding/billing staff to quickly search for applicable measures and their detailed specifications. This tool will allow users to search for applicable measures based on a single code or a combination of codes. The *User Guide* provides instruction on how to use the PQRI Measure Finder Tool (Version 1.1).

To access the tool kit, visit, *http://www.cms.hhs.gov/PQRI*, on the CMS Web site in the *PQRI Tool Kit* section. Once on the *PQRI Tool Kit* page, scroll down to the "**Downloads**" section.

Source: CMS Provider Education Resource 200706-38

New 2007 Physician Quality Reporting Initiative Educational Resource Expands the PQRI Tool Kit

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) Measure Finder Tool (version 1.0) is now available as part of the *2007 PQRI Tool Kit – Six Steps to Success*.

The Measure Finder Tool (version 1.0) is designed to help eligible professionals and their coding/billing staff to quickly search for applicable measures and their detailed specifications. This tool will allow users to search for applicable measures based on a single code or a combination of codes.

The addition of this new product expands the tool kit to six new and existing educational resources that will assist eligible professionals with successful reporting.

To access the tool kit, visit, *http://www.cms.hhs.gov/PQRI*, on the CMS Web site in the *PQRI Tool Kit* section. Once on the *PQRI Tool Kit* page, scroll down to the "**Downloads**" section.

PQRI 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" can only be calculated after the reporting period ends because it is equal to (the total amount of allowed charges under the physician fee schedule 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).

Example

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

> Dr. Smith had $400,000 in allowed charges during the PQRI reporting period. The 1.5 percent 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, one million instances of PQRI quality data codes being reported in the same time period).
>
> 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.

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

Source: Provider Education Resources Listserv, Message 200706-31

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.

PROVIDER CUSTOMER SERVICE PROGRAM

Provider Customer Service Program Updates

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

Provider Types Affected

All physicians, suppliers, and providers who submit written inquiries to, or contact the toll-free lines at, their Medicare contractors [fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative Contractors (DME/MACs), and/or regional home health intermediaries (RHHIs)].

Provider Action Needed

Change request (CR) 5597 contains a number of revisions to the *Medicare Contractor Beneficiary and Provider Communications Manual*, including changes for authenticating providers who make inquiries of Medicare contractors. Due to the Medicare fee-for-service contingency plan for the national provider identifier (NPI), the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare fee-for-service provider contact centers (PCCs), will be the required authentication element for all inquiries to interactive voice response (IVR) systems, customer service representatives (CSRs), and written inquiry units. **While the authentication rules are part of CR 5597, for complete details about these rules under the Medicare NPI contingency plan, see *MLN Matters* article SE0721,** which you will find on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf*.

The remainder of this article provides information on the highlights of changes announced in CR 5597.

Background

CR 5597 modifies *Medicare Contractor Beneficiary and Provider Communications Manual*, Publication 100-09. These changes are summarized as follows:

Overlapping Claims—New Rules

- Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.
- When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/ legacy number or NPI, beneficiary name, health insurance claim number (HICN), and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.
- Contractors shall release overlapping claim information whether a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.
- For specific information regarding the resolution of claims rejected by Medicare's common working file (CWF) system, refer to the *Medicare Claims Processing Manual, Chapter 27, Section 50* on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c27.pdf*.

Information Available on the IVR

- **USE THE IVR whenever possible**. Providers should be aware that if a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information is available on the IVR, the CSR/correspondent will probably encourage you to use the self-service options that are available.
- If at any time during a telephone inquiry, you request information that can be found on the IVR the CSR will most likely refer you back to the IVR.

Information Available on the Remittance Advice (RA)

- **THE RA whenever possible**. If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.
- To make your job easier you may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available on the CMS Web site at: *http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp*.
- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* which is available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

Provider Customer Service Program Updates, continued

- Also available is a Web site that serves as a resource allowing providers to check the definitions of *Claim Adjustment Reason Codes* and *Remittance Advice Remark Codes*. This information is available on the Washington Publishing Company Web site at *http://www.wpc-edi.com/products/codelists/alertservice*.
- There is a Web-based training course, Understanding the Remittance Advice for Professional Providers, which is available on the CMS Web site at: *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

  The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading electronic remittance advices (ERAs) and standard paper remittance advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

Authentication of Beneficiary Elements—Additions to Current Rules

CR 5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR 5597 is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf*.

Additional Key Points of CR 5597

- Medicare's CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the report of contact made during a telephone response to a written inquiry, Medicare contractors will send you a letter detailing the discussion. This letter may be sent to you by e-mail or fax, if you request, unless the details include specific beneficiary or claim related information.
- When your Medicare contractor schedules a training event for which there is a charge for attendance and you register and pay, but are unable to attend, you may be entitled to a refund of some or all of your payment. But, to receive such a refund, **you must notify the contractor before the event.**

Additional Information

For complete details regarding this CR please see the official instruction (CR 5597) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to the CMS Web site to *http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf*.

If you have questions, please contact your Medicare carrier, FI or A/B MAC, DME MAC, or RHHI at their toll-free number, which may be found 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: MM5597
Related Change Request (CR) Number: 5597
Related CR Release Date: July 13, 2007
Related CR Transmittal Number: R20COM
Effective Date: May 23, 2007
Implementation Date: July 30, 2007

GENERAL

Charges for Missed Appointments

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs]).

Provider Action Needed

STOP – Impact to You

The Centers for Medicaid & Medicare Services (CMS) policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments. However, Medicare itself does not pay for missed appointments, so such charges should not be billed to Medicare.

CAUTION – What You Need to Know

Providers may **not charge ONLY** Medicare beneficiaries for missed appointments; they must **also charge non-Medicare patients.** The amount the physician/supplier charges Medicare beneficiaries for missed appointments must be the same as the amount that they charge non-Medicare patients.

Charges for Missed Appointments, continued

GO – What You Need to Do

Make certain that your billing staff is aware that you may bill the beneficiary directly, that Medicare itself does not make any payments for missed appointments, and that Medicare should not be billed for these charges.

Background

According to chapter 12, section 30.3.13 of the *Medicare Claims Processing Manual*, which is attached to CR 5613, CMS policy allows physicians, providers, and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments and the charges for Medicare and non-Medicare patient are the same. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

The other key points of CR 5613 are:

- The provider may bill the Medicare beneficiary directly.
- Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians, or other suppliers.
- Claims for missed appointments sent to Medicare will be denied with the reason code 204 (This service/equipment/drug is not covered under the patient's current benefit plan.).
- In most instances, a hospital outpatient department can charge a beneficiary a missed appointment charge.
- In the event, however, that a hospital inpatient misses an appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the beneficiary a missed appointment fee.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5613) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1279CP.pdf* on the CMS website.

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

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

MLN Matters Number: MM5613
Related Change Request (CR) #: 5613
Related CR Release Date: June 29, 2007
Effective Date: October 1, 2007
Related CR Transmittal #: R1279CP
Implementation Date: October 1, 2007

CMS Proposes Policy and Payment Changes For Physicians' Services In 2008

The Centers for Medicare & Medicaid Services (CMS) projects that it will pay approximately $58.9 billion to 900,000 physicians and other health care professionals in calendar year (CY) 2008, under a proposed rule released today that would revise payment rates and policies under the Medicare physician fee schedule (MPFS). This proposed rule is a further step in Medicare's efforts to ensure that payment policies provide incentives to improve the quality of care.

"This proposed rule builds on the changes the Centers for Medicare & Medicaid Services made last year to pay more appropriately for practice expenses and to transform Medicare into an active purchaser of higher quality services, rather than just paying for procedures" said acting CMS Administrator Leslie V. Norwalk, Esq. "It also includes an important new initiative to encourage the use of electronic prescribing to improve the speed and accuracy of care furnished to beneficiaries, as well as proposals for additional quality measures for use in the Physician Quality Reporting Initiative in 2008."

Comments will be accepted on the proposed rule until August 31, 2007, and a final rule will be published later in the fall. The final rule will be effective for services on or after January 1, 2008. The proposed rule (CMS-1385-P) may be viewed on the CMS Web site at *http://www.cms.hhs.gov/apps/ama/license.asp?file=/physicianfeesched/downloads/CMS-1385-P.pdf* .

The press release may be viewed on the CMS Web site at *http://www.cms.hhs.gov/apps/media/press_releases.asp*, and the fact sheet is posted at: *http://www.cms.hhs.gov/apps/media/fact_sheets.asp*.

Sources: Provider Education Resources Listserv 200707-01
Provider Education Resources Listserv 200707-02
Provider Education Resources Listserv 200707-04
Provider Education Resources Listserv 200707-07

News from the Medicare Learning Network

Getting *Medicare Learning Network* Products

Want to know when the latest *Medicare Learning Network* (*MLN*) products are available? By subscribing to the *MLN_EDUCATION_PRODUCTS-L listserv* you will receive e-mail notifications of new and updated *MLN* products. To subscribe to the *MLN_EDUCATION_PRODUCTS-L listserv* or to any of the many other CMS listservs, go to the CMS Mailing Lists Web page at *http://www.cms.hhs.gov/apps/mailinglists/* and sign up today.

Rural Referral Center Fact Sheet

The *Rural Referral Center Fact Sheet*, which provides information about Rural Referral Center program requirements, is now available in print format from the *Medicare Learning Network*. To place your order for the fact sheet, visit *http://www.cms.hhs.gov/mlngeninfo*, scroll down to "Related Links Inside CMS," and select "*MLN* Product Ordering Page."

Source: Provider Education Resources Listserv, Message 200706-40

Requests for Information Available on the Remittance Advice

New federal regulations and guidelines require Medicare contractors to advise providers to refer to the remittance advice (RA) whenever a written or telephone inquiries/questions are received for which the answers are available on the RA. Providers are also advised that any billing staff or representatives that make inquiries on the provider's behalf will need a copy of the remittance advice in question.

In accordance with this CMS mandate, the provider/representative's needs to refer and research the appropriate RA for any inquiry or question relative to information that can be found on the RA. The Centers for Medicare & Medicaid Services (CMS) is encouraging Medicare providers to use the self-service tools and products available to facilitate and understand the Medicare program.

Providers may take advantage of the training material to educate themselves and their representatives about reading and understanding the RA tittle "*Understanding the Remittance Advise: A Guide for Medicare Providers, Physicians, Suppliers and Billers*" available on CMS Web site *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

Source: CMS Pub. 100-09, Transmittal 19, CR 5597

Revisions to Connecticut Contact Information

Please make note of revisions to the Connecticut "Important Addresses, Phone Numbers, And Web sites" section of this publication. Some of the changes include:

- New call center numbers for Provider Enrollment, Appeals and Medicare Secondary Payer.
- Revised "Empire Medicare Services" to "National Government Services (NGS)" and corresponding telephone number.
- Revised the durable medical equipment regional contractor (DMERC) information to the new durable medical equipment Medicare administrative contractor (DME MAC) contractor (National Heritage Insurance Company [NHIC]) and corresponding telephone number.

Please make any necessary revisions to your internal file.

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.

New LCDs

J2357: Omalizumab (Xolair®)—New LCD

Asthma is a chronic inflammatory lung disease. Allergic asthma is the most common form of asthma and its symptoms may include coughing, wheezing, shortness of breath and chest tightness. Allergens and IgE antibodies are the main causes of allergic asthma. IgE antibodies are produced by the body in response to being exposed to allergens. This combination results in the release of mediators (histamine, prostaglandins and leukotrienes), which cause the asthma symptoms to manifest.

Xolair® (omalizumab) is a recombinant DNA-derived monoclonal antibody that selectively binds to human immunoglobulin E (IgE). Xolair inhibits the binding of IgE to the high affinity IgE receptor on the surface of mast cells and basophils. Xolair® is indicated for adults and children (12 years of age and older) with moderate to severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids. Xolair has been shown to decrease the incidence of asthma exacerbations in these patients.

This new local coverage determination (LCD) was developed to provide coverage guidelines for this drug. This LCD incorporates indications and limitations, documentation requirements, utilization and dosing guidelines and ICD-9-CM codes that support medical necessity for procedure code J2357.

Effective Date

This new LCD will be effective for services rendered **on or after September 30, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

J9055: Cetuximab (Erbitux®)—New LCD

Cetuximab (Erbitux®) is a recombinant, human/mouse chimeric monoclonal antibody that binds specifically to the extracellular domain of the human epidermal growth factor receptor (EGFR). The Food and Drug Administration (FDA) has approved Cetuximab for the following indications:

- When used in combination with irinotecan for the treatment of EGFR-expressing metastatic colorectal carcinoma in patients who are refractory to irinotecan-based chemotherapy;
- When administered as a single agent for the treatment of EGFR-expressing metastatic colorectal carcinoma in patients who are intolerant to irinotecan-based chemotherapy;
- When used in combination with radiation therapy for the treatment of locally or regionally advanced squamous cell carcinoma of the head and neck; and
- When used as a single agent for the treatment of patients with recurrent or metastatic squamous cell carcinoma of the head and neck where platinum-based therapy has failed.

An evaluation was completed to determine if current documentation justified the administration of this drug for the treatment of all metastatic colorectal malignancies without a required demonstration of EGFR positivity, and based on the submitted documentation, a decision to allow this off-label indication was made.

This new local coverage determination (LCD) was developed to include indications and limitations of coverage (including the off-label indication mentioned above), documentation requirements, utilization guidelines, ICD-9-CM codes that support medical necessity, and coding guidelines.

Effective Date

This new LCD will be effective for services rendered **on or after September 30, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

0171T: Interspinous Process Decompression—New LCD

Interspinous Process Decompression (IPD®) System also known as X-Stop® is an emerging technology which is intended for the treatment of patients who have failed to respond to conservative treatment of lumbar spinal stenosis. It is indicated for patients 50 years and older who have moderately impaired physical function from back and leg pain caused by spinal stenosis and who have obtained little or no pain relief after at least six months of non-surgical treatments such as pain medications, physical therapy, injections and/or manipulations.

This local coverage determination (LCD) was developed to provide indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines for the IPD® procedure.

Effective Date

This new LCD will be effective for services rendered **on or after September 30, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

64702: Surgical Decompression for Peripheral Polyneuropathy of Diabetes—New LCD

Surgical decompression of multiple lower extremity peripheral nerves is being utilized as an alternative approach for the treatment of symptomatic diabetic polyneuropathy. Currently, the preponderance of clinical evidence as noted in various publications in the peer reviewed literature is not sufficient to support the efficacy of surgical decompression of peripheral nerves for the treatment of symptomatic diabetic metabolic, inflammatory or toxic polyneuropathy.

This local coverage determination (LCD) was developed to provide noncoverage of this procedure specifically when used for treating peripheral polyneuropathy of diabetes.

Effective Date

This new LCD will be effective for services rendered **on or after September 30, 2007.** The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

68761: Lacrimal Punctal Plugs—New LCD

Dry eye is a disorder of the tear film due to tear deficiency

or excessive tear evaporation and involves damage to the ocular surface, which may result in an epithelial disorder called keratoconjunctivitis sicca (KCS), dry eye syndrome (DES) or dysfunctional tear syndrome (DTS) and is associated with symptoms which include: dryness, redness, burning, reflex tearing, itching, foreign body sensation, grittiness, stinging, soreness, photophobia and pain. In moderate cases, the ocular discomfort becomes marked and visual acuity may be reduced. Diabetic patients and patients with other corneal neuropathies may exhibit signs of DES with or without discomfort.

To determine the appropriate treatment, an eye examination should be performed to exclude other causes of irritation of the ocular surface. These may include eyelid malposition, inturned eyelashes, incomplete lid closure, allergies, meibomian gland disease, ocular inflammatory processes or systemic diseases (i.e., rheumatoid arthritis, diabetes). Corneal sensation should also be assessed when trigeminal nerve dysfunction is suspected.

When medical therapy is not effective, punctual occlusion may be accomplished by inserting lacrimal punctal plugs into the punctal orifice to decrease tear clearance and increase retention of the tear film by blocking the outflow of tears to the nasolacrimal system.

The occlusion of lacrimal puncta by collagen plugs (temporary/dissolvable) is generally used for the diagnosis of dry eye syndrome. The collagen plugs dissolve within one to two weeks. If a trial of temporary punctual occlusion proves successful, semi-permanent/non-dissolvable occlusion is usually considered.

Silicone or thermal labile polymer plugs (semi-permanent/non-dissolvable) are therapeutic and are generally used after the diagnosis has been made. After the silicone plugs are inserted, the patient intermittently returns to the physician to insure the integrity of the plugs.

While the choice of initially using collagen (temporary/dissolvable) or silicone (semi-permanent/non-dissolvable) is left to the clinician's discretion, the semi-permanent plugs afford a more extensive trial of punctal closure, and may better serve to delineate candidates for permanent closure.

First Coast Service Options, Inc. (FCSO) will consider lacrimal punctal plugs medically reasonable and necessary for patients with the following:

- Symptomatic, moderate, or severe dry eye syndrome when more conservative treatments (i.e., artificial tears) have proven to be ineffective; **and**
- A diagnosis of aqueous tear deficiency has been confirmed by:
- One or more of the following diagnostic tests: tear break-up time (TBUT), Schirmer test, ocular surface dye staining pattern (rose bengal, sodium fluorescein, or lissamine green); **and**
- Slit-lamp biomicroscopy exam.

The Centers for Medicare & Medicaid (CMS) On-line Manual System, Pub. 100-8, *Program Integrity Manual*, chapter 13, section 13.5.1 (*http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf*) outlines that "reasonable and necessary" services are "ordered and/or furnished by qualified personnel." Services will be considered medically reasonable and necessary only if performed by appropriately trained providers. Training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty or must reflect extensive continued medical education activities. If these skills have been acquired by way of continued medical education, the courses must be comprehensive, offered or sponsored or endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States, and designated by the American Medical Association (AMA) as Category 1 Credit.

Effective Date

This new LCD will be effective for services rendered **on or after September 30, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or htt *http://www.floridamedicare.com* on or after this effective date.

98925: Osteopathic Manipulative Treatment—New LCD

Osteopathic manipulative treatment (OMT) is a distinct manual procedure employed by a physician that aims to optimize a patient's health and function. OMT is defined in the Glossary of Osteopathic Terminology as the therapeutic application of manually guided forces by an osteopathic physician to improve physiologic function and/or support homeostasis that have been altered by somatic dysfunction.

This new local coverage determination (LCD) was developed to provide coverage guidelines for this procedure. This LCD incorporates indications and limitations, documentation requirements, utilization guidelines, and ICD-9-CM codes that support the medical necessity for procedure codes *98925, 98926, 98927, 98928 and 98929*.

Effective Date

This new LCD will be effective for services rendered **on or after September 30, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

99324: E&M Home and Domiciliary Visits—New LCD

A home or domiciliary visit includes a patient history, examination, problem solving and decision making in various levels depending upon a patient's need and diagnosis. Visits may also be performed as counseling or coordination of care if medically necessary outside the office environment and are an integral part of a continuum of care. The patients seen may have chronic conditions, may be disabled, either physically or mentally, making access to a traditional office visit very difficult, or may have limited support systems. The home or domiciliary visit in turn can lead to improved medical care by identification of unmet needs, coordination of treatment with appropriate referrals and potential reduction of acute exacerbations of medical conditions, resulting in less frequent trips to the hospital or emergency room**.**

This new local coverage determination (LCD) was originally posted for notice and comment in June 2006. Due to the numerous comments received during the original comment period and the considerable amount of revisions done to the LCD, the final draft looked different than the draft posted for comment. There were still concerns among certain physicians that the LCD may have some unintended consequences. Because of these concerns, First Coast Service Options, Inc. (FCSO) elected to delay the effective date of this LCD until further notice.

Since that time, this LCD has been posted again for notice and comment from May 21, 2007 – July 4, 2007. This new LCD was developed to provide indications and limitations for coverage, including medical necessity criteria, documentation requirements, and utilization guidelines. This LCD also provides clarification between E&M home and domiciliary visits and services provided through a home health agency. The *CPT* codes associated with this LCD are as follows*: 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349 and 99350*.

This new LCD will be effective for services rendered **on or after September 30, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

REVISION TO THE LCDS

J1566: Intravenous Immune Globulin—Revision to the LCD

The local coverage determination (LCD) for intravenous immune globulin was last revised on October 30, 2006. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued change request 5635, transmittal 1261, dated June 1, 2007, to implement Health Care Procedure Code System (HCPCS) coding changes for intravenous immune globulin.

HCPCS code J1567 (Injection, immune globulin, intravenous, non-lyophilized [e.g., liquid], 500 mg) will no longer be payable by Medicare. The following HCPCS codes will replace HCPCS code J1567:

Q4087 Injection, immune globulin (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg

Q4088 Injection, immune globulin (Gammagard liquid), intravenous, non-lyophilized (e.g. liquid), 500 mg

Q4091 Injection, immune globulin (Flebogamma), intravenous, non-lyophilized (e.g. liquid), 500 mg

Q4092 Injection, immune globulin (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg

J1566: Intravenous Immune Globulin, continued

Effective Date

This LCD revision is effective for services rendered **on or after July 1, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

J2792: Rho (D) Immune Globulin Intravenous—Revision to the LCD

The local coverage determination (LCD) for Rho (D) immune globulin intravenous was last revised on October 1, 2005. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued change request 5635, transmittal 1261, dated June 1, 2007 to implement Health Care Procedure Code System (HCPCS) coding changes for Rho (D) immune globulin intravenous.

A new HCPCS code, Q4089 (Injection, Rho (D) immune globulin (human), (Rhophylac®), intramuscular or intravenous, 100 iu), has been established. Currently, Rhophylac® is the only product that should be billed using HCPCS code Q4089. If other products under the Food and Drug Administration approval for Rhophylac® become available, HCPCS code Q4089 would be used to bill for such products.

Effective Date

This LCD revision is effective for services rendered **on or after July 1, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

J9000: Doxorubicin HCl—Revision to the LCD

The local coverage determination (LCD) for doxorubicin HCl was last updated on April 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Association (FDA) drug label, and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI) for doxorubicin HCl – J9000.

Revisions for FDA-approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This LCD revision will be effective for services rendered **on or after September 30, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

J9206: Irinotecan (Camptosar®)—Revision to the LCD

The local coverage determination (LCD) for irinotecan (Camptosar®) was last updated on April 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Association (FDA) drug label, and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI) for irinotecan – J9206.

Revisions for FDA approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This LCD revision will be effective for services rendered **on or after September 30, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

NCSVCS: The List of Medicare Noncovered Services—Revision to the LCD

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised on March 1, 2007. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued change request 5530, Transmittal 67, dated April 6, 2007, which determined that the use of osmotic blood brain barrier disruption is not reasonable and necessary when it is used a part of a treatment regimen for brain tumors. Therefore, this LCD is revised to add *CPT* code *64999* when used to bill for Blood Brain Barrier Osmotic Disruption for the treatment of brain tumors to the "National Noncoverage Decisions" section of the LCD. This LCD revision is effective for **services rendered on or after March 20, 2007**.

Additionally, CMS issued change request 5614, transmittal 1258, dated May 29, 2007, which made changes to the Medicare physician fee schedule database (MPFSDB). Effective for **services rendered on or after January 1, 2007,** *CPT* codes *0115T, 0116T, and 0117T* were assigned a procedure status indicator of "N" (Non-covered service). Furthermore, effective for **services rendered on or after July 1, 2007**, *CPT* code *0133T* was assigned a procedure status indicator of "I" (Not valid for Medicare purposes). Therefore, *CPT* codes *0115T, 0116T, 0117T* and *0133T* have been removed from the "Local Noncoverage Decisions" section of the LCD.

NCSVCS: The List of Medicare Noncovered Services, continued

The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

VISCO: Viscosupplementation Therapy For Knee—Revision to the LCD

This local coverage determination (LCD) was last revised February 27, 2007. Since that time, a provider specific probe, prompted by data analysis for knee arthrography, revealed that providers were using imaging for the purpose of needle guidance when performing viscosupplementation. This LCD has been revised to clarify the indications and limitations, documentation requirements, and utilization guidelines.. The "indications" and "limitations" have been separated and revised under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to reflect additional requirements. The "Documentation Requirements" section of the LCD was revised to include the requirement of an x-ray report to support the diagnosis of osteoarthritis; and the requirement that the height and weight must be recorded in the medical record has been removed. Revisions under the "Utilization Guidelines" section of the LCD include a listing of the hyaluronic preparations, the weekly dosages and the total dosages per course of treatment. Additionally, there is a statement regarding the use of imaging procedures when performing viscosupplementation.

Effective Date

This LCD revision will be effective for services rendered **on or after September 30, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

77078: Bone Mineral Density Studies—Revision to the LCD

The local coverage determination (LCD) for bone mineral density studies was last revised on January 1, 2007. Since that time, the LCD has been revised based on change request 5521, dated May 11, 2007. The following sections have been revised: Indications and Limitations of Coverage and/or Medical Necessity, *CPT*/HCPCS Codes, ICD-9 Codes that Support Medical Necessity, Documentation Requirements, and Utilization Guidelines.

Revisions made to the LCD include:

- A reduction of dosage requirements for glucocorticoid (steroid) therapy from 7.5 mg of prednisone per day to 5.0 mg.
- Deletion of *CPT* code *78350* as a covered procedure code.
- Language to indicate only dual-energy x-ray absorptiometry will be allowed to monitor osteoporosis drug therapy.
- Addition of ICD-9-CM codes 255.0 and 733.03 to the 'ICD-Codes that Support Medical Necessity' section of the LCD for *CPT* code *77080*.
- Addition of statement to indicate that, effective for dates of service on or after January 1, 2007, procedure codes G0130, *77078*, *77079*, *77081*, *77083* and *76977* will be denied when billed with ICD-9-CM codes 255.0, 733.00, 733.01, 733.02, 733.03, 733.09 or 733.90.
- The language which recommended ICD-9-CM codes for the indications was deleted from the 'Indications' section under the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD.

Effective Date

This LCD revision is effective for services rendered **on or after January 1, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

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.

ADDITIONAL INFORMATION

20550: Injection of Tendon Sheath, Ligament, or Trigger Points—Revision to the Coding Guidelines

The coding guideline attachment for the injection of tendon sheath, ligament, or trigger points local coverage determination (LCD) was effective November 8, 2005 for Connecticut and January 24, 2005 for Florida. Since that time, the coding guidelines have been revised to include the addition of language clarifying the noncoverage of dry needling.

Effective Date

This revision is effective for services rendered **on or after June 19, 2007**. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

95860: Electromyography and Nerve Conduction Studies—Revision to the Coding Guidelines

The local coverage determination (LCD) coding guideline attachment for electromyography and nerve conduction studies (95860) was effective June 30, 2007. Since that time, the "Coding Guidelines" section has been revised to include coding information regarding H-Reflex studies for *CPT* codes *95934* and *95936*. This information is based on the recommendations from the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) and includes information related to performing H-Reflex studies bilaterally, assessment of the gastrocnemius/soleus muscle, and testing in other muscles.

Effective Dates

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

CONNECTICUT ONLY - REVISION TO THE LCD

92025: Computerized Corneal Topography—Revision to the LCD

Computerized Corneal Topography (also known as computer-assisted video keratography (CAVK) and corneal mapping is a computer assisted diagnostic imaging technique in which a special instrument projects a series of light rings on the cornea, creating a color coded map of the corneal surface as well as a cross-section profile. This service is used to provide a detailed map or chart of the physical features and shape of the anterior surface of the cornea. This permits a more accurate portrayal of the physical state of the cornea and the subtle detection of corneal surface irregularity and astigmatism.

The local coverage determination (LCD) for computerized corneal topography was last revised on January 1, 2007. Since that time, the LCD has been revised in the following sections: "Indications and Limitations of Coverage" and/or "Medical Necessity", "ICD-9 Codes that Support Medical Necessity", "Documentation Requirements", "Sources of Information" and "Basis for Decision". A "Coding Guideline" attachment was also developed.

Revisions include the addition of coverage for pre-operative evaluation of irregular astigmatism prior to cataract surgery, monocular diplopia, and bullous keratopathy in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. The following ICD-9-CM codes were added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD: 368.2, 371.23, 371.61, 372.40, 372.41, 372.43, 372.44, 372.45, 372.52 and V42.5 and the following ICD-9-CM codes were deleted: 370.01, 370.02, 370.03, 370.05, 370.06 and 996.53.

Effective Date

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

FLORIDA ONLY - REVISION TO THE LCDS

G0108: Diabetes Outpatient Self-Management Training—Revision to the LCD

The local coverage determination (LCD) for diabetes outpatient self-management training was last revised on January 1, 2004. Since that time, the LCD has been revised to delete the language under the 'Medical Eligibility for Coverage' section in the latter part of the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD, as CMS change request 3185, dated May 28, 2004, replaced this language effective for **services rendered on or after January 1, 2004**.

The full text of this LCD is available through our provider education Web site at *http://www.floridamedicare.com* on or after this effective date.

64470: Paravertebral Facet Joint Blocks—Revision to the LCD

Medicare will consider facet joint blocks to be reasonable and necessary for chronic pain suspected to originate from the facet joint. Facet joint block is one of the methods used to document/confirm suspicions of posterior element biomechanical pain of the spine. This local coverage determination (LCD) was last revised April 11, 2005. Since that time the LCD has been revised to include changes to the following sections of the LCD:

- Indications and Limitations of Coverage and/or Medical Necessity
- Utilization Guidelines
- Documentation Requirements
- Coding Guidelines

Effective Date

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

92025: Computerized Corneal Topography—Revision to the LCD

Computerized corneal topography (also known as computer-assisted video keratography (CAVK) and corneal mapping is a computer assisted diagnostic imaging technique in which a special instrument projects a series of light rings on the cornea, creating a color coded map of the corneal surface as well as a cross-section profile. This service is used to provide a detailed map or chart of the physical features and shape of the anterior surface of the cornea. This permits a more accurate portrayal of the physical state of the cornea and the subtle detection of corneal surface irregularity and astigmatism.

The local coverage determination (LCD) for computerized corneal topography was last revised on January 1, 2007. Since that time, the LCD has been revised in the following sections: "Indications and Limitations of Coverage and/or Medical Necessity", "ICD-9 Codes that Support Medical Necessity", "Documentation Requirements", "Sources of Information" and "Basis for Decision". A "Coding Guideline" attachment was also developed.

Revisions include the addition of coverage for pre-operative evaluation of irregular astigmatism prior to cataract surgery, monocular diplopia, and bullous keratopathy in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. The following ICD-9-CM codes were also added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD: 368.2, 371.00, 371.23, 371.61, 371.62, 372.40, 372.41, 372.43, 372.44, 372.45 and 372.52.

Effective Date

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

CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

August 2007 – September 2007

Ask the Contractor Teleconference (ACT) – Physician Quality Reporting Initiative (PQRI)

When: August 18, 2007
Time: 12:00 p.m. – 1:30 p.m.
Type of Event: Webcast with Teleconference

Hot Topics Teleconference

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

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

Provider Outreach & Education Advisory Group Meeting

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

When: September 19, 2007 (Location to be announced)
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 *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

August 2007 – September 2007

Medicare 101 Seminar (Medicare Part A and B)

When: August 9, 2007
Time: 8:00 a.m. – 5:00 p.m.
Where: Marriott Orlando Airport
7499 Augusta National Drive
Orlando, Florida

Ask the Contractor Teleconference – Provider Enrollment

When: August 16, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Hot Topics Teleconference – Topics to be determined

When: September 13, 2007
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

Two Easy Ways To Register

Online – To register for this seminar, please visit our new training Web site at *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 FCSO Provider Education and Outreach Registration Hotline 1-904-791-8103 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: _____

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 — 2007 PART B MATERIALS

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

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

QUANTITY	ITEM	ACCOUNT NUMBER	COST PER ITEM
	***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Hardcopy or CD-ROM distribution is limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers who meet the above criteria must register to receive the *Update!* in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason can be shown why the electronic publication available free of charge on the Internet cannot be utilized. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2006 through September 2007 (back issues will be sent upon receipt of order).	700395	$85.00 (Hardcopy) $20.00 (CD-ROM)
	2007 Fee Schedule – The revised Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2007, through December 31, 2007, is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Providers having technical barriers that are registered to receive hardcopy publications will automatically receive one copy of the annual fee schedule. Additional copies or a CD-ROM is available for purchase. The Fee Schedule contains calendar year 2007 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: Revisions to fees may occur; FCSO will republish any revised fees in future editions of the *Medicare B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	Hardcopy: $5.00 (CT) $10.00 (FL) CD-ROM: $6.00 (Specify CT or FL)

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: _____ FAX Number: _____

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 ***