Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue…

Features

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

Routing Suggestions:

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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:

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

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

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

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

Who Receives the *Update?*

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

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

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

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

Advance Beneficiary Notices

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

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

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

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

Patient Liability Notice

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

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

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

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

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

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

Connecticut
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

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.

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 claim 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 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 Change Request 5568

- Change request (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) 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.
- Providers submitting the Form CMS-1500 (12-90) are only required to submit their legacy provider number on that form, since the 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 site.

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 1-866-419-9455 (CT).

MLN Matters Number: MM5568
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

Important Notice Regarding the Revised Form CMS-1500

In July 2006, the National Uniform Claim Committee (NUCC) revised the Form CMS-1500 (12-90), predominantly for the purpose of accommodating the national provider identifier. Since that time, the industry has been preparing for the implementation of the revised Form CMS-1500 (08-05). In September 2006, Medicare announced that it would implement the revised Form CMS-1500 (08-05) on January 1, 2007, with dual acceptability of both versions until March 31, 2007. Medicare further announced that beginning April 1, 2007, the only acceptable version of the form would be the Form CMS-1500 (08-05) and that the prior version, Form CMS-1500 (12-90), would be rejected.

It has recently come to the Centers for Medicare & Medicaid Services (CMS) attention that there are incorrectly formatted versions of the revised form being sold by print vendors, specifically the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized form designer were improperly formatted. This resulted in the sale of both printed forms and negatives that do not comply with the form specifications.

Given the circumstances, **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. Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, CMS is 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 you, CMS is able to make you aware of the situation, which will allow you to begin communications with your form supplier.

The following will help you to properly identify which form is which:

- The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form (typically on the lower right corner) signifying the version is the December 1990 version.
- The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form signifying the version is the August 2005 version.

The best way to identify if your CMS-1500 (08-05) version forms are correct is by looking at the upper right hand corner of the form. On properly formatted claim forms, there will be approximately a ¼" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications.

Source: Provider Education Resources Listserv, Message 200703-08

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

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

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 national provider identifier (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 is 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 Form 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 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.pd* ; 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*; and
- 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 claim instructions are being updated to reflect the appropriate items in which the NPI will be reported.

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

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.
- To use the appropriate remittance advice remark codes provided in the *Medicare Claims Processing Manual*, Chapter One, (Pub. 100-04), Chapter One, 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 1-866-419-9455 (CT).

MLN Matters Number: MM5391
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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April 2007 Quarterly Update to Correct Coding Initiative Edits—Version 13.1

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).

What You Need to Know

Change request (CR) 5492, from which this article is taken, gives your carriers and A/B MACs the latest package of Correct Coding Initiative (CCI) edits. These edits (version 13.1), which include all previous versions and updates from January 1, 1996, will be effective on April 1, 2007.

Background

This article and related CR 5492 provide a reminder for physicians to take note of the latest quarterly CCI updates. This package of CCI edits, version 13.1, effective April 1, 2007, will be available via the CMS Data Center (CDC) at the website shown below.

The CMS National CCI helps promote national correct coding methodologies and helps control improper coding. The policies are based on coding conventions defined in the *American Medical Association'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 13.1, is effective on April 1, 2007. This version will include all previous versions and updates from January 1, 1996, to the present; and will be organized in two tables: 1) Column 1/Column 2 Correct Coding Edits table; and 2) Mutually Exclusive Code (MEC) Edits table.

Additional Information

You may find the official instruction, CR 5492, issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1201CP.pdf* on the CMS website. The CCI and Mutually Exclusive Code (MEC) file formats will be maintained in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 20.9, which may be found at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website. You may see the current CCI and MEC edits at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/* 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 1-866-419-9455 (CT).

MLN Matters Number: MM5492
Related Change Request (CR) #: 5492
Related CR Release Date: March 9, 2007
Effective Date: April 1, 2007
Related CR Transmittal #: R1201CP
Implementation Date: April 2, 2007

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AMBULANCE SERVICES

Medical Conditions List for Ambulance Services

The medical conditions list is intended primarily as an educational guideline. It will help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list information does not guarantee payment of the claim or payment for a certain level of service. Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, and miles traveled, all of which must be available in the event the claim is selected for medical review (MR) by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage. The Healthcare Common Procedure Coding System (HCPCS) code or the medical conditions list information by themselves are not sufficient to justify coverage. All current Medicare ambulance policies remain in place.

CMS issued the medical conditions list as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. While the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are not precluded from use on ambulance claims, they are currently not required (per Health Insurance Portability and Accountability Act [HIPAA]) on most ambulance claims, and these codes generally do not trigger a payment or a denial of a claim. Some carriers and fiscal intermediaries have local coverage determinations (LCD) in place that cite ICD-9-CM codes that can be added to the claim to assist in documenting that the services are reasonable and necessary, but this is not common.

Since ICD-9-CM codes are not required and are not consistently used, not all carriers or fiscal intermediaries edit on this field, and it is not possible to edit on the narrative field. The ICD-9-CM codes are generally not part of the edit process, although the medical conditions list is available for those who do find it helpful in justifying that services are reasonable and necessary.

The medical conditions list is set up with an initial column of primary ICD-9-CM codes, followed by an alternative column of ICD-9-CM codes. The primary ICD-9-CM code column contains general ICD-9-CM codes that fit the transport conditions as described in the subsequent columns. Ambulance crew or billing staff with limited knowledge of ICD-9-CM coding would be expected to choose the one or one of the two ICD-9-CM codes listed in this column to describe the appropriate ambulance transport and then place the ICD-9-CM code in the space on the claim form designated for an ICD-9-CM code. The option to include other information in the narrative field always exists and may be used whenever an ambulance provider or supplier believes that the information may be useful for claim processing purposes. If an ambulance crew or billing staff member has more comprehensive clinical knowledge, then that person may select an ICD-9-CM code from the alternative ICD-9-CM code column. These ICD-9-CM codes are more specific and detailed. An ICD-9-CM code does not need to be selected from both the primary column and the alternative column. However, in several instances in the alternative ICD-9-CM code column, there is a selection of codes and the word "PLUS." In these instances, the ambulance provider or supplier would select an ICD-9-CM code from the first part of the alternative listing (before the word "PLUS") and at least one other ICD-9-CM code from the second part of the alternative listing (after the word "PLUS"). The ambulance claim form does provide space for the use of multiple ICD-9-CM codes. Please see the example below: The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 [from the alternative column on the medical conditions list]). In addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 (fits the "PLUS any other code" requirement when using the alternative list for this condition [abnormal vital signs]). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other abnormal clinical findings) would work just as well. None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.

While the medical condition/ICD-9-CM code list is intended to be comprehensive, there may be unusual circumstances that warrant the need for ambulance services using ICD-9-CM codes not on this list. During the medical review process contractors may accept other relevant information from the providers or suppliers that will build the appropriate case that justifies the need for ambulance transport for a patient condition not found on the list.

Because it is critical to accurately communicate the condition of the patient during the ambulance transport, most claims will contain only the ICD-9-CM code that most closely informs the Medicare contractor why the patient required the ambulance transport. This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side. For example, if an advanced life support (ALS) ambulance responds to a condition on the medical conditions list that warrants an ALS-level response and the patient's condition on-scene also corresponds to an ALS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport. (All claims are required to have HCPCS codes on them, and may have modifiers as well.) Similarly, if a basic life support (BLS) ambulance responds to a condition on the medical condition list that warrants a BLS-level response and the patient's condition on-scene also corresponds to a BLS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport.

When a request for service is received by ambulance dispatch personnel for a condition that necessitates the skilled assessment of an advanced life support paramedic based upon the medical conditions list, an ALS-level

Medical Conditions List for Ambulance Services, continued

ambulance would be appropriately sent to the scene. If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the on-scene condition of the patient. Because in this example, this code corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level. In these cases, when MR is performed, the Medicare contractor will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

Contractors may have (or may develop) individual local policies that indicate that some codes are not appropriate for payment in some circumstances. These continue to remain in effect.

Information on appropriate use of transportation indicators

When a claim is submitted for payment, an ICD-9-CM code from the medical conditions list that best describes the patient's condition and the medical necessity for the transport may be chosen.

In addition to this code, one of the transportation indicators below may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim.

Air and Ground Transportation

Indicator "C1" – indicates an interfacility transport (to a higher level of care) determined necessary by the originating facility based upon EMTALA regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or nonemergency category on the list.

Indicator "C2" – indicates a patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or nonemergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.

Indicator "C3" – may be included on claims as a secondary code where a response was made to a major incident or mechanism of injury. All such responses – regardless of the type of patient or patients found once on-scene – are appropriately advanced level service responses. A code that describes the patient's condition found on-scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified. Some examples of these types of responses would include patient(s) trapped in machinery, explosions, a building fire with persons reported inside, major incidents involving aircraft, buses, subways, trains, watercraft and victims entrapped in vehicles.

Transportation Indicator "C4" – indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appear to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.

Ground Only Transportation

Indicator "C5" – added for situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter for any number of reasons, but the ambulance service is informing you that although the patient transported had an ALS-level condition, the actual service rendered was through a BLS-level ambulance in a situation where an ALS-level ambulance was not available.

For example, a BLS ambulance is dispatched at the emergency level to pick up a 76-year old beneficiary who has undergone cataract surgery at the eye surgery center. The patient is weak and dizzy with a history of high blood pressure, myocardial infarction, and insulin-dependent diabetes mellitus. Therefore, the on-scene ICD-9-CM equivalent of the medical condition is 780.02 (unconscious, fainting, syncope, near syncope, weakness, or dizziness – ALS Emergency). In this case, the ICD-9-CM code 780.02 would be entered on the ambulance claim form as well as transportation indicator C5 to provide the further information that the BLS ambulance transported a patient with an ALS-level condition, but there was no intervention by an ALS service. This claim would be paid at the BLS level.

Indicator "C6" – added for situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. If once on-scene, the crew determines that the patient requiring transport has a BLS-level condition, this transportation indicator should be included on the claim to indicate why the ALS-level response was indicated based upon the information obtained in the operation's dispatch center. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.

Indicator C7 – used for those circumstances where IV medications were required en route. C7 is appropriately used for patients requiring ALS level transport in a nonemergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., normal saline, lactate ringers, 5 percent dextrose in water, etc.).

The patient's condition should also be reported on the claim with a code selected from the list.

Medical Conditions List for Ambulance Services, continued

Air Transporation Only

All "transportation indicators" imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.

D1 Long Distance – patient's condition requires rapid transportation over a long distance.

D2 Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.

D3 Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits to the patient.

D4 Pick up point not accessible by ground transportation.

Ambulance Services - Medical Conditions List

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
	Emergency Conditions - Non-Traumatic					
535.50	458.9, 780.2, 787.01, 787.02, 787.03, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60 through 789.69, or 789.40 through 789.49 PLUS any other code from 780 through 799 except 793, 794, and 795.	Severe abdominal pain	With other signs or symptoms	ALS	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	A0427/A0433
789.00	726.2, 789.01, 789.02, 789.03, 789.04, 789.05, 789.06, 789.07, or 789.09.	Abdominal pain	Without other signs or symptoms	BLS		A0429
427.9	426.0, 426.3, 426.4, 426.6, 426.11, 426.13, 426.50, 426.53, 427.0, 427.1, 427.2, 427.31, 427.32, 427.41, 427.42, 427.5, 427.60, 427.61, 427.69, 427.81, 427.89, 785.0, 785.50, 785.51, 785.52, or 785.59.	Abnormal cardiac rhythm/cardiac dysrythmia.	Potentially life-threatening	ALS	Bradycardia, junctional and ventricular blocks,non-sinus tachycardias, PVC's >6, bi and trigeminy, ventricular tachycardia , ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED fired	A0427/A0433
780.8	782.5 or 782.6	Abnormal skin signs		ALS	Diaphorhesis, cyanosis, delayed cap refill, poor turgor, mottled.	A0427/A0433
796.4	458.9, 780.6, 785.9, 796.2, or 796.3 PLUS any other code from 780 through 799.	Abnormal vital signs (includes abnormal pulse oximetry).	With or without symptoms.	ALS		A0427/A0433

Medical Conditions List for Ambulance Services, continued

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
995.0	995.1, 995.2, 995.3, 995.4, 995.60, 995.61, 995.62, 995.63, 995.64, 995.65, 995.66, 995.67, 995.68, 995.69 or 995.7.	Allergic reaction	Potentially life-threatening	ALS	Other emergency conditions, rapid progression of symptoms, prior hx of anaphylaxis, wheezing, difficulty swallowing.	A0427/A0433
692.9	692.0, 692.1, 692.2, 692.3, 692.4, 692.5, 692.6, 692.70, 692.71, 692.72, 692.73, 692.74, 692.75, 692.76, 692.77, 692.79, 692.81, 692.82, 692.83, 692.89, 692.9, 693.0, 693.1, 693.8, 693.9, 695.9, 698.9, 708.9, 782.1.	Allergic reaction	Other	BLS	Hives, itching, rash, slow onset, local swelling, redness, erythema.	A0429
790.21	790.22, 250.02, or 250.03.	Blood glucose	Abnormal <80 or >250, with symptoms.	ALS	Altered mental status, vomiting, signs of dehydration.	A0427/A0433
799.1	786.02, 786.03, 786.04, or 786.09.	Respiratory arrest		ALS	Apnea, hypoventilation requiring ventilatory assistance and airway management.	A0427/A0433
786.05		Difficulty breathing		ALS		A0427/A0433
427.5		Cardiac arrest—Resuscitation in progress		ALS		A0427/A0433
786.50	786.51, 786.52, or 786.59.	Chest pain (non-traumatic)		ALS	Dull, severe, crushing, substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC.	A0427/A0433
784.99	933.0 or 933.1.	Choking episode	Airway obstructed or partially obstructed	ALS		A0427/A0433
991.6		Cold exposure	Potentially life or limb threatening	ALS	Temperature< 95F, deep frostbite, other emergency conditions.	A0427/A0433

Medical Conditions List for Ambulance Services, continued

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
991.9	991.0, 991.1, 991.2, 991.3, or 991.4.	Cold exposure	With symptoms	BLS	Shivering, superficial frostbite, and other emergency conditions.	A0429
780.97	780.02, 780.03, or 780.09.	Altered level of consciousness (non-traumatic)		ALS	Acute condition with Glascow Coma Scale<15.	A0427/A0433
780.39	345.00, 345.01, 345.2, 345.3, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.80, 345.81, 345.90, 345.91, or 780.31.	Convulsions, seizures	Seizing, immediate post-seizure, postictal, or at risk of seizure & requires medical monitoring/observation.	ALS		A0427/A0433
379.90	368.11, 368.12, or 379.91.	Eye symptoms, non-traumatic	Acute vision loss and/or severe pain	BLS		A0429
437.9	784.0 PLUS 781.0, 781.1, 781.2, 781.3, 781.4, or 781.8	Non traumatic headache	With neurologic distress conditions or sudden severe onset	ALS		A0427/A0433
785.1		Cardiac symptoms other than chest pain.	Palpitations, skipped beats	ALS		A0427/A0433
536.2	787.01, 787.02, 787.03, 780.79, 786.8, or 786.52.	Cardiac symptoms other than chest pain.	Atypical pain or other symptoms	ALS	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions.	A0427/A0433
992.5	992.0, 992.1, 992.3, 992.4, or 992.5.	Heat Exposure	Potentially life-threatening	ALS	Hot and dry skin, Temp>105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions.	A0427/A0433
992.2	992.6, 992.7, 992.8, or 992.9.	Heat exposure	With symptoms	BLS	Muscle cramps, profuse sweating, fatigue.	A0429
459.0	569.3, 578.0, 578.1, 578.9, 596.7, 596.8, 623.8, 626.9, 637.1, 634.1, 666.00, 666.02, 666.04, 666.10, 666.12, 666.14, 666.20, 666.22, 666.24, 674.30, 674.32, 674.34, 786.3, 784.7, or 998.11.	Hemorrhage	Severe (quantity) and potentially life threatening	ALS	Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis, hemoptysis, epistaxis, active postsurgical bleeding.	A0427/A0433

Medical Conditions List for Ambulance Services, continued

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
038.9	136.9, any other condition in the 001 through 139 code range which would require isolation.	Infectious diseases requiring isolation procedures / public health risk.		BLS		A0429
987.9	981, 982.0, 982.1, 982.2, 982.3, 982.4, 982.8, 983.0, 983.1, 983.2, 983.9, 984.0, 984.1, 984.8, 984.9, 985.0, 985.1, 985.2, 985.3, 985.4, 985.5, 985.6, 985.8, 985.9, 986, 987.0, 987.1, 987.2, 987.3, 987.4, 987.5, 987.6, 987.7, 987.8, 989.1, 989.2, 989.3, 989.4, 989.6, 989.7,989.9, or 990.	Hazmat exposure		ALS	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation.	A0427/A0433
996.00	996.01, 996.02, 996.04, 996.09, 996.1, or 996.2.	Medical device failure	Life or limb threatening malfunction, failure, or complication.	ALS	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device.	A0427/A0433
996.30	996.31, 996.40, 996.41, 996.42, 996.43, 996.44, 996.45, 996.46, 996.47, 996.49, or 996.59.	Medical device failure	Health maintenance device failures that cannot be resolved on location.	BLS	Oxygen system supply malfunction, orthopedic device failure.	A0429
436	291.3, 293.82, 298.9, 344.9, 368.16, 369.9, 780.09, 780.4, 781.0, 781.2, 781.94, 781.99, 782.0, 784.3, 784.5, or 787.2.	Neurologic distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait/ balance; slurred speech, unable to speak	ALS		A0427/A0433
780.96		Pain, severe not otherwise specified in this list.	Acute onset, unable to ambulate or sit due to intensity of pain.	ALS	Pain is the reason for the transport. Use severity scale (7–10 for severe pain) or patient receiving pharmalogic intervention	A0427/A0433

Medical Conditions List for Ambulance Services, continued

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
724.5	724.2 or 785.9.	Back pain—non-traumatic (T and/or LS).	Suspect cardiac or vascular etiology	ALS	Other emergency conditions, absence of or decreased leg pulses, pulsatile abdominal mass, severe tearing abdominal pain.	A0427/A0433
724.9	724.2, 724.5, 847.1, or 847.2.	Back pain—non-traumatic (T and/or LS).	Sudden onset of new neurologic symptoms	ALS	Neurologic distress list.	A0427/A0433
977.9	Any code from 960 through 979.	Poisons, ingested, injected, inhaled, absorbed.	Adverse drug reaction, poison exposure by inhalation, injection or absorption.	ALS		A0427/A0433
305.0	303.00, 303.01, 303.02, 303.03, or any code from 960 through 979.	Alcohol intoxication or drug overdose (suspected).	Unable to care for self and unable to ambulate. No airway compromise.	BLS		A0429
977.3		Severe alcohol intoxication.	Airway may or may not be at risk. Pharmacological intervention or cardiac monitoring may be needed. Decreased level of consciousness resulting or potentially resulting in airway compromise.	ALS		A0427/A0433
998.9	674.10, 674.12, 674.14, 674.20, 674.22, 674.24, 997.69, 998.31, 998.32, or 998.83.	Post—operative procedure complications.	Major wound dehiscence, evisceration, or requires special handling for transport.	BLS	Non-life threatening.	A0429
650	Any code from 660 through 669 or from 630 through 767.	Pregnancy complication/ Childbirth/Labor		ALS		A0427/A0433
292.9	291.0, 291.3, 291.81, 292.0, 292.81, 292.82, 292.83, 292.84, or 292.89.	Psychiatric/Behavioral	Abnormal mental status; drug withdrawal.	ALS	Disoriented, DT's, withdrawal symptoms	A0427/A0433
298.9	300.9	Psychiatric/Behavioral	Threat to self or others, acute episode or exacerbation of paranoia, or disruptive behavior	BLS	Suicidal, homicidal, or violent.	A0429
036.9	780.6 PLUS either 784.0 or 723.5.	Sick Person - Fever	Fever with associated symptoms (headache, stiff neck, etc.). Neurological changes.	BLS	Suspected spinal meningitis.	A0429

Medical Conditions List for Ambulance Services, continued

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
787.01	787.02, 787.03, or 787.91.	Severe dehydration	Nausea and vomiting, diarrhea, severe and incapacitating resulting in severe side effects of dehydration.	ALS		A0427/A0433
780.02	780.2 or 780.4	Unconscious, fainting, syncope, near syncope, weakness, or dizziness.	Transient unconscious episode or found unconscious. Acute episode or exacerbation.	ALS		A0427/A0433
Emergency Conditions—Trauma						
959.8	800.00 through 804.99, 807.4, 807.6, 808.8, 808.9, 812.00 through 812.59, 813.00 through 813.93, 813.93, 820.00 through 821.39, 823.00 through 823.92, 851.00 through 866.13, 870.0 through 879.9, 880.00 through 887.7, or 890.0 through 897.7.	Major trauma	As defined by ACS Field Triage Decision Scheme. Trauma with one of the following: Glascow <14; systolic BP<90; RR<10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; 2 or more long bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls >20'', 20'' deformity in vehicle or 12'' deformity of patient compartment, auto pedestrian/ bike, pedestrian thrown/run over, motorcycle accident at speeds >20 mph and rider separated from vehicle.	ALS	See "Condition Specific" Column	A0427/A0433
518.5		Other trauma	Need to monitor or maintain airway	ALS	Decreased LOC, bleeding into airway, trauma to head, face or neck.	A0427/A0433

Medical Conditions List for Ambulance Services, continued

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
958.2	870.0 through 879.9, 880.00 through 887.7, 890.0 through 897.7, or 900.00 through 904.9	Other trauma	Major bleeding	ALS	Uncontrolled or significant bleeding.	A0427/A0433
829.0	805.00, 810.00 through 819.1, or 820.00 through 829.1.	Other trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport.	BLS	Spinal, long bones, and joints including shoulder elbow, wrist, hip, knee, and ankle, deformity of bone or joint.	A0429
880.00	880.00 through 887.7 or 890.0 through 897.7.	Other trauma	Penetrating extremity injuries	BLS	Isolated with bleeding stopped and good CSM.	A0429
886.0 or 895.0	886.1 or 895.1.	Other trauma	Amputation—digits	BLS		A0429
887.4 or 897.4	887.0, 887.1, 887.2, 887.3, 887.6, 887.7, 897.0, 897.1, 897.2, 897.3, 897.5, 897.6, or 897.7.	Other trauma	Amputation—all other	ALS		A0427/A0433
869.0 or 869.1	511.8, 512.8, 860.2, 860.3, 860.4, 860.5, 873.8, 873.9, or 959.01.	Other trauma	Suspected internal, head, chest, or abdominal injuries.	ALS	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration.	A0427/A0433
949.3	941.30 through 941.39, 942.30 through 942.39, 943.30 through 943.39, 944.30 through 944.38, 945.30 through 945.39, or 949.3.	Burns	Major—per American Burn Association (ABA)	ALS	Partial thickness burns > 10% total body surface area (TBSA); involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical; chemical; inhalation; burns with preexisting medical disorders; burns and trauma	A0427/A0433

Medical Conditions List for Ambulance Services, continued

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
949.2	941.20 through 941.29, 942.20 through 942.29, 943.20 through 943.29, 944.20 through 944.28, 945.20 through 945.29, or 949.2.	Burns	Minor—per ABA	BLS	Other burns than listed above.	A0429
989.5		Animal bites, stings, envenomation	Potentially life or limb-threatening	ALS	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other emergency conditions.	A0427/A0433
879.8	Any code from 870.0 through 897.7.	Animal bites/sting/envenomation	Other	BLS	Local pain and swelling or special handling considerations (not related to obesity) and patient monitoring required.	A0429
994.0		Lightning		ALS		A0427/A0433
994.8		Electrocution		ALS		A0427/A0433
994.1		Near Drowning	Airway compromised during near drowning event.	ALS		A0427/A0433
921.9	870.0 through 870.9, 871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, or 921.0 through 921.9.	Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations.	BLS		A0429
995.83	995.53 or V71.5 PLUS any code from 925.1 through 929.9, 930.0 through 939.9, 958.0 through 958.8, or 959.01 through 959.9.	Sexual assault	With major injuries	ALS	Reference codes 959.8, 958.2, 869.0/869.1	A0427/A0433

Medical Conditions List for Ambulance Services, continued

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition (General)	Condition (Specific)	Service Level	Comments/ Examples	HCPCS Crosswalk
995.80	995.53 or V71.5 PLUS any code from 910.0 through 919.9, 920 through 924.9, or 959.01 through 959.9.	Sexual assault	With minor or no injuries	BLS		A0429

Non-Emergency

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition	Service Level	Comments/ Examples	HCPCS Crosswalk
428.9		Cardiac/hemodynamic monitoring required en route.	ALS	Expectation monitoring is needed before and after transport.	A0426
518.81 or 518.89	V46.11 or V46.12.	Advanced airway management.	ALS	Ventilator dependent, apnea monitor, possible intubation needed, deep suctioning.	A0426, A0434
293.0		Chemical restraint.	ALS		A0426
496	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Suctioning required en route, need for titrated O_2 therapy or IV fluid management.	BLS	Per transfer instructions.	A0428
786.09		Airway control/positioning required en route.	BLS	Per transfer instructions.	A0428
492.8	491.20, 491.21, 492.0 through 492.8, 493.20, 493.21, 493.22, 494.0, or 494.1.	Third party assistance/attendant required applying, administering, or regulating or adjusting oxygen en route.	BLS	Does not apply to patient capable of self-administration of portable or home O2. Patient must require oxygen therapy and be so frail as to require assistance.	A0428
298.9	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient safety: Danger to self or others - in restraints.	BLS	Refer to definition in 42 C.F.R Sec. 482.13(e).	A0428
293.1		Patient Safety: Danger to self or others monitoring.	BLS	Behavioral or cognitive risk such that patient requires monitoring for safety.	A0428

Medical Conditions List for Ambulance Services, continued

ICD9 Primary Code	ICD9 Alternative Specific Code	Condition	Service Level	Comments/ Examples	HCPCS Crosswalk
298.8	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Danger to self or others seclusion (flight risk).	BLS	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely. Refer to 42 C.F.R. Sec. 482.13(f)(2) for definition	A0428
781.3	Add 295.0 through 295.9 with 5th digits of 0, 1, 3, or 4, 296.00 or 299.90.	Patient Safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity).	BLS	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints. Indirect indicators include MDS criteria.	A0428
041.9		Special handling en route - isolation.	BLS	Includes patients with communicable diseases or hazardous material exposure who must be isolated from public or whose medical condition must be protected from public exposure; surgical drainage complications.	A0428
907.2		Special handling en route to reduce pain - orthopedic device.	BLS	Backboard, halotraction, use of pins and traction, etc. Pain may be present.	A0428
719.45 or 719.49	718.40, 718.45, 718.49, or 907.2.	Special handling en route – positioning requires specialized handling.	BLS	Requires special handling to avoid further injury (such as with >grade 2 decubiti on buttocks). Generally does not apply to shorter transfers of <1 hour. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures — post-op hip as an example	A0428

Transportation Indicators

Indicator	Category	Indicator Description		Service Level	Comments/ Examples	HCPCS Crosswalk
C1	Interfacility Transport	EMTALA-certified inter-facility transfer to a higher level of care.	Beneficiary requires higher level of care.	BLS, ALS, SCT, FW, RW	Excludes patient requested EMTALA transfer	A0428, A0429, A0426, A0427, A0433, A0434
C2	Interfacility Transport	Service not available at originating facility, and must meet one or more emergency or non-emergency conditions.		BLS, ALS, SCT, FW, RW		A0428, A0429, A0426, A0427, A0433, A0434

Medical Conditions List for Ambulance Services, continued

Indicator	Category	Indicator Description		Service Level	Comments/ Examples	HCPCS Crosswalk
C3	Emergency Trauma Dispatch Condition Code	Major Incident or Mechanism of Injury	Major Incident-This transportation indicator is to be used ONLY as a secondary code when the on-scene encounter is a BLS-level patient.	ALS	Trapped in machinery, close proximity to explosion, building fire with persons reported inside, major incident involving aircraft, bus, subway, metro, train and watercraft. Victim entrapped in vehicle.	A0427/A0433
C4	Medically necessary transport but not to the nearest facility.	BLS or ALS Response	Indicates to Carrier/Intermediary that an ambulance provided a medically necessary transport, but that the number of miles on the Medicare claim form may be excessive.	BLS/ ALS	This should occur if the facility is on divert status or the particular service is not available at the time of transport only. In these instances the ambulance units should clearly document why the beneficiary was not transported to the nearest facility.	Based on transport level.
C5	BLS Transport of ALS level Patient	ALS-Level Condition treated and transport by a BLS-level ambulance	This transportation indicator is used for ALL situations where a BLS-level ambulance treats and transports a patient that presents an ALS-level condition. No ALS-level assessment or intervention occurs at all during the patient encounter.	BLS		A0429
C6	ALS-level Response to BLS-level Patient	ALS Response Required based upon appropriate Dispatch Protocols - BLS-level patient transport	Indicates to Carrier/Intermediary that an ALS-level ambulance responded appropriately based upon the information received at the time the call was received in dispatch and after a clinically appropriate ALS-assessment was performed on scene, it was determined that the condition of the patient was at a BLS level. These claims, properly documented, should be reimbursed at an ALS-1 level based upon coverage guidelines under the Medicare ambulance fee schedule.	ALS		A0427

Medical Conditions List for Ambulance Services, continued

Indicator	Category	Indicator Description		Service Level	Comments/ Examples	HCPCS Crosswalk
C7		IV meds required en route.	This transportation indicator is used for patients that require an ALS level transport in a nonemergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., Normal Saline, Lactate Ringers, 5% Dextrose in Water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.	ALS	Does not apply to self-administered IV medications.	A0426

Air Ambulance Transportation Indicators

Indicator	Indicator Description	Service Level	Comments/ Examples	HCPCS Crosswalk
D1	Long Distance-patient's condition requires rapid transportation over a long distance	FW, RW	If the patient's condition warrants only.	A0430, A0431
D2	Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.	FW, RW		A0430, A0431
D3	Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of-hospital time to maximize clinical benefits for the patient.	FW, RW		A0430, A0431
D4	Pick-up point not accessible by ground ambulance	FW, RW		A0430, A0431

Note: HCPCS Crosswalk to ALS1E (A0427) and ALS2 (A0433) would ultimately be determined by the number and type of ALS level services provided during transport. All medical condition codes may be cross walked to fixed wing and rotor wing HCPCS codes provided the air ambulance service has documented the medical necessity for air ambulance service versus ground or water ambulance. As a result, codes A0430 (fixed wing) and A0431 (rotor wing) may be included in Column 7 for each condition listed.

Source: Publication 100-04, Transmittal 1185, Change Request 5442

Adjustment to the Rural Mileage Payment Rate for Ground Ambulance Services—Reminder

The ambulance fee schedule (AFS) payment includes a rural adjustment to take into consideration the regional and operational variances in the cost of providing services in different areas of the country. Effective for dates of service on or after July 1, 2004, the first 17 rural ground miles are priced at 150 percent of the rural mileage rate as reflected in the AFS. Miles 18-50 will be allowed at the standard rural ground mileage rate. Additionally, miles 51 and greater will receive a 25 percent increase to the standard mileage rate for dates of service on or after July 1, 2004 – December 31, 2008. The AFS is available for download at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp#TopOfPage.*

For the purpose of all categories of ground ambulance services (except paramedic intercept), a rural area is defined as a U.S. Postal Service ZIP code that is located, in whole or in part, outside of either a metropolitan statistical area (MSA) or a New England metropolitan area (NECMA), or is an area wholly within an MSA or NECMA that has been identified as rural under the "Goldsmith modification."

The Goldsmith modification establishes an operational definition of rural area within the large countries that contain one or more metropolitan areas. The Goldsmith areas are so isolated by distance or physical features that they are more rural than urban in character and lack easy geographic access to health services.

For a list of rural ZIP codes visit the following website: *http://www.cms.hhs.gov/AmbulanceFeeSchedule/*

Source: CMS Publication 100-04, Chapter 15, Section 10.3

DRUGS AND BIOLOGICALS

April 2007 Quarterly Average Sale Price Medicare Part B Drug Pricing File and Revisions to the January 2007

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5517, which informs Medicare contractors to download the April 2007 average sales price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 ASP files.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303[c]) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the outpatient prospective payment system (OPPS), will be paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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

ASP Methodology

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

Beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for the following:

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

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood-clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the ambulatory payment classification (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. The payment allowance limits will not be updated in 2007. Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded.
- Payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs that are not included in the ASP Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration [FDA]) are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the Medicare contractors follow the methodology

April 2007 Quarterly Average Sale Price Medicare Part B Drug Pricing File and Revisions to the January 2007, continued

specified in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 17, Drugs and Biologicals) for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood-clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file.

- The payment allowance limits for new drugs that are produced or distributed under a new drug application approved by the FDA and that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on 106 percent of the WAC or invoice pricing, if the WAC is not published. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after March 19, 2007, the revised January 2007 and April 2007 ASP files and ASP NOC files will be available for retrieval from the CMS ASP Web page, and the payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP Web page is located at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/* on the CMS site. The revised files are applicable to claims based on dates of service as shown below:

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

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

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

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

Additional Information

For complete details, please see the official instruction issued to your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1204CP.pdf* on the CMS website.

If you have any questions, please contact your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs 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 1-866-419-9455 (CT).

MLN Matters Number: MM5517
Related Change Request (CR) #: 5517
Related CR Release Date: March 16, 2007
Effective Date: April 1, 2007
Related CR Transmittal #: R1204CP
Implementation Date: April 2, 2007

DURABLE MEDICAL EQUIPMENT

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

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5537, which provides the April 2007quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure billing staff are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), chapter 23, section 60; *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*).

CR 5537 provides specific instructions regarding the April quarterly update for the 2007 DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834[a], [h], and [i]). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in Title 42 of the *Code of Federal Regulations* (42 CFR 414.102).

Key Changes

The following are key changes in the April 2007 quarterly update of the DMEPOS fee schedule:

L8690 and L8691

The A/B MACs,local carriers, and FIs will adjust previously processed claims for L8690 (Auditory osseointegrated device, includes all internal and external components) and L8691 (Auditory osseointegrated device, external sound processor, replacement), with dates of service on or after January 1, 2007, if you resubmit such claims as adjustments.

Code E1002 (Wheelchair accessory, Power Seating System, Tilt Only)

Code E1002 was added to the Healthcare Common Procedure Coding System (HCPCS), effective January 1, 2004. The fee schedule amounts that were calculated and implemented for this code include systems with tilts less than 45 degrees from horizontal. As described in the November 2006 Policy Article for Wheelchair Options/Accessories, power tilt seating systems (falling under code E1002) must have the ability to tilt to greater than or equal to 45 degrees from horizontal. Therefore as part of this quarterly update, the fee schedule amounts for code E1002 are being revised in order to remove pricing information for power seating systems with tilts less than 45 degrees.

The DME MACs, and DMERCs will adjust previously processed claims for code E1002 with dates of service on or after January 1, 2007, if they are resubmitted as adjustments.

Code E2377 (Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics and Mounting Hardware, Upgrade Provided at Initial Issue)

Code E2377 was added to the HCPCS effective January 1, 2007, for use in paying claims for upgraded expandable controllers and mounting hardware provided at initial issue. The fee schedule amounts for code E2377 do not include payment for the proportional joystick and electronics/cables/junction boxes necessary to upgrade from a non-expandable controller. Suppliers need to submit claims for the upgraded proportional joysticks and electronics provided at initial issue for dates of service on or after January 1, 2007, using HCPCS code E2399.

Further Changes for Power Wheelchairs

CMS is in the process of making refinements to the fee schedule amounts for several HCPCS codes for power wheelchairs to be implemented as part of the April quarterly update for the 2007 DMEPOS fee schedule. Additional instructions regarding these changes will be issued in the near future under separate cover.

Additional Information

The official instruction, CR 5537, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1203CP.pdf* on the CMS website.

If you have any questions, please contact your Medicare carrier, intermediary, RHHI, A/B MAC, DMERC, or DME 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 1-866-419-9455 (CT).

MLN Matters Number: MM5537
Related Change Request (CR) #: 5537
Related CR Release Date: March 9, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R1203CP
Implementation Date: April 2, 2007

MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

April Update to the 2007 Medicare Physician Fee Schedule Database

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

Provider Types Affected

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

Background

This article and related change request (CR) 5528 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS final rule. CR 5528 amends those payment files.

The following reflects the key changes from CR 5528:

CPT/HCPCS	ACTION
17311	Multiple Procedure Indicator – 0
17313	Multiple Procedure Indicator – 0
36478	Transitional Non-Facility PE RVU = 41.71
	Fully Implemented Non-Facility PE RVU = 26.53 (Informational Only)
37210	Transitional Non-Facility PE RVU = 79.88
	Fully Implemented Non-Facility PE RVU = 79.88 (Informational Only)
77056	Fully Implemented Non-Facility PE RVU = 1.96 (Informational Only)
	Fully Implemented Facility PE RVU = 1.96 (Informational Only)
77056 TC	Fully Implemented Non-Facility PE RVU = 1.72 (Informational Only)
	Fully Implemented Facility PE RVU = 1.72 (Informational Only)
93225	Transitional Non-Facility PE RVU = 1.14
	Fully Implemented Non-Facility PE RVU = 0.85 (Informational Only)
	Transitional Facility PE RVU = 1.14
	Fully Implemented Facility PE RVU = 0.85 (Informational Only)
93226	Transitional Non-Facility PE RVU = 1.93
	Fully Implemented Non-Facility PE RVU = 1.18 (Informational Only)
	Transitional Facility PE RVU = 1.93
	Fully Implemented Facility PE RVU = 1.18 (Informational Only)
93231	Transitional Non-Facility PE RVU = 1.32
	Fully Implemented Non-Facility PE RVU = 0.71 (Informational Only)
	Transitional Facility PE RVU = 1.32
	Fully Implemented Facility PE RVU = 0.71 (Informational Only)
93232	Transitional Non-Facility PE RVU = 1.97
	Fully Implemented Non-Facility PE RVU = 1.34 (Informational Only)
	Transitional Facility PE RVU = 1.97
	Fully Implemented Facility PE RVU = 1.34 (Informational Only)
95991	Transitional Facility PE RVU = 0.17
	Fully Implemented Facility PE RVU = 0.18 (Informational Only)

The codes in the following table are either bundled or not valid for Medicare purposes. Values for these codes have been established as a courtesy to the general public. These codes will remain bundled or not valid for Medicare purposes even though relative value units have been established.

CPT/HCPCS	ACTION
78351	Transitional Non-Facility PE RVU = 1.41
	Fully Implemented Non-Facility PE RVU = 0.47 (Informational Only)
98960	Transitional Non-Facility PE RVU = 0.57
	Fully Implemented Non-Facility PE RVU = 0.57 (Informational Only)
	Transitional Facility PE RVU = 0.57
	Fully Implemented Facility PE RVU = 0.57 (Informational Only)
98961	Transitional Non-Facility PE RVU = 0.27
	Fully Implemented Non-Facility PE RVU = 0.27 (Informational Only)
	Transitional Facility PE RVU = 0.27
	Fully Implemented Facility PE RVU = 0.27 (Informational Only)

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

CPT/HCPCS	ACTION
98962	Transitional Non-Facility PE RVU = 0.20 Fully Implemented Non-Facility PE RVU = 0.20 (Informational Only) Transitional Facility PE RVU = 0.20 Fully Implemented Facility PE RVU = 0.20 (Informational Only)

These changes are effective January 1, 2007. However, providers may wish to note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims that you bring to their attention.

Additional Information

CR 5528 is the official instruction (CR5528) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1188CP.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 1-866-419-9455 (CT).

MLN Matters Number: MM5528
Related Change Request (CR) #: 5528
Related CR Release Date: February 26, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R1188CP
Implementation Date: April 2, 2007

Connecticut Fees

Code/Mod	Participating	Nonparticipating	Limiting Charge	
36478	2,102.61	1,997.48	2,297.10	
36478	357.06	339.21	390.09	*
37210	3,942.97	3,745.82	4,307.69	
37210	534.06	507.36	583.46	*
93225	53.32	50.65	58.25	
93226	90.42	85.90	98.78	
93231	62.32	59.20	68.08	
93232	91.86	87.27	100.36	
95991	97.11	92.25	106.09	
95991	36.71	34.87	40.11	*

Florida Fees

	Participating			Nonparticipating			Limiting charge			
Code/Mod	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	Loc 01/02	Loc 03	Loc 04	
36478	1,725.98	1,817.29	1,916.79	1,639.68	1,726.43	1,820.95	1,885.63	1,985.39	2,094.09	
36478	331.93	342.81	355.93	315.33	325.67	338.13	362.63	374.52	388.85	*
37210	3,223.12	3,396.23	3,584.50	3,061.96	3,226.42	3,405.28	3,521.26	3,710.38	3,916.07	
37210	500.64	516.68	536.25	475.61	490.85	509.44	546.95	564.47	585.85	*
93225	44.23	47.85	52.05	42.02	45.46	49.45	48.32	52.28	56.86	
93226	75.10	81.30	88.50	71.35	77.24	84.08	82.05	88.82	96.69	
93231	52.04	56.51	61.73	49.44	53.68	58.64	56.85	61.74	67.44	
93232	76.04	82.16	89.24	72.24	78.05	84.78	83.07	89.76	97.49	
95991	83.27	87.36	91.99	79.11	82.99	87.39	90.97	95.44	100.50	
95991	35.02	36.34	37.98	33.27	34.52	36.08	38.26	39.70	41.49	*

* = These amounts apply when service is performed in a facility setting

PATHOLOGY/LABORATORY

Changes to the Laboratory National Coverage Determination Edit Software for April 2007

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

Provider Types Affected

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

Provider Action Needed

This article and related change request (CR) 5514 announces the changes that will be included in the April 2007 release of the edit module for clinical diagnostic laboratory national coverage determinations (NCDs). You may want to assure your billing staff is aware of these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Subsequently, the Centers for Medicare & Medicaid Services (CMS) contracted for nationally uniform software to be developed and incorporated into its claims processing systems so that laboratory claims subject to one of the 23 NCDs can be processed uniformly throughout the nation effective April 1, 2003. The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the *Medicare Claims Processing Manual* [Publication 100-04], chapter 16, section 120.2, available at *http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf* on the CMS website.)

These updating changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs, and biannual updates of the ICD-9-CM codes. In addition, many of the listed changes may correct *Current Procedural Terminology* (*CPT*) codes to reflect the current *CPT* update.

CR 5514 informs your Medicare carrier, FI, or A/B MAC about changes to the laboratory edit module and changes in laboratory NCD code lists effective for services furnished on or after April 1, 2007.

Key Point of CR 5514

Effective for dates of service on or after April 1, 2007:

- The new HCPCS code G0394 for blood occult test (e.g., guaiac), feces, for single determination for colorectal neoplasm (i.e., patient was provided three cards or single triple card for consecutive collection) is added to the list of HCPCS codes for the fecal occult lood test NCD (190.34).

Additional Information

If you have questions, please contact your Medicare carrier, FI, or A/B MAC, at their toll-free number which may be found at ht*tp://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 1-866-419-9455 (CT).

To see the official instruction (CR 5514) issued to your Medicare carrier, FI, or A/B MAC, go to *http://www.cms.hhs.gov/Transmittals/downloads/R1200CP.pdf* on the CMS website.

MLN Matters Number: MM5514
Related Change Request (CR) #: 5514
Related CR Release Date: March 9, 2007
Effective Date: April 1, 2007
Related CR Transmittal #: R1200CP
Implementation Date: April 2, 2007

New Waived Tests—Correction to CR 5404

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

Change request (CR) 5482, from which this article is taken, corrects information provided in CR 5404 (released November 24, 2006) and published in the January 2007 *Medicare B Update!* (pages 46-47)

CAUTION – What You Need to Know

CR 5404, which informed carriers and A/B MACS about new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments of 1988 (CLIA), contained an incorrect *Current Procedural Terminology* (*CPT*) code for the Gryphus Diagnostics BVBlue test. The correct code for this test is *87999QW* (Unlisted microbiology procedure).

GO – What You Need to Do

You should ensure that your billing staffs are made aware of this *CPT* code correction, and bill accordingly.

Background

CR 5404, which informed carriers and A/B MACS of new waived tests approved by the FDA under the CLIA, contained an incorrect *CPT* for the Gryphus Diagnostics BVBlue test. In both the table in the background section of the recurring update notification attachment and in the waived test list attachment, CR 5404 listed the *CPT* code for the Gryphus Diagnostics BVBlue as *CPT* Code: *87899QW*.

The *CPT* code *87899* is for infectious agent activity detection tests by immunoassay with direct optical observation; not otherwise specified. In contrast, the Gryphus Diagnostics BVBlue test is an enzyme activity test that detects sialidase activity in vaginal fluid specimens and is not an immunoassay test. The code in this table and in the waived test list attachment should have been *87999QW* (*Unlisted microbiology procedure*). See the table below for the correct codes.

Note: All the other information in CR 5404 remains the same.

Table 1

***CPT* Code/Modifier**	**Effective Date**	**Description**
82274QW G0328QW	June 15, 2006	*Immunostics, Inc., hema-screen specific* Immunochemical fecal occult blood test
87999QW	June 30, 2006	*Gryphus Diagnostics BVBlue*
83655QW	September 18, 2006	*ESA Biosciences LeadCare II Blood Lead Testing System (whole blood)*

You should remember that the CLIA regulations require a facility to be appropriately certified for each test performed, and that laboratory claims are currently edited at the CLIA certificate level.

Note: Carriers and A/B MACs will not search their files to correct affected claims processed prior to the implementation date of this change, but will adjust any claims that you bring to their attention.

Additional Information

You may find the official instruction, CR 5482, issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1197CP.pdf* on the CMS website.

The *MLN Matters* article, MM5404, related to CR5404 may be found at *http://www.cms.hhs.gov/MLNMAttersArticles/downloads/MM5404.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* 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 1-866-419-9455 (CT).

MLN Matters Number: MM5482 Related Change Request (CR) #: 5482
Related CR Release Date: March 9, 2007 Effective Date: April 1, 2007
Related CR Transmittal #: R1197CP Implementation Date: April 2, 2007

New Waived Tests

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

Provider Types Affected

Providers and suppliers who bill Medicare carriers or Medicare administrative contractors (A/B MACs) for clinical diagnostic laboratory services.

Provider Action Needed

CR 5484, from which this article is taken, notifies your carriers and A/B MACs of the new Food and Drug Administration (FDA)-approved tests (effective October 4, 2006) that are waived under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), so that they can accurately process your claims.

Background

First, remember that CLIA regulations require a laboratory facility to be appropriately certified for each test it performs. Further, to ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Some specific background about waived tests may, at this point, also be helpful. These new laboratory tests (which the FDA approves on a flow basis) are valid (and marketed) as soon as they are approved. Therefore, as soon as informed by the FDA of the test approvals, the Centers for Medicare & Medicaid Services (CMS) must immediately notify the carriers and A/B MACs so that they are ready to process claims when submitted. CR 5484, from which this article is taken, announces the latest tests approved by the FDA as waived tests under CLIA. These tests are described in the bulleted paragraph (below), and displayed in red/bold print in Table 1, that follows. Note that each of the *Current Procedural Terminology* (*CPT*) codes for these new tests must have the modifier QW to be recognized as a waived test, and that these new waived tests are effective on October 4, 2006.

New FDA Waived Tests Under CLIA

- *CPT* code, *82042QW*, has been assigned for the albumin test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- *CPT* code, *82150QW*, has been assigned for the amylase test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- *CPT* code, *82247QW*, has been assigned for the total bilirubin test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- *CPT* code, *82977QW*, has been assigned for the gamma glutamlytransferase (GGT) test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- *CPT* code, *84075QW*, has been assigned for the alkaline phosphatase test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- *CPT* code, *84157QW*, has been assigned for the total protein test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- *CPT* code, *84520QW*, has been assigned for the urea (BUN) test performed using the Arkray SPOTCHEM EZ Chemistry Analyzer.

Table 1 - Latest FDA Waived Tests Under CLIA*

CPT Code/Modifier	Effective Date	Description
84450QW and *84460QW*	August 16, 2005	Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}
87899QW	March 30, 2006	Rapid Pathogen Screening RPS Adeno Detector
86308QW	July 27, 2006	PerMaxim RediScreen Mononucleosis {Whole Blood}
82274QW, G0328QW	August 3, 2006	Enterix Insure II Fecal Immunochemical Test
82274QW, G0328QW	August 9, 2006,	Teco Rapid Fecal Occult Blood (FOB) Card Test
82274QW, G0328QW	September 22, 2006	OcculTech Fecal Occult Blood Rapid Test
82042QW, *82150QW*, *82247QW*, *82977QW*, *84075QW*, and *84157QW*	October 4, 2006	Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}
84520QW	October 4, 2006	Arkray SPOTCHEM EZ Chemistry Analyzer{whole blood} for urea (BUN)

New Waived Tests, continued

CPT Code/Modifier	Effective Date	Description
84450QW	October 5, 2006	Arkray SPOTCHEM EZ Chemistry Analyzer{whole blood} for aspirate amminotransferase (AST)(SGOT)
85018QW	October 10, 2006	HemoCue Hb 301 System
87999QW	October 16, 2006	Genzyme Diagnostics OSOM BVBlue Test
87880QW	November 1, 2006	Inverness Medical BioStar Acceava Strep A Test
80101QW	November 14, 2006	Branan Medical Corporation, QuickTox Drug Screen Dipcard
80101QW	November 14, 2006	Branan Medical Corporation, FasTox Multiple Drug Dipcard
86308QW	November 22, 2006	LifeSign Status Mono {for whole blood}

*The *Current Procedural Terminology* (*CPT*) codes for these new tests must have the modifier QW to be recognized as a waived test.

In addition, it is also important that you note that the tests displayed in Table 2, below, do **not** require a modifier QW to be recognized as a waived test.

Table 2

Waived Tests Not Requiring Modifier QW

CPT Code(S)	Test Name	Manufacturer	Use
81002	Dipstick or tablet reagent urinalysis – nonautomated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen	Various	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
81025	Urine pregnancy tests by visual color comparison	Various	Diagnosis of pregnancy
82270 *82272* G0394 (Contact your Medicare carrier for claims instructions.)	Fecal occult blood	Various	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening)
82962	Blood glucose by glucose monitoring devices cleared by the FDA for home use	Various	Monitoring of blood glucose levels
83026	Hemoglobin by copper sulfate – nonautomated	Various	Monitors hemoglobin level in blood
84830	Ovulation tests by visual color comparison for human luteinizing hormone	Various	Detection of ovulation (optimal for conception)
85013	Blood count; spun microhematocrit	Various	Screen for anemia
85651	Erythrocyte sedimentation rate – nonautomated	Various	Nonspecific screening test for inflammatory activity, increased for majority of infections, and most cases of carcinoma and leukemia

New Waived Tests, continued

Final Note: Carriers and A/B MACs do not need to search their files to either retract payment or retroactively pay affected claims processed prior to the implementation of this change; however, they will adjust claims that you bring to their attention.

Additional Information

You may find the official instruction, CR 5484, issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1195CP.pdf* on the CMS website. As an attachment to that CR, you will find the complete list of laboratory tests granted waived status under CLIA.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

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Implementation Date: April 2, 2007

PREVENTIVE SERVICES

One-time Ultrasound Screening for Abdominal Aortic Aneurysms

Aortic Aneurysms as Part of the Initial Preventive Physical Examination

The Centers for Medicare & Medicaid Services (CMS) invites you to join with us in promoting awareness of abdominal aortic aneurysms (AAA) and the new screening benefit for the early detection of this disease.

Three in four aortic aneurysms are AAAs. Aortic aneurysms account for about 15,000 deaths in the United States annually; of these 9,000 are AAA-related. Men are 5 to 10 times more likely than women to have an AAA and the risk increases with age. Although AAAs may be asymptomatic for years, as many as 1 in 3 eventually rupture if left untreated i[i] ii[ii]. Early diagnosis allows for more effective treatment and cure.

Diagnosis of an AAA can be done painlessly with a simple ultrasound scan. Medicare now provides coverage for this screening service for eligible beneficiaries.

Medicare Coverage

Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time ultrasound screening for AAA for beneficiaries who are at risk (has a family history of AAA or is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime). Eligible beneficiaries must receive a referral for the screening as a result of their initial preventive physical examination (IPPE) also referred to as the Welcome to Medicare physical exam. There is no Part B deductible. The coinsurance/copayment applies.

Important Note: Only Medicare beneficiaries who receive a referral for the AAA ultrasound screening as part of the Welcome to Medicare physical exam will be covered for the AAA benefit.

How Can You Help?

As a trusted source, your recommendation is the most important factor in increasing the use of preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their Welcome to Medicare physical exam within the first six months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the ultrasound screening as part of their Welcome to Medicare physical exam. It could save their lives!

For More Information

- For more information about Medicare's coverage of the AAA benefit, refer to *MLN Matters* article MM5235 (2006), *Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination*, located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5235.pdf* on the CMS website.
- 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.
- The *MLN* Preventive Services Educational Products Web Page provides descriptions and ordering information for all provider specific educational products related to preventive services.

One-time Ultrasound Screening for Abdominal Aortic Aneurysms, continued

The Web page is located at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* on the CMS website.

- For information to share with your Medicare patients, visit *www.medicare.gov* on the Web.
- For more information about AAA, please visit *http://www.nhlbi.nih.gov/health/dci/Diseases/arm/arm_what.html* on the Web.

Thank you for helping CMS to increase awareness of AAA disease and the new AAA preventive benefit.

i[i] **National Heart Lung and Blood Institute Diseases and Conditions Index;** *http://www.nhlbi.nih.gov/health/dci/Diseases/arm/arm_what.html*

ii[ii] **U.S. Preventive Services Task Force** ***Screening for Abdominal Aortic Aneurysm: A Best Evidence Systematic Review*** *http://www.ahrq.gov/clinic/uspstf05/aaascr/aaarev.htm*

Provider Education Resources Listserv, Message 200703-07

Coverage of a One-Time Ultrasound Screening for Abdominal Aortic Aneurysms

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for the initial preventive physical examination (IPPE) and the ultrasound screening for abdominal aortic aneurysms (AAA).

Provider Action Needed

This article conveys no new policy information. This article is for informational purposes only and serves as a reminder that Medicare provides coverage of a one-time initial preventive physical examination and a one-time preventive ultrasound screening for abdominal aortic aneurysms subject to certain coverage, frequency, and payment limitations. The Centers for Medicare & Medicaid Services (CMS) needs your help to get the word out and to encourage eligible beneficiaries to take full advantage of these benefits and all preventive services and screenings covered by Medicare.

Background

In January 2005, the Medicare program expanded the number of preventive services available to Medicare beneficiaries, as a result of Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, to include coverage under Medicare Part B of a one-time IPPE, also referred to as the "Welcome to Medicare" physical exam, for all Medicare beneficiaries whose Medicare Part B effective date began on or after January 1, 2005.

On January 1, 2007, Medicare further expanded the number of preventive benefits, as provided for in Section 5112 of the Deficit Reduction Act (DRA) of 2005, to include coverage under Medicare Part B of a one-time preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at risk beneficiaries as part of the IPPE. Both benefits (the IPPE and AAA) are subject to certain eligibility and other limitations.

The information in this special edition *MLN Matters* article reminds health care professionals that Medicare now pays for these benefits as well as a broad range of other preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their "Welcome to Medicare" physical exam within the first six months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the preventive ultrasound screening as part of their "Welcome to Medicare" physical exam.

Benefit Coverage Summary

The Initial Preventive Physical Examination ("Welcome to Medicare" Physical Exam)

Effective for dates of service on or after January 1, 2005: Medicare beneficiaries whose Medicare Part B effective date is on or after January 1, 2005, are covered for a one-time IPPE visit. The beneficiary must receive the IPPE within the first six months of their Medicare Part B effective date. The IPPE is a preventive evaluation and management (E/M) service that includes the following seven components:

1. A review of an individual's medical and social history with attention to modifiable risk factors.
2. A review of an individual's potential (risk factors) for depression.
3. A review of the individual's functional ability and level of safety.
4. An examination to include an individual's height, weight, blood pressure measurement, and visual acuity screen.
5. Performance of an electrocardiogram (EKG) and interpretation of the EKG.
6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements.
7. Education, counseling, and referral (including a brief written plan such as a checklist provided to the individual for obtaining the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits).

Important reminders about the IPPE:

1. The IPPE is a unique benefit available only for beneficiaries new to the Medicare program and must be received within the first six months of the effective date of their Medicare Part B coverage.

Coverage of a One-Time Ultrasound Screening for Abdominal Aortic Aneurysms, continued

2. This exam is a preventive physical exam and not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified nonphysician practitioner. Medicare does not provide coverage for routine physical exams.

The Part B deductible and coinsurance/copayment apply to this benefit.

Note: The deductible does not apply for an IPPE provided in a federally qualified health center (FQHC). Only the coinsurance/copayment applies.

Other preventive services and screenings covered under Medicare Part B include: Adult immunizations (flu, pneumococcal, and hepatitis B), bone mass measurements, cardiovascular screening, diabetes screening, glaucoma screening, screening mammograms, screening Pap test and pelvic exam, colorectal and prostate cancer screenings, diabetes self-management training, medical nutrition therapy for beneficiaries diagnosed with diabetes or renal disease, and smoking and tobacco-use cessation counseling. Benefits are subject to certain eligibility and other limitations.

Note: The IPPE/Welcome to Medicare physical exam does not include any clinical laboratory tests. The physician, qualified nonphysician practitioner, or hospital may also provide and bill separately for the preventive services and screenings that are currently covered and paid for by Medicare Part B. (See the Additional Information section below for links to *MLN Matters* articles MM3771 and MM3638, which provide detailed coverage criteria and billing information about the IPPE benefit.)

Preventive Ultrasound Screening for Abdominal Aortic Aneurysms

Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time preventive ultrasound screening for AAA for beneficiaries who are at risk (has a family history of AAA or is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime). Eligible beneficiaries must receive a referral for the screening as a result of their "Welcome to Medicare" physical exam. There is no Part B deductible applied to this benefit, but coinsurance/copayment applies.

Important Note: Only Medicare beneficiaries who receive a referral from their physician or other qualified nonphysician practitioner for the preventive ultrasound screening, as part of their "Welcome to Medicare" physical exam, will be covered for the AAA benefit. (See the Additional Information section below for a link to *MLN Matters* article MM5235, which provides detailed coverage criteria and billing information about the AAA benefit.)

Additional Information

For more information about Medicare's coverage criteria and billing procedures for the AAA and IPPE benefits, refer to the following *MLN Matters* articles:

- MM5235 (2006), Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination, *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5235.pdf*
- MM3771 (2005), MMA – Clarification for Outpatient Prospective Payment System (OPPS) Hospitals Billing the Initial Preventive Physical Exam (IPPE), *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3771.pdf*
- MM3638 (2004), MMA – Initial Preventive Physical Examination, *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf*

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.

- 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* on the CMS website.
- The CMS website provides information for preventive service covered by Medicare. Visit *http://www.cms.hhs.gov*, select "Medicare" and scroll down to "Prevention".

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

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Coverage and Billing for Colorectal Cancer Screening

Colorectal Cancer: Preventable, Treatable, and Beatable

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, nurse practitioners, physician assistants, clinical nurse specialists, outpatient hospital departments, and community surgical centers who furnish or provide referrals for and /or file claims for Medicare-covered colorectal cancer screening services.

Provider Action Needed

STOP – Impact to You

March is National Colorectal Cancer Awareness Month. The Centers for Medicare & Medicaid Services (CMS) would like to remind providers to encourage their eligible patients, age 50 and older, to get screened for colorectal cancer. This special edition *MLN Matters* article highlights coverage changes that became effective January 1, 2007 and reviews Medicare coverage and billing processes for colorectal cancer screening.

CAUTION – What You Need to Know

Medicare has covered colorectal cancer screening since 1998, but the benefit is underused. Claim data from 1998-2002 indicate that less than half of Medicare beneficiaries had any screening test during this five-year period, and less than one-third were tested according to recommended intervals.

GO – What You Need to Do

Be sure your staff is aware of this coverage and CMS urges physicians to encourage their patients to take advantage of this important coverage.

Background

Colorectal cancer is the second leading cause of cancer death in the U.S., and the third most common type of cancer. In 2006, colorectal cancer was expected to account for 55,170 deaths and 148,610 new cases. Colorectal cancer primarily affects men and women ages 50 and older, and risk increases with age. If detected early, colorectal cancer can be treated and cured.

In January 1998, Medicare began covering colorectal cancer screening. The data currently available (1998- 2002) indicate the Medicare colorectal cancer screening benefit is underused. Less than half of enrollees had any colorectal cancer test during the five-year period and less than one-third were tested according to recommended intervals.

The U.S. Preventive Services Task Force (USPSTF) evaluates the clinical merits of preventive measures, and strongly recommends ("A" rating) that clinicians screen men and women ages 50 and older for colorectal cancer. The choice of screening strategy should be based on patient preferences, medical contraindications, patient adherence, and resources for testing and follow-up. There are insufficient data to determine which screening strategy is best in terms of the balance of benefits and potential harms or cost-effectiveness. Studies reviewed by the USPSTF indicate that colorectal cancer screening is likely to be cost-effective (less than $30,000 per additional year of life gained) regardless of the strategy chosen. To read the full recommendation, go to the following link*: http://www.ahrq.gov/clinic/uspstf/uspscolo.htm* on the Web.

The Partnership for Prevention conducted a systematic assessment of the clinical preventive services recommended by the USPSTF to help decision-makers identify those services that provide the most value based on two criteria—burden of disease prevented and cost-effectiveness. Screening adults for colorectal cancer screening was among the services considered to be of the greatest value. To read about the ranking of clinical preventive services, go to the following link: *http://prevent.org/content/view/46/96/* on the Web.

Risk Factors

Beneficiaries are considered to be at high risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- A personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Coverage Information

Medicare covers the following colorectal cancer screening tests and procedures:

- Fecal occult blood test (FOBT): Medicare covers one FOBT annually for beneficiaries 50 and older. A written order from the beneficiary's attending physician is required. Medicare will pay for an immunoassay-based FOBT as an alternative to the guaiac-based FOBT, but will only pay for one FOBT, not both, per year. Beneficiaries do not have to pay coinsurance for the FOBT, and do not have to meet the annual Medicare Part B deductible.

  Note: In 2006, and effective for services provided January 1, 2007 and later, CMS adopted the more specific *CPT* code *82270* (patient was provided three single cards or single triple card for consecutive collection) and discontinued the G code G0107 (FOBT, 1-3 simultaneous determinations) to encourage quality colorectal cancer screening practices. Two studies published in January 2005 in the *Annals of Internal Medicine* suggested that the office-based single sample screening fecal occult blood test is of limited value, and that many physicians are not following practice guidelines for screening and follow-up.

- Screening flexible sigmoidoscopy: Medicare covers a screening flexible sigmoidoscopy once every four years for beneficiaries 50 and older. If a beneficiary had a screening colonoscopy in the previous ten years, then the next screening flexible sigmoidoscopy would be covered only after 119 months have passed following the month in which the last screening colonoscopy was performed. A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist may perform a screening flexible sigmoidoscopy.

Coverage and Billing for Colorectal Cancer Screening, continued

- Screening colonoscopy: Medicare coverage for a screening colonoscopy is based on beneficiary risk. For beneficiaries 50 and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every ten years, but not within 47 months of a previous screening flexible sigmoidoscopy. For beneficiaries considered being at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every two years, regardless of age. A doctor of medicine or osteopathy must perform a screening colonoscopy.
- Screening barium enema: Medicare covers a screening barium enema as an alternative to a screening flexible sigmoidoscopy for all beneficiaries under the same coverage requirements and at the same frequency as for the screening flexible sigmoidoscopy. Medicare will cover only one such service during the coverage timeframe: it will cover either the screening flexible sigmoidoscopy or the barium enema, but not both.

  Medicare also covers a barium enema as an alternative to a screening colonoscopy rendered to a beneficiary at high risk for developing colorectal cancer under the same coverage requirements, at the same frequency. Medicare will cover only one such service during the coverage timeframe: it will cover either the screening colonoscopy for the high-risk beneficiary or the barium enema rendered in lieu of it, but not both.

  A screening barium enema must be ordered in writing and collected by a doctor of medicine or osteopathy once it is determined that it is the appropriate screening method for a beneficiary. A double contrast barium enema is preferable, but the physician may order a single contrast barium enema if it is more appropriate for the beneficiary.

The beneficiary is liable for paying 20 percent of the Medicare-approved amount (the coinsurance) for screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema. See "2007 Changes" for changes to coinsurance amount.

2007 Changes

- Starting January 1, 2007, the Medicare Part B deductible has been waived for screening colonoscopy, sigmoidoscopy, and barium enema (as an alternative to colonoscopy or sigmoidoscopy). However, the deductible is not waived if the colorectal cancer-screening test becomes a diagnostic colorectal test; that is the service actually results in a biopsy or removal of a lesion or growth.
- Starting January 1, 2007, for a screening flexible sigmoidoscopy or a screening colonoscopy performed in a non-outpatient prospective payment system hospital outpatient department, the beneficiary is liable for paying 25 percent of the Medicare-approved amount (the coinsurance). The 25 percent coinsurance is currently being applied in the outpatient prospective payment system (OPPS) for OPPS hospitals. However, it is not being applied to non-OPPS hospitals.
- Starting January 1, 2007, for a screening colonoscopy performed in an ambulatory surgical center, the beneficiary is liable for paying 25 percent of the Medicare-approved amount (the coinsurance).

In addition, G0107 (FOBT, 1-3 simultaneous determinations) has been discontinued. *CPT* code *82270* (patient was provided three single cards or single triple card for consecutive collection) has been adopted to encourage quality colorectal cancer screening.

How to Bill Medicare

The following Healthcare Common Procedure Coding System/*Current Procedure Terminology* (HCPCS/*CPT*) codes should be used to bill for colorectal cancer screening services:

HCPCS/*CPT*	Descriptors
G0104	Colon cancer screening; flexible sigmoidoscopy
G0105*	Colon cancer screening; colonoscopy on individual at high risk
G0106	Colon cancer screening; barium enema as an alternative to G0104
82270	Colon cancer screening; FOBT, patient was provided 3 single cards or single triple card for consecutive collection
G0120	Colon cancer screening; barium enema as an alternative to G0105
G0121	Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk
G0122**	Colon cancer screening; barium enema (non-covered)
G0328	Colon cancer screening; fecal occult blood test, immunoassay

* When billing for the "high risk" beneficiary, the screening diagnosis code on the claim must reflect at least one of the high-risk conditions mentioned previously. Examples of diagnostic codes are in the colorectal cancer-screening chapter of the Guide to Preventive Services. This guide is available at: *http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf* on the CMS website.

**Medicare covers colorectal barium enemas only in lieu of covered screening flexible sigmoidoscopies (G0104) or covered screening colonoscopies (G0105). However, there may be instances when the beneficiary has elected to receive the barium enema for colorectal cancer screening other than specifically for these purposes. In such situations, the beneficiary may require a formal denial of the service from Medicare in order to bill a supplemental insurer who may cover the service. These noncovered barium enemas are to be identified by G0122 (colorectal cancer screening; barium enema). Code G0122 should not be used for covered barium enema services, that is, those rendered in place of the covered screening colonoscopy or covered flexible sigmoidoscopy. The beneficiary is liable for payment of the non-covered barium enema.

If billing carriers, the appropriate HCPCS and corresponding diagnosis codes must be provided on Form CMS-1500 (or the HIPAA 837 Professional electronic claim record).

If billing intermediaries, the appropriate HCPCS, revenue, and corresponding diagnosis codes must be provided on Form CMS-1450 (or the HIPAA Institutional electronic claim record). Information on the type of bill and associated revenue code is also provided in the colorectal

Coverage and Billing for Colorectal Cancer Screening, continued

cancer-screening chapter of the *Guide to Preventive Services*. Once again, this guide is available at: *http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf* on the CMS website.

Reimbursement information is also provided in this guide.

Additional Information

- CMS has developed a comprehensive prevention website that provides information and resources for all Medicare preventive benefits. The following link is to the colorectal cancer screening section, and includes website links to information and resources developed by other organizations interested in promoting colorectal cancer screening, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American Cancer Society. *http://www.cms.hhs.gov/ColorectalCancerScreening/*
- Other *MLN Matters* articles on colorectal cancer screening changes mentioned in this special edition are MM5387 (coinsurance changes) *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf* and MM5127 (deductible change) *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf*.

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.

- 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* on the CMS website.
- The CMS website provides information for each preventive service covered by Medicare. Visit *http://www.cms.hhs.gov/*, select "Medicare", and scroll down to "Prevention".

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

Medicare beneficiaries can obtain information about Medicare preventive benefits at *http://www.medicare.gov/* and then click on "Preventive Services". They can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For more information about National Colorectal Cancer Awareness Month, please visit *http://www.crfa.org/colorectal/* on the Web.

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Prostate Cancer Screening Coverage

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for Medicare-covered prostate cancer screening services.

Provider Action Needed

This article conveys no new policy that requires provider action. The article is for informational purposes only and serves as a reminder that Medicare provides coverage of certain prostate cancer screening tests subject to certain coverage, frequency, and payment limitations.

Introduction

Effective for services furnished on or after January 1, 2000, Medicare Part B covers annual preventive prostate cancer screening tests/procedures for the early detection of prostate cancer. The information in this special edition *MLN Matters* article reminds health care professionals about the coverage criteria, eligibility requirements, frequency parameters, and correct coding when billing for prostate cancer screening services so that you can talk with your Medicare patients about this preventive benefit and file claims properly for the screening service.

The Screening Services Defined

A. Screening Digital Rectal Examination (DRE)

Medicare defines a screening DRE as a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate. This screening must be performed by a doctor of medicine or osteopathy, physician assistant, nurse practitioner, clinical nurse specialist, or by a certified nurse midwife who is authorized under State law to perform the examination, fully

Prostate Cancer Screening Coverage, continued

knowledgeable about the beneficiary's medical condition, and would be responsible for explaining the results of the examination to the beneficiary.

B. Screening Prostate Specific Antigen (PSA) Tests

Medicare defines a screening PSA as a test that measures the level of prostate specific antigen in an individual's blood. This screening must be ordered by the beneficiary's physician (doctor of medicine or osteopathy) or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife who is fully knowledgeable about the beneficiary's medical condition, and would be responsible for explaining the results of the test to the beneficiary.

Coverage Information

Medicare provides coverage of the following prostate cancer screening tests;

- Screening digital rectal examination (DRE), and
- Screening prostate specific antigen (PSA) blood test.

Eligibility and Frequency

Medicare provides coverage of an annual preventive prostate cancer screening PSA test and DRE once every 12 months for all male beneficiaries age 50 and older (coverage begins the day after the beneficiary's 50□□ birthday), if at least 11 months have passed following the month in which the last Medicare-covered screening DRE or PSA test was performed for the early detection of prostate cancer.

Calculating Frequency

When calculating frequency, to determine the 11-month period, the count starts beginning with the month after the month in which a previous test/procedure was performed.

Example: The beneficiary received a screening PSA test in January 2006. The count starts beginning February 2006. The beneficiary is eligible to receive another screening PSA test in January 2007 (the month after 11 months have passed).

Deductible and Coinsurance/Copayment

- The screening PSA blood test – is a lab test for which neither the deductible nor coinsurance/copayment apply.
- The screening DRE – the Medicare Part B deductible and coinsurance/copayment apply.

Claim Filing Information

The following Healthcare Common Procedure Coding System (HCPCS) codes and diagnosis code must be reported when filing claims for prostate cancer screening services:

HCPCS Codes	Code Descriptors
G0102	Prostate cancer screening; digital rectal examination
G0103	Prostate cancer screening; prostate specific antigen test (PSA), total

Diagnosis	Description
V76.44	Prostate cancer screening digital rectal examinations (DRE) and screening prostate specific antigen (PSA) blood tests must be billed using screening ("V") code V76.44 (Special screening for malignant neoplasms, prostate).

Important Note: When submitting claims for the annual preventive prostate cancer screening PSA test it is important to bill for a screening test, which is covered once every 12 months, and not for a diagnostic test.

Payment for Prostate Cancer Screening Services

- Screening PSA tests (G0103) – are paid under the clinical diagnostic laboratory fee schedule.
- Screening DREs (G0102) – are paid under the Medicare physician fee schedule (MPFS) except for the following bill types identified (FI only). Bill types not identified are paid under the MPFS.
  - 12x, 13x, and 14x* = Outpatient prospective payment system
  - 71x and 73x = Included in All Inclusive Rate
  - 85x = Cost (Payment should be consistent with amounts paid for code *84153* or code *86316*.)

*Effective April 1, 2006, the type of bill 14x is for nonpatient laboratory specimens.

Additional Notes:

- Rural health clinics (RHCs) and federally qualified health centers (FQHCs) should include the charges on the claims for future inclusion in encounter rate calculations.
- Billing and payment for a DRE (G0102) is bundled into the payment for a covered evaluation and management service (*CPT* codes *99201 – 99456* and *99499*) when the two services are furnished to a patient on the same day. If the DRE is the only service or is provided as part of an otherwise noncovered service, HCPCS code G0102 would be payable separately if all other coverage requirements are met.

Additional Information

For more information about Medicare's prostate cancer screening benefit, visit the CMS Prostate Screening Web page: *http://www.cms.hhs.gov/ProstateCancerScreening/* on the CMS website.

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.

- 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* on the CMS website.
- The CMS website provides information for each preventive service covered by Medicare. Visit *http://www.cms.hhs.gov* , select "Medicare", and scroll down to "Prevention".

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

Medicare beneficiaries can obtain information about Medicare preventive benefits at *http://www.medicare.gov/* and then click on "Preventive Services." They can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

Prostate Cancer Screening Coverage, continued

MLN Matters Number: SE0709 Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

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.

RADIOLOGY

Claim Denials of New Mammography Codes

Change request 5327 introduced new *CPT* codes for reporting screening and diagnostic mammography services effective with dates of service on or after January 1, 2007.

A recent review of claims data has identified a large amount of these services denied during the initial three-month period. The reason of the denials were:

- Claim submitted without a Food and Drug Administration (FDA) certification number
- FDA certification number submitted in conjunction with a CLIA certification number

The Mammography Quality Standards Act (MQSA) requires that all mammography centers billing Medicare be certified by the FDA. However, when a claim is submitted with both mammography and CLIA certification numbers, the multi-carrier system (MCS) mapping process overlays the mammography number with the CLIA number, resulting in the mammography service(s) being returned as unprocessable (return unprocessable claim, or RUC).

To avoid RUC denials, providers must submit separate claims. Mammography services must be submitted with the FDA certification number on one claim, while another claim must be submitted for laboratory services that require a CLIA number. This applies to paper claims as well as those submitted electronically. Providers/entities who use Form CMS-1500 pre-printed with a CLIA certification number must ensure they do not use such forms when submitting claims for mammography services.

Source: CMS Publication 100-04, Chapter 18, Section 20

Pet Scan Radioactive Tracer Payment Update

First Coast Service Options, Inc. (FCSO) has evaluated and updated the pricing for HCPCS code A9552 (Fluorodeoxyglucose F-18 FDG). Based on section 5102(b) of the Deficit Reduction Act of 2005, which requires a payment cap on the technical component (TC) of imaging services, FCSO will no longer include the cost for the FDG radioactive tracer in the cost of the pet scan effective for services processed on or after March 16, 2007, for date of services on or after January 1, 2007.

The payment allowance for HCPCS codes A9526 (Nitrogen N-13 ammonia) and A9555 (Rubidium Rb-82) will be based on invoice. Upon request, providers will be required to submit the following information:

- Name of the radioactive tracer
- Dose administered
- Unit price per dose
- Total charge

Code	Fee
A9526	Invoice
A9552	$220.80 per study dose
A9555	Invoice

Please note that FCSO reimburses at 92 percent of the average wholesale price (AWP) for the most current years' *Redbook* whenever possible.
We apologize for any inconveniences this may have caused.

Source: CMS Pub 100-04/1083, Change Request 5357

SURGERY

Extracorporeal Photopheresis

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

Provider Types Affected

All providers who bill Medicare carriers, fiscal intermediaries (FI), or Part A/B Medicare administrative contractors (A/B MACs) for rendering extracorporeal photopheresis services.

Provider Action Needed

STOP – Impact to You

For services provided on or after December 19, 2006, coverage for extracorporeal photopheresis is now expanded to include additional health conditions.

CAUTION – What You Need to Know

Change request (CR) 5464, from which this article is taken, announces (effective December 19, 2006), the expansion of coverage of extracorporeal photopheresis to include patients with acute cardiac allograft rejection and chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

GO – What You Need to Do

Make sure that your billing staffs are aware of this expanded coverage for extracorporeal photopheresis, and bill accordingly.

Background

Extracorporeal photopheresis is a medical procedure in which a patient's white blood cells are exposed first to a drug called 8-methoxypsoralen (8-MOP) and then to an ultraviolet A (UVA) light. The procedure starts with the removal of the patient's blood, which is centrifuged to isolate the white blood cells. The drug is typically administered directly to the white blood cells after they have been removed from the patient (referred to as ex vivo administration), but the drug can alternatively be administered directly to the patient before the white blood cells are drawn. After UVA light exposure, the treated white blood cells are then re-infused into the patient.

Formerly, Medicare covered extracorporeal photopheresis only when used in the palliative treatment of the skin manifestations of cutaneous T-cell lymphoma that has not responded to other therapy. On April 6, 2006, a request for reconsideration of this national coverage determination (NCD) to allow additional indications initiated a national coverage analysis.

CR 5464 announces the NCD resulting from that analysis. It provides that CMS has reviewed the evidence and determined that extracorporeal photopheresis is reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act for patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment, and for patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment. Therefore, effective December 19, 2006, coverage has been expanded to include these conditions.

Billing Requirements for Extracorporeal Photopheresis

You should use *CPT* code *36522* (Photopheresis, extracorporeal) when submitting your outpatient or physician claims for this service under these expanded coverage guidelines. Effective for dates of service on or after December 19, 2006, Medicare contractors will pay hospital inpatient, including CAH, claims for extracorporeal photopheresis, based on the normal payment methodology for type of bills (TOBs) 11x, 13x or 85x, according to the expanded coverage conditions. Specifically, Medicare will accept claims for extracorporeal photopheresis:

- With *CPT* code *36522* when submitted for the treatment of hospital outpatients and for physician services with ICD-9-CM diagnosis codes: 996.83 or 996.85; and
- With ICD-9-CM procedure code 99.88 when submitted for the treatment of hospital inpatients, including CAHs, with ICD-9-CM diagnosis codes: 996.83 or 996.85.

Medicare contractors will not search for claims for services on or after December 19, 2006, but processed prior to the April 2, 2007, implementation date for this change. However, they will adjust such claims if you bring them to their attention.

Note: All other indications for extracorporeal photopheresis remain noncovered. Further, note that contractors will edit for an appropriate oncological and autoimmune disorder diagnosis prior to paying according to the NCD.

Medicare Summary Notices, Remittance Advice Remark Codes and Claim Adjustment Reason Code

Contractors will continue to use the appropriate existing messages that they have in place when denying claims submitted that do not meet the Medicare coverage criteria for extracorporeal photopheresis.

Contractors will deny claims when the service is not rendered to an inpatient or outpatient of a hospital, including CAHs, using the following codes:

- Claim adjustment reason code: 58 – "Claim/service denied/reduced because treatment was deemed by payer to have been rendered in an inappropriate or invalid place of service."
- MSN 16.2 – "This service cannot be paid when provided in this location/facility." Spanish translation: "Este servicio no se puede pagar cuando es suministrado en esta sitio/facilidad." (Include either MSN 36.1 or 36.2 dependant on liablity.)
- RA MA 30 – "Missing/incomplete/invalid type of bill." (FIs and A/MACs only)
- Group code – CO (contractual obligations) or PR (patient responsibility) dependant on liability.

Extracorporeal Photopheresis, continued

Advance Beneficiary Notice and Hospital Issued Notice of Noncoverage Information

- If this service is not reasonable and necessary under 1862(a)(1)(A) of the Act (falls outside the scope of the revised NCD found in Publication 100-03, Chapter 1, Section 110.4), the physicians and/or hospital outpatient departments, including CAHs, will be held liable for charges unless the physician and/or hospital has the beneficiary sign an advance beneficiary notice (ABN) in advance of providing the service.
- If this service is provided to a hospital inpatient, including CAHs, for a reason unrelated to the admission (outside of the bundled payment), the hospital billing for the inpatient services will be held liable for charges unless the hospital has the beneficiary sign a Hospital Issued Notice of Noncoverage (HINN) letter 11 in advance of providing the service.

Note: This addition/revision of section 110.4 of the *Medicare National Coverage Determinations Manual* (100-03) is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060[a][4][2005]). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869[f][1][A][I] of the Social Security Act.)

Additional Information

You can find the official instruction, CR 5464, issued to your carrier, FI or A/B MAC by visiting:

- *http://www.cms.hhs.gov/Transmittals/downloads/R66NCD.pdf* for the updated *Medicare National Coverage Determinations Manual* (100-03), Chapter 1, Part 2 (Sections 90-160.25) (Coverage Determinations), Section 110.4 (Extracorporeal Photopheresis); and
- *http://www.cms.hhs.gov/Transmittals/downloads/R1206CP.pdf* for the updated *Medicare Claims Processing Manual* (100.04), Chapter 32 (Billing Requirements for Special Services), Section 190 (Billing Requirements for Extracorporeal Photopheresis).

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-866-419-9455 (CT).

MLN Matters Number: MM5464
Related Change Request (CR) #: 5464
Related CR Release Date: March 16, 2007
Effective Date: December 19, 2006
Related CR Transmittal #: R1206CP and R66NCD
Implementation Date: April 2, 2007

Extracorporeal Photopheresis (*CPT* Code *36522*)—National Coverage Guideline Clarification

Since April 8, 1988, the Centers for Medicare & Medicaid Services (CMS) has allowed coverage for extracorporeal photopheresis for the pallative treatment of skin manifestations of cutaneous T-cell lymphoma (CTCL). For this covered indication, the following ICD-9-CM codes are considered medically necessary and appropriate:

202.10-202.18 Mycosis fungoides

202.20-202.28 Sezary's disease

Effective for dates of services **on or after December 19, 2006,** CMS has expanded coverage for extracorporeal photopheresis to include the following indications and ICD-9-CM codes:

- Patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment; and
- Patients with chronic graft versus host disease whose disease is refractory to standard immunopsuppressive drug treatment.
- Appropriate ICD-9-CM codes for these new indications are 996.83 (complications of transplanted heart) and 996.85 (complications of transplanted bone marrow).

All other indications for extracorporeal photopheresis remain noncovered.

For additional information on this national coverage decision (NCD) please refer to change request 5464, transmittal 1206, dated March 16, 2007, available on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R1206CP.pdf*.

THERAPY SERVICES

Incorrect Denials for Therapy Claims Billed with the Modifier KX

This information was previously published in the September 2006 Medicare B Update! page 21.

Therapy claims submitted with the modifier KX processed on or after March 13, 2006, were incorrectly denying with the following message: PR-119-Benefit maximum for this time period has been reached. The Medicare claims processing system was corrected on February 06, 2007. Claims processed on or after February 06, 2007, will be processed correctly.

No Action Required by Providers

Providers do not need to take action at this time. We will perform adjustments on all affected claims. However, if you do not wish to wait for the adjustments, you may resubmit the denied services.

We apologize for any inconvenience this may have caused.

GENERAL COVERAGE

Medically Unlikely Edits

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], and/or regional home health intermediaries [RHHIs]).

Background

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

- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- For carrier claims, the MUEs will automatically deny or suspend claim line items containing units of service billed in excess of the MUE criteria and for FI claims, the MUEs will return to provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

Key Points

- Change request (CR) 5495 announces the upcoming release of the next version of the MUEs, which is version 1.1.
- CR 5495 states that Medicare carriers and A/B MACs will deny the entire claim line from noninstitutional providers with units of service that exceed MUE criteria and pay the other services on the claims.
- FIs and A/B MACs will RTP claims from institutional providers with units of service that exceed MUE criteria.
- An appeal process will not be allowed for RTP'd claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the national correct coding contractor.
- Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"), and this provision can neither be waived nor subject to an advanced beneficiary notice (ABN).

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5495) 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/R1202CP.pdf* on the CMS website.

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

Medically Unlikely Edits, continued

MLN Matters Number: MM5495
Related Change Request (CR) #: 5495
Related CR Release Date: March 9, 2007
Effective Date: April 1, 2007
Related CR Transmittal #: R1202CP
Implementation Date: April 2, 2007

Services Not Provided Within United States

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 carriers, fiscal intermediaries (FIs) and A/B Medicare administrative contractors (A/B MACs).

Key Points

Change request (CR) 5427 clarifies that payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States.

Take Note: Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States. For example, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India.

Background

This article and related CR 5427 outlines the limited items and services that are reimbursable by Medicare outside the United States according to Section 1862(a)(4) of the Social Security Act.

The law specifies the following **exceptions** to the "foreign" exclusion:

- Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
  - Emergency arose within the U.S.; or
  - Emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another state
- Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual's residence within the U.S. than the nearest U.S. hospital that is adequately equipped and available to treat the individual's condition, whether or not an emergency exists.
- Physician and ambulance services in connection with, and during, a foreign inpatient hospital stay that is covered in accordance with either of the above.

Additional Information

CR 5427 is the official instruction issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R66BP.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 1-866-419-9455 (CT).

Note: The previously published CR 3781 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3781.pdf* also provides information and instructions about services not provided within the United States by defining "United States" for the purposes of the Social Security Act (Section 1814 (f) along with the parameters of this Medicare rule.

MLN Matters Number: MM5427
Related Change Request (CR) #: 5427
Related CR Release Date: February 23, 2007
Effective Date: November 13, 2006
Related CR Transmittal #: R66BP
Implementation Date: April 2, 2007

Sign up to our *eNews* electronic mailing list

Join our eNews mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Connecticut and Florida Medicare carrier. By signing up, you will receive automatic email notification when new or updated information is posted to the provider education 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.

HIPAA – The Health Insurance Portability and Accountability Act

Temporary Addition to the Administrative Simplification Compliance Act Exception List for Medicare Secondary Payer Claims

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

Provider Types Affected

Physicians and providers submitting copayment reimbursement claims to Medicare carriers and Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5488 that informs Medicare carriers and A/B MACS that a temporary waiver to a requirement of the Administrative Simplification Compliance Act (ASCA) is being granted for certain claims as discussed in this article.

CAUTION – What You Need to Know

An exception has been created in CR 5488 that instructs carriers and A/B MACs, who use the Medicare multi-carrier system (MCS) for claims processing, to grant a temporary ASCA waiver (until July 1, 2007) for electronic media claim (EMC) Medicare secondary payer (MSP) claims to allow processing for reimbursement of a beneficiary for copayment paid to the provider when the primary payer is an employer managed care organization (MCO).

GO – What You Need to Do

Participating Medicare providers must not accept from the beneficiary any co-payment, or coinsurance, upon services rendered when the primary payer is an employer MCO insurance, or any other type of primary insurance. Providers must follow the MSP rules and bill Medicare as the secondary payer after the primary payer has made payment. Medicare will inform you on its remittance advice the amount you may collect from the beneficiary. See the Background and Additional Information sections of this article for further details regarding these changes.

Background

The ASCA requires that claims must be submitted to Medicare electronically. CR 5488 instructs MCS contractors to grant a temporary waiver (until July 1, 2007) for EMC MSP claims to allow processing for reimbursement of a beneficiary for copayment paid to the provider when the primary payer is an employer MCO. Therefore, until July 1, 2007, MCS contractors are instructed to temporarily:

- Allow for copayment reimbursement claims to be submitted on paper, and
- Send reimbursement directly to the beneficiary.

Additional Information

The official instruction, CR 5488, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1194CP.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 1-866-419-9455 (CT).

MLN Matters Number: MM5488
Related Change Request (CR) #: 5488
Related CR Release Date: March 9, 2007
Effective Date: April 9, 2007
Related CR Transmittal #: R1194CP
Implementation Date: July 1, 2007

FRAUD

Medicare Finds Billions in Savings to Taxpayers

New Contractors To Help Identify Fraud, Waste and Abuse

Through more aggressive local oversight and specially targeted fraud and abuse initiatives, the Centers for Medicare & Medicaid Services (CMS) has saved more than $2 billion in Medicare claims in special projects focusing on infusion therapy and those services provided by independent diagnostic testing facilities (IDTFs). CMS has made more than 980 Medicare fee-for-service (FFS) program referrals to law enforcement authorities since October 2004.

In addition, CMS is continuing its aggressive local efforts in FFS oversight and helping to identify and combat fraud in the new Medicare prescription drug benefit with the addition of four new Medicare drug integrity contractors (MEDICs).

"CMS is using every tool available to find and fight waste, fraud and abuse across Medicare and Medicaid, to help ensure that drug benefit dollars are spent appropriately," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "Our fraud and abuse prevention programs are already working to save money, and today's actions will provide even more protections for beneficiaries and taxpayers."

In 2006, CMS expanded its satellite offices in Miami and Los Angeles, providing additional on-the-ground efforts to identify and report fraud, waste and abuse in Medicare. In Los Angeles, Medicare has:

- Revoked the billing numbers of 117 Medicare providers who submitted false claims or invalid business operations, generating a savings of approximately $200 million.
- Implemented claim processing edits that prevent the payment of claims submitted with a deceased provider's identification number, resulting in savings of more than $4 million.
- Implemented plans that have denied approximately $163 million in charges for IDTFs, revoked the billing privileges of 83 IDTFs and denied $445 million in claims for beneficiary Sharing or "Capping."
- Denied the enrollment of highly suspicious providers in Medicare, resulting in the prevention of potentially inappropriate payments of more than $10 million.

In the Miami office, CMS is:

- Working with the Governor's office, federal and state law enforcement officials, state health and licensure agencies, the Medicare carrier and payment safeguard contractors, CMS is participating in the Florida Infusion Fraud Federal/State Task Force. Through the use of administrative actions, auto denial and medical record reviews, site visits, data analysis and complaint investigations, the initiative has saved more than $1 billion and resulted in the suspension of 104 payment claims submitted by more than 300 providers. Approximately 400 new investigations have resulted from this effort.
- Using a variety of prepayment edits that have contributed to the Medicare savings (Medically unbelievable service edits – $200+ million; high claim volume infusion beneficiary edits – $400+ million; service-specific edits – $200+ million). In addition, the U.S. Department of Justice opened 63 criminal and 38 civil Medicare fraud cases since October 2005. The Agency for Health Care Administration has suspended or revoked 11 clinic licenses and the Department of Health revoked the licenses of 5 practitioners involved in criminal activity associated with these clinics. CMS and the State are also pursuing legislative and regulatory changes to address programmatic vulnerabilities.
- Leading an identity theft initiative in South Florida involving 2,500 Medicare beneficiaries whose Medicare numbers have been compromised or who are participating in fraud. Through the use of prepayment edits, more than $600 million has been saved.
- Revoking the provider numbers of more than 500 durable medical equipment suppliers, resulting in a drop in Medicare billing from $93 million in 2004 to $16 million in 2005 and in Medicare payment from $74 million to $13 million in that same timeframe.

By using the Medicare integrity contractors, CMS is able to use new and innovative techniques to monitor and analyze data to help identify fraud; work with law enforcement, prescription drug plans, consumer groups and other key partners to protect consumers and enforce Medicare's rules; and provide basic tips for consumers so they can protect themselves from potential scams. The three new regional MEDICs are:

- Science Applications International Corporation in the West
- Electronic Data Systems (EDS) in the North and Northeast
- Health Integrity (the current MEDIC serving the entire country, which will now cover) the Southeast only.

In addition to the three regional MEDIC contractors, CMS awarded a fourth MEDIC contract entitled the "One Program Integrity System Integrator" (One PI) to EDS. EDS is tasked with assisting CMS in the development of a centralized data approach for program integrity activities. The One PI MEDIC will assist CMS by:

- Providing data analysis tools necessary for CMS, the three regional MEDICs and other CMS contractors to detect potential fraud, waste and abuse in Medicare and Medicaid programs.

Medicare Finds Billions in Savings to Taxpayers, continued

- Using data analysis methods to uncover potential fraud, waste and abuse on a national level.
- Identifying duplicate payments for Medicare Part B and Part D medications.
- Assisting CMS, the three regional MEDICs and other CMS contractors with the fulfillment of data requests from law enforcement and other entities.

The work of the new MEDICs will add to the range of steps already in place to prevent fraud and abuse in the Medicare prescription drug benefit. MEDICs are already responding to and investigating beneficiary complaints; looking proactively at claims and enrollment data to identify suspicious activities; and conducting education and outreach activities to plans, law enforcement, and other agencies. More specifically, with the support of the MEDICs, CMS has:

- Referred to HHS Office of the Inspector General (OIG) and the Federal Bureau of Investigation the $299 ring, a scam where beneficiaries are offered a "Medicare sponsored prescription drug plan" in exchange for an initial "payment" of $299 or up to $379. In some instances, the callers have prior access to the beneficiary's personal data such as Medicare related numbers or social security numbers. CMS and local partners, including state attorneys general and insurance commissioners, worked to increase awareness of these scams, resulting in nearly 300 complaints and a significant reduction in the number of potential victims to the scam.
- Identified and referred cases to the OIG where beneficiaries may have been enrolled in plans against their will.
- Identified and referred potential cases of drug diversion to the OIG.

"Vigilance in protecting beneficiaries and taxpayers from waste, fraud and abuse is one of our top priorities in Medicare," said Dr. McClellan.

Medicare Continues To Reduce Improper Claim Payments

The Centers for Medicare & Medicaid Services (CMS) Administrator, Mark B. McClellan, M.D., Ph.D., announced on October 12, 2006, that aggressive oversight and improvement efforts have resulted in a further reduction of the number of improper Medicare claims payments from 5.2 percent in 2005 to 4.4 percent in 2006; a $1.3 billion reduction in improper payments.

"We have been increasing our efforts to reduce improper Medicare claim payments, and for the second year in a row, it's paying off," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "Because we are able to measure the accuracy of payments more closely now, we are able to target our efforts more effectively with Medicare contractors and providers."

The Medicare fee-for-service (FFS) error rate has declined from 14.2 percent in 1996, when the Medicare improper payment rate was first reported, to the current 4.4 percent in 2006. The recent error rate reductions have led to approximately $11 billion less in improper payments over the past two years. CMS pays more than one billion FFS claims each year.

CMS conducted detailed reviews of randomly sampled Medicare FFS claims submitted between April 1, 2005, and March 31, 2006. Approximately 160,000 claims spanning all types of Medicare FFS payments were included in the Medicare error rate-testing program. By providing accurate statistical information to its personnel and contractors, CMS can identify where problems exist and target improvement efforts to address the problems.

This effort reflects the agency's increased commitment to use more detailed data and analysis to identify and eliminate improper payments. CMS has worked with the contractors to apply the data collected to improve system edits, update coverage policies, and direct provider education efforts. In addition, CMS has developed national and state-specific models for predicting inpatient-hospital payment errors to study the areas prone to payment error.

CMS reports its Medicare FFS improper payment findings in an annual report released every November. The complete report will contains additional error rate information along with more specific improper payment estimates. Once completed, the report will be released to the public via the CMS website at *http://www.cms.hhs.gov/cert/01_overview.asp?*.

GENERAL INFORMATION

Connecticut Provider Call Center Phone Number Change

Currently, the Connecticut customer service representative (CSR) and the interactive voice response (IVR) lines are combined.

In an effort to better serve the provider community, the toll free CSR line and the IVR line will be separated. The IVR number will remain the same (1-866-419-9455).

Effective Monday April 23, 2007, the new CSR number will be 1-888-760-6950.

- CSR line hours of operation: 8:00 a.m. – 4:00 p.m. Monday through Friday (excluding holidays).
- IVR line hours of operation: 6:00 a.m. – 6:00 p.m. Monday through Friday for specific claim information. 24 hours a day, 7 days a week for recorded information on current Medicare issues.

National Provider Identifier—Will You Be Ready?

GET IT. The compliance date, **May 23, 2007,** is only **two months** away. Covered health care providers have had 22 months to apply for their NPI – further procrastination could disrupt your cash flow. Act **now** if you still don't have your NPI! **It's easy and it's free!**

SHARE IT. Have your NPI and don't know what to do with it? Share it. Share it with health plans you bill and the colleagues who rely on having your NPI to submit their claims (e.g., those who bill for ordered or referred services). You should also share it with your business associates, such as a billing service, vendor, or clearinghouse. Pay attention to information from health plans with which you do business as to when they will begin accepting the NPI in claims and other standard transactions.

USE IT. Once your health plans have informed you that they are ready to accept NPIs, begin the testing process. Consider sending only a few claims at first as you test the ability of plans to accept the NPI. Fewer claims will make it easier to keep track of status and payment, as well as troubleshooting any potential problems that may arise during the testing process.

Revisions to the NPPES Website

We are revising some of the language on the NPPES NPI Application Help page that relates to the selection of the Entity Type. Among other changes, our revision will remove a reference to "atypical services." This reference is being removed because entities that furnish only "atypical services" are not eligible to apply for NPIs.

NPI Disclosures by Industry Entities to Industry Entities

A new guidance document is available on the CMS NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIdisclosures.pdf*.

This guidance relates to the disclosure of health care providers' NPIs by health industry entities for the purpose of using NPIs in HIPAA standard transactions.

New Frequently Asked Questions Posted

CMS has posted new NPI frequently asked questions (FAQs) on its website.

Questions include:

- I have been told to protect my national provider identifier (NPI) and I have been told to share my NPI – How am I to protect my NPI if I must share it with others?
- With whom should I share my NPI?
- Am I required to share my NPI with health plans, other providers and any other entity that requests it?
- Does the National Plan and Provider Enumeration System (NPPES) handle applications for health plan identifiers, as it does for health care provider identifiers?
- May a health plan require that an individual health care provider obtain two NPIs if that provider has two separate business roles – for example, as a physician seeing patients at a group practice, and as a durable medical equipment (DME) supplier?

To view these FAQs, please go to the CMS dedicated NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/*. Click on Educational Resources. Scroll down to the section that says "Related Links Inside CMS" and click on Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated".

Important Information for Medicare Providers

Reminder to Use the NPI and Legacy Identifiers on Medicare Claims

Medicare is accepting the NPI on claims; however, providers should also submit their Medicare legacy identifiers on their claims until further instructions are released.

Important Notice: Medicare Extends 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 print vendors, specifically 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, which do not comply with the form specifications. However, not all of the new forms are in error.

Given the circumstances, 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. Medicare contractors have been 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

National Provider Identifier—Will You Be Ready?, continued

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

The following will help to properly identify whether their version of the form needs to be updated. The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form (typically on the lower right corner) signifying the version is the December 1990 version. The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form signifying the version is the August 2005 version. Checking the information at the upper right hand corner of the form is the best way to identify if that particular version is correct. On properly formatted claim forms, there will be approximately a ¼" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper.

If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications.

Upcoming WEDI Events

WEDI will host the 16th WEDI National Conference May 14 – 17, 2007, in Baltimore, Maryland. Visit the WEDI website for more details on this event, as well as others, at *http://www.wedi.org/npioi/index.shtml*.

Please note that there is a charge to participate in WEDI events.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it?

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

Providers can apply for an NPI online at *http://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: CMS Provider Education Resource 200703-19

NPI: Will You be Ready?

NPI: Get It. Share It. Use It.

There are fewer than 90 days left between today and the national provider identifier (NPI) compliance date of May 23, 2007. It is estimated that it may take at least this much time to implement the NPI into your business practices. Failure to prepare could result in a disruption in cash flow. Will you be ready to use your NPI? Time is running out!

Updating National Plan and Provider Enumeration System (NPPES) Information

All health care providers, including Medicare providers, should include their legacy identifiers, as well as associated provider identifier type(s), on their NPI applications. If a provider has already completed an application and did not submit a legacy identifier, this provider should go back and update its information in NPPES. A provider can easily do so by using the Web (*https://nppes.cms.hhs.gov*). While doing so, providers should also validate other data in NPPES, such as address, contact person information, etc. and update anything that has changed.

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 must share their NPI with any entity that may need it for billing purposes — including those who need it 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.

New Frequently Asked Questions (FAQs) Posted

CMS has posted new NPI FAQs on its website. Questions include:

- For Medicare provider enrollment purposes, will group practices need to submit new CMS-855R's for every member of the group practice to let Medicare know their NPIs?
- Will health plans link the National Provider Identifiers (NPIs) of group practices to the NPIs of the health care providers who are members of the group practices?
- Who needs an NPI – who is not eligible to apply for an NPI - what if I have a drug enforcement administration (DEA) number – what if I only bill on paper – what if I do not submit claims to Medicare?
- Can my office employer identification number (EIN) be used instead of an NPI?
- When do I need to use my NPI?
- Is a corporation that owns pharmacies that have NPIs required to have an NPI to receive payments on behalf of the owned pharmacies?

To view these FAQs, please go to the CMS dedicated NPI webpage at *http://www.cms.hhs.gov/NationalProvIdentStand* and click on Educational Resources. Scroll down to the section that says "Related Links Inside CMS" and click on Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated."

NPI: Will You be Ready?, continued

Upcoming WEDI Events

WEDI has several NPI events scheduled in the upcoming month. Visit *http://www.wedi.org/npioi/index.shtml* to learn more about these events. Please note that there is a charge to participate in WEDI events.

Important Information for Medicare Providers

Sharing NPIs with Medicare

In addition to updating critical data and legacy identifiers in the NPPES, Medicare providers should include both their NPIs and their Medicare legacy numbers on their Medicare claims. This will help Medicare build its NPI crosswalk by enabling Medicare to link providers' NPIs to their Medicare legacy identifiers. Also, when Medicare providers make changes to their Medicare enrollment information, they are now required to furnish their NPIs when making those changes. Providers applying for Medicare enrollment must furnish their NPIs on their enrollment applications. These actions inform Medicare of providers' NPIs.

There are no additional actions that Medicare providers need to take to inform Medicare of their NPIs.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can 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.

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.*

Source: CMS Learning Resource, Message 200702-14

Medicare Clinical Laboratory Services Competitive Bidding Demonstration

Information about the Medicare Clinical Laboratory Services Competitive Bidding Demonstration project may be found at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=keyword&filterValue=lab&filterByDID=0&sortByDID=3&sortOrder*.

The Centers for Medicare & Medicaid Services (CMS) is waiting for final approval of the demonstration design from the Office of Management and Budget (OMB). Once we receive OMB approval, we will make announcements – including start date and demonstration area.

Announcements will be made via the CMS (clinical labs) listserv and the CMS press office.

Source: CMS Provider Education Resource 200703-18

Flu Shot Reminder

It's Not Too Late to Give and Get the Flu Shot!

The peak of flu season typically occurs between late December and March; however, flu season can last until May. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination.

Remember – influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' website: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf*.

Source: Provider Education Resources Listserv, Message 200703-04

Request for Telephone Clerical Reopening Form

The "Request for Clerical Reopening" form on the following page has been added to the Forms section of the Florida provider education website. The form simplifies and standardizes filing requirements for requesting a telephone clerical reopening. All related information (dates of service, ICN, etc.) **must** be completed on the form or the request will not be honored.

A new confirmation number **must** be obtained for each FAXED clerical reopening request by calling Medicare Part B at 1-866-454-9007. Fax your completed request is 1-904-791-6910.

FIRST COAST SERVICE OPTIONS, INC.

CMS CENTERS for MEDICARE & MEDICAID SERVICES

A CMS CONTRACTED INTERMEDIARY & CARRIER

MEDICARE

Request For Telephone Clerical Reopening Form for Part B

Date Faxed: _____

Confirmation Number: _____

Customer Service Representative/Supervisor Name: _____

Contact Person (First and Last Name): _____

Contact Phone Number: _____

Provider Number: _____ Tax ID/SSN: _____

Health Insurance Claim Number	Date of Service	Internal Control Number (ICN)	Reason for Clerical Reopening Request

Instructions:

- **All related information (dates of service, ICN, etc.) must be completed on the form or the request will not be honored.**
- **A new confirmation number** must **be obtained for each faxed clerical reopening request by calling Medicare Part B at (866) 454-9007.**
- **A limit of 10 forms can be submitted per day.**
- **Fax your completed request to (904) 791-6910.**

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.

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.
- 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 five digits. Please remember not all diagnosis codes are five 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 may also be found in the *Current Procedural Terminology* book. It is important to be using a current book.
- When Medicare is secondary, Item 11, 11a, 11b, and 11c must be completed.

Common Billing Errors to Avoid when Billing Medicare Carriers, continued

Billing Tips

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

A. Provider Numbers

Individual versus. 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 is 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.

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 % 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.

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,

Common Billing Errors to Avoid when Billing Medicare Carriers, continued

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/mailinglists/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 1-866-419-9455 (CT).

MLN Matters Number: SE0712 Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

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.

Part C Plan Type Description Display on Medicare's Common Working File

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! page 25.

Note: This article was revised on March 27, 2007, to reflect that the Medicare Advantage (MA) plan directory has been posted on the CMS website. The directory is located at *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/*. See the *Additional Information* section of this article for more details.

Provider Types Affected

Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through Medicare common working file (CWF) eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).

Provider Action Needed

Be aware of the expanded list of MA Plan type descriptions that are being displayed by Medicare's CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in private fee-for-service (PFFS) plans.

A plan directory, which is quite descriptive, contains the list of all active Medicare contracts and their corresponding plan type. The directory is posted at the following URL: *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/*

Background

When you query Medicare regarding a beneficiary's entitlement and eligibility, Medicare's CWF system responds with information on the Medicare managed care contract number in which a beneficiary is enrolled, including the plan type description associated with the contract. Currently, CWF largely displays the label "HMO" for these contracts. In many cases, the "HMO" label is incorrect since the list of possible plan type values has grown far larger since the creation of the Medicare Advantage program.

For example, under the MA Part C program, Medicare beneficiaries can enroll in PFFS plans. PFFS plans are very different from the more traditional MA HMO type plan.

Private Fee-for-Service (PFFS) Plans

PFFS plans generally have no plan specific provider network. Enrollees in a PFFS plan can obtain plan covered health care services from any Medicare FFS enrolled provider in the U.S. who is willing to furnish services to a PFFS plan beneficiary. It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan.

In most cases, a PFFS enrollee will inform a provider before obtaining a service that they are enrolled in a PFFS plan. In addition, the PFFS enrollee will have an enrollment card provided by the PFFS plan identifying them as enrollees in a PFFS plan. The card will specify a phone number and/or a web address where the provider can obtain the PFFS plan's terms and conditions of participation.

At a minimum, the terms and conditions will specify:

- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures, including
  - The amount the provider is permitted to collect from the enrollee; and
  - Whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

Part C Plan Type Description Display on Medicare's Common Working File, continued

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers in the U.S. from whom its enrollees seek health care services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a web site and also make them available upon written or phoned request.

To be paid by a PFFS organization, the provider must send their bill to the address (or electronic address) provided in the PFFS plan's terms and conditions of participation

For more detailed information on PFFS plans as they relate to providers, see the "Provider Q&A" Downloadable document on *http://www.cms.hhs.gov/PrivateFeeforServicePlans/*.

Additional Information

If you have questions regarding the plan of a specific Medicare MA enrolled patient, you may wish to contact that plan.

To view the official instruction (CR 5349) issued to your Medicare FI, carrier, MAC, DMERC or RHHI, visit *http://www.cms.hhs.gov/Transmittals/downloads/R1175CP.pdf* on the CMS website.

To review a related article that explains Medicare's Common Working File (CWF) Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes go to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5118.pdf* on the CMS website.

MLN Matters Number: MM5349 *Revised*
Related CR Release Date: February 2, 2007
Related CR Transmittal #: R1175CP
Related Change Request (CR) #: 5349
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Medicare Advantage and Prescription Drug Plan Addresses

The Centers for Medicare & Medicaid Services (CMS) provides an address list for claim-processing submission to Medicare Advantage (MA) plans, Medicare Advantage-prescription drug (MA-PD) plans, and prescription drug plans (PDPs).

Note: Medicare Advantage plans include health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

The list of addresses for MA and PDPs is available on the CMS website at *http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/claims_processing_20060120.pdf*.

For additional information on Medicare managed care plans, refer to CMS Internet-only-Manual (IOM), Pub 100-16, Medicare Managed Care Manual. You may also find additional information on manage care plans on the CMS website at *http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage*.

Differentiating Mass Adjustments from Other Types of Adjustments for Crossover Claims

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on CR 5472, which implements changes to Medicare contractor systems so that their claim transmissions to the coordination of benefits contractor (COBC) for mass adjustments and other kinds of adjustments may be differentiated from all other types of claims sent for crossover.

CAUTION – What You Need to Know

This will be accomplished through modifications to the 837 COB flat files and National Council for Prescription Drug Programs (NCPDP) Part B drug claim files, all of which are transmitted to the COBC on a daily basis.

Through CR 5472, Medicare contractors' systems will be modified so that the COBC Detailed Error Report information that is printed on the outgoing special provider notification letters/report that you receive when claims will not be crossed over due to claim data errors will be modified to also include the error/trading partner rejection code and accompanying description. These changes to the special provider letters should enable your billing service to determine why claims that were previously selected by Medicare for crossover were not actually crossed over.

Without these changes, CMS would be unable to isolate mass adjustment claims as part of the national COBA crossover process. This change corrects a problem that the Centers for Medicare & Medicaid Services (CMS) encountered as part of its

Differentiating Mass Adjustments from Other Types of Adjustments for Crossover Claims, continued

implementation of the Deficit Reduction Act (DRA). Also, providers would continue to be unaware of the specific reasons as to why their patients' claims were not crossed over.

GO – What You Need to Do

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

Background

All Medicare contractors currently send processed claims, for which Medicare systems show the beneficiary has other insurance to the COBC for crossover under the national Coordination of Benefits Agreement (COBA) program.

The Centers for Medicare & Medicaid Services (CMS) requires a method whereby its COBC can differentiate among the various categories of adjustment crossover claims including:

- Mass adjustments – Medicare physician fee schedule (MPFS),
- Mass adjustments – other, and
- All other adjustments.

Having the ability to differentiate among the various categories of adjustment crossover claims will enable CMS (and the COBC) to better address the kinds of contingencies that arise with the passage of legislation such as the Deficit Reduction Act, which mandate changes for Medicare that can affect claims already processed.

CR 5472 instructs that the COBC Detailed Error Report process be modified to ensure that the contractor-generated special provider letters which are created and sent in accordance with CR 3709 contain the specific Claredi rejection code returned for the claim along with its description. (See the *MLN Matters* article at *http://www.cms.hhs.gov/mlnMattersArticles/downloads/MM3709.pdf* for information on CR 3709.)

Providers may wish to contact their billing agent/vendor to obtain a better understanding of these error codes and accompanying descriptions, which, in turn, explains why their patients' claims were not crossed over successfully. In addition, providers should notify their billing agent/vendor when they receive special provider letters or reports stating why their patients' claims were not crossed over.

Additional Information

The official instruction, CR 5472, issued to your carrier, FI, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1189CP.pdf* on the CMS website. Attached to CR 5472, you will find the new chapter of the *Medicare Claims Processing Manual* explaining in detail the new special mass adjustment process for COB. In addition, you will also find revised chapters for other portions of that manual, which discuss the COB process.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, DMERC, or DME 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 1-866-419-9455 (CT).

MLN Matters Number: MM5472
Related Change Request (CR) #: 5472
Related CR Release Date: February 28, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1189CP
Implementation Date: July 2, 2007

Physician Quality Reporting Initiative—Frequently Asked Questions

The Centers for Medicare & Medicaid Services (CMS) now has over 50 frequently asked questions (FAQs) about the Physician Quality Reporting Initiative (PQRI) available on its website. You may access these FAQs by visiting the PQRI Web page at *http://www.cms.hhs.gov/PQRI*.

Once on the Overview page, scroll down to the "Related Links Inside CMS" section and click on the "Frequently Asked Questions" link.

Source: CMS Provider Education Resource 200703-13 & 14

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.

2007 Physician Quality Reporting Initiative—Program Overview

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

Provider Types Affected

Physicians, practitioners, and therapists (as defined in the "Eligible Professionals" section) submitting claims to Medicare carriers 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) 5558 that provides overview information on the Physician Quality Reporting Initiative (PQRI). The Centers for Medicare & Medicaid Services (CMS) encourages all physicians to be familiar with the PQRI, its importance, and benefits.

Background

CMS is developing and implementing payment for performance to encourage quality improvement and avoidance of unnecessary costs in the care of Medicare beneficiaries. Physician services comprise a significant component of the larger CMS value-based purchasing enterprise initiative that also includes hospitals, nursing homes, home health agencies, and dialysis facilities.

Introduction to the 2007 Physician Quality Reporting Initiative

On December 20, 2006, President Bush signed the Tax Relief and Health Care Act of 2006 (TRHCA). Division B, Title I, Section 101 of the TRHCA authorizes a financial incentive for eligible professionals to participate in a voluntary quality-reporting program. Eligible professionals, who choose to participate and successfully report on a designated set of quality measures for services paid under the Medicare Physician Fee Schedule and provided between July 1 and December 31, 2007, may earn a bonus payment of 1.5 percent of their charges during that period, subject to a cap. CMS has titled the statutory program the 2007 Physician Quality Reporting Initiative (PQRI).

The purpose of this document is to give a high-level overview of CMS' approach to 2007 PQRI implementation, as directed by the statute. Detailed program instructions, educational materials, and supportive tools will be posted as they become available on the CMS PQRI website at: *http://cms.hhs.gov/PQRI*. This overview of the 2007 PQRI will address: (1) eligible professionals, (2) quality measures, (3) form and manner of reporting, (4) determination of successful reporting, (5) bonus payment, (6) validation, (7) appeals, (8) confidential feedback reports, (9) transition from the 2006 Physician Voluntary Reporting Program (PVRP), and (10) 2008 considerations.

Eligible Professionals

TRHCA Section 101 defines "eligible professional" as the following:

1. Medicare physician, as defined in Social Security Act (SSA) section 1861(r):
   - Doctor of Medicine
   - Doctor of Osteopathy
   - Doctor of Podiatric Medicine
   - Doctor of Optometry
   - Doctor of Oral Surgery
   - Doctor of Dental Medicine
   - Chiropractor
2. Practitioners described in SSA section 1842(b)(18)(C):
   - Physician assistant
   - Nurse practitioner
   - Clinical nurse specialist
   - Certified registered nurse anesthetist
   - Certified nurse midwife
   - Clinical social worker
   - Clinical psychologist
   - Registered dietician
   - Nutrition professional
3. Therapists:
   - Physical therapist
   - Occupational therapist
   - Qualified speech-language pathologist

All Medicare-enrolled professionals in these categories are eligible to participate in the 2007 PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims.

Quality Measures for Reporting

For 2007, TRHCA section 101 specifies that the quality measures for the PQRI shall be the "2007 physician quality measures under the Physician Voluntary Reporting Program as published on the public website of the Centers for Medicare & Medicaid Services as of the date of enactment of this subsection, except as may be changed … based on the results of a consensus-based process in January 2007 …." This provision refers to the list of 66 Physician Voluntary Reporting Program (PVRP) measures that CMS had posted on its website on December 5, 2006 (see Transition from 2006 PVRP section below). The list referred to in the statute was expanded based on actions approved at the January 22, 2007 AQA Alliance consensus process. The result is a final 2007 PQRI Quality Measures List, which is available at *www.cms.hhs.gov/PQR* , as a download from the Measures/ Codes Web page.

In addition, the statute allows modifications or refinements, such as code additions, corrections, or revisions, to the detailed specifications for the measures included in the final 2007 PQRI Measures List until the beginning of the reporting period. The final 2007 PQRI Quality Measure Specifications will be available on the CMS PQRI website well in advance of the July 1, 2007 start date for the reporting period. The detailed specifications for each measure describe: (1) when that measure is reportable and (2) which quality-data code to report.

Prior to the July 1, 2007 start date, eligible professionals who plan to participate in the 2007 PQRI should familiarize themselves and their office staff with the PQRI Quality Measures List and the specifications for each measure that applies to their patient populations.

Form and Manner of Reporting

TRHCA section 101 allows CMS to specify the form and manner of reporting. For 2007, CMS will be building on the claims-based quality reporting system implemented for the 2006 Physician Voluntary Reporting Program (PVRP), which ended December 31, 2006 (see Transition from 2006 PVRP section below). Participating eligible professionals whose Medicare patients fit the specifications of the 2007 PQRI

2007 Physician Quality Reporting Initiative—Program Overview, continued

quality measures will report the corresponding appropriate *CPT* category II codes or G-codes (where *CPT* category II codes are not yet available) on their claims. *CPT* category II codes and G-codes are Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P. Importantly, there is no need to enroll or register to begin claims-based reporting for 2007 PQRI.

The applicable *CPT* category II code or G-code quality data must be reported on the same claim as the patient diagnosis and service to which the quality-data code applies. The analysis algorithms that determine successful reporting match the quality-data codes to the diagnosis, service, and procedure codes on the claim. Thus, quality-data codes that are not submitted on the same claim as the applicable patient diagnosis, service, and procedure codes will not count toward successful reporting or for calculation of a potential bonus payment.

Determination of Successful Reporting

The statutory description of satisfactory reporting depends on how many quality measures are applicable to the services furnished by the eligible professional during the entire reporting period of July 1-December 31, 2007. If there are no more than three quality measures applicable to the services provided by the eligible professional, then each measure must be reported for at least 80 percent of the cases in which the measure was reportable. If there are four or more quality measures applicable to the services provided by the eligible professional, then at least three measures, selected by the eligible professional, must be reported for at least 80 percent of the cases in which each measure was reportable.

The analysis of whether an eligible professional has successfully reported is expected to be performed at the individual eligible professional level using the individual-level national provider identifier (NPI). The eligible professional's individual NPI must be listed along with the HCPCS codes for services, procedures, and quality data on the claim. Thus, to participate in the 2007 PQRI, eligible professionals must have their individual-level NPIs and must consistently use their individual NPIs to correctly identify their services, procedures, and quality-data codes for an accurate determination of satisfactory reporting.

Eligible professionals select the quality measures that are applicable to their practices. If an eligible professional submits data for a quality measure, then that measure is presumed to be applicable for the purposes of determining satisfactory reporting. CMS recommends that eligible professionals report on every quality measure that is applicable to their patient populations to: (1) increase the likelihood that they will reach the 80 percent satisfactorily reporting requirement for the requisite number of measures and (2) increase the likelihood that they will not be affected by the bonus payment cap.

As detailed instructions, education, and tools to support successful claims-based reporting become available, they will be posted on the CMS PQRI website at *http://www.cms.hhs.gov/PQRI*.

Payment for Reporting

Participating eligible professionals who successfully report as prescribed by TRHCA section 101 may earn a 1.5 percent bonus, subject to cap. The potential 1.5 percent bonus will be based on allowed charges for covered professional services: (1) furnished during the reporting period of July 1 through December 31, 2007, (2) received into the CMS National Claims History (NCH) file by February 29, 2008, and (3) paid under the Medicare physician fee schedule. Because claims processing times may vary by time of the year and Medicare Carrier/Medicare Administrative Contractor (MAC), participating eligible professionals should submit claims from the end of 2007 promptly, so that those claims will reach the NCH file by February 29, 2008. Bonuses will be paid as a lump sum in mid-2008. There is no beneficiary co-payment or notice to the beneficiary regarding the bonus payments.

The bonus will apply to allowed charges for all covered professional services, not just those charges associated with reported quality measures. The term "allowed charges" refers to total charges, including the beneficiary deductible and copayment, not just the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Note that the amounts billed above the physician fee schedule amounts for assigned and non-assigned claims will not apply to the bonus. The statute defines PQRI covered services as those paid under the Physician Fee Schedule only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology. Other Part B services and items that may be billed by eligible professionals but are not paid under the Physician Fee Schedule, such as clinical laboratory services, pharmaceuticals billed by physicians, and Rural Health Center/Federally Qualified Health Center services, do not apply to the bonus.

A payment cap that would reduce the potential bonus below 1.5 percent of allowed charges may apply in situations where an eligible professional reports relatively few instances of quality measure data. Eligible professionals' caps are calculated by multiplying: (1) their total instances of reporting quality data for all measures (not limited only to measures meeting the 80 percent threshold), by (2) a constant of 300 percent, and by (3) the national average per measure payment amount.

The national average per measure payment amount is one value for all measures and all participants that is calculated by dividing: (1) the total amount of allowed charges under the physician gee dchedule for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program by (2) the total number of instances for which data were reported by all participants in the program for all measures during the reporting period. (Note that the national average per measure payment amount calculation only takes into account the charges on claims for which quality measures were reported, whereas the individual bonus calculation takes into account charges for all services furnished during the reporting period.) Thus, while the purpose of the cap is clear, it is not possible to determine the impact of the cap until the national average per measure payment amount can be calculated after the end of the reporting period.

TRHCA section 101 specifies that for 2007, CMS must use the taxpayer identification number (TIN) as the billing unit, so any bonuses earned will be paid to the TIN holder of record. Though the analysis of satisfactory reporting will be performed at the individual eligible professional level using individual-level NPI data (as discussed above in the Form and Manner of Reporting section), bonuses will paid to the holder of the TIN, aggregating individual bonuses for

2007 Physician Quality Reporting Initiative—Program Overview, continued

groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS plans to group claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the bonus payment under more than one TIN will receive a separate bonus payment associated with each TIN.

In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, the statute specifies that any bonus payment earned will be paid to the employers or facilities.

Validation

TRHCA section 101 requires CMS to validate, using sampling or other means, whether quality measures applicable to the services furnished by a participating eligible professional have been reported. CMS plans to focus on situations where eligible professionals have successfully reported fewer than three quality measures. If CMS finds that eligible professionals who have reported fewer than three quality measures have not reported additional measures that are also applicable to the services they furnished during the reporting period, then CMS cannot pay those eligible professionals the bonus incentive payment.

Appeals

The statute specifically states that there shall be no administrative or judicial review of the determination of: (1) quality measures applicable to services furnished by eligible professionals, (2) satisfactory reporting, (3) the payment limitation or cap, or (4) the bonus incentive payment. However, CMS will establish a process for eligible professionals to inquire about these matters.

Confidential Feedback Reports

CMS will provide confidential feedback reports to participating eligible professionals at or near the time that the lump sum bonus payments are made in mid-2008. There will be no interim feedback during 2007. Quality data reported under the 2007 PQRI will not be publicly reported.

Access to confidential feedback reports may require eligible professionals to complete an identity-verification process to obtain a login identification and password for a secure interface. However, this process is not required to participate in the 2007 PQRI or to receive a bonus payment.

Transition from the 2006 Physician Voluntary Reporting Program (PVRP)

The 2007 PQRI will build on and replace the 2006 Physician Voluntary Reporting Program (PVRP), which was implemented as the first step toward pay for performance for physician services. For services provided to Medicare beneficiaries from January 1 through December 31, 2006, physicians were able to voluntarily report to CMS a starter set of 16 evidence-based performance measures that captured quality of care data. The data were collected via claims using *CPT* category II codes and G-codes where *CPT* codes were not yet available. In December 2006, CMS provided confidential feedback reports containing reporting and performance rates to the physicians who had submitted performance data during the second calendar quarter of 2006. Though PVRP ended December 31, 2006, feedback reports for services provided during the third and fourth calendar quarters of 2006 will be made available during 2007.

2008 Considerations

For 2008, quality measures for eligible professionals must be proposed and finalized through rulemaking. According to the statue, the measures shall: (1) have been adopted or endorsed by a consensus organization, such as the AQA Alliance or National Quality Forum (NQF), (2) include measures that have been submitted by a physician specialty, (3) be identified by CMS as having used a consensus-based process for development, and (4) include structural measures, such as the use of electronic health records and electronic prescribing technology. The proposed 2008 quality measures set must be published by August 15, 2007 and finalized by November 15, 2007.

Though the short lead time for implementation of the 2007 PQRI will not allow CMS to offer registry-based or electronic health record-based reporting for 2007, CMS is exploring the use of these reporting mechanisms for 2008. CMS has already begun a series of meetings with representatives of physicians, medical boards, group practices, and therapists to discuss how CMS can promote the use of standardized specifications for centralized, electronic reporting.

Additional Information

Additional information is available on the CMS PQRI website at: *http://www.cms.hhs.gov/PQRI* or by contacting your Medicare Carrier/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 1-866-419-9455 (CT).

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Related CR Release Date: March 9, 2007
Effective Date: March 2, 2007
Related CR Transmittal #: R265OTN
Implementation Date: N/A

Use of Nine-Digit ZIP codes for Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule and Anesthesia Services

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 27-30.

Note: This article was revised on March 9, 2007, to reflect a revised CR transmittal number and CR release date. Also the Web address for accessing CR 5208 has been changed. All other information remains the same.

Provider Types Affected

Physicians and providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [MACs]) for services paid under the MPFS and for anesthesia services.

Provider Action Needed

STOP – Impact to You

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed below, if you do not include the full nine-digit ZIP code on your claims for services paid by Medicare carriers or MACs under the Medicare physician fee schedule (MPFS) and for anesthesia services, your claim will be treated as unprocessable.

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed below, if a valid full nine-digit ZIP code is not present on the provider master file address ZIP code, services paid by the FIs/MACs under the MPFS and for anesthesia services, your claim will be treated as unprocessable.

CAUTION – What You Need to Know

Effective October 1, 2007, for services rendered in the areas defined by the ZIP codes indicated below, Medicare will require that you provide the nine-digit ZIP code for the location where services were rendered on your claims for services paid by carriers/MACs under the MPFS and for anesthesia services. CMS is implementing this requirement to prevent payment issues generated by ZIP codes that cross payment localities.

Effective October 1, 2007, for services rendered in the areas defined by the nine-digit ZIP codes indicated below, Medicare will require a valid nine-digit ZIP code on the provider file master address for services paid by the FIs/MACs under the MPFS and for anesthesia services.

GO – What You Need to Do

Make sure that your billing staffs are aware that if you provide services paid by carriers/MACs under the MPFS or anesthesia services in a payment locality whose ZIP code appears below, effective for dates of service **on or after October 1, 2007,** they must include the nine-digit ZIP code in the claim.

Make sure that if you provide services paid by FIs/MACs under the MPFS or anesthesia services in a payment locality whose ZIP code appears below, a valid nine-digit ZIP code is present on the provider file master address. If a valid nine-digit ZIP code is not on the file, submit a CMS-855A, the Medicare Enrollment Application, with a valid nine-digit ZIP code.

Background

Reimbursement Based on the Location Where the Service Was Rendered

Where you actually provide services paid under the MPFS and anesthesia services determines the amount of your reimbursement. More specifically, Medicare reimburses you for these services based on the locality, which is determined from the ZIP code that is on the claim submitted to carriers/MACs. The ZIP code on the provider file master address is used to determine the locality on the claims submitted to FIs/MACs.

The ZIP codes that your Medicare contractors use to determine the payment locality come from the CMS ZIP code file, which conforms to the United States Postal Service convention of assigning ZIP codes into dominant counties.

CMS has become aware that some ZIP codes cover more than one payment locality; in some cases, while the service may actually be rendered in one county, because of the ZIP code it may be assigned into a different county. This causes a payment issue when each of the counties is associated with a different payment locality and therefore a different payment amount.

Nine-Digit ZIP Codes

CR 5208, from which this article was taken, corrects this issue. **Effective October 1, 2007**, you will have to include the full nine-digit ZIP code for anesthesia services and for services paid under the MPFS by carriers/MACs when those services are provided in a ZIP code area that crosses payment localities (see below). Note that services on the purchased diagnostic abstract file are all payable under the MPFS, thus the nine-digit ZIP code requirement also applies to those services.

There are some important details that you should know:

Exceptions

There are two instances in which you do not need to submit the nine-digit ZIP code in claims for services payable under the MPFS and for anesthesia services:

- You may continue to submit claims with five-digit ZIP codes if you provide these services in ZIP code areas that do not cross payment localities (not listed below).
- There is no current requirement for the submission of a ZIP code when the place of service (POS) is "Home" or any other places of service that your Medicare contractor currently considers to be the same as "Home."

As necessary, CMS will provide quarterly updates of the list of the ZIP codes that cross localities.

You should submit your claims for ambulance and laboratory services using five-digit ZIP codes, as your carrier/MAC will continue to use the five-digit codes for determining payment.

Claims for ambulance services will continue to be priced using five-digit ZIP codes by the FIs/MACs. Laboratory services will continue to be priced by the FIs/MACs using the locality for non-fee based services.

Use of Nine-Digit ZIP codes for Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule and Anesthesia Services, continued

Master Address

FIs determine locality based upon the ZIP code of the provider's physical address, which, including the ZIP code is stored on the provider file as the master address.

Effective July 1, 2007, institutional providers, with a ZIP code displayed below, will need to submit a valid nine-digit ZIP code on the CMS 855-A when the provider file master address ZIP code is five-digits, the last four-digits of a nine-digit ZIP code are zeroes, or the last four-digits of a nine-digit ZIP code do not match a four-digit extension on the ZIP code file.

Claims Returned as Unprocessable

To re-emphasize, if you provide only a five-digit ZIP code on a claim for services payable under the MPFS and for anesthesia services that you provide in one of the ZIP code areas that crosses localities (and therefore requires a nine-digit ZIP code to be processed), your carrier/MAC will return this claim as unprocessable. Returned claims will have the following remittance advice and remark code messages:

Adjustment Reason Code 16 – Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

Remark Code MA 130 – Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Remark Code MA114 – "Missing/incomplete information on where the services were furnished."

Effective for dates of service on or after October 1, 2007, if an invalid ZIP code is present on the Provider File Master Address for claims payable under the MPFS and for anesthesia services provided in one of the ZIP code areas that crosses localities, your FI/MAC will return the claim as unprocessable.

ZIP Codes that Cross Payment Localities by State

Arkansas (AR)
71749 71953 72338 72395 72444 72644

Arizona (AZ)
85534

California (CA)
90265 90623 90630 90631 90638 91304 91307
91311 91361 91362 91709 91766 91792 93013
93243 93252 93536 93560 94303 94514 94515
94550 94571 95023 95033 95076 95304 95377
95391 95476 95616 95690 95694 96056

Delaware (DE)
19952 19973

Florida (FL)
32948 33440 33917 33920 33955 33972 34141
34142 34972 34974

Georgia (GA)
30011 30014 30019 30025 30040 30055 30056
30101 30102 30107 30120 30135 30143 30153
30178 30179 30180 30183 30184 30185 30187
30205 30223 30224 30228 30233 30234 30248
30268 30276 30506 30517 30518 30519 30534
30548 30559 30620 30641 30650 30663 30730
31029

Idaho (ID)
83342 83856

Illinois (IL)
60007 60010 60013 60015 60021 60042 60050
60051 60074 60081 60089 60090 60102 60103
60118 60120 60126 60133 60140 60142 60151
60172 60178 60401 60407 60410 60416 60423
60431 60432 60439 60447 60449 60464 60466
60467 60468 60475 60477 60481 60504 60506
60511 60521 60523 60527 60538 60543 60544
60554 60559 60935 60940 60950 62031 62044
62052 62053 62054 62075 62080 62081 62082
62083 62231 62237 62238 62253 62262 62263
62268 62272 62280 62286 62355 62361 62366
62538 62546 62553 62557 62558 62630 62638
62643 62667 62690 62692 62801 62808 62831
62877 62882 62883 62907 62916

Iowa (IA)
51630 51640 52542 52573 52626 52761

Kansas (KS)
66012 66013 66018 66021 66025 66083 66102
66109 66112

Kentucky (KY)
40965 42079 42223 42602

Massachusetts (MA)
01432 01434 01930 02324 02339 02762

Maryland (MD)
20601 20607 20613 20714 20736 20754 20842
20871 21757 21771 21776 21787 21791

Michigan (MI)
48005 48041 48062 48118 48137 48160 48166
48169 48178 48189 48353 48371 48380 48428
48430 48438 48439 48442 48455 48462 49229
49236 49240 49285

Minnesota (MN)
56136 56144 56164 56219 56220 56257 56744

Missouri (MO)
63005 63015 63020 63023 63028 63030 63041
63060 63069 63071 63072 63087 63348 63357
63535 63548 63627 64024 64034 64048 64061
64062 64070 64075 64077 64080 64082 64147
64439 64444 64484 64492 64733 64784

Montana (MT)
59030 59847

Nebraska (NE)
68719 68755 68777 69168 69212 69216 69352
69358

Nevada (NV)
89061

New Hampshire (NH)
03579 03813

Use of Nine-Digit ZIP codes for Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule and Anesthesia Services, continued

New Jersey (NJ)
07735 07747 08512 08525 08530 08540 08558
08560

New York (NY)
10505 10541 10579 11001 11040 11096 12167
12434 13750

North Dakota (ND)
58030 58041 58043 58053 58225 58413 58436
58439 58568 58623 58653

Oregon (OR)
97002 97014 97032 97056 97064 97071 97119
97123 97128 97132 97140 97231 97362 97375

Pennsylvania (PA)
17527 17555 18036 18041 18042 18055 18070
18077 18092 18951 19087 19310 19344 19362
19363 19464 19504 19505 19512 19520 19525
19543

South Dakota (SD)
57005 57026 57030 57034 57068 57078 57255
57260 57270 57430 57437 57441 57446 57457
57523 57632 57638 57641 57642 57645 57648
57660 57717 57724

Tennessee (TN)
37317 37391 37821 38326

Texas (TX)
75007 75019 75028 75044 75048 75050 75051
75052 75054 75067 75080 75082 75088 75089
75098 75104 75115 75125 75146 75148 75154
75159 75182 75248 75252 75287 75839 75844
75847 75851 75856 75862 76008 76020 76028
76036 76051 76052 76063 76065 76071 76092
76108 76126 76177 76262 77047 77053 77082
77083 77085 77099 77339 77357 77365 77381
77382 77426 77430 77444 77447 77450 77474
77477 77480 77484 77485 77489 77493 77494
77511 77520 77521 77532 77535 77539 77546
77550 77568 77581 77583 77622 77656 77665
77833 78610 78612 78613 78615 78617 78620
78621 78634 78641 78652 78654 78657 78663
78664 78669 78727 78728 78729 78734 78736
78737 78738 78750 78759 78933 78940 78950
78954 79835 79922 79932

Virginia (VA)
20120 20135

Washington (WA)
98019 98022 98047 98072 98077 98092 98177
98251 98354 99033 99128

Wisconsin (WI)
54540

Wyoming (WY)
82063 82082 82240 82716 82725 82731 82930
83114 83120 83127

Additional Information

You can find more information about the use of nine-digit ZIP codes for determining the correct payment locality for anesthesia services and services paid under the MPFS by going to CR 5208, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1193CP.pdf*.

You might also want to look at updated *Medicare Claims Processing Manual*, Publication 100-04, Chapter 1 (General Billing Requirements), Section 10.1.1 (Payment Jurisdiction among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services) that you will find as an attachment to this CR.

If you have any questions, please contact your carrier/FI/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 1-866-419-9455 (CT).

MLN Matters Number: MM5208
Related Change Request (CR) Number: 5208
Related CR Release Date: March 9, 2007
Related CR Transmittal Number: R1193CP
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Revised Physician Quality Reporting Initiative Presentation—Module One

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a revised version of the 2007 Physician Quality Reporting Initiative (PQRI) module one PowerPoint® presentation has been posted to the CMS website. Updates have been made to the presentation and speaker's notes have been added to assist in the explanation and understanding of the training module.

To access the presentation, visit *http://www.cms.hhs.gov/PQRI* on the CMS website and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the "Downloads" section and click on the "Physician Quality Reporting Initiative PowerPoint Module One" link.

We would also like to remind you that frequently asked questions (FAQ) about the PQRI are now available on the CMS website. As new FAQs are added regularly, you may want to check this site often.

You can access these FAQs by visiting the PQRI Web page at, *http://www.cms.hhs.gov/PQRI*, on the CMS website. Once on the Overview page, scroll down to the "Related Links Inside CMS" section and click on the "Frequently Asked Question" link.

Source: CMS Provider Education Resource 200703-15

March is National Colorectal Cancer Awareness Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of colorectal cancer and the colorectal cancer screening benefit covered by Medicare. Colorectal cancer is largely preventable through screening, which can find colon growths called polyps that can be removed before they turn into cancer. Screening can also detect cancer early when it is easier to treat and cure.

Screening for colorectal cancer is recommended for all adults ages 50 and older, although screening may start at younger ages for individuals who are at high risk for colon cancer. The frequency of screening is based on an individual's risk for colorectal cancer and the type of screening test that is used.

An individual is considered to be at high risk for colorectal cancer if he or she has had colorectal cancer before or has a history of polyps, has a family member who has had colorectal cancer or a history of polyps, or has a personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

In addition, risk for colorectal cancer increases with age. It is important to encourage patients who were screened before entering Medicare to continue with screening at clinically appropriate intervals.

Medicare Covers Screening Tests

Medicare covers the following screening tests to detect colorectal cancer early, when it is most treatable, and to identify people at high risk for developing this type of cancer:

- Fecal occult blood test (FOBT)—Medicare covers both guaiac and immunoassay tests, but Medicare will only pay for **one** FOBT **each year.**
- Colonoscopy—Medicare covers every **ten** years for normal risk; more frequently for high-risk persons.
- Sigmoidoscopy—Medicare covers every **four** years.
- Barium enema—Medicare covers every **four** years for normal risk; every **two** years for high risk.

For specific details on Medicare coverage criteria and billing procedures for colorectal cancer screening services, refer to special edition *MLN Matters* article SE0710 available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf*.

New Coverage Information for 2007!

Starting in January 2007, Medicare waived the requirement that beneficiaries meet the deductible for **screening** colonoscopy, sigmoidoscopy, or barium enema (as an alternative to colonoscopy or sigmoidoscopy). In addition, the coinsurance for colonoscopy and sigmoidoscopy is now 25 percent when performed in ambulatory surgical centers and non-outpatient prospective payment system hospital outpatient departments.

For specific details about these changes, click on the following links:

- *MLN Matters* article MM5387 (coinsurance changes) *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf*.
- *MLN Matters* article MM5127 (deductible change) *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf*.

CMS Needs Your Help

CMS needs your help to get the word out to your Medicare patients and their caregivers about the benefits of colorectal cancer screening. We hope that you will encourage your eligible Medicare patients to take advantage of this potentially life saving benefit.

For information and resources to help you discuss colorectal cancer screening with your patients, visit the following American Cancer Society website: *http://www.cancer.org/docroot/PRO/PRO_4_ColonMD.asp*.

Thank you for supporting CMS effort to increase awareness of colorectal cancer and the colorectal cancer screening benefit covered by Medicare.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives.

Source: CMS Provider Education Resource 200703-12

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

Colorectal Cancer Awareness Month

Are You and Your Staff Ready?

March is National Colorectal Cancer Awareness Month. Is your practice or office organized to make sure that your patients are screened for colorectal cancer and get the appropriate follow-up? Several resources are available to help practitioners and their office staff to improve their practices – including delivery of colorectal cancer screening, referrals for screening, care transitions, and follow-up.

The American Cancer Society and the National Colorectal Cancer Roundtable developed a guide titled, ***What You Should Know about Screening for Colorectal Cancer: A Primary Care Clinician's Evidence-Based Toolbox and Guide.*** The guide is designed to help clinicians improve office practices to support colorectal cancer screening. This resource is available at the following link: *http://www.cancer.org/docroot/PRO/content/PRO_4_1x_ColonMD_Clinicians_Manual.pdf.asp?utm_source=CMSlistserves&utm_medium=email&utm_term=Colon&utm_content=ColonMD%2Bmanual*.

The American Cancer Society has developed materials to help support practitioners in discussing colorectal cancer screening with their patients. These resources include reminder letters, phone reminder scripts, brochures, and wall charts, and are available for downloading or ordering at the following link:

Colorectal Cancer Awareness Month, continued

http://www.cancer.org/docroot/PRO/PRO_4_2_ColonMD_Educating_Patients.asp?utm_source=CMSlistserve&utm_medium=email&utm_term=colon&utm_content=ColonMDeducatingP.

For specific details on Medicare coverage criteria and billing procedures for colorectal cancer screening services, refer to special edition *MLN Matters* article SE0710 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0710.pdf*.

Thank you for supporting CMS effort to increase awareness of colorectal cancer and the colorectal cancer screening benefit covered by Medicare.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened—it could save their lives.

Source: CMS Provider Education Resource 200703-17

March is National Nutrition Month®

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of nutrition, healthful eating and the medical nutrition therapy (MNT) benefit covered by Medicare. Approximately 8.6 million Americans (source: The United States Renal Data System and National Diabetes Information clearinghouse; *http://diabetes.niddk.nih.gov/dm/pubs/statistics*) at least 60 years or older are diagnosed with diabetes or acute renal failure. MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

Medicare Coverage

Medicare provides coverage of medical nutrition therapy (MNT) for beneficiaries diagnosed with diabetes or renal disease (except for those receiving dialysis) when provided by a registered dietitian or nutrition professional who meets the provider qualifications requirement, or a "grandfathered" dietitian or nutritionist who was licensed or certified as of December 21, 2000. A referral by the beneficiary's treating physician indicating a diagnosis of diabetes or renal disease is required.

Medicare provides coverage for three hours of MNT in the first year and two hours in subsequent years.

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 requests your help to ensure that all eligible people with Medicare take full advantage of the medical nutrition therapy benefit. Talk with your eligible Medicare patients about the benefits of managing diabetes and renal disease through MNT and encourage them to make an appointment with a registered dietitian or nutrition professional qualified to provide MNT services covered by Medicare.

For More Information

- For more information about Medicare's coverage of MNT services, visit the CMS website *http://www.cms.hhs.gov/MedicalNutritionTherapy/*.
- CMS has also developed a variety of educational products and resources to help health care professionals and their staffs become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.
  - 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 on the CMS website at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
  - The CMS website provides information for each preventive service covered by Medicare. Go to *http://www.cms.hhs.gov/*, select "Medicare" and scroll down to the "Prevention" heading.
- For information to share with your Medicare patients, visit *http://www.medicare.gov* on the Web.
- For more information about National Nutrition Month®, please visit *http://www.eatright.org/*.

Source: CMS Provider Education Resource 200703-01

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

Referral of Patients for X-rays by Chiropractors

The Centers for Medicare & Medicaid Services (CMS) has rescinded the *MLN Matters* special edition article SE0416 regarding the "Referral of Patients for X-rays by Chiropractors". CMS has received feedback that some of the provisions contained therein are confusing and/or not entirely accurate. *This article was previously published in the Fourth Quarter 2004 Medicare B Update! (pages 17-18).*

Source: CMS MLN Matters Listserv, March 2, 2007

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

Local Coverage Determinations - Table of Contents

Advance Notice Statement

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

REVISIONS TO LCDS

72192: Computed Tomography of the Abdomen and Pelvis—LCD Revision

The local coverage determination (LCD) for computed tomography of the abdomen and pelvis was last revised on February 28, 2007. Since that time, the LCD has been revised to add an additional indication for computed tomography of the pelvis for follow-up metastasis (i.e., breast, lung cancer, etc.) in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Effective Date

This LCD revision is effective for services rendered on or after March 13, 2007. 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.

EPO: Epoetin alfa—LCD Revision

This local coverage determination (LCD) was last revised on October 1, 2006. Since that time the LCD has been revised. The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add diagnosis codes 238.71 (essential thrombocythemia) and 238.76 (myelofibrosis with myeloid metaplasia) as medically necessary for HCPCS code J0885. The coding guideline was revised accordingly.

Effective Date

This revision is effective for services rendered on or after February 26, 2007. 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.

J9000: Antineoplastic Drugs—LCD Revision

The local coverage determination (LCD) for antineoplastic drugs was last updated on January 22, 2007. Since that time, a revision was made to add an additional off-label indication for alemtuzumab (Campath®) - J9010, based on The United States Pharmacopeia Drug Information (USP DI).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the following off-label indication was added to alemtuzumab (J9010):

- First-line monotherapy for the treatment of progressive, B-cell chronic lymphocytic leukemia.

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

Effective Date

This revision is effective for services rendered on or after February 8, 2007. 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.

NESP: Darbepoetin alfa (Aranesp®)(novel erythropoiesis stimulating protein [NESP])—LCD Revision

This local coverage determination (LCD) was last revised on October 1, 2006. Since that time the LCD has been revised. The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add diagnosis codes 238.71 (essential thrombocythemia) and 238.76 (myelofibrosis with myeloid metaplasia) as medically necessary for HCPCS code J0881. The coding guideline was revised accordingly.

Effective Date

This revision is effective for services rendered on or after February 26, 2007. 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.

NESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—LCD Revision

The local coverage determination (LCD) for darbepoetin alfa (Aranesp) (novel erythropoiesis stimulating protein [NESP]) was last updated February 26, 2007. Since that time, the FDA (U.S. Food and Drug Administration) notified health care professionals of new safety information for erythropoiesis-stimulating agents (ESAs) Aranesp (darbepoetin alfa), Epogen® (epoetin alfa), and Procrit® (epoetin alfa), drugs used to treat certain causes of anemia. Four new studies in patients with cancer found a higher chance of serious and life-threatening side effects or death with the use of ESAs. These research studies were evaluating an unapproved dosing regimen, a patient population for which ESAs are not approved, or a new unapproved ESA. In another study, patients scheduled for orthopedic surgery had a higher rate of deep venous thrombosis when treated with ESA at the approved dose. This new information is consistent with risks found in two clinical studies in patients with chronic renal failure treated with an unapproved regimen of an ESA that were reported in November 2006.

The Agency will present this new information to the Oncologic Drugs Advisory Committee on May 10, 2007. The FDA will seek advice on the need for additional labeling changes and/or additional studies to further assess safety.

Medicare covers all labeled (FDA-approved) indications for the drugs, though issues of dose and endpoints have been raised by the recent studies. Also, First Coast Service Options, Inc. (FCSO) as well as other Medicare contractors allow off-label (non FDA-approved) drug coverage based on the local coverage determination process that includes review of the evidence based medical literature and input from practicing physicians. ESAs currently have coverage for off-label indications such as the anemia of cancer not due to concurrent chemotherapy for Medicare patients in Florida and Connecticut. Given the preliminary data and warning released by the manufacturer to health care professionals and now the FDA notification, FCSO has evaluated all off-label coverage of darbepoetin alfa (Aranesp) and will be removing coverage for anemia of malignancy **not** due to concurrent chemotherapy for Medicare patients in Florida and Connecticut.

With this decision, the LCD for Aranesp (darbepoetin alfa), will be revised in several ways:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD:
  - Removed the indication for anemia of malignancy not due to concurrent chemotherapy.
  - Revised the FDA-approved covered indications to read exactly per the FDA-approved label.
  - Under general indications and limitations, removed recommended dosing for anemia associated with malignancy not due to concurrent chemotherapy.
- Under the "Utilization Guidelines" section of the LCD:
  - Added a statement about endpoints for administering Aranesp for anemia associated with concurrent chemotherapy and added language from the FDA-approved label regarding the safety and effectiveness of Aranesp.
- Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD for HCPCS code J0881:
  - Removed ICD-9-CM codes 205.00-205.91, 206.00-206.91 and 207.00-208.91 as these ICD-9-CM codes are no longer supported as medically necessary.
  - Added a dual diagnosis requirement for the following ICD-9-CM codes:

140.0-149.9	150.0-159.9	160.0-165.9	170.0-176.9	179-189.9	190.0-199.1
200.00-200.88	201.00-201.98	202.00-202.98	203.00-203.81	204.00-204.91	230.0-234.9
235.0-235.9	236.0-236.99	237.0-237.9	238.0	238.1	238.2
238.3	238.4	238.5	238.6	238.8	238.9
239.0-239.9	995.20	995.29	V58.11		

One of the malignancy ICD-9-CM codes in the list above and one of the following ICD-9-CM: 995.20, 995.29 and V58.11 must be billed when Aranesp is given for anemia of malignancy related to concomitantly administered chemotherapy. ICD-9-CM V58.11 would be billed with a malignancy code if the patient is currently receiving chemotherapy treatment. ICD-9-CM 995.20 or 995.29 would be billed with one of the malignancy codes if the patient has received chemotherapy treatment and it has been no more than 120 days since the last chemotherapy treatment.

FCSO is making these revisions in accordance with the Program Integrity Manual, Pub 100-08, Chapter 13, Section 13.7.3, "being issued for compelling reasons."

CMS announced on March 14, 2007, the opening of a national coverage analysis (NCA) on the use of ESAs for the conditions other than end-stage renal disease (ESRD). This is the first step toward issuing a national coverage determination (NCD). Information on this national coverage analysis may be found at *http://www.cms.hhs.gov/mcd/viewtrackingsheet.asp?id=203*.

FCSO is continuing to evaluate all off-label coverage of darbepoetin alfa (Aranesp) and epoetin alfa (Epogen, Procrit). FCSO will communicate to physicians and allied providers if and when such off-label indications are removed from the local coverage determinations.

Effective Date

These revisions to the LCD are effective for services **rendered on or after April 19, 2007.**

The full text for this LCD is available through the Connecticut provider education website at *http://wwwconnecticutmedicare.com*, and the Florida provider education website at *http://www.floridamedicare.com* on or after this effective date.

CONNECTICUT EDUCATIONAL RESOURCES

Ask-the-Contractor Teleconference

Date: Wednesday, April 25, 2007
Time: 12:00 pm – 1:00 pm
Registration Deadline: April 23, 2007 – *space limited to 100 phone lines*

On the day of the teleconference, please dial in to 1-800-860-2442 a few minutes before noon.

This teleconference is the latest installment of educational efforts designed to support and inform the provider community by answering the questions that are on your mind. The session will begin with a short presentation on the topics listed below and will be followed by a question and answer period:

- Revised Form CMS-1500 Implementation
- National Provider Identifier (NPI) Implementation
- How to Avoid Common Comprehensive Error Rate Testing (CERT) Errors

Please join us for this very informative training session and obtain first-hand answers to your questions from Medicare subject matter experts. Don't miss out on this great learning opportunity!

Two Easy Ways To Register!

- **Online** – Go to the Education page on *http://www.connecticutmedicare.com* in order to complete an online registration form. An email confirmation will be sent to you upon successful completion of the form. Handouts and the evaluation form will be available for download on the Education page under "Ask the Contractor Teleconference" by April 24, 2007.
- **Fax** – Providers without Internet access can leave a message on our Registration Hotline at 203-634-5527 requesting a fax registration form. Handouts and the evaluation form will be faxed to you the morning of the teleconference.

Important Note

In order to prepare for the teleconference, attendees are strongly encouraged to submit their questions in advance via email (*eventsct@fcso.com*) or by leaving a voice message on the registration hotline (203-634-5527) by April 13, 2007.

2007 Medifest Symposium

Marriott Hartford
100 Capital Boulevard
Rocky Hill, CT 06067

Presented by First Coast Service Options, Inc.
Provider Outreach and Education (POE)
Revised Dates – June 6 & 7, 2007

Join us in June for the one and only Medifest Symposium held by your Connecticut Medicare Part B contractor. Participate with hundreds of your fellow providers, suppliers, billing staff, and coders, throughout Connecticut. These educational seminars will address important and timely topics related to the Medicare program that will include some of the following:

- Appeals & Overpayments
- CMS-1500 08/05 revisions and implementation
- Electronic Data Interchange
- Evaluation and Management (E/M) Coding
- Evaluation and Management (E/M) Documentation
- Exhibitors featuring the latest product and service offerings
- Fraud and Abuse
- Global Surgery
- "Incident-to" provision, locum tenens and reciprocal billing rules
- Medical Review & Data Analysis
- Office Reimbursement Efficiency
- Primary Care & Preventive Services
- Provider Enrollment
- Self-Help Techniques (websites)
- Specialty classes (To be determined)

This is our only Medifest in Connecticut for 2007, so don't miss out!

Not to mention the networking opportunities and much more. This event will provide you with the opportunity to attend many educational sessions over a one and a half day time period.

Additional information and registration for the above sessions will be coming soon to the *http://www.connecticutmedicare.com* website, or you may contact us at our event registration hotline 203-634-5527.

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

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

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

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

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

Attention: Correspondence

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

Attention: Financial Services

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

Attention: Fraud and Abuse

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

Attention: Freedom of Information (FOIA)

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

Attention: Medical Review

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

Attention: MSP

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

Attention: Pricing/ Provider Maintenance

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

Attention: Resolutions

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

MAILING ADDRESS EXCEPTIONS

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

Redeterminations/Appeals

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

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

Hearings

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

Post Office Box for Appeals/Hearings:

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

Electronic Media Claims/EDI

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

Post Office Box for EDI:

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

Claims

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

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

CONNECTICUT MEDICARE PHONE NUMBERS

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

Provider Services
Medicare Part B
1-888-760-6950 (*toll-free*) ***effective 4/23/07****
*See article on page 47

1-866-419-9455 ***(toll-free) prior to 4/23/07***

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 EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

April 2007 – July 2007

Ask the Contractor – Evaluation & Management Coding and Top Duplicate Claim Denials

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

Ask the Contractor Teleconference – Topics to be determined

When: May 10, 2007
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

2007 Medifest Symposium (Medicare Part A and B)

When: May 15, 2007 – May 17, 2007
Where: Marriott Tampa Westshore
Tampa, Florida

Ask the Contractor Teleconference – Topics to be determined

When: July 12, 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*, 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*) 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: _____

Medifest Class Schedule

May 15-17, 2007

A– Part A Class
B – Part B Class
(A/B) – Both Parts A&B

Registrant's Name: _____

May 15-16, 2007
Marriott Tampa Westshore
1001 N Westshore Blvd
Tampa, FL 33607
Please contact hotel for directions and/or reservations (813) 287-2555
PLEASE MARK ONLY ONE CLASS PER TIME SLOT.
Cost $233.00

Day 1

General Session 8:00 am to 8:30 am

8:45 AM - 10:15 AM SESSION 1

- ☐ Appeals (A)
- ☐ Appeals (B)
- ☐ CPT Coding (A/B)
- ☐ Direct Data Entry (A)
- ☐ Global Surgery (B)
- ☐ Medicare Self Service Techniques (A/B)

10:30 AM – 12:00 PM SESSION 2

- ☐ eLearning (A/B)
- ☐ E/M Coding (B)
- ☐ Fraud & Abuse (A/B)
- ☐ Medicare Easy Remit Print (B)
- ☐ Modifiers (A)
- ☐ National Correct Coding Initiative (NCCI) Modifiers (B)

1:15 PM – 3:15 PM SESSION 3

- ☐ E/M Documentation (B)
- ☐ Life of a Part A Claim (A)
- ☐ Medicare Secondary Payer (A)
- ☐ Medicare Secondary Payer (B)
- ☐ Provider Enrollment/NPI (A/B)

3:30 PM – 5:30 PM SESSION 4

- ☐ Claims Resolution (B)
- ☐ ICD-9-CM Coding (A/B)
- ☐ Incident to/Locum Tenens/Reciprocal Billing (B)
- ☐ Medical Review/Data Analysis (A/B)

Day 2

8:00 AM - 10:00 AM SESSION 1

- ☐ E/M Documentation (B)
- ☐ Incident to/Locum Tenens/Reciprocal Billing (B)
- ☐ Medicare Secondary Payer (B)
- ☐ Provider Enrollment/NPI (A/B)
- ☐ Reimbursement Efficiency (A)

10:15 AM – 12:15 PM SESSION 2

- ☐ Claims Resolution (B)
- ☐ ICD-9-CM Coding (A/B)
- ☐ Medical Review/Data Analysis (A/B)
- ☐ Medicare Outpatient PPS (A)
- ☐ Medicare Part D (A/B)

1:30 PM – 3:00 PM SESSION 3

- ☐ Appeals (B)
- ☐ CPT Coding (A/B)
- ☐ Direct Data Entry (A)
- ☐ Global Surgery (B)
- ☐ Medicare Easy Remit Print (B)
- ☐ Primary Care (B)

3:15 PM – 4:45 PM SESSION 4

- ☐ eLearning (A/B)
- ☐ E/M Coding (B)
- ☐ Fraud & Abuse (A/B)
- ☐ Medicare Self Service Techniques (A/B)
- ☐ National Correct Coding Initiative (NCCI) Modifiers (B)

Day 3

May 17, 2007
Cost $149.00

9:00 AM - 12:00 PM

- ☐ Ambulatory Surgery Center (B)
- ☐ Cardiology (B)
- ☐ Independent Diagnostic Testing Facility (B)
- ☐ Rehabilitation Services (A/B)
- ☐ Skilled Nursing Facility (A/B)

MEDIFEST 2007, Tampa Registration Form

Marriott Tampa Westshore
1001 N Westshore Blvd Tampa, FL 33607
Please contact hotel for directions and/or reservations (813) 287-2555

Registrant's Name _____

Telephone Number _____

Email Address _____

Fax Number _____

Provider's Name _____

Street Address _____

City, State, ZIP Code _____

Cost for Medifest	
Medifest (Day 1 & 2)	$233.00
Medifest Specialty (Day 3)	$149.00

FAXED REGISTRATION
Fax registration form to (904) 791-6035.
A confirmation will be faxed to you. The invoice will be sent under a separate cover.
Make checks payable to: FCSO Account #700390
Mail the forms (after you have faxed them) and payment to:

Medifest Registration
P.O. Box 45157
Jacksonville, FL 32231
Bring your Medifest confirmation notice to the event.

CANCELLATIONS AND REFUNDS
All cancellation requests must be received 7 days prior to the event. All refunds are subject to a $25.00 cancellation fee per person. (Rain checks will not be issued for cancellations.)

SUBSTITUTIONS
If you are unable to attend, your company may send one substitute to take your place for the entire seminar. Remember: You must inform the Registration Office of all changes.

Once you have signed in at the registration desk, substitutions will not be permitted during the remainder of the event.

CONFIRMATION NOTICE
On-line registration: When registering online for an education event, you will automatically receive your confirmation via e-mail notification.

Faxed registration: A confirmation notice will be faxed or e-mailed to you within 7 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Provider Outreach and Education), please contact us at (904) 791-8103.

HOTEL INFORMATION
Marriott Tampa Westshore
1001 N Westshore Blvd
Tampa, FL 33607
(813) 287-2555

Ask for FCSO's Special Room Rate.

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

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.

PROVIDERS

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

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

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

ORDER FORM — 2007 PART B MATERIALS

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

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

QUANTITY	ITEM	ACCOUNT NUMBER	COST PER ITEM
☐	***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Hardcopy or CD-ROM distribution is limited to individual providers and professional association groups who billed at least one Part B claim (to either Connecticut or Florida Medicare) for processing during the twelve months prior to the release of each issue. **Beginning with publications issued after June 1, 2003**, providers who meet the above criteria must register to receive the *Update!* in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason can be shown why the electronic publication available free of charge on the Internet cannot be utilized. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2006 through September 2007 (back issues will be sent upon receipt of order).	700395	$85.00 (Hardcopy) $20.00 (CD-ROM)
☐	**2007 Fee Schedule –** The revised Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2007, through December 31, 2007, is available free of charge online at *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*. Providers having technical barriers that are registered to receive hardcopy publications will automatically receive one copy of the annual fee schedule. Additional copies or a CD-ROM is available for purchase. The Fee Schedule contains calendar year 2007 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note: Revisions to fees may occur; FCSO will republish any revised fees in future editions of the *Medicare B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	Hardcopy: $5.00 (CT) $10.00 (FL) CD-ROM: $6.00 (Specify CT or FL)

Please write legibly

Subtotal $ _____
Tax (***add % for your area***) $ _____
Total $ _____

Mail this form with payment to:
First Coast Service Options, Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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

MEDICARE B UPDATE!

FIRST COAST SERVICE OPTIONS, INC.
P.O. BOX 2078 JACKSONVILLE, FL 32231-0048 (FLORIDA)
P.O. BOX 44234 JACKSONVILLE, FL 32231-4234 (CONNECTICUT)

* ATTENTION BILLING MANAGER *