

# Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

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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.

**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
  - Nursing Staff
  - Other \_\_\_\_\_



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## Medicare B Update!

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

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

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

# THE FCSO MEDICARE B UPDATE!

## About the Connecticut and Florida Medicare B Update!

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

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

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

### Who Receives the Update?

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

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

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

We use the same mailing address for *all* correspondence, and cannot designate that the *Update!* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Registration 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 Medical Review 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.

# Annual Medicare B Update! Hardcopy/CD-ROM Registration Form

To receive the *Medicare B Update!* in hardcopy, CD-ROM or email format, you must complete this registration form. Please complete and fax or mail it to the number or address listed at the bottom of this form. **To receive a hardcopy, CD-ROM or email of future issues of the *Medicare B Update!* your form must be faxed or postmarked on or before August 1, 2007.** Providers currently receiving hardcopy publications that do not return this form by August 1, 2007, will not receive hardcopy versions after that date.

Please note that you are not obligated to complete this form to obtain information published in the *Medicare B Update!* Issues published beginning in 1997 are available **free** of charge on our provider education websites <http://www.floridamedicare.com> or <http://www.connecticutmedicare.com> .

**Provider/Facility Name:**

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**Medicare Provider Identification Number (PIN):**

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**Address:**

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**City, State, ZIP Code:**

---

**Contact Person/Title:**

---

**Telephone Number:**

**Fax Number:**

**Email Address:**

---

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Please share your questions and/or concerns regarding this initiative with us:

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Additional questions or concerns may be submitted via the Medicare Provider websites at <http://www.floridamedicare.com> or <http://www.connecticutmedicare.com> using the "Contact Us" section or sent via fax to (904) 791-6292 . Our Provider Contact Center will not be able to respond to inquiries about this form.

## Advance Beneficiary Notices

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

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

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

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

### Patient Liability Notice

Form CMS-R-131 is the approved ABN, *required for services provided on or after January 1, 2003*. Form CMS-R-131 was developed as part of the Centers for Medicare & Medicaid Services' (CMS) Beneficiary Notices Initiative

(BNI), and was approved by OMB (Office of Management and Budget) on June 18, 2002. The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

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

Attention: Medical Review  
Medicare Part B CT  
PO Box 45010  
Jacksonville, FL 32232-5010

OR

#### Florida

Attention: Medical Review  
Medicare Part B Claim Review  
PO Box 2360  
Jacksonville, FL 32231-0018

## CLAIMS

## Quarterly Update to Correct Coding Initiative Edits, Version 13.2, Effective July 1, 2007

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

### Provider Types Affected

Physicians who submit claims to Medicare carriers and A/B Medicare administrative contractors (A/B MACs).

### Background

This article is based on change request (CR) 5604, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The latest package of CCI edits, version 13.2, effective July 1, 2007, and the current Mutually Exclusive Code (MEC) edits will be available at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> on the Centers for Medicare & Medicaid Services (CMS) website.

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

- The American Medical Association's (AMA's) *Current Procedural Terminology (CPT) Manual*,
- National and local policies and edits,
- Coding guidelines developed by national societies,
- Analysis of standard medical and surgical practice, and
- Review of current coding practice.

The latest package of CCI edits, version 13.2, includes all previous versions and updates from January 1, 1996, to the present and will be organized in two tables:

- Column 1/ Column 2 Correct Coding Edits
- Mutually Exclusive Code (MEC) Edits.

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### Additional Information

The CCI and MEC file formats will be maintained in the *Medicare Claims Processing Manual* (Chapter 23, Section 20.9) which may be found at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS website.

The official instruction, CR 5604, issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1243CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare carrier or A/B MAC at their toll-free number, which may be found on the CMS website 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: MM5604  
 Related Change Request (CR) #: 5604  
 Related CR Release Date: May 18, 2007  
 Effective Date: July 1, 2007  
 Related CR Transmittal #: R1243CP  
 Implementation Date: July 2, 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.

## Extension for Acceptance of Form CMS-1500 (12-90)

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the April 2007 Medicare B Update! page 6.

**Note:** This article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS website.

### Provider Types Affected

Physicians, nonphysician practitioners and suppliers, who submit claims for their services using the Form CMS-1500 to Medicare contractors (carriers, Part A/B Medicare administrative contractors [A/B MACs], durable medical equipment regional carriers [DMERCs], and/or DME Medicare administrative contractors [DME/MACs]). **Be aware that some of the new Form CMS-1500 (08-05) forms have been printed incorrectly. This article contains details on this issue.**

### Background

Form CMS-1500 is one of the basic forms prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the

**Extension for Acceptance of Form CMS-1500 (12-90), continued**

implementing regulation at 42 CFR 424.32. The Form CMS-1500 (12-90) was revised in July of 2006, to accommodate the reporting of the national provider identifier (NPI).

Recently it came to the attention of CMS that there are incorrectly formatted versions of the revised form being sold by print vendors. After reviewing the situation, CMS determined that the source files received from the authorized form designer were improperly formatted. This resulted in the sale of printed forms and negatives, which do not comply with the form specifications.

Therefore, CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007, deadline while this situation is resolved. The specific formatting issue involves top and bottom margins only, but may not be isolated to only top and/or bottom.

**Key Points of CR 5568**

- CR 5568 states that the Form CMS-1500 (12-90) will continue to be accepted until CMS instructs otherwise.
- All Form CMS-1500 (08-05) forms received by Medicare contractors that are incorrectly formatted will be returned to the provider or supplier if the Medicare contractor is unable to scan the form with its optical character reader scanning equipment. An incorrectly formatted form is one that is ¼" or more off in the top, bottom, right, and/or left margins.
- The best way to identify the incorrect forms is by looking at the upper right hand corner of the form. If the tip of the red arrow above the vertically stacked word "CARRIER" is touching or close to touching the top edge of the form, then the form is not printed to specifications. There should be approximately ¼" between the tip of the arrow and the top edge of the paper on properly formatted forms.

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.

- Providers submitting the Form CMS-1500 (12-90) are only required to submit their legacy provider number on that form, since the Form CMS-1500 (12-90) cannot accommodate the NPI.

**It is important to note that this issue involves the paper claim form only, not the electronic claim format, which can accommodate the NPI. In addition, this situation does not affect the current NPI implementation date of May 23, 2007.**

**Additional Information**

To see the official instruction (CR 5568) issued to your Medicare carrier, A/B MAC, DME MAC, or DMERC, go to <http://www.cms.hhs.gov/Transmittals/downloads/R1208CP.pdf> on the CMS website.

To view the original communication from CMS regarding this issue, visit

<http://www.cms.hhs.gov/ElectronicBillingEDITrans/downloads/1500%20problems.pdf> on the CMS website.

If you have questions, please contact your Medicare carrier, A/B MAC, DME MAC, or DMERC 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: MM5568 *Revised*

Related Change Request (CR) #: 5568

Related CR Release Date: March 19, 2007

Effective Date: April 1, 2007

Related CR Transmittal #: R1208CP

Implementation Date: April 2, 2007

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## **Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500**

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the March 2007 Medicare B Update! pages 6-7.*

**Note:** This article was revised on May 8, 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 website.

**Provider Types Affected**

Physicians and suppliers who bill Medicare carriers including durable medical equipment regional carriers (DMERCs) for their services using the Form CMS-1500.

**Key Points**

- The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the NPI.
- The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.
- During this transition time there will be a dual acceptability period of the current and the revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the **split provider identifier fields**.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.



### *Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500, continued*

- There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

#### **January 2, 2007 – March 30, 2007**

Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version. **Note:** Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08-05) by January 2, 2007.

#### **April 2, 2007**

The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used. **Note:** All **rebilling** of claims should use the **revised** Form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12-90).

### **Background**

Form CMS-1500 is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The CMS-1500 form is being revised to accommodate the reporting of the NPI.

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Thus, small plans may need to receive legacy provider numbers on coordination of benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

In a related change request (CR), 4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report provider identification numbers (PINs) and unique physician identification numbers (UPINs) as applicable.

There were no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. CR 4293 provided guidance for implementing the revised Form CMS-1500 (08-05). This article, based on CR 5060, provides additional Form CMS-1500 (08-05) information for Medicare carriers and DMERCs, related to validation edits and requirements.

### **Billing Guidelines**

When the NPI number is effective (May 23, 2007, although it can be reported starting January 1, 2007) **and the billed service requires the submission of an NPI**, claims will be **rejected** (in most cases with reason code 16 – “claim/service lacks information that is needed for adjudication”) in tandem with the appropriate remark code that specifies the missing information, **if**

- The appropriate **NPI is not entered** on Form CMS-1500 (08-05) in items:

**24J** (replacing item 24K, Form CMS-1500 [12-90]);

**17B** (replacing item 17 or 17A, Form CMS-1500 [12-90]);

**32a** (replacing item 32, Form CMS-1500 [12-90]); and

**33a** (replacing item 33, Form CMS-1500 [12-90]).

### **Additional Information**

#### **When the NPI Number is Effective and Required (May 23, 2007)**

To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.

Legacy identifiers are pre-NPI such as:

- PINs (provider identification numbers)
- UPINs (unique physician identification numbers)
- OSCARs (online survey certification & reporting system numbers)
- NSCs (national supplier clearinghouse) numbers for DMERC claims.

### **Additional NPI-Related Information**

Additional NPI-related information may be found at <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS website.

The change log which lists the various changes made to the Form CMS-1500 (08-05) version may be viewed at the NUCC website at [http://www.nucc.org/images/stories/PDF/change\\_log.pdf](http://www.nucc.org/images/stories/PDF/change_log.pdf).

MLN Matters article MM4320, “Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms,” may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf> on the CMS website.

CR 4293, Transmittal Number 899, “Revised Health Insurance Claim Form CMS-1500,” provides contractor guidance for implementing the revised Form CMS-1500 (08-05). It may be found at <http://www.cms.hhs.gov/transmittals/downloads/R899CP.pdf> on the CMS website.

MLN Matters article MM4023, “Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms,” may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf> on the CMS website.

CR 5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1058CP.pdf> on the CMS website.

**Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500, continued**

Please refer to your local carrier or DMERC if you have questions about this issue. To find their toll free phone number, please go to: <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: MM5060 *Revised*

Related Change Request (CR) #: 5060

Related CR Release Date: September 15, 2006

Effective Date: January 1, 2007

Related CR Transmittal #: R1058CP

Implementation Date: January 2, 2007

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## Revisions to Incomplete or Invalid Claims Instructions Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (8/05)

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the April 2007 Medicare B Update! pages 7-8.

**Note:** This article was revised on May 8, 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 website.

### Provider Types Affected

Physicians and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment regional carriers [DMERCs], DME Medicare administrative contractors [DME MACs], and 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) 5391, which revises the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 1, Section 80.3.2) relating to the handling of incomplete and invalid claims to reflect the changes in reporting items for the NPI on the revised Form CMS-1500 version 08/05 and updates the references to remark codes in the instructions and revises the instructions to indicate what is consistent with Health Insurance Portability and Accountability Act (HIPAA) guidelines. Affected providers should assure their billing staff are aware of NPI reporting requirements. These changes apply to claims received on or after May 23, 2007.

### Background

The Centers for Medicare & Medicaid Services Form 1500 (CMS-1500; Health Insurance Claim Form) has been revised to accommodate the reporting of the NPI. The revised form is designated as Form CMS-1500 (8/05). The revisions to CMS-1500 include additional items for the reporting of the NPI. The manual revisions also include items that have already been implemented through the Competitive Acquisition of Part B Drugs and Biologicals (CAP) through the following CRs:

- CR 4064 at <http://www.cms.hhs.gov/Transmittals/Downloads/R777CP.pdf>, and *MLN Matters* article MM4064 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>
- CR 4306 at <http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf>
- CR 4309 at <http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf>; and *MLN Matters* article MM4309 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf>
- CR 5079 at <http://www.cms.hhs.gov/transmittals/downloads/R1055CP.pdf>
- CR 5259 at <http://www.cms.hhs.gov/transmittals/downloads/R1034CP.pdf>.

As a result of the revisions included in the Form CMS-1500 (8/05), the incomplete and invalid claims instructions are being updated to reflect the appropriate items in which the NPI will be reported.

CR 5391 instructs Medicare contractors (carriers, DMERCs, DME MACs, and A/B MACs):

- To make all necessary changes to their internal business processes to enable the return of claims as unprocessable that do not report an NPI when required in a provider name segment or another provider identification segment in an electronic or a CMS-1500 (08/05) paper claim. See the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter One (Sections 80.3.2.1.1 through 80.3.2.1.3) included as an attachment to CR 5391, and the Health Care Claim Professional 837 Implementation Guide (<http://www.wpc-edi.com/>) for further information.

**Revisions to Incomplete or Invalid Claims Instructions Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (8/05), continued**

- To use the appropriate remittance advice remark codes provided in the *Medicare Claims Processing Manual*, (Pub. 100-04), Chapter 4, Sections 80.3.2.1.1 through 80.3.2.1.3, when returning claims as unprocessable.
- To not search their internal files:
  - To correct a missing or inaccurate NPI on a Form CMS-1500 (8/05) or on an electronic claim.
  - To correct missing or inaccurate information required for HIPAA compliance for claims governed by HIPAA.

**Additional Information**

For complete details, please see the official instruction issued to your Medicare contractor (carrier, DMERC, A/B MAC, or DME MAC) regarding this change. That instruction may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1187CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found on the CMS website 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: MM5391 *Revised*

Related Change Request (CR) #: 5391

Related CR Release Date: February 23, 2007

Effective Date: May 23, 2007

Related CR Transmittal #: R1187CP

Implementation Date: May 23, 2007

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## DRUGS AND BIOLOGICALS

## Revision to Radiopharmaceutical Code Allowances

First Coast Service Options, Inc. (FCSO) published the established pricing allowance for HCPCS code A9500, A9502, A9503, A9505 and A9516 in the May 2007 *Medicare B Update!* (page 18). Since then, the payment allowances for HCPCS code A9500 have been revised.

The following table indicates the correct carrier-priced payment allowances for services rendered **on or after January 1, 2007**.

Procedure Code/Descriptor	Par Fee	Non-Par Fee	Limiting Charge
<b>A9500</b> – Technetium Tc-99m sestamibi, diagnostic, per study dose up to 40 millicuries (Cardiolite®)	\$120.91	\$114.86	\$132.09
<b>A9502</b> – Technetium Tc-99m tetrofosmin, diagnostic, per study dose, up to 40 millicuries (Myoview®)	\$119.70	\$113.72	\$130.78
<b>A9503</b> – Technetium Tc-99m medronate, diagnostic, per study dose, up to 30 millicuries (/MPI MDP)	\$54.93	\$52.18	\$60.01
<b>A9505</b> – Thallium Tl-201 thallos chloride, per millicurie	\$88.40	\$83.98	\$96.58
<b>A9516</b> – Iodine I-123 sodium iodide capsule(s), diagnostic, per 100 microcuries	\$92.99	\$88.34	\$101.59

As a result of this revision, payment for HCPCS code A9500 has been overpaid for services rendered **on or after January 1, 2007, and processed between February 5, 2007, and May 13, 2007**.

Claims processed **on or after May 14, 2007**, are being paid correctly.

FCSO will pursue overpayments on claims paid at the incorrect payment allowance.

## Requirement for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents

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

### Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment regional carriers [DMERCs] and DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], and Medicare administrative contractors [MACs]) for providing ESA administration services to Medicare end-stage renal disease [ESRD] beneficiaries.

### What You Need to Know

CR 5480, from which this article is taken, instructs all providers and suppliers on the voluntary reporting of route of administration modifiers on claims for erythropoiesis stimulating agents (ESAs) for ESRD beneficiaries. Route of administration modifiers were published and effective January 1, 2007, for reporting on Medicare claims submitted on or after February 1, 2007, for dates of service on or after January 1, 2007. Please see the *Background* section for details.

### Background

Current claims processing requirements do not allow you to report the method of administering ESA—such as epoetin alfa (EPO) and darbepoetin alfa (Aranesp) – to treat your ESRD patients who are anemic. However, in order to study the efficacy of both intravenous administration and subcutaneous administration methods of ESA administration, the Centers for Medicare & Medicaid Services (CMS) will begin requesting you to voluntarily report modifiers, which will indicate the method of ESA administration.

Specifically, CR 5480, from which this article is taken, announces that, effective for claims submitted on or after *February 1, 2007* (with dates of services on or after *January 1, 2007*), all providers and suppliers who bill for administering ESA to ESRD beneficiaries (Healthcare Common Procedure Coding System (HCPCS) codes Q4081, J0882, or J0886) are encouraged to include:

- Modifier JA on the claim to indicate an intravenous administration or
- Modifier JB to indicate a subcutaneous administration.

You should be aware that in the future, this reporting of the route of ESA administration will be a requirement, and additional instructions will be issued at that time. But until then, a claim for an ESA that does not report the route of administration will not be returned to the provider, and will be paid the same as a claim that does report the route of administration. Also, be aware that renal dialysis facilities whose claims include charges for ESA administration by both methods should report them in separate lines in order to identify the number of administrations provided by each method.

*Requirement for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents, continued***Additional Information**

You may find more information about route of administration codes for ESAs by going to CR 5480, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1212CP.pdf> on the CMS website. As attachments to this CR, you will find updated *Medicare Claims Processing Manual*, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 60.2.3.1 (Requirement for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents [ESAs]); and Chapter 17 (Drugs and Biologicals), Section 80.11 (Requirements for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents [ESAs]).

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> 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: MM5480 *Revised*

Related Change Request (CR) #: 5480

Related CR Release Date: March 30, 2007

Effective Date: January 1, 2007

Related CR Transmittal #: R1212CP

Implementation Date: June 29, 2007

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## Update to Information Regarding Medicare Payment and Coding for Drugs and Biologicals

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

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

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

- Q codes for Euflexxa<sup>TM</sup>, Orthovisc<sup>®</sup>, and Synvisc<sup>®</sup> effective January 1, 2007
- Q codes for immune globulin and the new Q code for Reclast<sup>®</sup> effective July 1, 2007

Section 1847A requires single source drugs or biologicals that were within the same billing and payment code as of October 1, 2003, be treated as multiple source drugs, so the payment under Section 1847A for these drugs and biologicals is based on the volume weighted average of the pricing information for all of the products within the billing and payment code. CMS is working to ensure that payments accurately reflect this “grandfathering” provision. Examples of how CMS is operationalizing this provision include:

- Q4083 for Hyalgan and Supartz effective January 1, 2007
- Q4094 for albuterol and levalbuterol and Q4093 for concentrated forms of albuterol and levalbuterol effective July 1, 2007

In addition, appropriate modifications of the national drug code (NDC) to HCPCS crosswalk used to calculate the payment limits for purposes of Section 1847A will be made to ensure that payment will be based on the pricing information for all products produced or distributed under an FDA-approval for the drug or biological.

One result is the same payment limit for J0885 (injection, epoetin alfa, [for non-ESRD use]) and J0886 (injection, epoetin alfa, [for ESRD on dialysis]).

CMS will continue to work to identify and implement payment and coding changes as necessary to ensure more accurate payments under Section 1847A. So that CMS can implement any further necessary changes during 2007, CMS will continue to use an internal process for modifying the HCPCS code set and for adjusting the NDC to HCPCS crosswalk.

**Update to Information Regarding Medicare Payment and Coding for Drugs and Biologicals, continued**

A full list of the July 2007 quarterly updates to the HCPCS is available at [http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02\\_HCPCS\\_Quarterly\\_Update.asp#TopOfPage](http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage).

Pricing information for Part B drugs and biologicals for the third quarter of 2007 (July 1 – September 30) will be posted on or after June 15th at [http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a\\_2007aspfiles.asp#TopOfPage](http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage).

The announcement for the Q codes for Euflexxa™, Orthovisc®, and Synvisc® effective January 1, 2007, and Q4083 for Hyalgan and Supartz also effective January 1, 2007, was posted on December 22, 2006, and is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf>.

Source: Provider Education Resources Listserv, Message 200705-23

**RADIOLOGY****Bone Mass Measurements**

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

**Provider Types Affected**

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

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

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

**CAUTION – What You Need to Know**

Medicare edits will deny claims that are not consistent with revised BMM policy and providers may be liable for noncovered BMMs unless they have issued an advanced beneficiary notice (ABN) as required. This article explains the changes as a result of the calendar year 2007 physician fee schedule final rule.

**GO – What You Need to Do**

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

**Background**

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

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

**Key Points**

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

**Chapter 13**

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

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

*Bone Mass Measurements, continued*

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

733.00      733.09  
 733.01      733.90  
 733.02      255.0  
 733.03

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

733.00      733.09  
 733.01      733.90  
 733.02      255.0  
 733.03
- Medicare will not cover single photon absorptiometry and procedure code 78350 will be denied for services on or after January 1, 2007.
- In informing beneficiaries about the denials of claims processed for BMMs, Medicare will use the following Medicare summary notice (MSN) messages, effective for services on or after January 1, 2007:
 

CPT procedure code 78350:  
 MSN# 16.10: "Medicare does not pay for this item or service."  
 CPT procedure codes 77078, 77079, 77081, 77083, 76977 and HCPCS G0131 when billed with ICD-9-CM diagnosis codes 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0  
 MSN #15.4: "The information provided does not support the need for this service or item"
- If an advance beneficiary notice (ABN) was issued, the following MSN will follow:
 

MSN# 36.1: "Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review."
- If an ABN was not issued the following MSN will be included:
 

MSN # 36.2: "It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within six months of the date of this notice. Future services of this type provided to you will be your responsibility."
- Effective January 1, 2007, the following remittance advice (RA) messages will be issued when Medicare denies BMM claims:
 

Claim adjustment reason code 50: "These are non-covered services because this is not deemed a "medical necessity" by the payer".  
 If an ABN was issued the RA issued is M38: "The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay."  
 If an ABN was not issued RA remark code is M27: "The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office."
- Physicians, practitioners and hospitals are liable for payment unless they issue an appropriate ABN. More information on ABNs may be found in Chapter 30, Sections 40-40.3.8 of the *Medicare Claims Processing Manual*, located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopofPage> on the CMS website.

**Chapter 15**

Definition of BMM: a radiologic, radioisotopic, or other procedure that meets all of the following conditions:

- Is performed to identify bone mass, detect bone loss, or determine bone quality.
- Is performed with either a bone densitometer (other than single-photon or dual-photon absorptiometry) or a bone sonometer system that has been cleared for marketing for BMM by the Food and Drug Administration (FDA) under 21 CFR part 807, or approved for marketing under 21 CFR part 814.
- Includes a physician's interpretation of the results.

*Bone Mass Measurements, continued***Conditions for Coverage**

- Medicare covers BMM if it is ordered by a qualified physician or nonphysician practitioner, who is treating the beneficiary following an evaluation of the need for a BMM and the appropriate BMM to be used.
- The BMM must be performed under the appropriate level of supervision as defined in 42 CFR 410.32(b).
- The BMM must be reasonable and necessary for diagnosis and treatment of a beneficiary who meets at least one of the following conditions:

A woman who has been determined by the physician or qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.

**Note:** Since not every woman who has been prescribed estrogen replacement therapy (ERT) may be receiving an “adequate” dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating nonphysician practitioner from ordering a bone mass measurement for her. If a BMM is ordered for a woman following a careful evaluation of her medical need, however, it is expected that the ordering treating physician (or other qualified treating nonphysician practitioner) will document in her medical record why he or she believes that the woman is estrogen-deficient and at clinical risk for osteoporosis.

An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture.

An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to an average of 5.0 mg of prednisone, or greater, per day, for more than three months.

An individual with primary hyperparathyroidism.

An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.

- In the case of any individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy, the BMM must be performed with a dual-energy X-ray absorptiometry system (axial skeleton).
- In the case of any individual who meets the above conditions and who has a confirmatory BMM, the BMM is performed by a dual-energy X-ray absorptiometry system (axial skeleton) if the initial BMM was not performed by a dual-energy X-ray absorptiometry system (axial skeleton). A confirmatory baseline BMM is not covered if the initial BMM was performed by a dual-energy X-ray absorptiometry system (axial skeleton).

**Frequency standards.**

- Medicare pays for a screening BMM once every two years.
- Medicare may pay for more frequent screenings when medically necessary. Examples include, but are not limited to, the following medical circumstances:

Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than three months.

Confirming baseline BMMs to permit monitoring of beneficiaries in the future.

- Noncovered BMMs occur when they are not considered reasonable and necessary under section 1862 (a) (1) (A) of the Act.

Single photon absorptiometry (effective January 1, 2007).

Dual photon absorptiometry (established in 1983).

**Additional Information**

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

- Transmittal 69, which contains the Medicare National Coverage Determination, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R69NCD.pdf> on the CMS website;
- Transmittal 70, which contains the revised Medicare Benefit Policy Manual sections, is at <http://www.cms.hhs.gov/Transmittals/downloads/R70BP.pdf> on the CMS website; and
- Transmittal 1236 contains the Medicare Claims Processing Manual revisions and is at <http://www.cms.hhs.gov/Transmittals/downloads/R1236CP.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).

A brochure outlining “Bone Mass Measurements” is available at [http://www.cms.hhs.gov/MLNProducts/downloads/bone\\_mass\\_06-08-05.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass_06-08-05.pdf).

MLN Matters Number: MM5521

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## SURGERY

**Clarification of Bariatric Surgery Billing Requirements Issued in CR 5013**

*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 carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for bariatric surgery related services provided to Medicare beneficiaries

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

This article is based on change request (CR) 5477, which clarifies the claims processing instructions contained in CR 5013 (Transmittals R931CP and R54NCD; titled Bariatric Surgery for Morbid Obesity).

**CAUTION – What You Need to Know**

On April 28, 2006, the Centers for Medicare & Medicaid Services (CMS) issued CR 5013 providing coverage for certain bariatric surgical procedures. CMS found that some claims not involving bariatric surgery are being denied in error while some covered bariatric surgery claims are being held rather than paid.

**GO – What You Need to Do**

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

**Background**

On April 28, 2006, CMS issued CR 5013 (Transmittals R931CP and R54NCD, dated April 28, 2006) providing coverage for certain bariatric surgical procedures. This national coverage determination (NCD) is contained in section 100.1 of the *Medicare NCD Manual*.

It came to the attention of the CMS that this NCD is not being implemented uniformly, and CMS found that:

- Some claims not involving bariatric surgery are being denied in error, and
- Some covered bariatric surgery claims are being held rather than paid.

Therefore, CMS is issuing CR 5477 to clarify the claims processing instructions contained in CR 5013.

Certain bariatric surgery procedures for treatment of co-morbidities associated with morbid obesity are considered reasonable and necessary under the Social Security Act (Section 1862(a)(1)(A) if the following conditions are satisfied:

1. The Medicare beneficiary:
  - Has a body-mass index (BMI)  $\geq 35$ ,
  - Has at least one co-morbidity related to obesity (such as diabetes or hypertension), and
  - Has been previously unsuccessful with medical treatment for obesity.
2. The procedure is performed in an approved facility listed at <http://www.cms.hhs.gov/MedicareApprovedFacilities/BSF/list.asp> on the CMS website.

**Note:** The NCD itself has not changed and treatments for obesity alone are noncovered.

The following revisions to the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 32) provide guidance for bariatric surgery claims payment:

**ICD-9-CM Diagnosis Codes for BMI  $\geq 35$** 

Code	Descriptor
V85.35	Body Mass Index 35.0-35.9, adult
V85.36	Body Mass Index 36.0-36.9, adult
V85.37	Body Mass Index 37.0-37.9, adult
V85.38	Body Mass Index 38.0-38.9, adult
V85.39	Body Mass Index 39.0-39.9, adult
V85.4	Body Mass Index 40 and over, adult

Claims must be submitted to carriers or A/B MACs with the ICD-9-CM diagnosis code of 278.01 for morbid obesity and one of the appropriate *CPT* codes as follows:

43770	Laparoscopy, surgical, gastric restrictive procedure: placement of adjustable gastric band (gastric band and subcutaneous port components)
43644	Laparoscopy, surgical, gastric restrictive procedure with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)

*Clarification of Bariatric Surgery Billing Requirements Issued in CR 5013, continued*

- 43645 Laparoscopy, surgical, gastric restrictive procedure with gastric bypass and small intestine reconstruction to limit absorption.
- 43845 Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common chanel) to limit absorption (biliopancreatic diversion with duodenal switch).
- 43846 Gastric restrictive procedure, with gastric bypass, for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy.
- 43847 Gastric restrictive procedure with small intestine reconstruction to limit absorption.

Medicare FIs and A/B MACS will accept bariatric surgery claims billed by institutional providers with and ICD-9-CM diagnosis code of 278.01 for morbid obesity and one of the following ICD-9-CM procedure codes:

- 44.38 Laparoscopic gastroenterostomy; bypass: gastroduodenostomy, gastroenterostomy, gastrogastrostomy; laparoscopic gastrojejunostomy without gastrectomy NEC.
- 44.39 Other gastroenterostomy; bypass: gastroduodenostomy, gastroenterostomy, gastrogastrostomy; gastrojejunostomy without gastrectomy NOS.
- 44.95 Laparoscopic gastric restrictive procedure; adjustable gastric band and port insertion.

**Note:** If ICD-9-CM diagnosis code 278.01 is present, but one of the listed ICD-9-CM procedure codes or HCPCS codes is not present, then the Medicare contractor will determine the claim is not for bariatric surgery and will process the claim accordingly. Also, if one of the ICD-9-CM procedure codes is present without ICD-9-CM diagnosis code 278.01, then the claim is not for bariatric surgery, and the contractor will process the claim accordingly.

Also, to describe either laparoscopic or open biliopancreatic diversion with duodenal switch (BPD/DS), **claims must contain all three of the following codes:**

- 43.89 Other; partial gastrectomy with bypass gastrogastrostomy; sleeve resection of stomach.
- 45.51 Isolation of segment of small intestine; isolation of ileal loop; resection of small intestine for interposition.
- 45.91 Small-to-small intestinal anastomosis.

Claims submitted to FIs or A/B MACs must contain International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) procedure code reported as specified according to the following conditions:

- The Medicare contractor will pay the bariatric surgery claim if ICD-9-CM diagnosis code 278.01 (Morbid obesity; severe obesity) **and all** of the following are present:
  - At least one of the specified ICD-9-CM diagnosis codes for BMI  $\geq 35$ ,
  - An appropriate procedure code(s) as listed in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 32, Sections 150.2 and 150.3,
  - An appropriate obesity-related co-morbid diagnosis code(s), and
  - The procedure was performed in an approved facility.
- The Medicare contractor will **deny the bariatric surgery claim** if ICD-9-CM diagnosis code 278.01 is present, but any of the following are not present:
  - At least one of the specified ICD-9-CM diagnosis codes for BMI  $\geq 35$ ,
  - An appropriate procedure code(s) as listed in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 32, Sections 150.2 and 150.3,
  - An appropriate obesity-related co-morbid diagnosis code(s), and
  - The procedure was performed in an approved facility.

**Note:** The term, “deny”, rather than “reject” is used because beneficiaries and providers are entitled to appeal rights.

- If ICD-9-CM diagnosis code 278.01 is not present, the contractor will adjudicate the non-bariatric surgery claim based on the ICD-9-CM procedure codes listed on the claim.

**Noncovered HCPCS/ICD-9-CM Procedure Codes**

Contractors (carriers and B MACs) will **deny** bariatric surgery claims when:

- Billed with CPT 43842 (*Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty*) when used for open vertical banded gastroplasty. **Note:** This code was included in the April 2006 update of the Medicare physician fee schedule database and the July update of the Medicare outpatient code editor.
- Billed with HCPCS not otherwise classified (NOC) code 43999 when used for the following noncovered procedures: (When this NOC coded is used, the procedure should be described.)
  - Laparoscopic vertical banded gastroplasty
  - Open sleeve gastrectomy
  - Laparoscopic sleeve gastrectomy
  - Open adjustable gastric banding

*Clarification of Bariatric Surgery Billing Requirements Issued in CR 5013, continued*

Contractors (FIs and A MACs) will **reject** bariatric surgery claims when:

- Billed with principal ICD-9-CM diagnosis code 278.01 and ICD-9-CM procedure code 44.68 when used for the following noncovered procedures:
  - Open adjustable gastric banding
  - Laparoscopic vertical banded gastroplasty.
- Billed with principal ICD-9-CM diagnosis code 278.01 and ICD-9-CM procedure code 44.69 when used for the noncovered procedure, Open vertical banded gastroplasty.
- Billed with principal ICD-9-CM diagnosis code 278.01 and ICD-9-CM procedure code 43.89 when used for the following noncovered procedures:
  - Open sleeve gastrectomy
  - Laparoscopic sleeve gastrectomy.

**Note:** Carriers, FIs, or A/B MACs will use claim adjustment reason code 50 when denying/rejecting claims for noncovered bariatric surgery procedures, reason code 58 when payment is denied due to performing the surgery at an unapproved facility, and reason code 167 when denying the claim because the patient did not meet the conditions for coverage. Appeal rights will be afforded to all parties.

**Additional Information**

The official instruction, CR 5477, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1233CP.pdf> on the CMS website. The manual revisions to the *Medicare Claims Processing Manual* (Pub. 100-04; Chapter 32) included as an attachment to CR 5477:

CR 5013, Transmittal R931CP and R54NCD, dated April 28, 2006, may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R931CP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R54NCD.pdf> on the CMS website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found on the CMS website 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).

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**Astigmatism-Correcting Intraocular Lens—Implementation of CMS 1536 Ruling**

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

**Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], 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.

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

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 CR 3927 (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 of 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 is otherwise achieved by two separate items:

- 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 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):

<b>Benefits for Which Medicare Makes Payment</b>	<b>Services for Which Medicare Does NOT Pay – No Benefit Category</b>
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
- Silicon 1P Toric IOL (models: AA4203TF and AA4203TL), manufactured by STAAR Surgical.

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

- 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 required 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).*

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

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 website at: [http://cms.hhs.gov/medicare/bni/20007\\_English.pdf](http://cms.hhs.gov/medicare/bni/20007_English.pdf) for the English language version and [http://cms.hhs.gov/medicare/bni/20007\\_Spanish.pdf](http://cms.hhs.gov/medicare/bni/20007_Spanish.pdf) for the Spanish language version.

**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 website.

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 website at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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## GENERAL INFORMATION

## Physician Quality Reporting Initiative Coding & Reporting Principles

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

### Provider Types Affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI).

### What Providers Need to Know

CR 5640, from which this article is taken, provides information about, and instructions for, the coding and reporting of, quality measures in the CMS PQRI. The current PQRI reporting period is for claims with dates of service from July 1, 2007, through December 31, 2007. **Prompt submission of claims with quality measures is imperative as the claims will only be included in the PQRI analysis (and the associated bonus payment calculation) if received by Medicare's national claims history (NCH) file on or before February 29, 2008.**

### Background

CMS (authorized under Title 1, Section 101 of the 2006 Tax Relief and Health Care Act of 2006 [TRHCA]), created the 2007 PQRI, which establishes a financial incentive for eligible professionals to participate in a voluntary quality-reporting program.

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

### 2007 Physician Quality Reporting Initiative Specifications

In 2007, PQRI reporting is based on 74 unique measures. The *CMS 2007 Physician Quality Reporting Initiative Specifications* document (referred to in this article and in related CR5640 as *Specifications*) contains the 74 measures associated with clinical conditions that are routinely represented on Medicare fee-for-service claims through the use of diagnosis codes from the *International Classification of Diseases, 9th Revision-Clinical Modification* (ICD-9-CM) and procedure codes from the *HealthCare Common Procedure Coding System* (HCPCS). You can find this *Specifications* document on the CMS PQRI website (<http://www.cms.hhs.gov/pqri>).

The *Specifications* describe specific measures and associated codes that address various aspects of care such as: prevention, management of chronic conditions, management of acute episodes of care, procedure-related care, resource utilization, and care coordination. They also contain descriptions for each PQRI quality measure and include instructions on how to code each measure's numerator and denominator.

Each measure has a **reporting frequency** requirement for each eligible patient seen during the reporting period, (for example, report one-time only, once for each procedure performed, once for each acute episode, per each eligible patient). Some measures also include specific **performance timeframes** related to the clinical action in the numerator that may be distinct from the measure's reporting frequency requirement. (For example, performance timeframes may be stated as "within 12 months" or "most recent.")

### PQRI Quality-Data Codes

There are specific PQRI quality-data codes associated with each of the 2007 PQRI measures. These quality-data codes, translate clinical actions so they can be captured in the administrative claims process, are primarily *CPT* II codes, although temporary G codes will be used on an exception basis where *CPT* category II codes have not yet been developed.

PQRI quality-data codes can relay information such as:

- The measure requirement was met;
- The measure requirement was not met due to documented allowable performance exclusions (i.e., using performance exclusion modifiers); and
- The measure requirement was not met and the reason is not documented in the medical record (i.e. using the 8P reporting modifier).

You should be aware that individual PQRI quality-data codes could be associated with more than one measure. In order to determine which quality-data codes and modifiers to report as a line item on a claim, you will need to understand the measures that you have selected to report.

Further, PQRI measures may require that you append a modifier to a *CPT* category II code. *CPT* category II modifiers serve to exclude patients from a given measure's denominator when the measure's specification permits their use, and may only be reported with *CPT* II codes. They cannot be used with G-codes. Coding instructions included in the *Specifications* document indicate when a modifier is required.

## GENERAL INFORMATION

### Physician Quality Reporting Initiative Coding & Reporting Principles, continued

There are two kinds of *CPT* II modifiers:

- 1. Performance Measure Exclusion Modifiers** indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. Performance measure exclusion modifiers fall into one of three categories:
  - **1P – Performance Measure Exclusion Modifier due to Medical Reasons:** Includes: Not indicated (absence of organ/limb, already received/performed, other); Contraindicated (patient allergic history, potential adverse drug interaction, other)
  - **2P – Performance Measure Exclusion Modifier due to Patient Reasons:** Includes: Patient declined; economic, social, or religious reasons; other patient reasons
  - **3P – Performance Measure Exclusion Modifier due to System Reasons:** Includes: Resources to perform the services not available; insurance coverage/payer-related limitations; other reasons attributable to health care delivery system
- 2. Performance Measure Reporting Modifier** facilitates reporting a case when the patient is eligible but an action described in a measure is not performed and the reason is not specified or documented.
  - **8P – Performance Measure Reporting Modifier:** Action not performed, reason not otherwise specified

#### Submission of Quality-Data Codes

2007 PQRI requires that the PQRI quality-data codes be added as a line item on the claim submitted to carriers/MACs for the associated covered service. Claims with quality-data code line items can be submitted on the electronic 837-P, or as a paper claim if you are authorized to submit paper claims.

Key claim submission information is listed below:

- The “submitted charge” field for the **quality-data code line item** cannot be left blank or the claim will be rejected;
- Carriers/MACs *will not* pass quality-data codes on **rejected claims** to the NCH file. You will need to re-submit rejected claims with all of the corrections that the carrier/MAC require, including all quality-data code line items;
- Quality-data code line items must be submitted with a **charge of zero dollars** (\$0.00). If your system does not allow a \$0.00 line item charge, use a small amount such as \$0.01. Carriers/MACs will deny quality-data code line items for payment when submitted with a charge of zero dollars or a small amount (e.g., \$0.01), but will pass these codes through to the **NCH file** to be processed for PQRI analysis.
- The *CPT* category II code, which supplies the numerator, must be reported on the same claim form as the payment ICD-9-C< and *CPT* category I codes, which supply the measure’s denominator.
- *Multiple CPT category II codes can be reported on the same claim, as long as the corresponding denominator codes are also included as line items for that claim.*
- *Multiple eligible professionals (using their national provider identifiers [NPIs]) may be reported on the same claim with each quality data code line item corresponding to the services rendered by that professional for that encounter.*
- *Medicare’s claims processing systems will treat previously submitted claims, that are resubmitted only to add PQRI quality-data codes, as duplicate claims. These claims will not be included in the PQRI analysis.*

#### National Provider Identifier (NPI) Requirement for Participation in 2007 PQRI

**To participate in PQRI, you must have an NPI, which you will need to provide in the “Rendering Provider” field on the claim.** For claims submitted by group practices, multiple individual eligible professionals can report quality-data codes on the same claim, with each individual’s NPI listed in the “Rendering Provider” field for the quality-data code line item. To learn more about the NPI and how to obtain one, visit the NPI website at

[http://www.cms.hhs.gov/NationalProvIdentStand/01\\_Overview.asp](http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp).

#### Timeliness of Claim Submission

Quality-data codes must be reported on claims for payment of services provided during the reporting period, which is for dates of service **on and after July 1, 2007**, through December 31, 2007. It is important to note that *all* claims must reach the NCH file by February 29, 2008, to be included in the bonus calculation. Therefore, you should promptly file claims for services furnished toward the end of the reporting period.

#### PQRI Analysis

The carrier or the MAC will not conduct analysis of PQRI claims. Rather, CMS will use an independent PQRI analysis contractor to analyze data from NCH and to evaluate PQRI data submitted on claims to determine eligibility for a bonus and to calculate the bonus amount.

#### 2007 PQRI Participation Handbook

CMS will issue a detailed handbook about how to implement PQRI measures in clinical practice, and facilitate successful reporting. The handbook will include information, arranged in alphabetical order by clinical condition, to help you:

- Identify eligible cases based on ICD-9-CM and *CPT* category I codes
- Choose the correct quality-data codes to report
- Know when to use “exclusion” modifiers (i.e., 1P, 2P, and 3P)
- Know when to use a reporting modifier (i.e., 8P).



*Physician Quality Reporting Initiative Coding & Reporting Principles, continued*

The handbook will also include sample clinical vignettes that will describe how to code and report a particular measure under unique circumstances that may arise.

**Additional Information**

You may find the official instruction, CR 5640, issued to your carrier or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R277OTN.pdf> on the CMS website. Also, you may wish to review *MLN Matters* article, MM5558, for additional information. That article provides an overview of the 2007 PGRI and identifies who is eligible to participate. The article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5558.pdf> on the CMS website.

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: MM5640  
 Related Change Request (CR) #: 5640  
 Related CR Release Date: May 18, 2007  
 Effective Date: May 18, 2007  
 Related CR Transmittal #: R277OTN  
 Implementation Date: May 18, 2007

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## Invalid Skilled Nursing Facility Informational Unsolicited Responses from Medicare's Common Working File System

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

**Provider Types Affected**

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

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

Medicare systems may have inadvertently rejected outpatient, Part B, and DME claims that overlapped periods of a SNF stay by a beneficiary, whose Medicare SNF benefits were exhausted and for whom a non-pay SNF claim was submitted to Medicare.

**CAUTION – What You Need to Know**

This problem may have affected some of your claims processed by Medicare from October 2, 2006 until January 29, 2007, when Medicare systems were fixed.

**GO – What You Need to Do**

You need not take any action as your Medicare contractor will take steps to adjust any claims affected and to reverse or stop any payment recovery actions. See the *Background* section for more details.

**Background**

Providers need to be aware that the Centers for Medicare & Medicaid Services (CMS) has identified an issue with processing outpatient, Part B, and DME claims for beneficiaries who are in a SNF, but whose Medicare coverage for the SNF stay has ended. In October of 2006 change request (CR) 4292 (Benefits Exhaust and No-Payment for Medicare FIs and SNFs) was implemented. CR 4292 (see *Additional Information* section for the CMS website address of CR 4292) mandated that providers submit ALL SNF non-pay claims after benefits were exhausted to allow CMS to track the beneficiary's benefit period.

Medicare system changes relating to CR 4292 caused outpatient, Part B, and DME paid claims that overlap non-pay SNF claims to be rejected. **This is an error and your Medicare contractor will adjust claims or payment recovery actions resulting from this problem.** The CWF coding change to fix this problem was effective and in production on January 29, 2007, and CWF will provide a list of claims to the applicable contractors to allow for corrections and payment to be made to providers.

**Key Points**

CMS has directed Medicare contractors to correct any claims that were adjusted as a result of the problem with implementation of CR 4292.

- Any providers whose claims were impacted will be paid any payment recovered to include any interest charged.
- Where the payment recovery has not occurred, the Medicare contractor will stop such action.

## GENERAL INFORMATION

### *Invalid SNF Informational Unsolicited Responses from Medicare's CWF System, continued*

#### **Additional Information**

For complete details regarding this CR please see the official instruction (CR 5587) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R274OTN.pdf> on the CMS website.

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

The *MLN Matters* article for CR4292, *Benefits Exhaust and No-Payment for Medicare FIs and SNFs*, may be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4292.pdf> on the CMS website.

MLN Matters Number: MM5587  
Related Change Request (CR) #: 5587  
Related CR Release Date: April 27, 2007  
Effective Date: April 27, 2007  
Related CR Transmittal #: R274OTN  
Implementation Date: July 2, 2007

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### **Announcement Regarding Part B Paid Claims that Overlap Non-Pay SNF Claims**

As was discussed at the March 28, 2007, Skilled Nursing Facility-Long Term Care Open Door Forum, Part B paid claims that overlap non-pay SNF claims are rejecting in error. On April 27, 2007, CMS released a change request (CR) that addresses the situation: CR 5587, transmittal R274OTN, "Invalid Skilled Nursing Facility (SNF) Informational Unsolicited Responses (IURs) from CWF." This CR may be found at <http://www.cms.hhs.gov/transmittals/downloads/R274OTN.pdf> on the CMS website.

CMS has commissioned the Common Working File (CWF) maintainer to create a program that will automatically identify the Part B claims that were erroneously rejected for the FIs, Part A MACs, MCS carriers, and DME MACs. The FISS maintainer has created an additional utility that will automatically adjust the Part B claims and reinstate the payment that was erroneously recouped. The FIs will utilize this program during the weekend of May 26 and May 27, 2007. The applicable providers will be able to view the corrected claims during the week of May 28, 2007, through June 1, 2007, and should expect payment shortly thereafter.

Regarding the Part B MCS carriers and DME MACs, these contractors will be manually adjusting these claims now that CR 5587 has been released. The applicable providers will begin seeing these claims online and should expect to receive payment immediately thereafter. Part B providers are encouraged to allow the Medicare contractors to reprocess these claims and to not resubmit or adjust them in the meantime. If there are any questions or concerns relating to the timeframes in which these claims will be reprocessed, please contact the appropriate FI, carrier, or DME MAC.

Source: Provider Education Resources Listserv, Message 200705-02

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### **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.*

#### **Provider Types Affected**

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

#### **Provider Action Needed**

This special edition (SE) 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.

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

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 website. 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 [http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS\\_Accreditation\\_Organizations.pdf](http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf) on the CMS website. *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.
- 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 website at [http://www.dmecompetitivebid.com/cbic/cbic.nsf/\(subpages\)/CBICSuppliersBid%20Application%20Tool%20Kit](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 website at [http://www.dmecompetitivebid.com/cbic/cbic.nsf/\(subpages\)/CBICSuppliersEducational%20Tools](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/maillinglists/> 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 website. A background review of the rationale for this program is at [http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DME\\_sum.pdf](http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DME_sum.pdf) on the CMS website.

*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 website.

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### Webcast for Medicare DMEPOS Competitive Bidding Program Suppliers

An educational webcast is now available at the Competitive Bidding website at <http://www.dmecompetitivebid.com>. The presentation is designed to help suppliers that intend to participate in the Medicare DMEPOS Competitive Bidding Program being implemented in ten metropolitan areas throughout the United States.

The webcast highlights key bidding dates, provides an overview of the Competitive Bidding Program, and guides bidders through required application forms. Suppliers may view it at any time and submit questions at the conclusion of the presentation.

The Competitive Bidding website contains other helpful educational materials for suppliers, including a supplier tool kit, fact sheets, frequently asked questions, and more. For more information, call the Competitive Bidding Helpline at (877) 577-5331.

Source: Provider Education Resources Listserv, Message 200704-37

### Provider Transaction Access Number (PTAN)—A Term You Need To Know

Effective May 23, 2007, First Coast Service Options, Inc. will make changes to the interactive voice response (IVR) system. Providers using the IVR will be prompted to enter their provider transaction access number (PTAN) when requesting certain information.

The PTAN is a new term that refers to your Medicare provider number. Therefore, when calling the IVR system, remember that your PTAN is your Medicare provider number.

In addition, when calling to speak with our customer service representatives, providers will be asked to provide their PTAN.

As a reminder, beginning May 23, 2007, the PTAN will be required by the IVR system as well as with any other communications to Connecticut or Florida Medicare.

Source: CMS JSM 07386, dated May 7, 2007

### Provider Authentication Requirements for Telephone and Written Inquiries During the Medicare FFS National Provider Identifier Contingency Plan

*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 call or write their Medicare fee-for-service (FFS) contractors (fiscal intermediaries [FIs], carriers, Part A/B Medicare administrative contractors [A/B MACs], DME Medicare administrative contractors [DME/MACs], DME regional carriers [DMERCs] and/or regional home health intermediaries [RHHIs] with general inquiries.

#### Provider Action Needed

##### **STOP – Impact to You**

Due to the Medicare FFS NPI contingency plan, 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 the written inquiries units.

##### **CAUTION – What You Need to Know**

Medicare FFS will give sufficient notice to providers of the contingency plan end date. Until the date, you will need to provide the following:

##### **For Inquiries to the IVR:**

- PTAN /legacy number, depending upon the contractor

##### **For Inquiries to a CSR and Written Inquiries:**

- PTAN /legacy number, depending upon the contractor
- Provider name.

Remember, if you make inquiries to more than one contractor, you may hear the provider identification number referred to as either the legacy number or PTAN. On the date that the NPI is required to be on all claim transactions, the provider authentication elements required by all contractors will be both the NPI and PTAN.

##### **GO – What You Need to Do**

If you have not yet done so, **you should obtain your NPI now**. You can apply on line at <https://nppes.cms.hhs.gov/> on the CMS website. Once CMS ends the contingency plans, your claims and inquiries will not be processed without NPIs.

#### Background

In order to give providers and other trading partners more time to obtain and use the NPI, Medicare FFS invoked a contingency plan that allows continued use of legacy numbers beyond the May 23, 2007, implementation for the NPI. As reported in *MLN Matters* article MM5595, for some period after May 23, 2007, Medicare FFS will:

***Authentication Requirements for Telephone and Written Inquiries during the Medicare FFS NPI Contingency Plan, continued***

- Allow continued use of legacy numbers on transactions
- Accept transactions with only NPIs
- Accept transactions with both legacy numbers and NPIs.

After May 23, 2008, legacy numbers will NOT be permitted on ANY inbound or outbound transactions.

As part of this plan, Medicare FFS is assessing health care provider submission of NPIs on claims. As soon as the number of claims submitted with an NPI for primary providers (billing, pay-to and rendering providers) is determined to be sufficient (and following appropriate notice to providers), Medicare will begin rejecting claims that do not contain an NPI for primary providers. Beginning May 23, 2007, Medicare FFS contractors will require that providers provide their PTAN as a required authentication element for all general telephone or written inquiries.

In this contingency environment, the PTAN is the provider legacy number. Some contractors may continue to use the provider legacy number as the required authentication element. Other contractors will begin to refer to the legacy number as the PTAN.

Provider enrollment letters may also continue to refer to the provider legacy number. Newly enrolled or re-enrolled providers will receive either a legacy number or PTAN in their provider enrollment letters depending on which is used for authentication.

Remember: CMS may end the contingency plan once it appears that the level of claims containing NPIs is sufficient to do so. CMS encourages you to get and use your NPI now. Also, remember to ready your other processes to use the NPI as soon as possible to avoid a situation where your claims are not processed when the contingency ends.

**Additional Information**

The CMS complete listing of all NPI resources is available at <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS website.

More details regarding the CMS NPI contingency plan are in the *MLN Matters* article MM5595 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS website.

If you have questions, please contact your Medicare carrier, FI, A/B MAC, DME/MAC, DMERC, or RHHI at their toll-free number, which may be found at: <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS 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: SE0721

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**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 May 2007 Medicare B Update! page 23.*

**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 website.

**Provider Types Affected**

Those submitting claims on behalf of physicians and providers who died before obtaining an 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 of 1996 (HIPAA) requires that the Secretary of the Department of Health and 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.

## GENERAL INFORMATION

### *Provider Education for Handling Issues Related to Deceased Providers, continued*

- 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 of CR 5508**

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

- A representative of the estate of a proprietor cannot apply for an NPI for that provider posthumously.
- 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], or 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 number of the Medicare contractors are available at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.
- 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:
  - 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 claim processing contractor, who will notify the representative 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 website.

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

You may 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 website.

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

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## **Important Guidance Regarding National Provider Identifier Usage in Medicare Claims**

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the September 2006 Medicare B Update! pages 29-31.*

**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 website.

### **Provider Types Affected**

Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries

### **Provider Action Needed**

#### ***STOP – Impact to You***

You must report your NPI correctly on all electronic data interchange (EDI) transactions that you submit, as well as on paper claims you send to Medicare and telephone interactive voice response (IVR) queries by no later than May 23, 2007, or your transactions will be rejected.

**Important Guidance Regarding National Provider Identifier Usage in Medicare Claims, continued****CAUTION – What You Need to Know**

Carriers have reported errors on claims (see *Background*, below) that will impact your payment when you begin to submit NPIs. Although not mandated until May 23, 2007, providers are currently allowed to submit NPIs in Medicare transactions other than paper claims. NPI will be accepted on the revised paper claim CMS-1500 (0805) and UB-04 forms early in 2007.

**GO – What You Need to Do**

Make sure that your billing staffs are using your NPI correctly when they submit your claims for services provided to Medicare beneficiaries or submit electronic beneficiary or claim status queries to Medicare.

**Background**

All HIPAA covered health care providers who would either bill Medicare; render care to Medicare beneficiaries; order durable medical equipment, supplies, or services for beneficiaries; refer beneficiaries for other health care services; act as an attending physician when a beneficiary is hospitalized; prescribe covered retail prescription drugs for beneficiaries; operate on beneficiaries; or could otherwise be identified on a claim submitted to Medicare for payment must obtain an NPI. This applies whether providers are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, managed care organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions.

Although the NPI requirement applies by law to covered entities such as health care providers, health care clearinghouses, and health plans in the U.S. when exchanging electronic transactions for which a national standard has been adopted under HIPAA, HIPAA permits health care plans to elect to require reporting of NPIs in paper claims and for non-HIPAA transaction purposes. Medicare will also require NPIs for identification of all providers listed on the UB-04 institutional paper claim form and of physicians and suppliers listed on the revised CMS-1500 (08-05) professional paper claim form by May 23, 2007.

Medicare will reject paper claims received after May 22, 2007, that do not identify each provider, physician or supplier listed on a paper or electronic claim with an NPI. Medicare will also begin to require an NPI in IVR queries effective May 23, 2007.

Retail pharmacies are required to use the NCPDP format adopted as a HIPAA standard for submission of prescription drug claims to Medicare. Since that format permits entry of only one provider identifier each for a pharmacy and the physician who prescribed the medication, retail pharmacies that use the NCPDP HIPAA format can use either their national supplier clearinghouse (NSC) number or their NPI to identify themselves, and either the unique provider identification number (UPIN) or the NPI to identify the prescribing physician prior to May 23, 2007.

May 23, 2007, and later, only an NPI may be reported for identification of pharmacies and prescribing physicians. NCPDP claims received by Medicare after May 22, 2007, that lack an NPI for either the pharmacy or the prescribing physician will be rejected.

This being said, Medicare carriers and fiscal intermediaries (FIs) have reported receiving X12 837-P (professional) and X12-837-I (institutional) claims containing errors that will result in claim rejection, and/or processing delays, if they continue to occur once NPI reporting begins.

Some of the errors seen by Medicare carriers include the following:

**Incorrect information in the 2010A/A Billing Provider Loop in X12 837-P Claims**

Prior to May 23, 2007, carriers will reject claims when the NPI in a loop does not belong to the owner of the provider identification number (PIN) or UPIN that should also be reported in REF02 of the same loop, or if the name and address of the provider in that loop do not correlate with either the NPI, PIN or UPIN in the same loop. The same edits will also be applied to NPIs when received on paper claims prior to May 23, 2007.

Carriers have also detected claims where the rendering physician's or supplier's NPI is reported in the 2010A/A NM1 segment when the claim was submitted by a group to which the physician belongs or the home office of a chain to which a supplier belongs. The 2010A/A loop of an 837-P claim must contain the identifier that applies to the groups/chains (NPI entity 2) that submitted the claims. This rule also applies to identification of the billing provider on a paper claim. Information concerning a billing agent or a healthcare clearinghouse may never be reported in the billing provider loop for a Medicare claim.

To prevent this error, you must report the rendering physician's or supplier's NPI in the NM109 data element in the rendering provider claim level loop (2310B), unless multiple services were furnished by different members of the group/chain. If multiple rendering providers were involved, the information for each must be reported in the service level 2420A loop along with the service(s) each of them rendered.

To facilitate claim processing prior to May 23, 2007, you should also report the rendering provider(s) PIN(s) as the REF02 data element with 1C in REF01 in that same rendering provider loop (2310B for the claim or 2420A for individual services, as applicable).

**Reporting of the Pay-to-Address in the Billing Provider (2010A/A) Loop**

Once NPI reporting begins, carriers will reject claims when the pay-to-address, if different than the actual practice location address, is in the 2010A/A (billing provider) loop, rather than in the 2010A/B (pay-to-provider) loop.

***When groups or organizations submit claims, and the billing and the pay-to providers are different individuals or entities, the pay-to information must always be reported in the 2010A/B loop and the billing provider information in the 2010A/A loop.***

**Reporting of the Name and Address of a Billing Provider in the 2010A/A Loop of an X12 837-I (Institutional) Electronic Claim**

FIs will reject claims in which the billing provider and the rendering provider are different entities, and you report the billing provider's name and address in the 2010A/A loop of an X12 837-I (institutional) electronic claim, and the online survey certification & reporting (OSCAR) number of the rendering provider in that same loop.

If the home office of a chain has obtained one NPI for all facilities it owns, or one of a chain's facilities bills for all (or other) facilities owned by that chain, or a hospital bills for its

## GENERAL INFORMATION

### Important Guidance Regarding National Provider Identifier Usage in Medicare Claims, continued

special units, the home office, hospital or other facility submitting those claims is considered a form of billing agent for Medicare purposes.

In this instance, you must identify the specific provider, for whom the claim is being submitted, as the billing provider for that claim. If a provider that furnished the care had a separate OSCAR number than the entity submitting its claims, the provider that furnished the care must be identified in the billing provider loop. You must also report the name of the facility for whom the claim is being submitted, that facility's address, and should report applicable NPI (when obtained prior to May 23, 2007), as well as the Medicare OSCAR number assigned to that provider in the 2010A/A (billing provider) loop of the claim.

If the home office, hospital or other entity that prepared the claim is to be sent payment for the claim, you must report the name and address, and should report the NPI if issued, and the applicable OSCAR number associated with that entity in the 2010A/B (pay-to-provider) loop prior to May 23, 2007.

However, you should note that Medicare will not issue payment to a third party for a provider solely as result of completion of the 2010A/B loop of an electronic claim. The facility that furnished the care, or the established owner of that facility, must have indicated on their 855 provider enrollment form filed when that facility enrolled in Medicare (or via a subsequent 855 used to update enrollment information) that payments for that facility are to be issued to that home office, hospital, other facility or an alternate third party.

#### Additional Information

For those providers still permitted to submit any paper claims under the restrictions imposed by the Administrative Simplification Compliance Act, Medicare plans to begin accepting paper claims on the revised CMS-1500 (08-05 version) beginning January 2, 2007 (allowing you to report a provider's NPI as well as the applicable PIN or UPIN); and on the revised UB-04 (CMS-1450) form beginning March 1, 2007, (allowing you to report a provider's NPI as well as the applicable OSCAR or UPIN). Medicare carriers plan to reject "old" CMS-1500 forms received after March 31, 2007, and FIs plan to reject UB-92 forms received after April 30, 2007.

**Note:** Medicare does not accept NPIs on the "old" versions of the CMS-1500 or UB-92 forms. There are no fields on those forms designed for NPI reporting.

CMS highly recommends that for electronic or paper Medicare claims that you submit during the transition period to full NPI implementation on May 23, 2007, you include both the NPI and the Medicare legacy identifier of each provider for whom you report information.

- When you report an NPI on a claim sent to a carrier for a referring, ordering, purchased service or supervising physician, or for a provider listed in the service facility

locator loop, use an UPIN as the Medicare legacy identifier. Furthermore, if any of those physicians are not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007, you should report OTH000 as the UPIN.

- When you report an NPI on a claim sent to an FI for an attending, operating or other physician, or in the service facility locator loop (when those loops apply), you should also report the provider's UPIN. And as above, you may report OTH000 as the surrogate UPIN if any of those providers is not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007.
- Finally, when you report an NPI for a billing, pay-to, or rendering provider identified on a claim sent to a carrier, you should also report the valid Medicare PIN that applies to that physician or supplier. Additionally, you should always report an OSCAR number for each billing, pay-to, or possibly a service facility locator loop provider identified on a claim sent to an FI, as well as the NPI if issued to each of those providers, prior to May 23, 2007.

Remember that failure to report information as described here may result in delayed processing or rejection of your claims.

You can find more information about the NPI by going to the NPI page at [http://www.cms.hhs.gov/apps/npi/01\\_overview.asp](http://www.cms.hhs.gov/apps/npi/01_overview.asp) on the CMS website. In addition, if you have any questions on the NPI, you may call your carrier or FI 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).

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## Reporting the National Provider Identifier on Physician Claims for Clinical Diagnostic Services Purchased Outside of the Local Carrier's Jurisdiction

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the December 2006 Medicare B Update! page 39.

**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 website.

### Provider Types Affected

Physicians billing Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for diagnostic services purchased outside the local carrier or A/B MAC's jurisdiction.

### Background

This article relates to change request (CR) 5289, in which the Centers for Medicare & Medicaid Services (CMS) provides specific instructions for physicians to modify their current reporting guidelines and requires physicians to begin **reporting, as of May 23, 2007, a national provider identifier (NPI) on claims for clinical diagnostic services purchased outside of the local carrier's jurisdiction.** Previously CMS instructed physicians to report their provider identification number (PIN) on claims when billing for clinical diagnostic services purchased outside of the local carrier's jurisdiction. (See CR 3630, Transmittal 415, issued on December 23, 2004 at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3630.pdf> on the CMS website).

As of May 23, 2007, physicians must begin using their NPI to bill the local carrier for a clinical diagnostic service purchased outside of the jurisdiction of the local carrier or A/B MAC. As of May 23, 2007, remember the following:

- When reporting the 2400 PS1 segment (Purchased Service Information) of the ANSI X12 837 electronic

MLN Matters Number: MM5289

Related Change Request (CR) #: 5289

Related CR Release Date: October 27, 2006

claim format, version 4010A, the billing physician must report their NPI.

- When submitting paper claims, physicians must report their NPI for both the purchased portion of the test and the portion of the test that they performed.
- Physicians may no longer report a PIN after May 22, 2007.

Prior to May 23, 2007, physicians may report the PIN, the NPI, or both PIN and the NPI.

### Additional Information

For complete details, please see the official instruction issued to your Medicare carrier or A/B MAC, regarding this change. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R243OTN.pdf> on the CMS website.

To learn more about the NPI and how to apply for one, visit <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS website.

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 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).

Effective Date: April 1, 2007

Related CR Transmittal #: R243OTN

Implementation Date: April 2, 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.

## National Provider Identifier—The Latest News!

### NPI: Get It. Share It. Use It.

Over 2 million providers have their national provider identifier (NPIs) – do you have your NPI yet? Covered entities (including health plans, covered health care providers and clearinghouses) across the country are making decisions regarding their need for contingency plans for NPI implementation. It is more important than ever to obtain an NPI as soon as possible and begin testing it on claims, as directed by your health plan.

**Medicare providers should pay special attention to the Medicare information section below for important news on the Medicare FFS contingency plan.**

### New Compliance Contingency Guidance Frequently Asked Questions

CMS has posted new frequently asked questions (FAQs) related to the previously posted NPI Compliance Contingency Guidance.

Questions include:

- What are the exact dates for the NPI contingency plan?
- If a complaint is filed against me for not being in compliance with the NPI after May 23, 2007, what will happen?
- What happens if a complaint for not being in compliance with the NPI is filed against me after May 23, 2008?
- Is it acceptable for a health plan to announce their NPI contingency now?
- Is the NPI contingency plan voluntary?
- Am I allowed to give my NPI to other providers as well as to the health plans with whom I exchange transactions?

To view these FAQs, you should:

- 1) Go to the CMS dedicated NPI Web page at <http://www.cms.hhs.gov/NationalProvIdentStand>
- 2) Scroll down to the section that says "Related Links Inside CMS"

### *National Provider Identifier—The Latest News!, continued*

3) Click on NPI Frequently Asked Questions. To find the latest FAQs, click on the arrows next to “Date Updated”. Look for the word “NEW” in red font to appear beside the most recent FAQs.

### **Obtain Information on Contingency Plans**

CMS strongly urges providers to pay attention to information from the health plans they bill so that they are aware if, and when, a specific health plan announces its own contingency plan.

### **Reminder – Sharing NPIs**

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business, and with health plans that request their NPIs. In fact, as outlined in current regulation, providers who are covered entities under HIPAA must share their NPIs with any entities that need them for billing purposes — including those who need them for designation of ordering or referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their NPIs for them.

### **Reminder – Enumerating a Group Practice**

A group practice that conducts any of the HIPAA standard transactions is a covered healthcare provider (a covered entity under HIPAA) and, as such, must obtain an NPI. The physicians employed by the group practice, on the other hand, are furnishing services at the group office(s) but they are not conducting any of the HIPAA standard transactions (such as submitting claims, checking eligibility and claim status). As such, the physicians would not be covered health care providers and are not required by the NPI final rule to obtain NPIs.

However, as the employer, the group could require these physicians to obtain NPIs and use the NPIs to identify them as the rendering providers in the claims that the group submits. If these physicians prescribe medication, the pharmacies may require their NPIs in the claims that the pharmacies submit to health plans. Additionally, health plans can require enrolled physicians to obtain NPIs in order to participate in that plan. Medicare is an example of a health plan with this requirement.

### **Reminder – Applying for an NPI Does Not Enroll a Health Care Provider in a Health Plan**

Applying for an NPI and enrolling in a health plan are two completely separate activities. Having an NPI does not guarantee payment by any health plan.

### **When to Contact the NPI Enumerator for Assistance**

Providers should remember that the NPI Enumerator *only* answers/addresses the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter (i.e., for those providers enumerated via paper or Web-based applications)
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203, TTY 1-800-692-2326, or

email the request to the NPI Enumerator at [CustomerService@NPIenumerator.com](mailto:CustomerService@NPIenumerator.com).

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

### **Important Information for Medicare Providers Medicare Fee-for-Service (FFS) Contingency Plan Announced!**

FFS Medicare has announced its contingency plan. View the associated change request at <http://www.cms.hhs.gov/transmittals/downloads/R1227CP.pdf>, as well as the related MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS website. Please note that these materials were recently revised; please be sure to visit the links above for the latest information. This information will also be available shortly on CMS’ dedicated NPI Web page.

A national NPI Roundtable on the Medicare FFS Contingency Plan is scheduled for May 10, 2007, from 2-3:30PM EDT. Registration details to follow.

### **Reporting a Group Practice NPI on Claims**

Medicare has identified instances where the multi-carrier system (MCS) is correcting billing or pay-to provider data on Part B claims submitted by group practices. As of May 18, 2007, the MCS Part B claims processing systems will no longer correct claims submitted by group practices that are reporting the individual rendering provider identification number (PIN) or individual rendering NPI in either the billing or pay-to provider identifier fields. Groups should enter either their group NPI or group NPI and legacy PIN number pair in either of these fields.

### **Reminder – Medicare Extending Date for Accepting Form CMS-1500 (12-90)**

While Medicare began to accept the revised Form CMS-1500 (08-05) on January 1, 2007, and was positioned to completely cutover to the new form on April 1, 2007, it has recently come to our attention that there are incorrectly formatted versions of the revised form being sold by the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC’s authorized forms designer were improperly formatted. The error resulted in the sale of both printed forms and negatives that do not comply with the form specifications. **However, not all of the new forms are in error.**

Given the circumstances, CMS is extending the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007, deadline while this situation is resolved. Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, we are targeting June 1, 2007, as that date.

During the interim, contractors will be directed to return, not manually key, any Form CMS-1500 (08-05) forms received that are not printed to specification. By returning the incorrectly formatted claim forms back to providers, CMS is able to make them aware of the situation so they can begin communications with their form suppliers.

For more details, and to learn how to identify the proper version of the new form, visit a recent *MLN Matters* article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5568.pdf> on the CMS website.

*National Provider Identifier—The Latest News!, continued***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 can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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

Source: Provider Education Resources Listserv, Message 200704-33

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**Modification of National Provider Identifier Editing Requirements in CR 4023 and an Attachment to CR 4320**

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the October 2006 Medicare B Update! pages 24-26.

**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 website.

**Provider Types Affected**

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Medicare carriers including durable medical equipment regional carriers (DMERCs) (or durable medical equipment Medicare administrative contractors [DME MACs] if appropriate).

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

This article is based on CR 5229, which corrects certain business requirements from CR 4023 that relate to edits for national provider identifiers (NPIs) and provider legacy identifiers when reported on claims, particularly for referring/ordering or other secondary providers, effective October 1, 2006 and later. Additionally, CR 5229 revises Attachment 1 to CR 4320. L

**CAUTION – What You Need to Know**

Some of those business requirements erroneously assumed that any provider for whom information is reported in a claim, including a referring/ordering or other secondary provider, would need to be enrolled in Medicare and therefore listed in the Medicare Provider Identifier Crosswalk. This is not always the case. CR 5229 modifies those business requirements.

**GO – What You Need to Do**

These modifications will enable correct processing of affected claims in October 2006 and later, and will avoid the unnecessary rejection of many claims that involve a referring/ordering or other secondary provider. Please refer to the *Background* section of this article and to CR 5229 for additional important information regarding these modifications.

**Background**

The *Medicare Learning Network (MLN)* articles, MM4023 and MM4320, which are based on CR 4023 and CR 4320 respectively, contain important information about the stages of the NPI implementation process. Some of this information is updated in the current article. The links to these articles are located in the Additional Information section of this article.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414)). To comply with this requirement, The Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs on May 23, 2005. Applications can be made by mail and online at <https://nppes.cms.hhs.gov>.

During Stage 2 of the NPI implementation process (October 2, 2006 - May 22, 2007), Medicare will utilize a Medicare provider identifier crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions.

**Primary and Secondary Providers**

Providers, for NPI provider identifier editing purposes, are categorized as either “primary” or “secondary” providers. Primary providers include billing, pay-to, and rendering providers. Primary providers are required to be enrolled in Medicare for the claim to qualify for payment.

Secondary providers are all other providers for which data could be reported on an institutional (837-I) or professional (837-P), free billing software or direct data entry (DDE) claim, or on a revised CMS-1500 or a UB-04 (once those paper claims are accepted by Medicare). Since the UB-92, the currently used CMS-1500, and the HIPAA NCPDP format do not allow reporting of both NPIs and legacy identifiers, information on secondary providers in those claims is not included in the

## GENERAL INFORMATION

### *Modification of NPI Editing Requirements in CR 4023, continued*

following requirements. Secondary providers may be enrolled, but are not required to be enrolled in Medicare (unless they plan to bill or be paid by Medicare for care rendered to Medicare beneficiaries).

#### **Secondary Provider Claims**

##### **Claims Submitted with NPI and Medicare Legacy Identifier:**

During stage 2, claim submitters should submit a provider's Medicare legacy identifier whenever reporting an NPI for a provider. Failure to report a Medicare legacy number for a provider enrolled in Medicare could result in a delay in processing of the claim. When an NPI and a legacy identifier are reported for a provider, Medicare contractors will apply the same edits to those numbers that would have been applied if that provider was a primary provider. (See MM4023.)

There are two exceptions:

1. A Medicare contractor cannot edit a surrogate unique provider identification number (sometimes called a dummy UPIN, such as OTN000). Despite its name, a surrogate is not actually unique for a specific provider.
2. Only a national supplier clearinghouse (NSC) identification number or a UPIN should ever be reported as the legacy numbers on a claim sent to a DMERC/DME MAC. If a carrier provider identification number (PIN) is reported as a legacy identifier with an NPI, DMERCs/DME MACs will edit as if the NPI was the only provider identifier reported for that provider.

##### **Claims Submitted with NPI Only:**

The NPI is edited to determine if it meets with the physical requirements of the NPI (10 digits, begins with a 1, 2, 3, or 4, and the check digit in the 10th position is correct), and whether there is a Medicare provider identifier crosswalk entry for that NPI.

##### **If the NPI is located in the crosswalk:**

- The taxpayer identification number (TIN) (employer identification number (EIN) or social security number (SSN) and legacy identifier will be sent to the trading partner in addition to the NPI if coordination of benefits (COB) applies.
- However, only the TIN will be forwarded to the COB payer if there is more than one legacy identifier associated with the same NPI in the Medicare provider identifier crosswalk because it may be difficult to know which Medicare legacy identifier applies to that claim.

##### **If the NPI is not located in the crosswalk:**

- No supplemental identifier can be reported to a COB payer.
- However, the claim will not be rejected if the NPI for a referring/ordering provider or another secondary provider cannot be located in the Medicare provider identifier crosswalk, with one exception. Reporting of a Medicare legacy identifier other than a surrogate UPIN signifies a provider is enrolled in Medicare. If a Medicare legacy identifier is reported and cannot be located in the crosswalk, the claim will be rejected, regardless of whether an NPI was reported for that provider.

##### **Claims (Including UB-92 or the Current CMS-1500 Paper Claims) Submitted with Medicare Legacy Identifier Only**

- A Medicare contractor may, but is not required to check a legacy number against the Medicare provider identifier crosswalk.
- As at present, claims will be rejected if any Medicare legacy identifier reported on a claim does not meet the physical requirements (length, if numeric or alphanumeric as applicable) for that type of Medicare provider identifier.

#### **COB and Medigap Trading Partners**

Legacy identifiers will not be reported to these trading partners for secondary providers if they are not submitted on the claim sent to Medicare, are surrogate UPINs or if the provider is not enrolled in Medicare. If not enrolled, a legacy identifier or a TIN cannot be sent for a "secondary" provider because Medicare would not have issued a legacy identifier to or collected a TIN from that provider.

#### **837-I or 837-P version 4010A1 Claims**

Attachment 1 to CR 4320 which is being revised as part of CR 5229 addresses (among other issues), the identification of secondary providers for which the 837-I or 837-P version 4010A1 implementation guides only require reporting of an NPI or other identifier "if known." Unless there is a pre-existing Medicare instruction that mandates the reporting of a specific identifier for those "if known" types of providers, there is no requirement for entry of any identifier for those entities/individuals. If there is no such requirement, claims received that lack an identifier for those types of providers will not be denied..

Note that "secondary" providers such as a referring/ordering physician are not required to be enrolled in Medicare as a condition for payment of the services or supplies they order, furnish, supervise delivery of, etc. for beneficiaries when those services are billed, paid-to or rendered by "primary" providers. For example, Medicare could pay:

- A hospital for services ordered for a patient for inpatient hospital care when the admitting or attending physician is not enrolled in Medicare
- Hospital surgery costs when the surgeon is not enrolled in Medicare
- A hospital when services are purchased from another provider "under arrangements" even if that other provider is not enrolled in Medicare.

#### **Implementation Date**

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

#### **Additional Information**

CR 4320, issued February 1, 2006, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms" is located at <http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf> on the CMS website.

**Modification of NPI Editing Requirements in CR 4023, continued**

The associated *MLN* article (with the same title) MM4320, may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf> on the CMS website.

CR 4023, dated November 3, 2005, “Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms” is located at <http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf> on the CMS website. MM4023, the associated *MLN* article, is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf> on the CMS website.

CR 5229 is the official instruction issued to your Medicare carrier/DMERC (DME MAC if appropriate), FI/RHHI regarding changes mentioned in this article. CR 5229 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R234OTN.pdf> on the CMS website.

If you have questions, please contact your local Medicare carrier/DMERC (DME MAC if appropriate), or FI/RHHI 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: MM5229 Revised  
Related CR Release Date: August 18, 2006  
Related CR Transmittal #: R234OTN

Related Change Request (CR) #: 5229  
Effective Date: October 1, 2006  
Implementation Date: October 2, 2006

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

**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 website.

### Provider Types Affected

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

### Background

This article instructs the shared system maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant electronic remittance advice (ERA) – transaction 835, and standard paper remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007.

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

Medicare has published CR 4320 (<http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf>) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via direct data entry screens, or on paper claim forms.

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

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

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

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

## GENERAL INFORMATION

*Stage 2 NPI Changes for Transaction 835, and SPR Advice, and Changes in Claims Processing Manual, continued*

### Key Points

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

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

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

**Scenario III:** Single NPI cross-walked to multiple Medicare legacy numbers

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

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

During stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers. The companion documents will be updated to reflect these changes and the updated documents will be posted at [http://www.cms.hhs.gov/ElectronicBillingEDITrans/11\\_Remittance.asp#TopOfPage](http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage) on the CMS website.

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

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

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

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

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

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

### Implementation

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

### Additional Information

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

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

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

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

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## Stage 2 Requirements for Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the October 2006 Medicare B Update! pages 26-29.*

**Note:** This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf> for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR 5060, which is available at <http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf>. Also, this article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS website.

### Provider Types Affected

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

### Provider Action Needed

The requirements for Stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are not based on the date of receipt of a transaction, unless otherwise stated in a business requirement.

Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the NPI in Stage 2 is October 1, 2006.

### Background

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

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005. Applications can be made by mail and also online at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

### NPI and Legacy Identifiers

The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers.

Legacy provider identifiers include:

- Online survey certification and reporting (OSCAR) system numbers;
- National supplier clearinghouse (NSC) numbers;
- Provider identification numbers (PINs); and
- Unique physician identification numbers (UPINs) used by Medicare.

They **do not** include taxpayer identifier numbers (TINs) such as:

- Employer identification numbers (EINs); or
- Social security numbers (SSNs).

### Primary and Secondary Providers

Providers are categorized as either “primary” or “secondary” providers:

- **Primary providers** include billing, pay-to, rendering, or performing providers. In the DMERCs, primary providers include ordering providers.
- **Secondary providers** include supervising physicians, operating physicians, referring providers, and so on.

### Crosswalk

During stage 2, Medicare will utilize a crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. Key elements of this crosswalk include the following:

- Each primary provider’s NPI reported on an inbound claim or claim status query will be cross-walked to the Medicare legacy identifier that applies to the owner of that NPI.
- The crosswalk will be able to do a two-directional search, from a Medicare legacy identifier to NPI, and from NPI to a legacy identifier.
- The Medicare crosswalk will be updated daily to reflect new provider registrations.

## GENERAL INFORMATION

### *Stage 2 Requirements for Use and Editing of NPI Numbers Received in EDI Transactions, via DDE Screens or Paper Claim Forms, continued*

#### **NPI Transition Plans for Medicare FFS Providers**

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

##### **May 23, 2005 - January 2, 2006:**

Providers should submit Medicare claims using only their existing **Medicare** numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.

##### **January 3, 2006 - October 1, 2006:**

Medicare systems will accept claims with an NPI, but an existing legacy Medicare number **must also be on the claim**. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes **only** an NPI. Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

##### **October 2, 2006 - May 22, 2007:**

*(This is stage 2, the subject of CR4023)*

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

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

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

##### **May 23, 2007 – Forward:**

CMS systems will only accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007.

#### **Claim Rejection**

Claims will be rejected if:

- The NPI included in a claim or claim status request does not meet the content criteria requirements for a valid NPI; this affects:
- X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only);
- National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only);
- Claims submitted using Medicare's free billing software;
- Electronic claim status request received via X12 276 or DDE screen; and
- Non-X12 electronic claim status queries;
- An NPI reported cannot be located in Medicare files;
- The NPI is located, but a legacy identifier reported for the same provider in the transaction does not match the legacy identifier in the Medicare file for that NPI;
- Claims include the NPI but do not have a taxpayer identification number (TIN) reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare's free billing software.

**Note:** If only provider legacy identifiers are reported on an inbound transaction prior to May 23, 2007, pre-NPI provider legacy number edit rules will be applied to those legacy identifiers.

#### **Additional Information**

##### **X12 837 Incoming Claims and COB**

During Stage 2, an X12 837 claim may technically be submitted with only an NPI for a provider, **but you are strongly encouraged to also submit the corresponding Medicare legacy identifier for each NPI** in X12 837 Medicare claims.

Use of both numbers could facilitate investigation of errors if one identifier or the other cannot be located in the Medicare validation file. When an NPI is reported in a claim for a billing or pay-to provider, a TIN must also be submitted in addition to the provider's legacy identifier as required by the claim implementation guide.

##### **National Council of Prescription Drug Plans (NCPDP) Claims**

The NCPDP format was designed to permit a prescription drug claim to be submitted with either **an NPI or a legacy identifier, but not more than one identifier** for the same retail pharmacy or prescribing physician. The NCPDP did provide qualifiers, including one for NPIs, to be used to identify the type of provider identifier being reported.

- For stage 1, retail pharmacies were directed to continue filing their NCPDP claims with their individual NSC number and to report the UPIN of the prescribing physician.
- During stage 2, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have the prescribing physician's NPI) in their claims.

When an NPI is submitted in an NCPDP claim, it will be edited in the same way as an NPI submitted in an X12 837 version 4010A1 claim. The retail pharmacy will be considered the primary provider and the prescribing physician as the secondary provider for NPI editing purposes.



*Stage 2 Requirements for Use and Editing of NPI Numbers Received in EDI Transactions, via DDE Screens or Paper Claim Forms, continued*

### Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006 and end February 1, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

Pending the start of submission of the revised CMS-1500 and the UB-04, **providers must continue to report legacy identifiers, and not NPIs, when submitting claims on the non-revised CMS-1500 and the UB-92 paper claim forms.**

Provider identifiers reported on those claim forms are presumed to be legacy identifiers and will be edited accordingly. “Old” form paper claims, received through the end of the transition period that applies to each form, may be rejected if submitted with an NPI.

Or, if they are not rejected—since some legacy identifiers were also 10-digits in length—could be incorrectly processed, preventing payment to the provider that submitted that paper claim.

### Standard Paper Remits (SPRs)

The SPR FI and carrier/DMERC formats are being revised to allow reporting of both a provider’s NPI and legacy identifier when both are available in Medicare’s files. If a provider’s NPI is available in the data center provider file, it will be reported on the SPR, even if the NPI was not reported for the billing/pay-to, or rendering provider on each of the claims included in that SPR. The revised FI and carrier/DMERC SPR formats are attached to CR 4023:

- CR 4023 Attachment 1: FI Standard Paper Remit (SPR) Amended Format for Stage 2; and
- CR 4023 Attachment 2: Carrier/DMERC SPR Amended Stage 2 Format.

### Remit Print Software

The 835 PC-Print and Medicare Remit Easy Print software will be modified by October 2, 2006, to enable either the NPI or a Medicare legacy number, or both, if included in the 835, to be printed during stage 2.

### Free Billing Software

Medicare will ensure that this software is changed as needed by October 2, 2006, to enable reporting of both an NPI and a Medicare legacy identifier for each provider for which data is furnished in a claim, and to identify whether an entered identifier is an NPI or a legacy identifier.

### In-Depth Information

Please refer to CR 4023 for additional detailed NPI-related claim information about the following topics:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Crosswalk</li> <li>• X12 837 Incoming Claims and COB</li> <li>• Non-HIPAA COB Claims</li> <li>• NCPDP Claims</li> <li>• DDE Screens</li> <li>• Paper Claim Forms</li> <li>• Free Billing Software</li> <li>• X12 276/277 Claim Status Inquiry and Response Transactions</li> <li>• 270/271 Eligibility Inquiry and Response Transactions</li> </ul> | <ul style="list-style-type: none"> <li>• 835 Payment and Remittance Advice Transactions</li> <li>• Electronic Funds Transfer (EFT)</li> <li>• Standard Paper Remits (SPRs)</li> <li>• Remit Print Software</li> <li>• Claims History</li> <li>• Proprietary Error Reports</li> <li>• Carrier, DMERC, and FI Local Provider Files, including EDI System Access Security Files</li> <li>• Med A and Med B Translators</li> <li>• Other Translators</li> <li>• Stages 3 and 4</li> </ul> |
|--|---|

CR 4023, the official instruction issued to your FI/ regional home health intermediary (RHHI) or carrier/durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to <http://www.cms.hhs.gov/transmittals/downloads/R1900TN.pdf> on the CMS website.

You may also wish to review *MLN Matters* article SE0555, “Medicare’s Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition *MLN Matters* Articles on NPI-Related Activities,” which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0555.pdf> on the CMS website. This article contains further details on the NPI and how to obtain one.

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

MLN Matters Number: MM4023 *Revised*

Related Change Request (CR) #: 4023

Related CR Release Date: November 3, 2005

Effective Date: April 1, 2006

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Implementation Date: April 3, 2006

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### Claims Submitted With Only a National Provider Identifier During the Stage 2 NPI Transition Period

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 64-65.*

**Note:** This article was revised on May 4, 2007, to add this statement that Medicare 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 website.

#### Provider Types Affected

Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries, with Medicare.

#### Provider Action Needed

##### **STOP – Impact to You**

Beginning October 1, 2006 and until further notice, claims that you submit containing only an NPI will be returned you as unprocessable if a properly matching legacy number cannot be found.

##### **CAUTION – What You Need to Know**

From the beginning of Medicare's stage 2 NPI transition period on October 1, 2006 and until further notice, you should submit both NPIs and legacy provider numbers on your Medicare claims to ensure that they are properly processed. During this period, claims submitted with only a NPI that Medicare systems are unable to properly match with a legacy number (e.g., PIN, OSCAR number), **may** be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

##### **GO – What You Need to Do**

You should make sure that when submitting Medicare claims with dates of service on or after October 1, 2006, your billing staff submit both your NPI **and** legacy provider numbers until further notice from CMS.

#### Background

As previously announced, the Centers for Medicare & Medicaid Services (CMS) plans to begin testing new software it has been developed to use the NPI in the existing Medicare fee-for-service claims processing systems. (Remember that you will be required to submit claims and other HIPAA transactions with only an NPI beginning on May 23, 2007).

During the Stage 2 NPI transition period of October 1, 2006, through May 22, 2007, Medicare will accept claims having only NPIs (as well as those having only legacy provider numbers); however in CR 5378, from which this article is taken, CMS recommends that during this period you submit claims using:

- The provider's legacy number, such as a provider identification number (PIN), NSC number, OSCAR number or UPIN; or
- Both the provider's NPI **and** legacy number.

**Note:** Until January 2, 2007, NPIs are not to be submitted on paper claims via CMS 1500 forms. Institutional providers are advised that the NPI will not be accepted on paper claims by FIs or A/B MACs until implementation of the UB-04 on May 23, 2007.

Until testing of Medicare's new software is complete, if you submit Medicare claims with only your NPI:

- 1) They may be processed and paid, or
- 2) If the Medicare systems are unable to properly match the incoming NPI with a legacy number (e.g., PIN, OSCAR number), they **may** be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

#### Additional Information

The official instruction issued to your Medicare contractor on this issue, CR 5378, is available at <http://www.cms.hhs.gov/Transmittals/downloads/R2490TN.pdf> on the CMS website.

If you have any questions, please contact your carrier, DMERC, DME MAC, A/B MAC, or FI 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: MM5378 *Revised*  
Related CR Release Date: November 13, 2006  
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## CMS Announces the National Provider Identifier Enumerator Contractor and Information on Obtaining NPIs

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Fourth Quarter 2005 Medicare B Update! pages 72-73.*

**Note:** This article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and national provider identifiers (NPIs). For details of this contingency plan, see the *MLN Matters* article, MM5595, at <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM5595.pdf> on the CMS website.

### Provider Types Affected

All health care providers - Medicare and non-Medicare

### Provider Action Needed

Learn about the NPI and how and when to apply for one.

### Background

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a new health care identifier for use in the HIPAA standard transactions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a final rule that adopted the national provider identifier (NPI) as this identifier.

The NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). The NPI will identify health care providers in the electronic transactions for which the Secretary has adopted standards (the standard transactions) after the compliance dates. These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace health care provider identifiers that are in use today in standard transactions. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting HIPAA standard transactions with multiple health plans.

All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.

**Important Note:** While you are urged to apply for an NPI beginning May 23, 2005, the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006.

### NPI Enumerator Contract Awarded

Recently, the CMS announced the selection of Fox Systems, Inc. as the contractor, to be called the Enumerator, to perform the support operations for the NPI project.

Fox Systems, Inc. will process NPI applications from health care providers and operate a help desk to assist health care providers in obtaining their NPIs.

### Who May Apply For The NPI?

All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices are eligible to apply for and receive an NPI.

**Note:** All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required by the NPI final rule to obtain NPIs. This is true even if they use business associates such as billing agencies to prepare the transactions.

### The NPI Application Process

Health care providers may begin applying for an NPI on May 23, 2005. Once the process begins, **it will be important to apply for your NPI** before the compliance date of May 2007 because health plans could require you to use your NPI before that date.

You will be able to apply for your NPI in one of three ways:

1. You may apply through an easy-to-use Web-based application process, beginning May 23, 2005. The Web address will be <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, but please note — the website is not available until May 23, 2005.
2. Beginning July 1, 2005, you may complete a paper application and send it to the Enumerator. A copy of the application, including the Enumerator's mailing address (where you will send it) will be available on <https://nppes.cms.hhs.gov/NPPES/Welcome.do> or you can call the Enumerator to receive a copy. The phone number is 1-800-465-3203 or TTY 1-800-692-2326. But remember, paper applications may not be submitted until July 1, 2005.
3. With your permission, an organization may submit your application in an electronic file. This could mean that a professional association, or perhaps a health care provider who is your employer, could submit an electronic file containing your information and the information of other health care providers. This process will be available in the fall of 2005.

## GENERAL INFORMATION

### *CMS Announces the NPI Enumerator Contractor and Information on Obtaining NPIs, continued*

You may apply for an NPI using only one of these methods. When gathering information for your application, be sure that all of your information, such as your social security number and the Federal Employer Identification Number, are correct. Once you receive your NPI, safeguard its use.

If all information is complete and accurate, the Web-based process could result in you being issued a number within minutes. If there are problems with the information received, it could take longer. The paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

The transition from existing health care provider identifiers to NPIs will occur over the next couple of years. Each health plan with which you conduct business, including Medicare, will notify you when it will be ready to accept NPIs in standard transactions like claims. You can expect to hear about the importance of applying for an NPI from a variety of sources. Be clear that you only have to apply for, and acquire, one NPI. Your unique NPI will be used for all standard transactions, Medicare and non-Medicare.

Please be particularly aware that applying for an NPI does not replace any enrollment or credentialing processes with any health plans, including Medicare.

### **Additional Information**

For additional information on NPIs:

- Visit [http://www.cms.hhs.gov/NationalProvIdentStand/06\\_implementation.asp](http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp) on the CMS website.
- Beginning May 23, 2005, visit <https://nppes.cms.hhs.gov/NPPES/Welcome.do> or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- For HIPAA information, you may call the HIPAA Hotline: 1-866-282-0659, or write to [AskHIPAA@cms.hhs.gov](mailto:AskHIPAA@cms.hhs.gov) on the Web.

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Related Change Request (CR) #: N/A

Related CR Release Date: N/A

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## **Common Billing Errors to Avoid when Billing Medicare Carriers**

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the April 2007 Medicare B Update! pages 52-54.*

**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 website.

### **Provider Types Affected**

Physicians and providers billing Medicare carriers for services provided to Medicare beneficiaries

### **Provider Action Needed**

This special edition article includes some general information regarding the most frequent errors that are found in claims submitted to Medicare carriers. The article is intended to help you correctly complete your Medicare claims so they will not be denied, rejected, or delayed because of incorrect or incomplete information.

### **Background**

The Administrative Simplification Compliance Act and its implementing regulation (42 CFR 44.32, <http://www.gpoaccess.gov/cfr/retrieve.html>) require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, (except from small providers with limited exceptions).

All Medicare providers, except for small providers defined in regulation, must bill Medicare electronically. A “small provider” is defined in the *Federal Register* (42 CFR 424.32(d)(1)(vii), <http://www.gpoaccess.gov/cfr/retrieve.html>). To simplify, Medicare will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 full-time employees (FTEs) that bill a Medicare carrier or DMERC to be small. Providers that qualify as “small” automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

### **Common Billing Errors**

The following list includes common billing errors that you should avoid when submitting your claims to Medicare carriers:

- The patient cannot be identified as a Medicare patient. Always use the Health Insurance Claim Number (HICN) and name as it appears on the patient’s Medicare card.

*Common Billing Errors to Avoid when Billing Medicare Carriers, continued*

- Item 32 (and the electronic claim equivalent) requires you to indicate the place where the service was rendered to the patient including the name and address –including a valid ZIP code– for all services unless rendered in the patient’s home. Please be advised that any missing, incomplete, or invalid information recorded in this required field will result in the claim being returned or rejected in the system as unprocessable. Any claims received with the word “SAME” in Item 32 indicating that the information is the same as supplied in Item 33 are not acceptable. (NOTE: References to an item number, such as item 32, refer to paper claim forms. However, note that the whenever an article number is used in this article, the related concept and information required also applies to equivalent fields on electronic claims.)
- The referring/ordering physician’s name and UPIN were not present on the claim. Please keep in mind this information is required in Item 17 and 17a on all diagnostic services, including consultations. In addition, be aware of the new requirements for use of national provider identifiers (NPIs). To learn more about NPIs and how to obtain your NPI, see the *MLN Matters* article SE0679 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf> on the CMS website. Also, see the *MLN Matters* articles SE0555, SE0659, and MM4203 for important information regarding CMS’ schedule for implementing the NPI. The articles are at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf> , <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0659.pdf> , and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf> , respectively.
- Evaluation and management (E&M) procedure codes and the place of service do not match. An incorrect place of service is being submitted with the E&M procedure code. (Example: Procedure code 99283, which is an emergency room visit, is submitted with place of service 11, which is office).
- Please keep in mind, when billing services for more than one provider within your group, that you must put the individual provider number in Item 24k, as Item 33 can only accept one individual provider number. Also, please make sure the provider number on the claim is accurate and that it belongs to the group. (Also, remember that as of May 23, 2007, NPIs are to be used.)
- Diagnosis codes being used are either invalid or truncated. Diagnosis codes are considered invalid usually because an extra digit is being added to make it 5 digits. Please remember not all diagnosis codes are 5 digits. Please check your ICD-9-CM coding book for the correct diagnosis code.
- Procedure code/modifier was invalid on the date of service. Remember that, as of January 1, 2005, CMS no longer provides a 90-day grace period for billing discontinued CPT/HCPCS codes. (Note: Please read the Medicare provider bulletins, especially at the end of each year, as Medicare list all the additions, deletions, and code changes for the following year.)
- Claims are being submitted with deleted procedure codes. This information can also be found in the *CPT Book*. It is important to be using a current book.
- When Medicare is secondary, Item 11, 11a, 11b, and 11c must be completed.

**Billing Tips**

The following topics will assist you with correct billing and help you complete and submit error free claims:

**A. Provider Numbers**

**Individual vs. Group PIN** - Use the individual rendering provider identification number (PIN) on each detail line. Make sure the group number, when applicable, corresponds to the appropriate individual PIN. When a physician has more than one PIN (private practice, hospital, etc.), use the appropriate PIN for the services rendered. A rendering provider number, if not a solo number, must always belong to the group number that is billing. Electronic submitter ID numbers (not UPINs) should be entered in place of the PIN (group or individual). When billing any service to Medicare, if you have doubts as to which provider number to use, please verify with your carrier. (Remember to use NPIs on claims as of May 23, 2007.)

“Zero-Filling” - Do not substitute zeros or a submitter identification number where a Medicare PIN, UPIN, or NPI is required.

**B. Health Insurance Claim (HIC) Numbers**

**HIC Accuracy** – Your carrier receives numerous claims that are submitted with invalid or incorrect HIC numbers. These claims require manual intervention and can sometimes result in beneficiaries receiving incorrect EOMB information. Please be certain the HIC number you are keying is entered correctly, and is also the HIC that belongs to the patient (based on what is on his/her Medicare card) for which you are billing.

**HIC Format** - A correct HIC number consists of nine numbers immediately followed by an alpha suffix. Take special care when entering the HIC number for members of the same family who are Medicare beneficiaries. A husband and wife may have a HIC number that share the same Social Security numerics. However, individuals have their own alpha suffix at the end of the HIC number. In order to ensure proper claim payment, it is essential that the correct alpha suffix be appended to each HIC. No hyphens or dashes should be used.

“**Railroad Retirees**” - Railroad Retirement HIC numbers generally have two alpha characters as a prefix to the number. These claims should be billed to United Health Care Insurance Company, at this address:

Palmetto Government Benefit Administrators  
Railroad Medicare Services  
PO Box 10066  
Augusta, GA 30999-0001

**C. Name Accuracy**

Titles should not be used as part of the name (e.g., Dr., Mr., Rev., M.D., etc.). Be sure to use the name as it appears on the patient’s Medicare card.

**Non-Medicare Claims** - Do not send claims for non-Medicare beneficiaries to your Medicare carrier.

## GENERAL INFORMATION

### *Common Billing Errors to Avoid when Billing Medicare Carriers, continued*

#### **D. Complete Address**

**U.S. Postal Addressing Standards** - It is very important to meet the U.S. postal addressing standards. Patient and provider information must be correct. This is necessary so that checks and Medicare Summary Notices (MSNs) or remittance notices arrive at the correct destination. It is also to ensure the quickest service to your office.

- A deliverable address may contain both a street name and number or a street name with a post office (P.O.) box number.
- A P.O. box by itself is acceptable.
- A rural route (RR) number must be with a box number. Note: It is incorrect to key P.O. in front of the box number when given with a rural route.
- A star route number is not a deliverable address. Use highway contract route (HC) instead of star route.
- RD numbers are no longer valid. If there are rural routes still existing in your area, the correct number should be preceded by RR, then the box number.
- A box number or a RR number by itself is not deliverable.
- A street name without a number cannot be delivered.
- Do not use percent or any other symbol when denoting an "in care of" address. C/O is appropriate.
- As always, no commas, hyphens, periods, or other special characters should be used.

**Nursing Home or Skilled Nursing Facility Address** - For a facility such as a nursing home or skilled nursing facility, it is preferred that a street name and number be supplied. In some cases, this information is not available, but if it is, please use it. Please verify the accuracy of your address before you send this information.

**Apartment Complex** - An apartment complex (words such as apartments, towers, or complex indicate such) should contain a street address and an apartment number. Again, this information is not always available, but should always be used when it exists.

**Development Center / Trailer Park** - If a development center or trailer park is given, it should contain the street address and number, if that information is part of the complete address.

**"No Street Address" (NSA)** - NSA (no street address) is not acceptable. This is not a deliverable address.

**Changes to Provider Address** - Please notify your carrier in writing of any address changes for your office practice.

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#### **E. Diagnosis and Procedure Codes**

Make sure you keep current with valid diagnosis and procedure codes. HIPAA requires that Medicare conform to these standard code sets reported codes must be valid as of the date of service. Remember that Medicare can no longer allow a grace period for using deleted codes.

#### **Additional Information**

##### **Medicare Claims Processing Manual**

The *Medicare Claims Processing Manual* (Publication 100-04) contains detailed instructions on Medicare's claims processes and detailed information on preparation and submission of claims. This manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS website.

##### **MLN Matters**

*MLN Matters* is a series of articles that CMS prepares especially for providers. These articles provide information on new and/or deleted procedure and diagnosis codes, changes to the Medicare physician fee schedule and other changes that impact physicians and providers. These articles are available at <http://www.cms.hhs.gov/MLNMattersArticles/> on the CMS website.

##### **Listservs**

Listservs are electronic mailing lists that CMS uses to get new information into the hands of physicians and providers as quickly as possible. To get your Medicare news as it happens, join the appropriate listserv(s) at <http://www.cms.hhs.gov/apps/maillinglists/> on the CMS website.

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

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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 websites <http://www.connecticutmedicare.com> or <http://www.floridamedicare.com>. It's very easy to do. Simply go to the website, click on the "eNews" link on the navigational menu and follow the prompts.

## Modification to the Redetermination Notice and Administrative Law Judge Filing Locations

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

### Provider Types Affected

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

### Provider Action Needed

#### STOP – Impact to You

The Centers for Medicaid & Medicare Services (CMS) issued change request (CR) 5554 in order to modify the Reconsideration Request Form and to amend the administrative law judge (ALJ) filing locations.

#### CAUTION – What You Need to Know

Providers and suppliers do not need to resubmit documentation when requesting a qualified independent contractor (QIC) reconsideration if the documentation was previously submitted as part of the redetermination process. This documentation is forwarded to the QIC as part of the case file utilized in the reconsideration process. Make certain that any additional evidence is submitted prior to the reconsideration decision. If all additional evidence is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence to the ALJ or further appeal unless you can demonstrate good cause for withholding the evidence from the QIC.

Be aware that when the service was rendered in **Delaware, Kentucky, Virginia, Puerto Rico, and/or the US**

**Virgin Islands**, the filing locations for ALJ requests are **modified** to identify the appropriate Office of Medicare Hearings and Appeals (OMHA) field office. All other jurisdictions remain unchanged.

#### GO – What You Need to Do

Make certain that your billing staff or other staff that handle reconsideration requests for you are aware of these changes.

#### Background

CR 5554 is the official document that announces these changes in Medicare processes. Attached to this CR are three documents that assist with the appeals process:

- A sample form letter titled: Medicare Appeal Decision.
- A paper outlining Important Information About Your Appeal Rights.
- A modified **Reconsideration Request Form** containing revised introductory instructions, as follows: “At a minimum, you must complete/include information for items 1, 2a, 6, and 7 but to help us serve you better, please include a copy of the redetermination notice you received with your reconsideration request.”

The revised filing locations for sending documentation for requesting ALJ hearings are as follows:

- **Cleveland, Ohio** is the filing location for services rendered in **Delaware and Kentucky**.
- **Arlington, Virginia** for services in **Virginia**.
- **Miami, Florida** for services in **Puerto Rico and the US Virgin Islands**.

The following table lists the addresses of all filing locations along with the place of service.

HHS OMHA Field Office & Mailing Address	Jurisdiction (Based on the place of service)			
Cleveland, OH BP Tower & Garage 200 Public Square, Suite 1300 Cleveland, OH 44114-2316	Connecticut Hampshire Rhode Island Puerto Rico West Virginia Ohio	Maine Vermont Virgin Islands <i>Kentucky</i> Michigan	Massachusetts New York Pennsylvania Illinois Minnesota	New Jersey <i>Delaware</i> Indiana Wisconsin
Miami, FL 100 SE 2nd Street, Suite 1700 Miami, FL 33131-2100	Alabama North Carolina Louisiana <i>Puerto Rico</i>	Florida South Carolina New Mexico <i>US Virgin Islands</i>	Georgia Tennessee Oklahoma	Mississippi Arkansas Texas
Irvine, CA 27 Technology Drive, Suite 100 Irvine, CA 92618-2364	Iowa Colorado Dakota Utah Hawaii Idaho Samoa Trust Territory of the Pacific Islands	Kansas Montana Wyoming Nevada Oregon	Missouri North Dakota Arizona Guam Washington	Nebraska South California Alaska American
Arlington, VA 1700 N. Moore St., Suite 1600 Arlington, VA 22209	<i>Virginia</i> Maryland District of Columbia			

## GENERAL INFORMATION

### *Modification to the Redetermination Notice and Administrative Law Judge Filing Locations, continued*

#### **Additional Information**

For complete details regarding this change request (CR) please see the official instruction (CR 5554) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R1229CP.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 at on the CMS website at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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

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## **Disclosure Desk Reference for Provider Contact Centers**

*CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the September 2006 Medicare B Update! pages 34-36.*

**Note:** This article was revised on May 7, 2007, to add this statement that Medicare 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 website.

### **Provider Types Affected**

All physicians, providers, and suppliers billing Medicare

### **Provider Action Needed**

#### **STOP – Impact to You**

When you call or write a Medicare fee-for-service provider contact center (PCC) to request beneficiary protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, will authenticate your identity prior to disclosure.

#### **CAUTION – What You Need to Know**

CR 5089 revises *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3, Section 30, and Chapter 6, Section 80, to update the guidance to PCCs for authenticating providers who call or write to request beneficiary protected health information, and to clarify the information they may disclose after authentication.

#### **GO – What You Need to Do**

Be prepared to supply the required authentication information when contacting a PCC to request protected health information.

### **Background**

In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare PCCs must first authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

CR 5089, from which this article is taken, completely revises Section 30 in Chapter 3 and Section 80 in Chapter 6 of the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9). It updates the PCC Disclosure Desk Reference, the main purpose of which is to protect the privacy of Medicare beneficiaries by ensuring that protected health information is disclosed to providers only when appropriate, to include:

- Guidance for authenticating providers who call or write to request beneficiary protected health information; and
- Clarification of the information that may be disclosed after authentication of writers and callers.

Please note that while new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements.

Below is the authentication guidance that the PCCs will be using:

#### **Telephone Inquiries**

##### **Provider Authentication**

**CSR Telephone Inquiries** - Through May 22, 2007, customer service representatives (CSR) will authenticate providers using provider number and provider name.



***Disclosure Desk Reference for Provider Contact Centers, continued***

**Interactive Voice Response (IVR) Telephone Inquiries** - Through May 22, 2007, IVRs will authenticate providers using only the provider number.

**Note:** See “Final Note” below to learn more about provider authentication after May 22, 2007.

**Written Inquiries****Provider Authentication**

Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider number and provider name.

**Note:** See “Final Note” below to learn more about provider authentication after May 22, 2007.

At this point, there are some specific details about provider authentication in written inquiries of which you should be aware.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider’s official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider’s name and address are included in the letterhead and clearly establish the provider’s identity.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered to be written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you.

Rather, they will send you the requested information by regular mail, or respond to these requests by telephone. In either of these response methods, or if they elect to send you an automated e-mail reply (containing no beneficiary-specific information), they will remind you that such information cannot be disclosed electronically via email or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

And lastly, inquiries received without letterhead, including hardcopy, fax, e-mail, pre-formatted inquiry forms, or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs), will be authenticated the same as written inquiries, (explained above) using provider name and the provider number.

**Insufficient or Inaccurate Requests**

You should also understand that for any protected health information request in which the PCC determines that the authentication elements are insufficient or inaccurate, you will have to provide complete and accurate input before the information will be released to you.

Such requests that are submitted in written form and those on pre-formatted inquiry forms, will be returned in their entirety by regular mail, with a note stating that the requested information will be supplied upon submission of all authentication elements, and identifying which elements are missing or do not match the Medicare record.

Alternatively, if you sent the request by e-mail (containing no protected health information), the PCC may return it by e-mail, or may elect to respond by telephone to obtain the rest of the authentication elements.

**Beneficiary Authentication**

Regardless of the type of telephone inquiry (CSR or IVR) or written inquiry, PCCs will authenticate four beneficiary data elements before disclosing any beneficiary information:

- 1) Last name;
- 2) First name or initial;
- 3) Health Insurance Claim Number; and
- 4) Either date of birth (eligibility, next eligible date, certificate of medical necessity (CMN)/durable medical equipment Medicare administrative contractor information form (DIF) [pre-claim]) **or** date of service (claim status, CMN/DIF [post-claim]).

Please refer to the disclosure charts attached to CR 5089 for specific guidance related to these data elements as well as details on the beneficiary information that will be made available in response to authenticated inquiries. CR 5089 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf> on the CMS website.

**Special Instances**

Below are three special instances that you should know about.

**Overlapping Claims**

Overlapping claims (multiple claims with the same or similar dates of service or billing period) occur when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

Sometimes this happens when the provider is seeking to avoid have a claim be rejected, for example:

- When some end stage renal disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated, thus allowing the facility to code the claim appropriately and bill around the inpatient hospital stay/stays; or
- Skilled nursing facility and inpatient hospital stays.

## GENERAL INFORMATION

### *Disclosure Desk Reference for Provider Contact Centers, continued*

These situations fall into the category of disclosing information needed to bill Medicare properly, and information can be released as long as all authentication elements are met.

#### **Pending Claims**

A pending claim is one that is being processed, or has been processed and is pending payment. CSRs can provide information about pending claims, including internal control number (ICN), pay date/amount or denial, as long as all authentication requirements are met.

Providers should note, however, that until payment is actually made or a remittance advice is issued, the information provided could change.

#### **Deceased Beneficiaries**

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, PCCs will comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

**Final note:** More information will be provided in a future *MLN Matters* article about authentication on and after May 23, 2007, the implementation date for the National Provider Identifier or NPI.

#### **Additional Information**

You may find more information about Provider Contact Center guidelines concerning authentication by going to <http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf> on the CMS website.

Attached to that CR, you will find the updated *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100.09), Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information); and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information).

If you have any questions, please contact your carrier, durable medical equipment (DME) regional carrier, DME Medicare administrative contractor (DME MAC), fiscal intermediary, or regional home health intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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Related CR Transmittal #: R16COM

Implementation Date: October 2, 2006

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## May Is Healthy Vision Month

Please join the Centers for Medicare & Medicaid Services (CMS) and the National Eye Institute (NEI) in promoting increased awareness of glaucoma and the glaucoma screening benefit provided by Medicare.

An estimated 2.2 million Americans have been diagnosed with primary open-angle glaucoma, the most common form of the disease. An additional 2 million Americans have glaucoma and don't even know it. Glaucoma has no warning signs and, if left untreated, can result in permanent vision loss. If glaucoma is detected early, there is treatment available to slow or stop vision loss and reduce the risk of blindness.

### **Medicare Coverage**

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high-risk groups:

- Individuals with diabetes mellitus
- African-Americans age 50 and older
- Individuals with a family history of glaucoma
- Hispanic-Americans age 65 and older

A covered glaucoma screening includes:

- Dilated eye examination with an intraocular pressure (IOP) measurement
- Direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination

### **What Can You Do?**

As a trusted source of health care information, your patients rely on their physician's or other health care professional's recommendations. CMS needs your help to ensure that all eligible people with Medicare take full advantage of the annual glaucoma screening benefit. Talk to your Medicare patients that are in the high risk groups identified above about their risk for glaucoma and encourage them to get regular yearly glaucoma screening examinations.

### **For More Information**

- For more information about Medicare's coverage of glaucoma screening, visit the CMS website <http://www.cms.hhs.gov/GlaucomaScreening/>
- CMS has also developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

*May is Healthy Vision Month, continued*

- The *MLN* Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at [http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp) on the CMS website.
- The CMS website provides information for each preventive service covered by Medicare. Go to <http://www.cms.hhs.gov>, select “Medicare”, scroll down to the

- “Prevention” heading.
- For information to share with your Medicare patients, please visit <http://www.nei.nih.gov/glaucomaeducation> and <http://www.nei.nih.gov/glaucoma/>.
- For more information about Healthy Vision Month, please visit <http://healthyvision2010.nei.nih.gov/hvm/>.

Help your at risk patients protect their vision. Encourage regular annual glaucoma screenings.

Source: Provider Education Resources Listserv, Message 200705-06

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

**May Is National Osteoporosis Awareness and Prevention Month**

In conjunction with this national health observance, the Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to remind health care professionals that Medicare provides coverage of **bone mass measurements** for beneficiaries at clinical risk for osteoporosis.

The facts are that one out of every two women and one in four men over 50 will have an osteoporosis-related fracture in their lifetime. Twenty percent of seniors who suffer a hip fracture die within one year.

According to the US Surgeon General’s 2004 report *Bone Health and Osteoporosis: A Report of the Surgeon General*, due to the aging of the population and the previous lack of focus on bone health, the number of hip fractures in the United States could double or triple by the year 2020.

The report found that many patients were not being given appropriate information about prevention, and many patients were not having appropriate testing to diagnose osteoporosis or establish osteoporosis risk. The good news is that osteoporosis is a disease that largely can be prevented and bone loss can be slowed with treatment. Medicare’s bone mass measurement benefit can aid in the early detection of osteoporosis before fractures occur, provide a precursor to future fractures, and determine rate of bone loss.

**What Can You Do?**

National Osteoporosis Awareness and Prevention Month presents an excellent opportunity for health care professionals to promote prevention, detection, and treatment of osteoporosis.

**Thanks for your help in this worthwhile endeavor! “Osteoporosis. It’s Beatable. It’s Treatable.”**

Source: Provider Education Resources Listserv, Message 200705-11

- 1) Become familiar with Medicare’s coverage of bone mass measurements.
- 2) Talk with your patients about their risks for osteoporosis, prevention measures they can take, and the importance of utilizing bone mass measurements.
- 3) Encourage eligible Medicare patients to take full advantage of Medicare’s bone mass measurement benefit.

As a health care professional, you play a critical role in helping your patients maintain strong, healthy bones throughout their life. Please join with CMS in spreading the word about prevention and early detection of osteoporosis and ensuring that all eligible Medicare beneficiaries take full advantage of the bone mass measurement benefit.

**For More Information**

- For more information about Medicare’s coverage of bone mass measurements, please visit the CMS website <http://www.cms.hhs.gov/BoneMassMeasurement/>.
- U.S. Department of Health and Human Services. *Bone Health and Osteoporosis: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Office of the Surgeon General, 2004. This document may be downloaded at <http://www.hhs.gov/surgeongeneral/library/bonehealth/> on the Department of Health and Human Services website.
- To learn more about National Osteoporosis Awareness and Prevention Month, please visit The National Osteoporosis Foundation website <http://www.nof.org/>.

**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 websites <http://www.connecticutmedicare.com> or <http://www.floridamedicare.com>. It’s very easy to do. Simply go to the website, click on the “eNews” link on the navigational menu and follow the prompts.

### National Women's Health Week

The Centers for Medicare & Medicaid Services (CMS) would like to invite you to join us in recognizing May 13, 2007 – May 19, 2007, as National Women's Health Week. This annual health observance is a perfect opportunity to help women learn how they can live longer, better, healthier lives through the promotion of disease prevention, early detection and lifestyle modifications that support a healthier life.

Heart disease, stroke, cancer, diabetes, osteoporosis, influenza, pneumonia, and other chronic diseases have a significant impact on the health and well being of women in the US. Yet the reality is, many of these diseases can be prevented and complications can be reduced. Medicare now provides coverage for a full range of preventive services and screenings that can help women stay healthy, detect disease early and manage conditions to reduce complications. Medicare-covered preventive benefits include:

- Abdominal Aortic Aneurysm Screening (new as of January 2007)
- Adult Immunizations
- Flu
- Pneumococcal
- Hepatitis B.
- Cancer Screenings
- Breast (mammogram and clinical breast exam)
- Cervical & Vaginal (Pap test and pelvic exam)
- Colorectal
- Cardiovascular Screening
- Diabetes Screening
- Diabetes Supplies
- Diabetes Self-management Training
- Glaucoma Screening
- Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam)
- Medical Nutrition Therapy (beneficiaries with diabetes or renal disease)
- Smoking and Tobacco-Use Cessation Counseling

Although Medicare is now helping to pay for more preventive benefits, many women with Medicare are not yet taking full advantage of them, leaving significant gaps in prevention. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease or even that they may already have a condition that preventive services are intended to detect. With your help we can begin to close the prevention gap.

#### How Can You Help?

As a trusted source, your recommendation is the most important factor in increasing women's use of Medicare preventive benefits. We need your help to ensure that women with Medicare are aware of these covered benefits and that they are encouraged to take advantage of the preventive services for which they may be eligible.

**For Women Patients New to Medicare** – When appropriate, provide the "Welcome to Medicare" physical exam. This one-time exam, which must be received within the first six months of a beneficiary's Medicare Part B effective date, is an excellent opportunity to orient new women patients to Medicare, assess risk factors for disease, discuss lifestyle modifications that support a healthy lifestyle and may reduce the complication of disease, and encourage utilization of preventive benefits through referral for appropriate services. Remember to follow-up with patients on all screening results, even negative ones - every one likes to hear good news.

**For Established Patients** – Remember to talk with your patients about their risk for disease and the importance and value of prevention, detection, early treatment, and lifestyle modifications. Encourage appropriate utilization of preventive services for which they may be eligible and provide follow-up on all screening results and continue to promote a prevention-oriented lifestyle.

#### Working together we can begin to:

- educate women about steps they can take to prevent disease
- increase awareness of risk factor for developing disease while promoting prevention, early detection and treatment of disease affecting women's health
- prevent and reduce serious complications of disease through better disease management
- reduce mortality for many diseases effecting women
- improve the health and quality of life of women
- ensure that women with Medicare take advantage of preventive benefits they may be eligible for, before they become sick
- ultimately save health care dollars

#### For More Information

For more information about Medicare-covered preventive services and screenings, including coverage, coding and billing guidelines, please visit the following CMS website:

- The *MLN* Preventive Services Educational Products Web page  
[http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage)
- For products to share with your Medicare patients go to <http://www.medicare.gov>
- To learn more about National Women's Health Week, please visit <http://www.4woman.gov/whw/>

Thank you for joining with CMS to spread the message about prevention, early detection and treatment.

Source: Provider Education Resources Listserv, Message 200705-18

# 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 websites, <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 website is considered the notice date.

### Electronic Notification

To receive quick, automatic notification when new LCDs are posted to the website, 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

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## Advance Notice Statement

**A**dvance beneficiary notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity (see page 5).

**REVISIONS TO LCDs**

**J0740: Ganciclovir and Cidofovir—LCD Revision**

This local coverage determination (LCD) was effective October 30, 2006. Since that time, the LCD has been revised. Under the list of medically necessary ICD-9-CM diagnosis codes, the note about diagnosis requirements for HCPCS codes J0740 and J7310 was revised to clarify that a diagnosis code from one of the following groups is also required when billing for these drugs: 363.00-363.08 or 363.10-363.15. The coding guidelines were also revised to include the revised billing instructions for HCPCS codes J0740 and J7310.

**Effective Date**

This revision was effective for services rendered **on or after October 30, 2006**. The full text of this LCD is available through our provider education website at <http://www.connecticutmedicare.com> or <http://www.floridamedicare.com> on or after this effective date.

**J1440: G-CSF (Filgrastim, Neupogen®)—LCD Revision**

This local coverage determination (LCD) was last revised on October 1, 2006. Since that time, the LCD has been revised. Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, diagnosis codes V42.81 and V42.82 were added as appropriate diagnosis codes. Also, a note was added to the ICD-9-CM code list indicating that diagnosis codes V42.81 and V42.82 are secondary diagnosis codes and that the underlying condition should be billed as the primary diagnosis code. In addition, the LCD was split out into individual FL B and CT B LCDs. Previously these LCDs were combined.

**Effective Date**

This revision is effective for services rendered **on or after May 7, 2007**. The full-text for this LCD may be viewed on the provider education website <http://www.connecticutmedicare.com> or <http://www.floridamedicare.com> on or after this effective date.

**RETIRED LCD**

**J9000: Antineoplastic Drugs—Retired LCD and Individual Revised LCDs**

The local coverage determination (LCD) for antineoplastic drugs was last revised on February 8, 2007. Since that time, this LCD is being retired as individual revised LCDs were developed for all drugs included in the Antineoplastic Drugs LCD. The following is a list of the drugs for which individual revised LCDs were developed:

- |  |  |
|--|--|
| J9000 – Doxorubicin HCl, 10mg                                | J9201 – Gemcitabine HCl, 200mg   |
| J9001 – Doxorubicin HCl, all lipid formulations, 10mg        | J9206 – Irinotecan, 20mg   |
| J9010 – Alemtuzumab, 10mg                                    | J9263 – Injection, oxaliplatin, 0.5mg                                      |
| J9015 – Aldesleukin, per single use vial                     | J9265 – Paclitaxel, 30mg   |
| J9045 – Carboplatin, 50mg                                    | J9280, J9290, & J9291 Mitomycin 5mg, 20mg, & 40mg<br>(combined in one LCD) |
| J9160 – Denileukin diftitox, 300mcg                          | J9300 – Gemtuzumab ozogamicin, 5mg   |
| J9170 – Docetaxel, 20mg                                      | J9310 – Rituximab, 100mg   |
| J9178 – Injection, epirubicin HCl, 2mg                       | J9350 – Topotecan, 4mg   |
| J9181 & J9182 – Etoposide 10mg & 100mg (combined in one LCD) | J9355 – Trastuzumab, 10mg  |
| J9185 – Fludarabine phosphate, 50mg                          | J9390 – Vinorelbine tartrate, per 10mg                                     |
| J9200 – Floxuridine, 500mg                                   | J9395 – Injection, fulvestrant, 25mg                                       |
|  | J9600 – Porfimer sodium, 75mg  |

**Effective Date**

The LCD retirement for J9000—Antineoplastic Drugs was effective for services rendered **on or after April 30, 2007**. The individual revised LCDs for the above drugs were effective for services rendered **on or after April 30, 2007**.

The full text of these LCDs are available through our provider education website at <http://www.connecticutmedicare.com> or <http://www.floridamedicare.com> on or after this effective date.

## ADDITIONAL INFORMATION

### Correct Coding of Bundled Procedures

Procedures should be reported with the *CPT* codes that most comprehensively describe the services performed. Correct coding requires reporting a group of procedures with the appropriate comprehensive code.

Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code. Two types of practices lead to unbundling. The first is unintentional and results from a misunderstanding of coding. The second is intentional and is used by providers to manipulate coding in order to maximize payment. Examples of unbundling are described below:

- Fragmenting one service into component parts and coding each component part as if it were a separate service: For example, the correct *CPT* comprehensive code to use for upper gastrointestinal endoscopy with biopsy of stomach is *CPT* code 43239. Separating the service into two component parts, using *CPT* code 43235 for upper gastrointestinal endoscopy and *CPT* code 43600 for biopsy of stomach is inappropriate.
- Reporting separate codes for related services when one combined code includes all related services: An example of this type of unbundling is coding an intermediate layer closure (I2032), when performed with a cardiac implant procedure such as 33249 (insertion or reposition of defibrillator/pulse generator) or 33208 (insertion or replacement of pacemaker). It is considered unbundling to report separately the code for the closure of a surgically created opening because the closing is integral to the operative procedure.

National Correct Coding Initiative (NCCI) edits were developed for the purpose of encouraging consistent and correct coding and controlling inappropriate payment. Edits and local coverage determinations do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. *CPT* codes, descriptions and other data only are copyrighted 2006 American Medical Association (or other such date of publication of *CPT*). All rights reserved. Applicable FARS/DFARS apply.**

### Article Clarification—Medicare Guidelines for Independent Diagnostic Testing Facilities—Specialty Manual Revision

The following information was published in the November 2006 Medicare B Update! However, an effective date for the *CPT* codes listed in this article, when billed by an independent diagnostic testing facility (IDTF), was omitted. The effective date for those codes that are no longer allowed by an IDTF was effective for services rendered on or after **December 15, 2006**. The effective date for those *CPT* codes which are allowed as medically necessary and reasonable was effective for services rendered on or after **November 28, 2006**. In addition, since the below article was published, *CPT* code 76006 has been deleted effective for services rendered on or after January 1, 2007 (see article published in the January 2007 *Medicare B Update!*, pg. 76).

The latest revision for the Medicare guidelines for independent diagnostic testing facilities (IDTFs) was effective in January 2006. Since that time, this specialty manual has been revised in cooperation with a national IDTF workgroup, facilitated by the Centers for Medicare & Medicaid Services (CMS).

In evaluating the information to be revised in the specialty manual, the procedure codes contained in the manual were evaluated. It has been determined that not all diagnostic testing is considered appropriate for inclusion in the listing of IDTF codes. IDTFs may not perform therapeutic, intra-operative or ablation procedures. It is not an extension of any outpatient facility and should not perform procedures such as removal of foreign body from the esophagus, placement of gastrointestinal tubes, dilatation of strictures, pain management or trans-catheter therapies to name a few. Therefore, any physician services and/or surgical procedures best provided in acute care facilities, ambulatory surgical centers, or a physician's office are not included in the *CPT* codes for IDTFs. Therefore, this notification serves as a 45-day notice that the following *CPT* codes will no longer be allowed when billed by an IDTF:

59020, 71090, 74235, 74340, 74350, 74355, 74360, 74363, 74475, 74480, 74485, 75893, 75894, 75896, 75898, 75900, 75940, 75945, 75946, 75960, 75961, 75962, 75964, 75966, 75968, 75970, 75978, 75980, 75982, 75984, 75989, 75992, 75993, 75994, 75995, 75996, 76012, 76013, 76355, 76362, 76394, 76930, 76932, 76936, 76941, 76945, 76948, 76950, 76965, 76986, 78890, 78891, 93501, 93505, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533, 93555, 93556, 93561, 93562, 93571, 93572, 93600, 93602, 93603, 93609, 93610, 93612, 93613, 93615, 93616, 93618, 93619, 93620, 93621, 93622, 93623, 93624, 93631, 93640, 93641, 93642, 93724, 95829, 95955, 95961, 95962, 96102.

In addition, it has been determined that the following *CPT* codes should be allowed as medically necessary and reasonable when billed by an IDTF:

75635, 76006, 76101, 91132, 91133, 92597, 93010, 93014, 93018, 93226, 93790, 94016, 94452, 94453, 95830, 0067T, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T and 0151T.

## LOCAL COVERAGE DETERMINATIONS

### Article Clarification—Medicare Guidelines for Independent Diagnostic Testing Facilities—Specialty Manual

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

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

The full text of this LCD is available through our provider education website at <http://www.connecticutmedicare.com> or <http://www.floridamedicare.com> on or after this effective date.

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## FLORIDA ONLY - LCD REVISIONS

### 43644: Surgical Management of Morbid Obesity – LCD Revision

The Centers for Medicare and Medicaid Services (CMS) issued a national coverage decision (NCD) for bariatric surgery for treatment of morbid obesity effective February 21, 2006. At that time, FCSO had an active local coverage determination (LCD). A decision was made to keep the LCD due to additional CPT codes in the LCD that are not included in the NCD.

It has recently been brought to the attention of First Coast Service Options, Inc. (FCSO) that there may be conflicting information in the LCD related to the requirement that beneficiaries receiving this service must have documentation supporting attempts at weight loss (bullet # 2 under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD). Therefore, this statement has been removed and replaced with “*Have been previously unsuccessful with medical treatment for obesity*”. Additionally, the following revisions were made to the LCD:

- Removed verbiage related to the requirement that psychological evaluation and counseling associated with the surgery have been performed prior to the surgery (Bullet #3 under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD)
- Correction to CMS national coverage policy references
- Updated the “Sources of Information and Basis for Decision” section of the LCD

#### Effective Date

This LCD revision is effective for services rendered **on or after April 17, 2007**. The full text of this LCD is available through our provider education website at <http://www.floridamedicare.com> on or after this effective date.

### 92541: Vestibular Function Tests—LCD Revision

This local coverage determination (LCD) was effective February 28, 2007. Since that time, the LCD has been revised. Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, the description (Sinusoidal vertical axis rotational testing) for CPT code 92546, was revised to remove reference to the two specific types of auto-head rotation tests mentioned. The new description describes this test without mention of specific types of auto-head rotation tests that can be performed.

#### Effective Date

This revision is effective for services rendered **on or after May 15, 2007**. The full text of this LCD is available through our provider education website at <http://www.floridamedicare.com> on or after this effective date.

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**CONNECTICUT EDUCATIONAL RESOURCES**

**Upcoming Provider Outreach and Education Events**

**June 2007 – August 2007**

**Hot Topics Teleconference – Topics based on data analysis, session includes discussion of new initiatives and changes in the Medicare program**

When: June 28, 2007  
Time: 11:00 a.m. – 12:30 p.m.  
Type of Event: Teleconference

**Ask the Contractor Teleconference (ACT) – Topic to be determined**

When: August 18, 2007  
Time: 12:00 p.m. – 1:00 p.m.  
Type of Event: Teleconference

If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to 904-791-6035. Keep checking our website, [www.connecticutmedicare.com](http://www.connecticutmedicare.com), or listening to information on the FCSO Provider Education Registration Hotline, (203) 634-5527, for details and newly scheduled events!

**Please Note:**

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to event advertisement.
- For event and registration details, check our website ([www.connecticutmedicare.com](http://www.connecticutmedicare.com)) or call our registration hotline at (203) 634-5527 a few weeks prior to the event.

Registrant's Name: \_\_\_\_\_

Registrant's Title: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

**FLORIDA EDUCATIONAL RESOURCES**

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**Upcoming Provider Outreach and Education Events**

***July 2007 – September 2007***

**Hot Topics Teleconference – Topics to be determined**

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

**Hot Topics Teleconference – Topics to be determined**

When: August 16, 2007  
Time: 11:30 a.m. – 1:30 p.m.  
Type of Event: Teleconference

**Hot Topics Teleconference – Topics to be determined**

When: September 13, 2007  
Time: 11:30 a.m. – 12:30 p.m.  
Type of Event: Teleconference

More events will be planned soon for this quarter. Keep checking our website, [www.floridamedicare.com](http://www.floridamedicare.com), or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events!

**Please Note:**

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to event advertisement.
- For event and registration details, check our website ([www.floridamedicare.com](http://www.floridamedicare.com)) or call our registration hotline at (904) 791-8103 a few weeks prior to the event.

Registrant's Name: \_\_\_\_\_

Registrant's Title: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

**CONNECTICUT  
MEDICARE PART B  
MAIL DIRECTORY**

Connecticut Medicare Part B welcomes any questions that you may have regarding the Medicare Part B program. Always be sure to clearly explain your question or concern. This will help our staff to know exactly what issues to address when developing a response to your inquiry.

Please submit your questions to the appropriate department. This will ensure that your concerns are handled in a proper and timely manner. This can be achieved by including an Attention Line below the address on the envelope. Listed below is a directory of departments that includes the issues that you would address to their attention.

With the exception of Redeterminations and Medicare EDI, please submit all correspondence with the appropriate attention line to:

**Attention: (insert dept name)  
Medicare Part B CT  
P.O. Box 45010  
Jacksonville, FL 32232-5010**

**Attention: Correspondence**

The Correspondence attention line is used for inquiries pertaining to general issues regarding Medicare Part B. Some examples of these issues are deductibles, assignment, and beneficiary address changes. Do not use words such as *REVIEW* or *RECHECK* when sending general correspondence.

**Attention: Financial Services**

Use this attention line to return duplicate payments or overpayment refunds.

**Attention: Fraud and Abuse**

If you encounter what you believe is suspected, potential, or possible fraud or abuse of the Medicare program, we encourage you to contact this department.

**Attention: Freedom of Information (FOIA)**

This department handles requests for information available under the Freedom of Information Act.

**Attention: Medical Review**

Questions regarding LMRPs/LCDs and correct documentation for evaluation and management services are handled by this department. Documentation for off-label chemotherapy use should also be submitted to the Medical Review Department.

**Attention: MSP**

Write to the Medicare Secondary Payer (MSP) department when submitting an Explanation of Benefits from a primary insurance, Exhaust letters from Auto Liability claims, and MSP calculation review requests.

**Attention: Pricing/  
Provider Maintenance**

Address your envelope to this department to apply for a new provider number, change a business or billing address of a provider, or to make any changes in the status of a provider. This department also handles fee schedule requests and inquiries, participation requests, and UPIN requests.

**Attention: Resolutions**

Use the Resolutions attention line when inquiring or submitting information regarding dates of death, incorrect Medicare (HIC) numbers, incorrect beneficiary information, etc.

**MAILING ADDRESS  
EXCEPTIONS**

We have established special P.O. boxes to use when mailing your redeterminations and hearings requests, paper claims, or to contact Medicare EDI:

**Redeterminations/Appeals**

Please mail only your requests for redeterminations to this P.O. Box. *DO NOT* send new claims, general correspondence, or other documents to this location; doing so will cause a delay in the processing of that item.

If you believe the payment or determination is incorrect and want a claim to be reconsidered, then send it to the attention of the review department. Requests for redeterminations must be made within 120 days of the date of the Medicare Summary Notice. These requests should not include redetermination requests on Medicare Secondary Pay calculations. Claims that are denied for return/reject need to be resubmitted and should **not** be sent as a redetermination. These resubmitted claims should be sent in as new claims.

**Hearings**

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

**Post Office Box for Appeals/Hearings:**

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

**Electronic Media Claims/EDI**

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

**Post Office Box for EDI:**

**Medicare Part B CT Medicare EDI  
P.O. Box 44071  
Jacksonville, FL 32231-4071**

**Claims**

The Health Insurance Portability and Accountability Act (HIPAA) requires electronic submission of most types of Medicare claims. We realize, however, that on occasion it is necessary to submit a paper claim. When this happens, submit your claims on the approved red-and-white Form CMS-1500 to:

**Medicare Part B CT Claims  
P.O. Box 44234  
Jacksonville, FL 32231-4234**

**CONNECTICUT  
MEDICARE PHONE  
NUMBERS**

**Beneficiary Services  
1-800-MEDICARE (toll-free)  
1-866-359-3614 (hearing impaired)  
First Coast Service Options, Inc.**

**Provider Services**

Medicare Part B  
1-888-760-6950

**Interactive Voice Response**

1-866-419-9455

**Electronic Data Interchange (EDI)**

**Enrollment**

1-203-639-3160, option 1

**PC-ACE® PRO-32**

1-203-639-3160, option 2

**Marketing and Reject Report Issues**

1-203-639-3160, option 4

**Format, Testing, and Remittance Issues**

1-203-639-3160, option 5

**Electronic Funds Transfer Information**

1-203-639-3219

**Hospital Services**

Empire Medicare Services  
Medicare Part A  
1-800-442-8430

**Durable Medical Equipment**

HealthNow NY  
DMERC Medicare Part B  
1-800-842-2052

**Railroad Retirees**

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

**Quality of Care**

Peer Review Organization  
1-800-553-7590

**OTHER HELPFUL  
NUMBERS**

**Social Security Administration**  
1-800-772-1213

**American Association of Retired Persons (AARP)**

1-800-523-5800

**To Report Lost or  
Stolen Medicare Cards**

1-800-772-1213

**Health Insurance Counseling Program**

1-800-994-9422

**Area Agency on Aging**

1-800-994-9422

**Department of Social Services/ConnMap**

1-800-842-1508

**ConnPace/**

**Assistance with Prescription Drugs**

1-800-423-5026

**MEDICARE WEBSITES**

**PROVIDER**

Connecticut

<http://www.connecticutmedicare.com>

Centers for Medicare & Medicaid

Services

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

**BENEFICIARIES**

Centers for Medicare & Medicaid

Services

<http://www.medicare.gov>

**Florida Medicare Part B Mail Directory****CLAIMS SUBMISSIONS****Routine Paper Claims**

Medicare Part B  
P. O. Box 2525  
Jacksonville, FL 32231-0019

**Participating Providers**

Medicare Part B Participating Providers  
P. O. Box 44117  
Jacksonville, FL 32231-4117

**Chiropractic Claims**

Medicare Part B Chiropractic Unit  
P. O. Box 44067  
Jacksonville, FL 32231-4067

**Ambulance Claims**

Medicare Part B Ambulance Dept.  
P. O. Box 44099  
Jacksonville, FL 32231-4099

**Medicare Secondary Payer**

Medicare Part B Secondary Payer Dept.  
P. O. Box 44078  
Jacksonville, FL 32231-4078

**ESRD Claims**

Medicare Part B ESRD Claims  
P. O. Box 45236  
Jacksonville, FL 32232-5236

**COMMUNICATIONS****Redetermination Requests**

Medicare Part B Claims Review  
P.O. Box 2360  
Jacksonville, FL 32231-2100

**Fair Hearing Requests**

Medicare Hearings  
Post Office Box 45156  
Jacksonville FL 32232-5156

**Administrative Law Judge Hearing**

Q2 Administrators, LLC  
Part B QIC South Operations  
P.O. Box 183092  
Columbus, Ohio 43218-3092  
Attn: Administration Manager

**Status/General Inquiries**

Medicare Part B Correspondence  
P. O. Box 2360  
Jacksonville, FL 32231-0018

**Overpayments**

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

**DURABLE MEDICAL EQUIPMENT (DME)****DME, Orthotic or Prosthetic Claims**

Palmetto GBA Medicare  
DMERC Operations  
P. O. Box 100141  
Columbia, SC 29202-3141

**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 Registration  
P. O. Box 44021  
Jacksonville, FL 32231-4021

**Provider Change of Address:**

Medicare Registration  
P. O. Box 44021  
Jacksonville, FL 32231-4021  
*and*

Provider Registration 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**

Palmetto GBA Medicare  
1-866-270-4909

**MEDICARE PART A****Toll-Free:**

1-866-270-4909

**Medicare Websites****PROVIDERS****Florida Medicare Contractor**

[www.floridamedicare.com](http://www.floridamedicare.com)

**Centers for Medicare & Medicaid Services**

[www.cms.hhs.gov](http://www.cms.hhs.gov)

**BENEFICIARIES****Centers for Medicare & Medicaid Services**

[www.medicare.gov](http://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
	<p><b>Medicare B Update! Subscription</b> – The <i>Medicare B Update!</i> is available free of charge on line at <a href="http://www.connecticutmedicare.com">http://www.connecticutmedicare.com</a> and <a href="http://www.floridamedicare.com">http://www.floridamedicare.com</a>. 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.</p> <p><b>Beginning with publications issued after June 1, 2003</b>, providers who meet the above criteria must register to receive the <i>Update!</i> 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).</p>	700395	<p>\$85.00 (Hardcopy)</p> <p>\$20.00 (CD-ROM)</p>
	<p><b>2007 Fee Schedule</b> – 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 <a href="http://www.connecticutmedicare.com">http://www.connecticutmedicare.com</a> and <a href="http://www.floridamedicare.com">http://www.floridamedicare.com</a>. 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 <i>Medicare B Update!</i> Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.</p>	700400	<p>Hardcopy: \$5.00 (CT) \$10.00 (FL)</p> <p>CD-ROM: \$6.00 (Specify CT or FL)</p>

**Please write legibly**

Subtotal \$ \_\_\_\_\_  
 Tax (add % for your area) \$ \_\_\_\_\_  
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**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: \_\_\_\_\_

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**(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)**  
**ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT**



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***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 \***

