Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

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

Routing Suggestions:

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

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

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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. We made this change to better serve our customers by making valuable information available in a more timely manner. The previous quarterly publications became too large in scope and size making it difficult to navigate through the large volume of information.

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

A header bar preceding articles clearly indicates whether the topic is applicable to both Connecticut and Florida, Connecticut only, or Florida only. 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 maintained in separate sections.

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.

Medical review and **comprehensive data analysis** will *always* be in state-specific sections, as will **educational resources**. Important **addresses, phone numbers**, and **websites** are also listed for each state.

Advance Beneficiary Notices (ABNs)

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. 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 "New 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 CMSs' 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 Claims Review
PO Box 2360
Jacksonville, FL 32231-0018

CLAIMS

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

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

Note: This article was revised on February 9, 2007, to clarify the language in the first bullet point under "Billing Guidelines". All other information remains the same. This information was previously published in the November 2006 *Medicare B Update!* pages 5-6.

Provider Types Affected

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

Key Points

- The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the national provider identifier (NPI).
- The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.
- During this transition time there will be a dual acceptability period of the current and the revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior Form CMS-1500 (12/90) is the **split provider identifier fields**.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.
- There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

January 2, 2007 – March 30, 2007

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

April 2, 2007

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

Background

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

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

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

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

Billing Guidelines

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

  IF

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

- 24J (replacing item 24K, Form CMS-1500 [12-90]);
- 17B (replacing item 17 or 17A, Form CMS-1500 [12-90]);
- 32a (replacing item 32, Form CMS-1500 [12-90]); and
- 33a (replacing item 33, Form CMS-1500 [12-90]).

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

Additional Information

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

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

Legacy identifiers are pre-NPI provider identifiers such as:

- PINs (provider identification numbers)
- UPINs (unique physician identification numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSCs (national supplier clearinghouse numbers) for DMERC claims.

Additional NPI-Related Information

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

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

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

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

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

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

If you have questions, please contact your Medicare carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5060 *Revised*
Related CR Release Date: September 15, 2006
Related CR Transmittal #: R1058CP
Related Change Request (CR) #: 5060
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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Health Professional Shortage Area Incentive Payment Processes

Physicians are eligible for a 10 percent incentive payment when they render service(s) in certain medically underserved areas. These areas, known as Health Professional Shortage Areas (HPSAs), may cover an entire county or a portion of a county or city, and are designated as either rural or urban HPSAs. HPSA designations are made by the Division of Shortage Designation (DSD) of the Public Health Service (PHS).

The incentive payments are based on 10 percent of the paid amount for both assigned and nonassigned claims for services performed by the physician. The incentive payment is not made on a claim-by-claim basis; rather, payments are issued quarterly.

Eligibility

A physician is eligible for the HPSA incentive payment *when services are furnished in an area designated as a HPSA*, regardless of where the physician's office is located. For example, a physician's office may be located in an area not designated as a HPSA; however, the physician may treat a patient in a nursing facility located in a HPSA. In this instance, the physician would be eligible for the HPSA incentive payment. Likewise, the physician's office may be in a HPSA; however, the physician may treat a patient in his/her home that is not located in a HPSA. In this case, the physician is *not* eligible for the HPSA incentive payment. Only physicians are eligible for the HPSA incentive payments. The following degrees/credentials are considered physicians eligible for the incentive payments: M.D., D.O., D.C., D.P.M., D.D.S., and O.D.

Physicians must review the information provided on the CMS website for HPSA designations to determine if the location where they render services is, indeed, within a HPSA incentive area. The specific CMS website for this information is *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/*. However, the Health Resources and Services Administration (HRSA) website should be reviewed for the most recent designations at *http://www.hrsa.gov/*.

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Health Professional Shortage Area Incentive Payment Processes, continued

Claims Filing Requirements

The submission of the QB or QU modifier, or the AQ modifier for claims with dates of service on or after January 1, 2006, will be required for the following:

- fully falls within a full county HPSA;
- partially falls within a full county HPSA and has been determined to be dominant for the county by the USPS; and
- fully falls within a partial county HPSA.

The submission of the AQ modifier will be required when services are provided in a ZIP code area that:

- does not fully fall within a designated full county HPSA incentive area;
- partially falls within a full county HPSA but is not considered to be in that county based on the dominance decision made by the USPS;
- partially falls within a partial county HPSA; and
- was not included in the automated file based on the date of the data run used to create the file.

To be considered for the incentive payment, the name, address, and ZIP code of where the service was rendered must be included on all electronic and paper claims submissions.

Appeal of HPSA Incentive Payments

The incentive payments do not include remittance advice notices; only a list of the claims to which the incentive payment applies is provided with the payment. As a result, physicians have not been provided with an opportunity to challenge the amounts of their HPSA incentive payments on nonassigned claims or to challenge nonassigned claims where incentive has not been paid.

CMS has provided clarification of these issues:

- In cases where a physician is not satisfied with the amount of the incentive payment on either assigned or nonassigned claims, he or she may request a review of the incentive payment. The review request must be made within 60 days of the date when the incentive payment was issued.
- In cases where an incentive payment was not made on a claim (assigned or nonassigned), but the physician believes that one should have been made, he or she may request a reopening of that particular claim. The request must be within one year of the claim payment.

Note: If the physician is unsure of the date a nonassigned claim was *processed*, the request for reopening may be made within one year of the date the claim was *submitted*, to ensure the request for the reopening is made within the one-year time limit.

Source: CMS Internet Only Manual, Publication 100-04, Chapter 12, Section 90.4

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Competitive Aquisition Program

Competitive Acquisition Program – Claim Processing for Not Otherwise Classified Drugs

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

Note: This article was revised on January 29, 2007, to alert participating physicians that the dose of the drug should be coded also in item 19 of paper claims or loop 2300 segment NTE on electronic claims. All other information remains the same. This information was previously published in the January 2007 *Medicare B Update!* (pages 41-42).

Provider Types Affected

Physicians participating in the Medicare Part B Drug Competitive Acquisition Program (CAP).

Impact on Providers

This article is based on change request (CR) 5259, which describes the process for adding not otherwise classified (NOC) drugs to the CAP beginning in 2007. It provides additional details, information and instructions for the implementation of the CAP as outlined previously in CRs 4064, 4306, 4309 and 5079 and the *MLN Matters* articles related to those CRs.

Background

As discussed in the November 21, 2005 CAP final rule (*http://www.access.gpo.gov/su_docs/fedreg/a051121c.html*) and in response to public comments about beneficiary access to new medications, CMS provided for the addition of NOC drugs to the CAP beginning in 2007. CMS believes that the addition of NOC drugs to the CAP will improve beneficiaries' access to newly marketed drugs that have a national sales price, will decrease the reliance on buy and bill acquisition and will further simplify the drug acquisition process for physicians who have elected to participate in the CAP.

Process To Add NOC Drugs To A CAP Vendor's Drug List

The process for adding NOC drugs to the CAP will basically follow the process for adding other drugs to the CAP as described in CR 5079. An approved CAP vendor will be required to submit a written request to add specific NOC drugs to the CAP designated carrier. The request must include:

- A rationale for the proposed change,
- A discussion of the impact on the CAP (including safety, waste, etc.), and
- The potential for cost savings.

CMS will define a list of CAP NOC drugs that the approved CAP vendor must use when requesting the addition of NOC drugs to the CAP. The CAP NOC drug list will be based on the ASP NOC list, but will include only drugs that are both likely to fit the existing CAP drug category (or categories) and drugs that have a single national ASP-based payment amount. The CAP NOC drug list will be posted on the CMS CAP web site and updated quarterly.

If approved, changes will become effective at the beginning of the following quarter. CMS will post the changes on the CMS website (*http://www.cms.hhs.gov/CompetitiveAcquisforBios/*) and notify the carriers and participating CAP physicians of any changes on a quarterly basis. Participating CAP physicians will be notified of changes to their approved CAP vendor's CAP drug list on a quarterly basis and at least 30 days before the approved changes are due to take effect. CAP drug list approvals apply only to the CAP vendor who submitted the request and to the category identified on the request. Therefore, each vendor's drug list may contain different drugs after changes to the initial drug list are approved. The CAP NOC drug payment amount will be at the same rate as published on the ASP NOC file consistent with the next quarterly update, and the payment amount will be updated annually as for other CAP drugs.

CAP NOC Claims Submission Requirements

CMS requires the use of a CAP-specific Q code (Q4082 Drug/bio NOC part B drug CAP) for CAP NOC drug claims in order to distinguish CAP NOC drug claims from ASP NOC claims and to prevent the CAP claims from being paid outside the Medicare Part B drug CAP. Physician drug administration claims for CAP NOC drugs are required to

- use the CAP-specific NOC Q-code: Q4082 Drug/bio NOC part B drug CAP
- and identify the specific NOC drug and dose that had been administered in Item 19 on paper claims or loop 2300 Segment NTE on electronic claims
- Physician claims must also contain the appropriate CAP modifiers (J1, J2, J3) All other CAP claim parameters will remain the same.

Note: Physicians who have elected to participate in the CAP should continue to use ASP NOC codes when billing for NOC drugs that are outside the CAP. Also remember that physicians who participate in the CAP are required to obtain all CAP drugs on the updates from the approved CAP vendor unless medical necessity requires the use of a formulation not supplied by the vendor.

Competitive Acquisition Program – Claim Processing for Not Otherwise Classified Drugs, continued

Returned CAP NOC Claims

For the following three situations, if:

- The claim is submitted with a CAP NOC code, but the description does not match a CAP NOC drug on the approved list; or
- The claim is submitted with a CAP NOC code by a non-CAP physician; or
- The claim is submitted with a J NOC code with a description of a CAP approved NOC drug.

Then:

- Claims will be returned to physicians with a reason code of 16 (Claim/service lacks information needed for adjudication) and remark code MA 130 (Your claims contain incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable).
- Remark code N350 (Missing/incomplete/invalid description of a service for a NOC code or unlisted procedure) will also appear in the first situation.
- Remark code N56 (Procedure code billed is not correct/ valid for the services billed or the date of service billed) will appear in the second and third situations.

Implementation

The implementation date for CR 5259 is January 2, 2007.

Additional Information

Section 303 (d) of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals ("drugs") not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians will be given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. A participating CAP physician will submit a claim for drug administration to the Medicare local carrier. An approved CAP vendor will submit a claim for the drug product to the CAP Medicare designated carrier.

CR 5259 is not a stand-alone CR. It provides additional details, information, and instructions for the implementation of the Competitive Acquisition Program (CAP) as outlined in:

- CR 4064 (*http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf*; *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf*),
- CR 4306 (*http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf*),
- CR 4309 (*http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf* ; *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf*) and
- CR 5079 (*http://www.cms.hhs.gov/Transmittals/downloads/R1055CP.pdf* ; *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf*).

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1034CP.pdf* on the CMS website.

If you have questions, please contact your Medicare carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5259 *Revised*
Related CR Release Date: August 18, 2006
Related CR Transmittal #: R1034CP
Related Change Request (CR) #: CR5259
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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Competitive Acquisition Program Web-Based Workshops

The Centers for Medicare & Medicaid Services (CMS) and Noridian Administrative Services (NAS) are offering Web-based workshops for **providers currently enrolled in the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals** on the following dates:

February 6, 2007 February 9, 2007
February 7, 2007 February 13, 2007

Registration information for these workshops can be found at *https://www.noridianmedicare.com/cap_drug/train/workshops/index.html*, on the CAP for Part B Drugs and Biologicals Workshop page. The session will include

- CAP billing procedures for physicians
- Identification of CAP physician billing resources
- Question and answer session on CAP billing.

We especially encourage providers who are new to the CAP to participate in these interactive workshops. Please remember that due to space limitations attendance is restricted to providers and their office staff who are currently participating in the CAP.

Source: CMS Provider Education Resource 200702-07

***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.*

PATHOLOGY/LABORATORY

Healthcare Common Procedure Coding System Subject to and Excluded from Clinical Laboratory Improvement Amendments Edits

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

Provider Types Affected

Clinical diagnostic laboratories billing Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for laboratory tests.

Provider Action Needed

STOP – Impact to You

If you do not have a valid, current, Clinical Laboratory Improvement Amendments (CLIA) certificate and submit a claim to your Medicare carrier or A/B MAC for a Healthcare Common Procedure Coding System (HCPCS) code that is considered to be a laboratory test, your Medicare payment may be impacted.

CAUTION – What You Need to Know

The CLIA of 1998 requires that for each test it performs, a laboratory facility must be appropriately certified. The HCPCS codes that CMS considers laboratory tests under CLIA (and thus requiring certification) change each year. CR 5457, from which this article is taken, informs carriers and A/B MACS about the new HCPCS codes for 2007 that are subject to CLIA edits and also about those that are now excluded from CLIA edits.

GO – What You Need to Do

Make sure that your billing staffs are aware of these CLIA-related HCPCS changes for 2007 and that you remain current with certification requirements.

Background

The CLIA require a laboratory facility to be appropriately certified for each test it performs.

To ensure that Medicare and Medicaid only pay for laboratory tests that are performed by certified facilities, carriers and A/B MACs will edit each Medicare claim submitted for a HCPCS code considered to be a CLIA laboratory test. These HCPCS codes change each year, and CR 5457, from which this article is taken, informs carriers and A/B MACs about the new HCPCS codes for 2007 that are both subject to, and excluded from, CLIA edits.

The HCPCS codes listed in the Table 1, below, are new for 2007 and are subject to CLIA edits (the list does not include new HCPCS codes for waived tests or provider-performed procedures.) This means that laboratory facilities performing these tests must have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). Conversely, a facility **without** a valid, current, CLIA certificate, or **with** a current CLIA certificate of waiver (certificate type code 2) or a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) will not be paid for these tests and the claims will be denied.

Table 1

Note: **Carriers and A/B MACS will add the LC code of 610 for the specialty of histopathology to the new Mohs HCPCS codes**

New 2007 HCPCS Codes Subject to CLIA Edits	
HCPCS Code	Description
17311	*Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including the routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks;*
17312	*Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including the routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure);*

HCPCS Subject to and Excluded from CLIA Edits , continued

New 2007 HCPCS Codes Subject to CLIA Edits	
HCPCS Code	Description
17313	*Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including the routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks;*
17314	*Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including the routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)*
17315	*Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including the routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure)*
82107	*Alpha-fetoprotein (AFP); APF-L3 fraction isoform and total AFP (including ratio)*
83698	*Lipoprotein-associated phospholipase* A_2*, (Lp-*PLA_2*)*
83913	*Molecular diagnostics; RNA stabilization*
86788	*Antibody; West Nile virus, IgM*
86789	*Antibody; West Nile virus*
87305	*Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Aspergillus*
87498	*Infectious agent detection by nucleic acid (DNA or RNA); enterovirus, amplified probe technique*
87640	*Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, amplified probe technique*
87641	*Infectious agent detection by nucleic acid (DNA or RNA); Staphylococcus aureus, methicillin resistant, amplified probe technique*
87653	*Infectious agent detection by nucleic acid (DNA or RNA); Streptococcus , group B, amplified probe technique*
87808	*Infectious agent detection by immunoassay with direct optical observation; Trichomonas vaginalis*

CR 5457 also provices HCPCS codes that were discontinued on December 31, 2006.

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HCPCS Subject to and Excluded from CLIA Edits , continued

Table 2

HCPCS codes discontinued in 2007	
HCPCS Code	Description
17304	*Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); first stage, fresh tissue technique, up to five specimens;*
17305	*Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); second stage, fixed or fresh tissue technique, up to five specimens;*
17306	*Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); third stage, fixed or fresh tissue technique, up to five specimens;*
17307	*Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); additional stage(s), up to five specimens, each stage; and*
17310	*Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histological preparation including the first routine stain (eg, hematoxylin and eosin, toluidine blue); each additional specimen, after the first five specimens, fixed or fresh tissue any stage (list separately in addition to code for primary procedure).*

Note: Carriers and A/B MACS will add the LC code of 610 for the specialty of histopathology to the new Mohs HCPCS codes (*17311, 17312, 17313, 17314*, and *17315*) even though are not currently edited at the laboratory certification (LC) level.

Remember that carriers and A/B MACs will return as unprocessable claims submitted with the HCPCS codes displayed in Table 1, above, **without** a CLIA number. Also, carriers and A/B MACs will deny payment for claims submitted without a valid current CLIA certificate, or **with** a CLIA certificate of waiver (certificate type code 2), or a CLIA certificate for provider-performed microscopy procedures (certificate type code 4). Finally, carriers and A/B MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims processed prior to the April 2, 2007, implementation date. They will adjust claims that are brought to their attention.

Additional Information

You may find the official instruction, CR 5457, issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1165CP.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.

MLN Matters Number: MM5457
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R1165CP
Related Change Request (CR) #: 5457
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

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Preventive Services

Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change

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

Provider Types Affected

Non-outpatient prospective payment system (non-OPPS) hospital outpatient departments and ambulatory surgical centers (ASCs) who bill Medicare fiscal intermediaries (FIs), carriers, or Part A/B Medicare administrative contractors (A/B MACs) for colorectal cancer screening flexible sigmoidoscopy, and colonoscopy.

Impact on Providers

Effective for services **on or after January 1, 2007,** Medicare requires:

1. A 25 percent beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies, and colonoscopies performed in the outpatient departments of non-OPPS hospitals.
2. A 25 percent beneficiary coinsurance for colorectal cancer screening colonoscopies performed in ASCs.

Background

Section 1834(d)(2) of the Social Security Act, imposes a 25 percent beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies (*Healthcare Common Procedure Coding System [HCPCS] code G0104 – Colorectal cancer screening; flexible sigmoidoscopy*) that are performed in hospital outpatient departments. While this coinsurance has already been applied in the OPPS for OPPS hospitals (effective for services performed on or after January 1, 1999), it will now be applied to non-OPPS hospitals, **effective January 1, 2007.**

Similarly, Section 1834(d)(3) of the Social Security Act, in part, imposes a 25 percent beneficiary coinsurance for colorectal cancer screening colonoscopies (*HCPCS codes G0105 - Colorectal cancer screening; colonoscopy on individual at high risk, and G0121 – Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk*) that are performed in ASCs) and in hospital outpatient departments. And while, as above, this coinsurance has already been applied in the OPPS for OPPS hospitals (effective for services performed on or after January 1, 1999), it is being applied to these services performed in ASCs or non-OPPS hospitals, **effective January 1, 2007.**

Therefore, effective for services on or after January 1, 2007 (as is currently done for OPPS hospitals), FIs, carriers, A/B Macs will apply the 25 percent coinsurance to colorectal cancer screening flexible sigmoidoscopies (G0104) and colonoscopies (G0105 and G0121) that are performed in non-OPPS hospitals and to colorectal cancer screening colonoscopies (HCPCS codes G0105 and G0121) that are performed in ASCs.

Pertinent details included in CR 5387 are:

- For services beginning January 1, 2007, FIs, carriers, A/B MACS will base the coinsurance amounts for colorectal screening sigmoidoscopies and colonoscopies, performed in non-OPPS hospitals, on the payment methodology currently in place for colorectal screening services and, for those performed in ASCs, on Medicare's ASC facility payment for services.
- FIs, carriers, and A/B MACs will neither search for nor adjust claims for colorectal screening colonoscopies and sigmoidoscopies that have been paid prior to the implementation of this change by Medicare on July 2, 2007, but they will adjust such claims that are brought to their attention.
- While prior to January 1, 2007, both a deductible and a coinsurance applied to these colorectal screening procedures, effective for services on or after January 1, 2007, **(as part of Section 5113 of the Deficit Reduction Act [DRA]), the deductible is waived for colorectal screening sigmoidoscopies and colonoscopies performed in ASCs or hospital outpatient departments.** (This change is implemented under CR 5127, transmittal 1004, dated July 21, 2006. The related *MLN Matters* MM5127 is available on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf*.)
- For procedures performed in ASCs, this change applies to the ASC bills, not to the physician bills.
- FIs, carriers, and A/B MACs will change the Medicare Summary Notices (MSNs) issued to beneficiaries to reflect this change in the coinsurance/copayment amount. They will use MSN message 61.41 – "You pay 25 percent of the Medicare-approved amount for this service."

Additional Information

You may find more information about the change in the coinsurance payment amount for colorectal cancer screening flexible sigmoidoscopy and colonoscopy performed in hospital outpatient departments and ASCs, by going to CR 5387, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1160CP.pdf*.

Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change, continued

Attached to the CR 5387, you will find updated *Medicare Claims Processing Manual* (Publication 100-04), Chapter 1 (General Billing Requirements), Section 30.3.1 (Mandatory Assignment on Carrier Claims); Chapter 14 (Ambulatory Surgical Centers), Section 40.2 (Carrier Adjustment of Base Payment Rates); and Chapter 18 (Preventive and Screening Services), Sections 60.1 (Payment), 60.1.1 (Deductible and Coinsurance); and 60.2.2 (Ambulatory Surgical Center [ASC] Facility Fee).

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

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

MLN Matters Number: MM5387 Related Change Request (CR) Number: 5387
Related CR Release Date: January 19, 2007 Related CR Transmittal Number: R1160CP
Effective Date: January 1, 2007 Implementation Date: July 2, 2007

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SURGERY

Coding Change for Lumbar Artificial Disc Replacement

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

Provider Types Affected

All physicians and providers who submit claims to Medicare carriers, Part A/B Medicare administrative contractors (A/B MACs), for lumbar artificial disc replacement (LADR).

Provider Action Needed

STOP – Impact to You

Effective for services on or after January 1, 2007, the *CPT* codes for billing LADR are changing.

CAUTION – What You Need to Know

No change in Medicare policy results from this coding change. Ensure billing staff uses the correct codes to assure prompt and correct payment of your claims.

GO – What You Need to Do

For services on or after January 1, 2007, use *CPT* code *22857* in place of *CPT* category III code *0091T* for LADR. Also, use new *CPT* category III code *0163T* in place of *CPT* category III code *0092T* for services on or after January 1, 2007. *CPT* category III codes *0091T* and *0092T* are still appropriate for services on or before December 31, 2006, but are discontinued as of December 31, 2006.

Background

This article is based on change request (CR) 5462 and the purpose is to announce a coding change effective January 1, 2007, for LADR. A prior CR 5057, transmittal 992, issued on June 23, 2006 contains correct codes for services rendered in 2006. However, beginning with services rendered on or after January 1, 2007, there are new coding changes. If you would like to review the *MLN* article that resulted from CR 5057 click on the following link: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5057.pdf* on the CMS website. Please be aware that the national coverage determination (NCD) issued under CR 5057 is not changing, only the codes that should be utilized have changed.

Effective for services performed on or after January 1, 2007, carriers will deny claims, for Medicare beneficiaries over sixty years of age, submitted with the following codes:

- *CPT* code *22857* for total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace.
- *CPT* category III code *0163T* for total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, each additional interspace.

Carriers and A/B MACs will continue to follow their normal claims processing criteria for investigational device exemptions (IDEs) for LADR performed with an implant eligible under the IDE criteria.

Carriers will allow claims submitted for approved IDEs/clinical trials submitted with:

- *0091T* or *0092T* for services performed from May 16, 2006 through December 31, 2006
- *22857* or *0163T* for services performed on or after January 1, 2007 with the modifier QA.

Coding Change for Lumbar Artificial Disc Replacement, continued

Additional Information

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

For complete details regarding this CR please see the official instruction (CR 5462) issued to your Medicare A/B MAC or carrier. That instruction may be viewed by going to http*://www.cms.hhs.gov/Transmittals/downloads/R1164CP.pdf* 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: MM5462
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R1164CP
Related Change Request (CR) #: 5462
Effective Date: January 1, 2007
Implementation Date: March 13, 2007

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THERAPY SERVICES

Infrared Therapy Devices

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

Note: CMS has revised this *MLN Matters* article on February 9, 2007, to correct the range of ICD-9-CM codes shown in bold print to ICD-9-CM range 880.00-887.7. The article was also revised to reflect the new change request (CR) transmittal number, the CR release date, and the Web address for accessing CR 5421. All other information remains the same. The original *MLN Matters* article was published in the January 2007 *Medicare B Update!* (pages 54-55).

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare carriers, Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME/MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs), for the use of infrared therapy devices for treatment of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5421. Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services (CMS) has made a national coverage determination (NCD) stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), **is noncovered for the treatment,** including symptoms such as pain arising from these conditions, of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Background

The use of infrared therapy devices has been proposed for a variety of disorders, including treatment of diabetic neuropathy, other peripheral neuropathy, skin ulcers and wounds, and similar related conditions, including symptoms such as pain arising from these conditions. A wide variety of devices are currently available. Previously there was no NCD concerning the use of infrared therapy devices, leaving the decision to cover or not cover up to local Medicare contractors.

The following requirements are in effect as of October 24, 2006:

- **Effective for services provided on or after October 24, 2006**, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) **are noncovered** as DME or PT/OT services when used for the treatment of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.
- Claims will be denied with *CPT 97026* (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9 codes:

250.60-250.63

354.4, 354.5, 354.9

355.1-355.4

355.6-355.9

356.0, 356.2-356.4, 356.8-356.9

357.0-357.7

674.10, 674.12, 674.14, 674.20, 674.22, 674.24

707.00-707.07, 707.09-707.15, 707.19

870.0-879.9

880.00-887.7

890.0-897.7

998.31-998.32.

Infrared Therapy Devices, continued

- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects type of bills (TOBs) 12x, 13x, 22x, 23x, 34x, 74x, 75x and 85x.
- If you submit a claim for one of the noncovered services, your patient will receive the Medicare summary notice (MSN) message stating "This service was not covered by Medicare at the time you received it". The Spanish translation is: "Este servicio no estaba cubierto por Medicare cuando usted lo recibió."
- If you submit a claim for one of the noncovered services you will receive a remittance advice notice that reads: Claim Adjustment Reason Code 50, "These are noncovered services because this is not deemed a 'medical necessity' by the payer."
- Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospital outpatient departments should note that **you are liable** if the service is performed, unless the beneficiary signs an advanced beneficiary notice (ABN).
- DME suppliers and HHA be aware that **you are liable** for the devices when they are supplied, unless the beneficiary signs an ABN.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5421) issued to your Medicare A/B MAC, FI, DME MAC, RHHI, or carrier. There are actually two transmittals associated with CR 5421. The first is the national coverage determination transmittal, located at on the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf*.

In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1183CP.pdf*.

If you have questions, please contact your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier 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: MM5421 *Revised*
Related CR Release Date: February 9, 2007
Effective Date: October 24, 2006

Related Change Request (CR) Number: 5421
Related CR Transmittal Number: R1183CP and R62NCD
Implementation Date: January 16, 2007

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GENERAL COVERAGE

Direct Billing and Payment for Nonphysician Practitioner Services Furnished to Hospital Inpatients and Outpatients

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

Provider Types Affected

All hospitals, clinical nurse specialists (CNSs), nurse practitioners (NPs), and the employers of physician assistants (PAs) who bill Medicare for hospital inpatient and outpatient services.

Background

Section 4511(a)(2)(B) of the Balanced Budget Act of 1997 amended section 1861(b)(4) of the Social Security Act **to exclude the professional services of NPs, CNSs and PAs from hospital inpatient services**. Accordingly, upon the effective date of change request (CR) 5221, NPs and CNSs are authorized to bill Medicare carriers directly for their professional services when furnished to hospital patients, both inpatients and outpatients. The **employer of a PA**, rather than the hospital, **must bill the carrier for their professional services when furnished to hospital patients**. **Hospitals should not bill for the professional services of a PA, unless the PA is employed by the hospital.**

Key Points

This article and CR 5221 describe the removal of the paragraph in the *Medicare Claims Processing Manual*, Chapter 12 Section 120.1 that contains outdated policy on payment for NP and CNS services furnished in a hospital setting. The changes are as follows:

- The professional services of NPs and CNSs furnished to hospital inpatients and outpatients may be billed directly by the NP or CNS to the carrier under their respective Medicare billing number or their National Provider Identifier (NPI), once

Direct Billing and Payment for NPP Services Furnished to Hospital Inpatients and Outpatients, continued

the NPI is effective.

- The employer of a PA may bill the carrier directly for the professional services of the PA furnished to hospital inpatients and outpatients under the PA's Medicare billing number or the PA's NPI, once the NPI is effective.
- Hospitals may bill the carrier for the professional services of an NP or a CNS furnished to hospital inpatients and outpatients when payment for the NP and CNS services has been reassigned to the hospital and when the hospital bills for these services under the NP's or CNS's unique provider identifier number (UPIN).
- Your Medicare carrier will identify and reprocess any claims submitted by NPs, CNSs, or the employer of a PA that have been denied since January 1, 2006, because the claim listed a hospital inpatient or outpatient setting place of service.
- For claims for dates of service prior to January 1, 2006, the carrier will reopen claims that were denied because they listed a hospital inpatient or outpatient place of service. However, the carrier will only reopen these claims if the NP, CNS, or employer of the PA brings the claim to the attention of the carrier and the carrier will pay these claims for dates of services on or after the January 1, 1998, effective date retroactive to the actual date that the services were rendered.

Additional Information

The official instructions, CR5 221, issued to your Medicare carrier regarding this change can be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1168CP.pdf*.

A revised Chapter 12, Section 120.1—Direct Billing and Payment—of the *Medicare Claims Processing Manual* is attached to CR 5221.

If you have questions, please contact your Medicare carrier 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: MM5221
Related Change Request (CR) Number: 5221
Related CR Release Date: January 26, 2007
Related CR Transmittal Number: R1168CP
Effective Date: April 26, 2007
Implementation Date: April 26, 2007

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

Processing All Diagnosis Codes Reported on Claims Submitted to Carriers

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

Provider Types Affected

All physicians and suppliers who submit claims for services provided to Medicare beneficiaries to carriers or A/B Medicare administrative contractors (MACs).

Provider Action Needed

This article is derived from CR 5441, which announces the requirement that (effective for claims processed July 1, 2007 and later) the Part B standard systems and the carrier claims processing systems capture and process up to eight diagnosis codes on all of your claims (both paper and electronic). You should make sure that your billing staff is aware of these changes that allow all eight diagnosis codes on Medicare claims effective, July 1, 2007.

Background

While the ANSI 837P 4010A allows a maximum of eight diagnosis codes to be reported for each claim, the Medicare Part B standard systems and the carrier claims processing systems have historically used only the first four diagnosis codes reported on the claim when processing the HIPAA format claims. Carriers have used a manual process to consider the remaining diagnosis codes in the Medicare payment determinations. The purpose of CR 5441 is to finalize the requirement that the Part B standard system and the carrier claims processing systems be modified to process your paper and electronic claims using all diagnosis codes that you report on the claim (up to eight).

Additional Information

You may find the official instruction, CR 5441, issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1157CP.pdf* on the CMS website.

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

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

MLN Matters Number: MM5441
Related Change Request (CR) #: 5441
Related CR Release Date: January 19, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1157CP
Implementation Date: July 2, 2007

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HIPAA – The Health Insurance Portability and Accountability Act

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

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

Provider Action Needed

CR 5456, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective April 2, 2007. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities .The health care claim adjustment reason code list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at *http://wpc-edi.com/codes*. **The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5456, effective on and after April 1, 2007.**

CMS has also developed a new tool to help you search for a specific category of code and that tool is at *http://www.cmsremarkcodes.info*. Note that this website does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You can see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5456, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1163CP.pdf*.

For additional information about remittance advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

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

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

X12N 835 Remittance Advice Remark Code Changes

New Codes	Current Narrative	Medicare Initiated
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf. **Note:** New code December 1, 2006.	No
N374	Primary Medicare Part A insurance has been exhausted and a Part B remittance advice is required. **Note:** New code December 1, 2006.	No
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility. **Note:** New code December 1, 2006.	No
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE. **Note:** New code December 1, 2006.	No

Remittance Advice Remark Code and Claim Adjustment Reason Code Update, continued

New Codes	Current Narrative	Medicare Initiated
N377	Payment adjusted based on a processed replacement claim. **Note:** New code December 1, 2006.	No
N378	Missing/incomplete/invalid prescription quantity. **Note:** New code December 1, 2006.	No
N379	Claim level information does not match line level information. **Note:** New code December 1, 2006.	No

Modified Code	Current Narrative	Modification Date
M143	The provider must update license information with the payer.	December 1, 2006
N181	Additional information is required from another provider involved in this service. **Note:** New code February 28,2003.	December 1, 2006
N361	Payment adjusted based on multiple diagnostic imaging procedure rules **Note:** New code November 18, 2005.	December 1, 2006

There are **no** deactivated codes.

Note II: Some remark codes may provide information that may not necessarily supplement the explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Newly created informational codes will have "Alert" in the text to identify them as informational rather than explanatory codes. An example of an informational code:

N369 Alert: **Although this claim has been processed, it is deficient according to state legislation/regulation.**

The above information is sent per state regulation, but does not explain any adjustment. These informational codes should be used only if specific information needs to be communicated but not as default codes.

X12 N 835 Health Care Claim Adjustment Reason Codes

New Code	Current Narrative	Notes
197	Payment denied/reduced for absence of precertification/authorization.	New as of October 2006
198	Payment denied/reduced for exceeded, precertification/authorization.	New as of October 2006
199	Revenue code and Procedure code do not match.	New as of October 2006
200	Expenses incurred during lapse in coverage.	New as of October 2006
201	Workers compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR).	New as of October 2006

Modified Code	Current Narrative	Notes
42	Charges exceed our fee schedule or maximum allowable amount. **Note:** This code will be deactivated on June 1, 2007.	Modified as of October 2006.
45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective June 1, 2007: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group codes PR or CO depending upon liability). **Note:** This code replaces code 42 (above) on June 1, 2007.	Modified as of October 2006. Effective June 1, 2007.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. **Note:** Changed as of February 2001, and October 2006. This code will be deactivated on April 1, 2007.	Modified as of October 2006.
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. **Note:** Changed as of February 1999 and October 2006.	Modified as of October 2006.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update, continued

Modified Code	Current Narrative	Notes
107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim. **Note:** Changed as of June 2003 and October 2006.	Modified as of October 2006.
136	Claim adjusted based on failure to follow prior payer's coverage rules. (Use Group Code OA). **Note:** Changed as of June 2000 and October 2006.	Modified as of October 2006.
196	Claim/service denied based on prior payer's coverage determination. **Note:** New as of June 2006. Changed October 2006. This code will be deactivated on 2/1/2007. Beginning on that date, value 136 will be used.	Modified as of October 2006.
A1	Claim/service denied. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code). **Note:** Changed as of October 2006.	Modified as of October 2006.
B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note:** Changed as of February 2001 and October 2006.	Modified as of October 2006.
D17	Claim/Service has invalid noncovered days. **Note:** This code was deactivated on February 1, 2007, and code 16 will then be used with appropriate claim payment remark code [M32, M33].	Modified as of October 2006.
D18	Claim/service has missing diagnosis information. **Note:** This code was deactivated on February 1, 2007, and then code 16 will be used with appropriate claim payment remark code [MA63, MA65].	Modified as of October 2006.
D19	Claim/service lacks physician/operative or other supporting documentation. **Note:** This code was deactivated on February 1, 2007, and code 16 will be used with appropriate claim payment remark code [M29, M30, M35, M66].	Modified as of October 2006.
D20	Claim/service missing service/product information. **Note:** This code was deactivated on February 1, 2007, and code 16 will be used with appropriate claim payment remark code [M20, M67, M19, MA67].	Modified as of October 2006.
D21	This (these) diagnosis(es) is (are) missing or are invalid. **Note:** New as of June 2005. This code was deactivated on February 1, 2007.	Modified as of October 2006.

MLN Matters Number: MM5456
Related Change Request (CR) Number: 5456
Related CR Release Date: January 26, 2007
Related CR Transmittal Number: R1163CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

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Sign up to our *eNews* electronic mailing list

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

Healthcare Provider Taxonomy Code Update

Effective April 1 2007, the health care provider taxonomy codes (HPTC) will be updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of HPTC is available from the Washington Publishing Company website at: *http://www.wpc-edi.com/codes/taxonomy*. If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level deletion (rejection) may occur. To ensure you do not receive a claim or file level rejection it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system please contact your software support vendor.

Source: CMS Publication 100-04, Transmittal 1154, Change Request 5436

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Issue with 835 Electronic Remittance Advice and TRICARE Crossover Claims

The Centers for Medicare &Medicaid Services (CMS) has identified an issue associated with the implementation of change request (CR) 5250 – Coordination of Benefits Agreement (COBA) Eligibility File Claim Recovery Process. The 835 electronic remittance advices (ERAs) for claims **processed on or after January 2, 2007,** associated with TRICARE crossover claims were missing remark code MA18. Remark code MA18 advises providers that the processed claim has been crossed over by the Medicare carrier system.

CMS has verified that the claims have in fact crossed over so there is no need for providers to send paper RA to TRICARE.

A coding correction has been implemented in the Medicare carrier system, however, only those claims received **on or after February 5, 2007**, will have the remark code MA18 present on the 835 ERA.

Source: CMS Provider Education Resource 200702-06

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.

General Information

2007 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD will be available on the Connecticut and Florida Medicare Part B websites on March 16, 2007 and may be accessed at:

Connecticut: *http://www.connecticutmedicare.com/common_shared_medpard_medpard.asp#TopOfPage*

Florida: *http://www.floridamedicare.com/common_shared_medpard_medpard.asp#TopOfPage*

Source: Pub 100-04, Transmittal 1131, Change Request 5448
Pub 100-04, Transmittal 1074, Change Request 5307

Centralized Billing for Flu and Pneumococcal Vaccination Claims

Centralized billing is a process in which a provider, who provides mass immunization services for influenza and pneumococcal (PPV) immunizations, can send all claims to a single carrier for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the flu and PPV vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in centralized billing must contact CMS central office (CO), in writing, at the following address by June 1 of the year they wish to begin centrally billing.

Center for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard
Mail Stop C4-12-18
Baltimore, Maryland 21244

Criteria For Centralized Billing

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

- To qualify for centralized billing, an individual or entity providing mass immunization services for flu and pneumonia must provide these services in at least three payment localities for which there are at least three different carriers processing claims.
- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.
- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the flu and PPV benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. This practice is unacceptable.
- The carrier assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned carrier for this year is TrailBlazer Health Enterprises.
- The payment rates for the administration of the vaccinations are based on the Medicare physician fee schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.
- The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.
- Centralized billers must submit their claims on roster bills in an **approved** electronic media claims standard format. Paper claims will not be accepted.

Centralized Billing for Flu and Pneumococcal Vaccination Claims, continued

- Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. TrailBlazer Health Enterprises must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare health insurance claim number) as the carrier will not be able to process incomplete or incorrect claims.
- Centralized billers must obtain an address for each beneficiary so that a Medicare summary notice (MSN) can be sent to the beneficiary by the carrier. Beneficiaries are sometimes confused when they receive an MSN from a carrier other than the carrier that normally processes their claims which results in unnecessary beneficiary inquiries to the Medicare carrier. Therefore, centralized billers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the processing carrier. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.
- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. TrailBlazer Health Enterprises will provide this information.
- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from TrailBlazer Health Enterprises. This is done by completing the Form CMS-855 (Provider Enrollment Application), which may be obtained from TrailBlazer Health Enterprises.
- If an individual or entity's request for centralized billing is approved, the approval is limited to the 12 month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. TrailBlazer Health Enterprises will not process claims for any centralized biller without permission from CMS CO.
- Each year the centralized biller must contact TrailBlazer Health Enterprises to verify understanding of the coverage policy for the administration of the PPV vaccine, and for a copy of the warning language that is required on the roster bill.
- The centralized biller is responsible for providing the beneficiary with a record of the PPV vaccination. The information in items 1 through 6 below must be included with the individual or entity's annual request to participate in centralized billing:
  1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations
  2. Estimates for the number of beneficiaries who will receive PPV vaccinations
  3. The approximate dates for when the vaccinations will be given
  4. A list of the states in which flu and PPV clinics will be held
  5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse); and
  6. Whether the nurses who will administer the flu and PPV vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering flu and PPV vaccinations.

  Source: CMS Internet Only Manuarl, Chapter 18, Section 10.3.1.1

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 pneumococcal vaccination and their administration are covered Medicare 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 CMSs' website: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf*.

Source: CMS Provider Education Resource 200701-13

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

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

Provider Types Affected

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

Provider Action Needed

Be aware of the expanded list of Medicare Advantage (MA) Plan type descriptions that are being displayed by Medicare's common working file (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 will soon be published that contains the list of all active Medicare contracts and their corresponding plan type. The directory will be posted at the following URL no later than March 1, 2007: *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage*.

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 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.

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 the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1175CP.pdf*.

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

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

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The 2007 Physician Quality Reporting Initiative Web Page is Now Available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) Web Page is now available.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the 2007 Physician Quality Reporting Initiative.

PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality-reporting program. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5 percent of total allowed charges for covered Medicare physician fee schedule services.

This newly established Web Page will be updated regularly, so check it often for timely and reliable information from CMS.

For more information on 2007 PQRI, visit *http://www.cms.hhs.gov/PQRI/01_Overview.asp#TopOfPage* on the CMS website.

Source: Provider Education Resources Listserv, Message 200702-09

Timely Claim Filing Guidelines for All Medicare Providers

All Medicare claims must be submitted to the contractor within the established timeliness parameters. For timeliness purposes, services furnished in the last quarter of the calendar year are considered furnished in the following calendar year. The time parameters are:

Dates of Service	Last Filing Date
October 1, 2004 – September 30, 2005	by December 31, 2006
October 1, 2005 – September 30, 2006	by December 31, 2007
October 1, 2006 – September 30, 2007	by December 31, 2008
October 1, 2007 – September 30, 2008	by December 31, 2009

If December 31 falls on a Saturday, Sunday, federal nonworking or legal holiday, the last filing date is extended to the next succeeding workday.

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned unprocessable, is not protected from the timely filing guidelines.

Source: CMS Pub. 100-04, (*Medicare Claims Processing Manual*), Chapter 1, Section 70

Update on CMS Actions to Reverse Invalid Overpayments Generated by Managed Care Informational Unsolicited Responses

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

Provider Types Affected

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

Provider Action Needed

This article provides information regarding overpayment recovery actions that may be taken by your Medicare contractor and the circumstances that have caused these recovery actions. We estimate that between 150,000 – 300,000 claims may be affected by these actions. If, due to the conditions stated below, an overpayment recovery action has occurred for your claims, your Medicare contractor is in the process of correcting the payment. **You need not take any action at this time.** Because these actions will affect Medicare contractors in varying degrees, you should stay tuned to your Medicare contractor's website for additional details.

Background

In *MLN Matters* article SE0681 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0681.pdf*), the Centers for Medicare & Medicaid Services (CMS) advised providers of certain eligibility system issues related to managed care Medicare beneficiaries. In brief, article SE0681 alerted providers that, in some instances, Medicare may be recovering certain overpayments due to system updates on beneficiary eligibility. When such overpayments are identified, Medicare systems generate a managed care informational unsolicited response (MCIUR), which triggers the overpayment recovery.

During the week of December 17, 2006, Medicare systems were updated with some incorrect managed care enrollment data, which, in turn, caused the systems to create some incorrect MCIURs. Medicare files have now been corrected and CMS is working diligently with Medicare contractors to stop the invalid overpayment recoveries from occurring. In addition, where action to recover the overpayments has already occurred, CMS has instructed your contractor to reverse the action and reissue payment to you.

Update on CMS Actions to Reverse Invalid Overpayments Generated by Managed Care Informational Unsolicited Responses, continued

Key Points

- CR 5507 states that recovery action should stop if it has been initiated and reversed if MCIURs have already effected a recovery.
- Physicians and other providers who bill Medicare contractors need not take any action since contractors will automatically make the necessary adjustments as CR 5507 is implemented.
- Your contractor will post more detailed information on their website as CR 5507 is implemented.

Additional Information

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

For complete details regarding this issue, please see the official instruction (CR 5507) issued to your Medicare carrier, FI, A/B MAC, DME MAC, and/or DMERC. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R262OTN.pdf*.

MLN Matters Number: MM5507
Related Change Request (CR) Number: 5507
Related CR Release Date: January 26, 2007
Related CR Transmittal Number: R262OTN
Effective Date: January 26, 2007
Implementation Date: April 26, 2007

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

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.

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.

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

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.

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.

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

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

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

Nevada (NV)
89061

New Hampshire (NH)
03579 03813

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/R1167CP.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).

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Related Change Request (CR) Number: 5208
Related CR Transmittal Number: R1167CP
Implementation Date: October 1, 2007

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Timeliness Standards for Processing Other-Than-Clean 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 carriers and Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is intended as informational only and is based on change request (CR) 5355, which provides requirements for all carriers and MACs for timeliness for processing "other-than-clean" claims.

Background

The Social Security Act (Section 1869(a)(2); *http://www.ssa.gov/OP_Home/ssact/title18/1869.htm*) mandates that the Centers for Medicare & Medicaid Services (CMS) process all "other-than-clean" claims and notify the individual filing such claims of the determination within 45 days of receiving such claims.

Claims that do not meet the definition of "clean" claims are classified as "other-than-clean" claims, and "other-than-clean" claims require investigation or development external to the contractor's Medicare operation on a prepayment basis.

"Clean claim" means a claim that does not contain a defect requiring the Medicare contractor to investigate or develop prior to adjudication. Clean claims must be filed within the timely filing period (see the Social Security Act 1842(c)(2)(B); *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm*).

"Other Than Clean Claims" Any claim that does not meet the definition of clean claim above. These are complete claims that require manual intervention on the part of the contractor to be adjudicated.

CR 5355 instructs the Medicare contractor (carrier/MAC) to process all "other-than-clean" claims and notify the provider and beneficiary of the determination within 45 calendar days of receipt. See *Medicare Claims Processing Manual* (Publication 100-4, Chapter 1, Section 80.2.1; *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf*) for the definition of "receipt date" and for timeliness standards for clean claims.

However, when the Medicare contractor develops the claim by asking the provider/supplier or beneficiary for additional information, the contractor will:

- Cease counting the 45 calendar days on the day that the contractor sends the development letter requesting the additional information, and
- Resume counting the 45 calendar days upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary.

EXAMPLE:

The Medicare contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this situation, 5 of the 45 allotted calendar days will have already passed before the contractor requested the additional information.

Upon receiving the information back from the provider/supplier and/or beneficiary, the Medicare contractor has 40 calendar days left to:

- Process the claim, and
- Notify the individual that filed the claim of the payment determination for that claim.

CR 5355 instructs Medicare contractors to follow existing procedures relative to both:

- The length of time the provider/supplier and/or beneficiary is afforded to return information requested in the development letters, and
- Situations where the provider/supplier and or beneficiary does not respond.

For dates of receipt on and after July 1, 2007, Medicare contractors are instructed to process all "other-than-clean" claims and notify the beneficiary and the provider filing the claim within 45 calendar days of receipt, except when the contractor requests additional information from the provider/supplier or beneficiary, or to another contractor (e.g., the Coordination of Benefits Contractor, another claims processing contractor).

Instructions in CR 5355 do not apply to the following types of claims:

- Claims where the Social Security Administration blocks a beneficiary's health insurance claim number (HIC),
- Claims the contractors are required to hold due to CMS instructions,
- Claims rejected by the translator process,
- Claims where the Medicare contractor is unable to process due to technical issues with Medicare's beneficiary record or beneficiary identification issues, and
- Claims in development due to processing requirements (e.g., medical review), in Publication 100-8, the *Medicare Program Integrity Manual* (*http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*).

Additional Information

For complete details, please see the official instruction issued to your carrier/MAC regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1173CP.pdf* on the CMS website.

If you have questions, please contact your Medicare carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5355
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Implementation Date: July 2, 2007

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

Revised Medicare Physician Fee Schedule Fact Sheet now Available

The **revised** *Medicare Physician Fee Schedule Fact Sheet*, which provides general information about the Medicare physician fee schedule, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*.

Print versions of the fact sheet will be available in approximately six weeks.

Source: CMS Provider Education Resource 200702-02

February Is American Heart Month

Heart disease is the leading cause of death for men and women in the United States. Found more often among people aged 65 or older, heart disease is largely preventable. The Centers for Medicare & Medicaid Services (CMS) wants to take this opportunity to remind health care professionals that Medicare beneficiaries are covered for certain cardiovascular screening blood tests.

Medicare provides coverage of the following cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke:

- Total cholesterol test
- Cholesterol test for high-density lipoproteins
- Triglycerides test

Coverage of cardiovascular screening blood tests is provided as a Medicare Part B benefit. The beneficiary will pay nothing for the blood tests (there is no coinsurance or copayment and no deductible for this benefit).

What Can You Do?

This benefit presents an opportunity for health care professionals to help Medicare beneficiaries learn if they have an increased risk of developing heart disease and how they can control their cholesterol levels through diet, physical activity, or if necessary with medication. CMS needs your help to get the word out about the Medicare cardiovascular screening benefit.

Talk to your patients about their risk for cardiovascular disease and encourage them to take full advantage of this potentially life saving benefit.

Important Note: The cardiovascular screening benefit covered by Medicare is a stand alone billable service separate from the initial preventive physical examination or welcome to medicare visit and does not have to be obtained within the first six months of a beneficiary's Medicare Part B coverage.

For More Information

- For more information about Medicare's coverage of cardiovascular screening blood test, visit the CMS website *http://www.cms.hhs.gov/CardiovasDiseaseScreening/*.
- 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 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 on the Web at *http://www.medicare.gov*.
- For information about American Heart Month, please visit the American Heart Association's website at *http://www.americanheart.org/presenter.jhtml?identifier=1200000* and the Centers for Disease Control and Prevention's website at *http://www.cdc.gov/DHDSP/announcements/american_heart_month.htm*.

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 pneumococcal vaccination and their administration are covered Medicare 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 CMSs' website: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf*.

Source: CMS Provider Education Resource 200702-04

General Medical Review

J1950: Luteinizing Hormone-Releasing Hormone (LHRH) Analogs—Clarification of Least Costly Alternative (LCA) Policy

Pricing for Procedure Codes J1950, J3315, J9217, J9202, J9219, and J9225

According to the local coverage determination (LCD) for luteinizing hormone-releasing hormone (LHRH) analogs (L5769), two least costly alternative (LCA) policies are in effect for these procedure codes. Short acting LHRH agents J1950, J3315, J9217, and J9202 comprise one LCA policy. The 12-month LHRH implants, J9219 and J9225, comprise the second LCA policy in this LCD.

The procedure code with the lowest allowance in each LCA policy will determine the allowance for all other codes in the same LCA group. Specifically, if J3315 has the lowest pricing allowance, then J1950, J9217, and J9202 will be allowed at the same rate as J3315. A higher allowance will only be considered if medical documentation supports the use of the more costly drug.

The average sales price (ASP) drug pricing files are revised on a quarterly basis, therefore, the reimbursement amount for the above procedure codes may change depending on which code has the lowest allowance. You can refer to the following website for the ASP drug pricing files: *http://www.cms.hhs.gov/providers/drugs/asp.asp*.

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.

CONNECTICUT MEDICAL REVIEW

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 website, *http://www.connecticutmedicare.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 , click on the "eNews" link on the navigational menu and follow the prompts.

More Information

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

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

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Advance Notice Statement

Advance beneficiary notice (ABN) is required in the event the service may be denied or reduced for reasons of medical necessity (see page 4).

New LCD

99324: E&M Home and Domiciliary Visits—New LCD

A home or domiciliary visit includes a patient history, examination, problem solving and decision making in various levels depending upon a patient's need and diagnosis. Visits may also be performed as counseling or coordination of care if medically necessary outside the office environment and are an integral part of a continuum of care. The patients seen may have chronic conditions, may be disabled, either physically or mentally, making access to a traditional office visit very difficult, or may have limited support systems. The home or domiciliary visit in turn can lead to improved medical care by identification of unmet needs, coordination of treatment with appropriate referrals and potential reduction of acute exacerbations of medical conditions, resulting in less frequent trips to the hospital or emergency room**.**

Home-based health care is rapidly expanding. Growth in hospital-based house call programs, early hospital discharge programs, and an increased effort to expand the role of house calls in medical education has contributed to this expansion. Physicians and qualified nonphysician practitioners (NPPs) are required to oversee or directly provide progressively more sophisticated home visits. Patients must understand the nature of a pre-arranged visit and consent to treatment in the home or domiciliary care facility. Payment for this type of service is based on face-to-face time with the patient, family and/or caregiver and the work performed during that time is documented in the chart, such as direct patient assessment, care coordination, etc. Travel time and related expenses have not been included in either the work or practice expense component of the billable service codes and are not separately billable services.

Contrary to the Home Health Benefit (a Medicare Part A benefit), for physician visits payable under Medicare Part B, patients do not need to be rendered homebound to satisfy the medical necessity requirement for home and domiciliary care visits by physicians and qualified NPPs. The visit must be medically necessary, with supporting documentation made available upon request.

This new local coverage determination (LCD) was developed to provide indications and limitations for coverage, including medical necessity criteria, documentation requirements and utilization guidelines. This LCD also provides clarification between E&M Home and Domiciliary visits and services provided through a home health agency. The *CPT* codes associated with this LCD are as follows*: 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349 and 99350.*

Effective Date

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

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

Revisions to LCDs

J2505: Pegfilgrastim (Neulasta®)—LCD Revision

This local coverage determination (LCD) was last revised on October 1, 2006. Since that time, the ICD-9-CM codes that support medical necessity were revised to remove the dual diagnosis requirement. In addition, ICD-9-CM code V58.11 (Encounter for antineoplastic chemotherapy) was removed from the list of diagnosis codes that support medical necessity. This decision was made after reviewing the indications and limitations found in this LCD and after reviewing the rules applied to this code found in the *Current Procedural Terminology, CPT 2007*. This review found that V58.11 was not appropriate for this LCD.

Effective Date

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

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J9041: Bortezomib (Velcade®)—LCD Revision

The local coverage determination (LCD) for bortezomib (Velcade®) was last updated on December 8, 2006. The revision at that time included the addition of the off-label indication of induction therapy for multiple myeloma patients in combination with one or more drugs. Since that time, the following revision was made under the "Documentation Requirements" section of the LCD. Verbiage was changed to read:

- "Documentation in the medical record must support that bortezomib is administered for an indication specified in this LCD and all applicable coverage criteria must be clearly documented."

  In addition, the following statement was **removed** based on the above mentioned added off-label indication:

- "If the treatment is for multiple myeloma, the medical record must clearly document that the patient received one prior therapy."

Effective Dates

This revision is effective for services rendered on or after December 8, 2006. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

92552: Audiometry—LCD Revision

The local coverage determination (LCD) for audiometry was last revised, effective October 1, 2006. Since that time, changes have been made to the following sections of the LCD:

- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- The ICD-9-CM code range 389.00-389.9* was changed to diagnoses 389.00-389.08, 389.10-389.18*, 389.2*, 389.7*, 389.8*, and 389.9*. In addition, language was added under the "ICD-9 codes that Support Medical Necessity" section of the LCD related to the (*) for clarification.

Effective Date

This LCD revision is effective for services rendered on or after January 30, 2007. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services was last updated on February 28, 2007. Since that time, the following revisions were made:

- Under the "CPT/HCPCS Codes for Local Noncoverage Decisions" section of the LCD, *CPT* code and descriptor "*99199* End diastolic pneumatic compression therapy (circulator boot) using a heart monitor; segmental and nonsegmental compression of the leg (for the treatment of ulcers) in the office setting" was added.
- Under the "*CPT*/HCPCS Codes for National Noncoverage Decisions" section of the LCD, *CPT* code and descriptor "*93799* Circulator Boot System (Pub. 100-3, Chapter 1, Section 20.20)" was removed.

The Centers for Medicare and Medicaid Services (CMS) reference above refers to External Counterpulsation (ECP) Therapy for severe angina. Currently, HCPCS code G0166 should be used for external counterpulsation, which is covered by Medicare for the treatment of severe angina. Therefore, *CPT* code *93799* is being removed.

Effective Date

This revision is effective for services rendered on or after March 1, 2007. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

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VISCO: Viscosupplementation Therapy For Knee—LCD Revision

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised January 1, 2007. Since that time, the LCD has been revised to define significant knee effusion(s). Significant knee effusions are characterized by a tense, bulging knee. Medical documentation should include the presence and size of the effusion(s).

Effective Date

This LCD revision is effective claims processed on or after February 27, 2007. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

Connecticut Educational Resources

First Coast Service Options, Inc.
Provider Outreach and Education
Presents…..

2007 Medifest Symposium—Revised Dates

Date	Location
June 6 & 7, 2007	Marriott Hartford 100 Capital Boulevard Rocky Hill, CT 06067

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

- 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.

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.

Upcoming Provider Outreach and Education Events

March 2007 – April 2007

Hot Topics Teleconference

Topics based on data analysis; session includes discussion of new initiatives and changes in the Medicare program.

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

Ask the Contractor Teleconference – Topics to be determined

When: April 25, 2007
Time: 12:00 a.m. – 1:00 p.m.
Type of Event: Teleconference

More events will be planned soon for this quarter. Keep checking our website, *www.connecticutmedicare.com*, or listening to information on the FCSO Provider Education Registration Hotline, (203) 634-5527, for details and newly scheduled events!

Please Note:

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

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.

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

Provider Services

First Coast Service Options, Inc.
Medicare Part B
1-866-419-9455 ***(toll-free)***

Beneficiary Services

1-800-MEDICARE ***(toll-free)***
1-866-359-3614 *(hearing impaired)*

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 MEDICAL REVIEW

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 website, *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.floridamedicare.com , click on the "eNews" link on the navigational menu and follow the prompts.

More Information

If you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048

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VISCO: Viscosupplementation Therapy For Knee 42

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 4).

New LCD

99324: E&M Home and Domiciliary Visits—New LCD

A home or domiciliary visit includes a patient history, examination, problem solving and decision making in various levels depending upon a patient's need and diagnosis. Visits may also be performed as counseling or coordination of care if medically necessary outside the office environment and are an integral part of a continuum of care. The patients seen may have chronic conditions, may be disabled, either physically or mentally, making access to a traditional office visit very difficult, or may have limited support systems. The home or domiciliary visit in turn can lead to improved medical care by identification of unmet needs, coordination of treatment with appropriate referrals and potential reduction of acute exacerbations of medical conditions, resulting in less frequent trips to the hospital or emergency room**.**

Home-based health care is rapidly expanding. Growth in hospital-based house call programs, early hospital discharge programs, and an increased effort to expand the role of house calls in medical education has contributed to this expansion. Physicians and qualified nonphysician practitioners (NPPs) are required to oversee or directly provide progressively more sophisticated home visits. Patients must understand the nature of a pre-arranged visit and consent to treatment in the home or domiciliary care facility. Payment for this type of service is based on face-to-face time with the patient, family and/or caregiver and the work performed during that time is documented in the chart, such as direct patient assessment, care coordination, etc. Travel time and related expenses have not been included in either the work or practice expense component of the billable service codes and are not separately billable services.

Contrary to the Home Health Benefit (a Medicare Part A benefit), for physician visits payable under Medicare Part B, patients do not need to be rendered homebound to satisfy the medical necessity requirement for home and domiciliary care visits by physicians and qualified NPPs. The visit must be medically necessary, with supporting documentation made available upon request.

This new local coverage determination (LCD) was developed to provide indications and limitations for coverage, including medical necessity criteria, documentation requirements and utilization guidelines. This LCD also provides clarification between E&M home and domiciliary visits and services provided through a home health agency. The *CPT* codes associated with this LCD are as follows: *99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349 and 99350.*

Effective Date

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

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Revisions to LCDs

J2505: Pegfilgrastim (Neulasta®)—LCD Revision

This local coverage determination (LCD) was last revised on October 1, 2006. Since that time, the ICD-9-CM codes that support medical necessity were revised to remove the dual diagnosis requirement. In addition, ICD-9-CM code V58.11 (Encounter for antineoplastic chemotherapy) was removed from the list of diagnosis codes that support medical necessity. This decision was made after reviewing the indications and limitations found in this LCD and after reviewing the rules applied to this code found in the *Current Procedural Terminology, CPT* 2007. This review found that V58.11 was not appropriate for this LCD.

Effective Date

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

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J9041: Bortezomib (Velcade®)—LCD Revision

The local coverage determination (LCD) for bortezomib (Velcade®) was last updated on December 8, 2006. The revision at that time included the addition of the off-label indication of induction therapy for multiple myeloma patients in combination with one or more drugs. Since that time, the following revision was made under the "Documentation Requirements" section of the LCD. Verbiage was changed to read:

- "Documentation in the medical record must support that bortezomib is administered for an indication specified in this LCD and all applicable coverage criteria must be clearly documented."

  In addition, the following statement was **removed** based on the above mentioned added off-label indication:

- "If the treatment is for multiple myeloma, the medical record must clearly document that the patient received one prior therapy.

Effective Dates

This revision is effective for services rendered on or after December 8, 2006. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised on February 28, 2007. Since that time, the LCD has been revised to delete *CPT* code *83883* (Nephelometry, each analyte not elsewhere specified) in the '*CPT*/HCPCS Codes' section under "Local Noncoverage Decisions, Laboratory Procedures", as current literature indicates that this service is considered to be reasonable and necessary during an episode of care for the diagnosis and management of myeloma and related diseases.

This LCD revision is effective for services rendered on or after February 28, 2007. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

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

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services was last updated on February 28, 2007. Since that time, the following revisions were made:

- Under the "*CPT*/HCPCS Codes for Local Noncoverage Decisions" section of the LCD, *CPT* code and descriptor "*99199* End diastolic pneumatic compression therapy (Circulator Boot) using a heart monitor; segmental and nonsegmental compression of the leg (for the treatment of ulcers) in the office setting" was added.
- Under the "*CPT*/HCPCS Codes for National Noncoverage Decisions" section of the LCD, *CPT* code and descriptor "*93799* circulator boot system (Pub. 100-3, Chapter 1, Section 20.20)" was removed.

The Centers for Medicare & Medicaid Services (CMS) reference above refers to external counterpulsation (ECP) therapy for severe angina. There is currently an LCD for external counterpulsation with HCPCS code G0166 that covers treatment for angina. Therefore, *CPT* code *93799* is being removed.

Effective Date

This revision is effective for services rendered on or after March 1, 2007. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

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VISCO: Viscosupplementation Therapy For Knee—LCD Revision

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised January 1, 2007. Since that time, the LCD has been revised to define significant knee effusion(s). Significant knee effusions are characterized by a tense, bulging knee. Medical documentation should include the presence and size of the effusion(s).

Effective Date

This LCD revision is effective for claims processed on or after February 27, 2007. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

Florida Educational Resources

Upcoming Provider Outreach and Education Events

March 2007 – May 2007

Medifest

When: March 13, 2007 – March 15, 2007
Where: Jacksonville Marriott
Jacksonville, Florida

Hot Topics Teleconference – Topics to be determined

When: March 22, 2007
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

Ask the Contractor Teleconference – Topics to be determined

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. – 1:00 p.m.
Type of Event: Teleconference

Medifest

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

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
- ☐ ANSI 101 (A/B)
- ☐ 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
- ☐ ANSI 102 (A/B)
- ☐ 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
- ☐ ANSI 101 (A/B)
- ☐ 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
- ☐ ANSI 102 (A/B)
- ☐ 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.
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 45280
Jacksonville, FL 32232-5280

Contact Name: ____

Provider/Office Name: ____

Phone: ______________________ FAX Number: ______________________

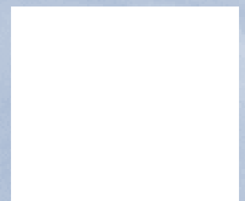
Mailing Address: ____

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 *