Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

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CENTERS for MEDICARE & MEDICAID SERVICES

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A CMS Contracted Intermediary & Carrier

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

Routing Suggestions:

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

Medicare B Update!

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Publications Staff
Terri Drury
Millie C. Pérez
Mary Barnes

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

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

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

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

The Provider Outreach & Education Publications team distributes the *Medicare B Update!* on a monthly basis. 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 CMS's BNI website at *http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage.*

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

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

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

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

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

OR

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

CLAIMS

Elimination of CMS-1491 and CMS-1490U Forms

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

Provider Types Affected

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

Impact on Providers

Ambulance suppliers should submit their paper ambulance claims using the Form CMS-1500 on or after April 2, 2007 (see *Additional Information* section for the CMS-1500 Web address).

Note: The April 2, 2007, date actually refers to the date your carrier or A/B MAC receives the claim. So, be sure the claims you send that will be received on or after April 2, 2007, are sent on the Form CMS-1500.

Background

The purpose of CR 5390 is to notify suppliers of ambulance services that the Centers for Medicare & Medicaid Services (CMS) determined that paper claim forms CMS-1491 and CMS 1490U will no longer be printed effective October 1, 2006. Therefore, as of April 2, 2007, carriers and A/B MACs are no longer permitted to accept claims from ambulance suppliers on the Forms CMS-1491 and CMS1490U. If your carrier or A/B MAC receives claims on forms CMS-1491 and/or CMS-1490U on or after April 2, 2007, they will reject the claim back to you and you will need to send it again using the CMS-1500 form.

The *Medicare Claims Processing Manual* Chapter 1, Section 70.8.4 is being revised to eliminate all information that pertains to CMS-1491 and CMS 1490U forms and Chapter 15, Section 30.1.3 is being deleted in its entirety. (See the official instructions for CR 5390 to review these manual sections)

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.

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 change request (CR) please see the official instruction (CR 5390) issued to your Medicare A/B MAC or carrier. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1144CP.pdf* on the CMS website.

If you would like to review the CMS-1500 claim form you may find it at: *http://www.cms.hhs.gov/cmsforms/downloads/CMS1500.pdf* on the CMS website. In order to purchase claim forms, you should contact the U.S. Government Printing Office at (202) 512-1800, local printing companies in your area, and/or office supply stores. Vendors typically sell the CMS-1500 claim form in its various configurations (single part, multi-part, continuous feed, laser, etc). Because many carriers and A/B MACs use scanner technology to read these forms, do not submit photocopied claims. Further specifications and information about the CMS-1500 claim form is available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp* on the CMS website.

MLN Matters article MM5060 provides background information about CMS-1500 claim form at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf* on the CMS website

MLN Matters Number: MM5390
Related Change Request (CR) #: 5390
Related CR Release Date: December 29, 2006
Effective Date: April 2, 2007
Related CR Transmittal #: R1144CP
Implementation Date: April 2, 2007

CARDIAC SERVICES

Intracranial Percutaneous Transluminal Angioplasty with Stenting

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

Provider Types Affected

Physicians and providers who may wish to submit claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for percutaneous transluminal angioplasty (PTA) stenting.

Provider Action Needed

Be aware that The Centers for Medicare & Medicaid Services (CMS) has reviewed the evidence and determined that, effective for discharges on or after November 6, 2006, Medicare will cover PTA with stenting of intracranial arteries for treatment of cerebral artery stenosis =50 percent in patients with intracranial atherosclerotic disease when furnished in accordance with Food and Drug Administration (FDA)-approved protocols governing category B investigational device exemption (IDE) clinical trials. Payment for intracranial PTA with stenting is considered reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act under these circumstances. All other indications for intracranial PTA with or without stenting to treat obstructive lesions of the vertebral and cerebral arteries remain noncovered.

Background

This article and related change request (CR) 5432 communicate the findings and revised national coverage determination (NCD) resulting from analysis to determine if Medicare should cover PTA. In the past, PTA to treat obstructive lesions of the cerebral arteries was noncovered by Medicare because the safety and efficacy of the procedure had not been established. This NCD meant that the procedure was also noncovered for beneficiaries participating in FDA-approved IDE clinical trials. On February 9, 2006, a request for reconsideration of this NCD initiated a national coverage analysis.

Key Points

- Effective November 6, 2006, Medicare covers PTA and stenting of intracranial arteries for the treatment of cerebral artery stenosis =50 percent in patients with intracranial atherosclerotic disease when furnished in accordance with the FDA-approved protocols governing category B IDE clinical trials. CMS determined that coverage of intracranial PTA and stenting is reasonable and necessary under these circumstances.
- Providers billing FIs and A/B MACs should note this coverage applies to claims with:
  - A discharge date on or after November 6, 2006
  - ICD-9-CM procedure codes of 00.62 and 00.65 both being present
  - ICD-9CM diagnosis code 437.0 present
  - The IDE number present on a 0624 revenue code line.
- Noninstitutional providers billing Medicare carriers or A/B MACs should note this coverage applies to claims with:
  - *CPT* code *37799* (*Unlisted procedure, vascular surgery*)
  - Modifier **QA** to denote category B IDE clinical trial
  - The appropriate IDE number.
- All other indications for PTA with or without stenting to treat obstructive lesions of the vertebral and cerebral arteries remain noncovered. The safety and efficacy of these procedures are not established.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5432) issued to your Medicare carrier, FI or A/B MAC. That instruction is contained in two transmittals. The first transmittal is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1147CP.pdf* and it contains the revised portions of the *Medicare Claims Processing Manual*. The second transmittal contains the national coverage determination and it is available at *http://www.cms.hhs.gov/Transmittals/downloads/R64NCD.pdf*.

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

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: MM5432
Related Change Request (CR) Number: 5432
Related CR Release Date: January 5, 2007
Related CR Transmittal Number: R64NCD and R1147CP

Effective Date: November 6, 2006
Implementation Date: February 5, 2007

COMPETITIVE ACQUISITION PROGRAM

Assignment of Dedicated Medicare Secondary Payer Modifier Introduced in Change Request 5332 (Transmittal 1088)

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

Provider Types Affected

Physicians who bill Medicare carriers and Part A/B Medicare administrative contractors (A/B MACs) for drugs paid under the Competitive Acquisition Program (CAP).

Key Information

In CR 5332 (transmittal 1088) "Instructions for the Coordination of Medicare Secondary Payer (MSP) claims for the Competitive Acquisition Program (CAP)", issued October 27, 2006, the Center for Medicare & Medicaid Services (CMS) indicated that, under certain circumstances, a participating CAP physician may procure a CAP drug from a source other than the CAP vendor because of a mistake in identifying the patient's primary insurer. Under these unusual circumstances, CR 5332 instructed CAP physicians to use the J3 modifier to receive payment for the drug at the non-CAP rate.

However, the M2 "Medicare secondary payer" modifier was created for the purpose described in CR 5332 and was included in the 2007 Alpha-HCPCS file posted to the CMS website in November 2006. Participating CAP physicians must note that, **effective January 1, 2007**, the M2 modifier will be the dedicated modifier for the unusual circumstances identified above, and Medicare will no longer accept the J3 modifier for this purpose.

Additional Information

For other details including the revised sections of Chapters 3 and 5 of the *Medicare Secondary Payer (MSP) Manual* and the revised sections of Chapter 17 of the *Medicare Claims Processing Manual*, please see the official instruction, CR 5332, issued to your Medicare carrier or A/B MAC regarding this change. There are two transmittals related to this instruction and they may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R57MSP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1088CP.pdf* on the CMS website. In addition, an *MLN Matters* article, MM5332, is also available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5332.pdf* on that site.

HCPCS files are available at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp*.

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

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

MLN Matters Number: SE0703	Related Change Request (CR) #: 5332
Related CR Release Date: October 27, 2006	Effective Date: January 1, 2007
Related CR Transmittal #: R57MSP & R1088CP	Implementation Date: January 2, 2007

New Competitive Acquisition Program Modifier Information

In change request (CR) 5332 (Transmittal 1088) "Instructions for the Coordination of Medicare Secondary Payer (MSP) claims for the Competitive Acquisition Program (CAP)", issued October 27, 2006, the Centers for Medicare & Medicaid Services (CMS) indicated that, under certain circumstances, a participating CAP physician may procure a CAP drug from a source other than the CAP vendor because of a mistake in identifying the patient's primary insurer. Under these unusual circumstances, CR 5332 instructed CAP physicians to use the modifier J3 to receive payment for the drug at the non-CAP rate. However, CR 5332 further indicated that a new modifier would be created in the near future for the situation described above.

Please take note that the new modifier M2 has been created and **effective January 1, 2007**, participating CAP physicians must use the modifier M2 when billing for the unusual circumstances identified above. Medicare will no longer accept the J3 modifier for this purpose.

For more information, please see the related *MLN Matters* article at *http://www.cms.hhs.gov/MLNMattersArticles/Downloads/SE0703.pdf*.

Source: Provider Education Resources Listserv, Message 200701-09

Instructions for the Coordination of Medicare Secondary Payer Claims for the Competitive Acquisition Program

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

Important Note: See special edition article SE0703, which contains important information regarding the M2 (Medicare Secondary Payer) modifier that must be used in certain circumstances. The information in SE0703 overrides the information in this article relating to the use of the modifier M2, instead of J3, in those circumstances, effective January 1, 2007. SE0703 is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0703.pdf* on the CMS site and is included on page 8 of this publication.

Provider Types Affected

Physicians who bill Medicare Carriers and Part A/B Medicare administrative contractors (A/B MACs) for drugs paid under the CAP program.

Background

This article and related change request (CR) 5332 provides additional details, information and instructions for CAP MSP claims **and** instances in which a beneficiary's MSP status is incorrectly determined. Section 303 (d) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established section 1847B of the Social Security Act requiring the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians are given a choice between buying and billing these drugs for beneficiaries with Medicare as their primary insurer under the average sales price (ASP) system or obtaining these drugs from vendors selected through a competitive bidding process.

Participating CAP physicians agree to obtain all drugs included in the CAP drug category for Medicare beneficiaries who do not have another primary insurer from the approved CAP vendor. However, Medicare statutes allow for limited exceptions to this requirement.

One such exception includes Medicare Secondary Payer (MSP) situations. Section 1862(b) establishes provisions for Medicare as a secondary payer that are codified in 42 CFR Part 411. Section 1862(b) (6) specifically instructs physicians and other suppliers to identify, from information obtained from the beneficiary, payers primary to Medicare and to bill such payers prior to billing Medicare.

This CR instructs carriers to continue allowing CAP physicians to obtain physician administered drugs from entities approved by the primary plan and bill the primary payer outside the CAP vendor when Medicare beneficiaries have other insurance primary to Medicare.

Note: The term "carrier" also refers to A/B MACS as those entities replace carriers as part of Medicare's contracting reform implementation.

Key Points

When drugs are obtained through the CAP for beneficiaries with insurance primary to Medicare:

- Where a CAP provider renders drugs covered under the CAP to a Medicare beneficiary, who has other coverage primary to Medicare, the provider and the CAP vendor must first bill the appropriate primary insurer for the drug and the administration service.
- In situations where the participating CAP provider and the approved CAP vendor determined that Medicare was the primary payer and ordered and administered the drugs through the CAP, but before Medicare paid the claim, learned that another payer was primary to Medicare, the approved CAP vendor and the participating CAP physician should first bill the primary payer.
- In both of the preceding situations, CAP providers should submit all MSP claims for drug administration services (even if they believe no balance is due).
- Upon receipt of the primary insurer's payment, MSP claims should then be submitted by the physician to the local carrier for the administration service and by the CAP vendor to the CAP designated carrier for the drug.
- Remember that your Medicare carrier will return all CAP MSP claims from CAP providers as unprocessable if the claim does not contain a prescription number and an applicable CAP no pay modifier with the following message: RA Remark Code MA130 – Your claim contains incomplete or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

When drugs are obtained outside of the CAP for beneficiaries with Medicare:

- CAP providers should report the CAP MSP modifier on each MSP claim drug line when the participating CAP provider obtained a CAP drug outside of the CAP program because the provider determined that another insurer was primary to Medicare but when the claim processed it was determined that Medicare was primary.
- CAP providers should use the "J3" modifier temporarily until a specific CAP MSP modifier is created.
- Participating CAP physicians are required to maintain documentation in the beneficiary's medical record to provide further information on why they determined that Medicare was secondary to another payer. The local carrier may request the physician provide this documentation for their review purposes.

Instructions for the Coordination of Medicare Secondary Payer Claims for the CAP, continued

- Be aware that local carriers will deny claims when a primary Medicare claim is received and MSP is indicated in Medicare's records unless the CAP MSP modifier is used.
- If Medicare paid as primary and the CAP provider later learns that there is another primary payer to Medicare, the physician is obligated to notify Medicare by contacting the Coordination of Benefits Contractor and provide them with the MSP information.

Implementation

The implementation date for this instruction is January 2, 2007

Additional Information

For complete details including the revised sections of Chapters 3 and 5 of the *Medicare Secondary Payer (MSP) Manual* and the revised sections of Chapter 17 of the *Medicare Claims Processing Manual*, please see the official instruction, CR 5332, issued to your Medicare carrier or A/B MAC regarding this change. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R57MSP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1088CP.pdf* on the CMS website.

For additional information about the implementation of the CAP program you may want to review the following *MLN Matters* articles on the CMS website.

- MM4404 (MMA Competitive Acquisition Program (CAP) for Part B Drugs Physician Election) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4404.pdf* on the CMS website.
- MM4309 (MMA - Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf* on the CMS website.
- MM5079 (Competitive Acquisition Program (CAP) - Creation of Automated Tables for Provider Information, Expansion of CAP Fee Schedule File Layout, and Additional Instructions for Claims Received from Railroad Retirement Board Beneficiaries) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf* on the CMS website.

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

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

MLN Matters Number: MM5332 *Revised*
Related Change Request (CR) #: 5332
Related CR Release Date: October 27, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R57MSP & R1088CP
Implementation Date: January 2, 2007

MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

Emergency Update to the 2007 Medicare Physician Fee Schedule Database

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

Note: CMS has revised this *MLN Matters* article on January 12, 2007, to reflect changes made to change request (CR) 5459. The CR release date and transmittal number have been changed and the Web address for accessing CR 5459 has been revised. All other information remains the same. The original *MLN Matters* article was published in the January 2007 *Medicare B Update!* (page 68-69).

Provider Types Affected

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

Background

This article and related change request (CR) 5459 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS final rule. CR 5459 amends those payment files.

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

Key Points

You may wish to **review Attachment 1** of the CR 5459, which is located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf*.

The following key points summarize the specifics that are identified in the attachment to CR 5459.

- The physician fee schedule status indicators for oncology demonstration HCPCS codes G9050 to G9062 for 2007 are "I"; these codes are invalid for Medicare use in 2007, thus, payment will not be made for these codes in 2007. (For more details on the oncology demonstration, see the *MLN Matters* article on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4219.pdf*.)
- Oncology demonstration HCPCS codes G9076, G9081, G9082, G9118, G9119, G9120, G9121, G9122, and G9127 are **deleted and will not be paid for services provided after December 31, 2006 in 2007.**
- Active oncology demonstration codes in the range G9063 to G9139 have status indicators of "M" on the Medicare physician fee schedule database. (Note: See requirement above for discontinued oncology demonstration codes within this range). Those filing claims may report these codes for oncology disease status in 2007, but payment will not be made for these codes for services provided after December 31, 2006.
- Category II codes *3047F* and *3076F* and category III code *0152T* have been deleted for 2007.
- HCPCS G codes G0377 and G8348 through G8368 will be added to the 2007 HCPCS file.
- HCPCS Q codes Q4083, Q 4084, Q4085, and Q4086 will be added, even though they are not on the 2007 HCPCS file. Note that corresponding average sale price (ASP) amounts will be reflected in updated 2007 ASP files to be posted to the CMS website.
- Incorrect diagnostic supervision indicators were assigned to some codes and these codes and correct indicators are listed in the attachment to CR 5459.
- Corrected multiple procedure codes of 0 and diagnostic family imaging indicators of 99 have been assigned to codes HCPCS codes G0389, G0389-TC, and *CPT* codes *70554*, *70554-TC*, *70555*, *70555-TC*, *76776*, and *76776-TC*.
- As identified in the attachment to CR 5459, correct work, practice expense, and/or malpractice relative value units (RVUs) have been assigned for *CPT* codes *44180*, *44186*, *73223*, *73223-26*, *76775*, *76775-TC*, *76775-26*, *93503*, *93539*, *93540*, *93541*, *93542*, *93543*, *93544*, *93545*, *95060*, *95065*, and HCPCS codes G0389, G0389-TC, and G0389-26.
- As a result of the Tax Relief and Health Care Act of 2006, effective January 1, 2007, HCPCS code G0377 (Administration of vaccine for Part D drug) is added to the MPFS with a status indicator of X. Payment for HCPCS code G0377 is linked to *CPT* code *90471* (just as payment is made for G0008, G0009, and G0010). For 2007 only, the legislation provides for Part B to pay for the administration of a covered Part D vaccine. When a physician administers a Part D vaccine, the physician should use HCPCS code G0377 to bill the local carrier for the administration of the vaccine. Payment to the physician will be on an assigned basis only. Normal beneficiary deductible and coinsurance requirements apply to this administration. Payment for Part D covered vaccines is made solely by the participating prescription drug plan. Medicare will not pay for the vaccine itself.
- Effective January 1, 2007, the following HCPCS G codes are added to the MPFS database with a status indicator of M: G8348, G8349, G8350, G8351, G8352, G8353, G8354, G8355, G8356, G8357, G9358, G8359, G8360, G8361, G8362, G8363, G8364, G8365, G8366, G8367, and G8368.
- CMS has established separate payment for sodium hyaluronate products that have come on the market since October 2003. Four interim Q codes are in effect for these products as of January 1, 2007:

  Q4083 Hyalgan/supartz inj per dose
  Q4084 Synvisc inj per dose
  Q4095 Euflexxa inj per does
  Q4086 Orthovisc inj per dose.
- Procedure status I is assigned to J7319, **effective January 1, 2007.**
- **Effective January 1, 2007,** the HCPCS codes Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, and Q9964 will be assigned to procedure status indicator E.
- As a courtesy to the public, CMS has established RVUs for a number of codes, even though the codes are either bundled or not valid for Medicare purposes. These *CPT* codes are *38204*, *38207*, *38208*, *38209*, *38210*, *38211*, *38212*, *38213*, *38214*, *and 38215*. The RVUs are listed for these codes in the attachment to CR 5459.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5459) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf*.

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

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: MM5459 *Revised*
Related Change Request (CR) Number: 5459
Related CR Release Date: January 11, 2007
Related CR Transmittal Number: R1152CP
Effective Date: January 1, 2007
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PATHOLOGY/LABORATORY

Tax Relief and Health Care Act of 2006 Changes to Independent Laboratory Billing for the Technical Component of Physician Pathology Services

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

Provider Types Affected

Independent laboratories submitting claims to Medicare contractors (carriers and Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries

Provider Action Needed

This article is based on change request (CR) 5468 which directs Medicare contractors to notify independent laboratories that those independent laboratories qualifying to bill under the Tax Relief and Health Care Act of 2006 (Section 104) may continue to bill their carrier or A/B MAC for the technical component (TC) of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed, through December 31, 2007.

Background

The TC of physician pathology services refers to the preparation of the slide, involving tissue or cells that a pathologist will interpret. (In contrast, the pathologist's interpretation of the slide is the professional component (PC) service. If this service is furnished by the hospital pathologist for a hospital patient, it is separately billable. If the independent laboratory's pathologist furnishes the PC service, it is usually billed with the TC service as a combined service.)

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999 (See *http://www.access.gpo.gov/su_docs/fedreg/a991102c.html*; Health Care Financing Administration), CMS stated that it would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology services for hospital patients. As pointed out in the final rule, this policy has contributed to the Medicare program paying twice for the TC service, first through the inpatient prospective payment rate to the hospital where the patient is an inpatient and again to the independent laboratory that bills the carrier, instead of the hospital, for the TC service.

Ordinarily, the provisions in the final physician fee schedule are implemented in the following year. In this case, the provision was delayed one year, at the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements. Additionally, new provisions established under the Benefits Improvement and Protection Act of 2000 (BIPA; Section 542), administrative extensions of these provisions, and provisions established under the Medicare Modernization Act (MMA; Section 732), have further delayed the policy change proposed in the regulation. Therefore, during this time, the Medicare contractors have continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.

Note: Covered hospital refers to a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were patients of a hospital and submitted claims for payment for the TC to a carrier.

CMS notified independent laboratories in previously issued instructions that they may no longer bill the carrier for these services after December 31, 2006. (See CR 5210, Transmittal 1046, at: *http://www.cms.hhs.gov/Transmittals/downloads/R1046CP.pdf*.)

However, the Tax Relief and Health Care Act of 2006 (Section 104) provides for a one-year extension to the Medicare Modernization Act (MMA; Section 732) that allows the carrier to continue to pay independent laboratories under the Medicare physician fee schedule (MPFS) for the TC of physician pathology services furnished to patients of a covered hospital.

Therefore, independent laboratories which qualify to bill for these services may continue to bill the carrier for the TC of physician pathology services furnished to patients of a covered hospital during calendar year 2007.

Additional Information

The official instruction, CR 5468, issued to Medicare carriers and A/B MACs regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1148CP.pdf* on the CMS website.

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

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

MLN Matters Number: MM5468
Related Change Request (CR) #:5468
Related CR Release Date: January 8, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R1148CP
Implementation Date: February 5, 2007

THERAPY SERVICES

Outpatient Therapy Cap Exception Process for 2007

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

Provider Types Affected

Providers, physicians, and nonphysician practitioners (NPP) who bill Medicare contractors (fiscal intermediaries (FI) including regional home health intermediaries (RHHI), carriers, and Part A/B Medicare administrative contractors (A/B MAC) under the Part B benefit for therapy services

Provider Action Needed

Be sure you are aware of the requirements for the therapy cap exceptions for calendar year 2007, especially the use of modifier KX and the rules governing the exceptions.

Background

Section 1833(g)(5) of the Social Security Act provided that, for services rendered during calendar year 2006, FIs, RHHIs, and carriers could, in certain circumstances, grant an exception to the therapy cap when requested by the individual enrolled under the Part B benefit (or by a person acting on behalf of that individual).

On January 1, 2006, Medicare implemented financial limitations on covered therapy services (therapy caps); however, the Deficit Reduction Act of 2006 provided for exceptions to this dollar limitation when the provision of additional therapy services is determined to be medically necessary. This exceptions process has been extended by recent legislation (the Tax Relief and Health Care Act of 2006) for one year (calendar year 2007).

Remember that a therapy cap exception may be made when a beneficiary requires continued skilled therapy, (in other words, therapy beyond the amount payable under the therapy cap) to achieve their prior functional status or maximum expected functional status within a reasonable amount of time. Documentation supporting the medical necessity of those therapy services must be kept on file by the provider.

Additionally, you should note that, in 2006, exception processes fell into two categories, automatic, and manual. Beginning January 1, 2007, there is no manual process for exceptions, and all services that require exceptions to caps will be processed using the automatic process.

Key Points

CR 5478, from which this article is taken, provides instructions to contractors regarding the short-term implementation of this legislation. Details about these instructions follow:

Contractors will grant exceptions for any number of medically necessary services if the beneficiary meets the conditions described in the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Section 10.2 (The Financial Limitation) for 2007, (displayed in Table 1, below).
The following ICD-9-CM codes describe the most typical conditions (etiology or underlying medical diagnoses) that may result in exceptions (marked X) and complexities that **might** cause medically necessary therapy services to qualify for the automatic process exception (marked *) for each discipline separately. When the cell in the table is marked with a dash (-), the diagnosis code in the corresponding row is not appropriate for services by the discipline in the corresponding column. Therefore, services provided by that discipline for that diagnosis do not qualify for exception to caps. Services may be appropriate when provided by that discipline for another diagnosis appropriate to the discipline, which may or may not be on this table, and that diagnosis should be documented on the claim, if possible, or in the medical record.

Table 1

ICD-9-CM codes describing diagnoses that may result in excepted conditions (marked X) and complexities (marked *) that **might** cause medically necessary therapy services to qualify for the automatic process exception.

ICD-9-CM Cluster	ICD-9-CM (Cluster) Description	PT	OT	SLP
V43.61-V43.69	Joint replacement	X	X	–
V45.4	Arthrodesis status	*	*	–
V45.81-V45.82 and V45.89	Other postprocedural status	*	*	–
V49-61-V49.67	Upper limb amputation status	X	X	–
V49.71-V49.77	Lower limb amputation status	X	X	–
V54.10-V54.29	Aftercare for healing traumatic or pathologic fracture	X	X	–
V58.71-V58.78	Aftercare following surgery to specified body systems, not elsewhere classified	*	*	*
244.0-244.9	Acquired hypothyroidism	*	*	*
250.00-251.9	Diabetes mellitus and other disorders of pancreatic internal secretion	*	*	*

Outpatient Therapy Cap Exception Process for 2007, continued

ICD-9-CM Cluster	ICD-9-CM (Cluster) Description	PT	OT	SLP
276.0-276.9	Disorders of fluid, electrolyte, and acid-base balance	*	*	*
278.00-278.01	Obesity and morbid obesity	*	*	*
280.0-289.9	Diseases of the blood and blood-forming organs	*	*	*
290.0-290.43	Dementias	*	*	*
294.0-294.9	Persistent mental disorders due to conditions classified elsewhere	*	*	*
295.00-299.91	Other psychoses	*	*	*
300.00-300.9	Anxiety, disassociative and somatoform disorders	*	*	*
310.0-310.9	Specific nonpsychotic mental disorders due to brain damage	*	*	*
311	Depressive disorder, not elsewhere classified	*	*	*
315.00-315.9	Specific delays in development	*	*	*
317	Mild mental retardation	*	*	*
320.0-326	Inflammatory diseases of the central nervous system	*	*	*
330.0-337.9	Hereditary and degenerative diseases of the central nervous system	X	X	X
340-345.91 and 348.0-349.9	Other disorders of the central nervous system	X	X	X
353.0-359.9	Disorders of the peripheral nervous system	X	X	–
365.00-365.9	Glaucoma	*	*	*
369.00-369.9	Blindness and low vision	*	*	*
386.00-386.9	Vertiginous syndromes and other disorders of vestibular system	*	*	*
389.00-389.9	Hearing loss	*	*	*
401.0-405.99	Hypertensive disease	*	*	*
410.00-414.9	Ischemic heart disease	*	*	*
415.0-417.9	Diseases of pulmonary circulation	*	*	*
420.0-429.9	Other forms of heart disease	*	*	*
430-438.9	Cerebrovascular disease	X	X	X
440.0-448.9	Diseases of arteries, arterioles, and capillaries	*	*	*
451.0-453.9 and 456.0-459.9	Diseases of veins and lymphatics, and other diseases of circulatory system	*	*	*
465.0-466.19	Acute respiratory infections	*	*	*
478.30-478.5	Paralysis, polyps, or other diseases of vocal cords	*	*	*
480.0-486	Pneumonia	*	*	*
490-496	Chronic obstructive pulmonary disease and allied conditions	*	*	*
507.0-507.8	Pneumonitis due to solids and liquids	*	*	*
510.0-519.9	Other diseases of respiratory system	*	*	*
560.0-560.9	Intestinal obstruction without mention of hernia	*	*	*
578.0-578.9	Gastrointestinal hemorrhage	*	*	*
584.5-586	Renal failure and chronic kidney disease	*	*	*
590.00-599.9	Other diseases of urinary system	*	*	*
682.0-682.8	Other cellulitis and abscess	*	*	–
707.00-707.9	Chronic ulcer of skin	*	*	–
710.0-710.9	Diffuse diseases of connective tissue	*	*	*
711.00-711.99	Arthropathy associated with infections	*	*	–
712.10-713.8	Crystal arthropathies and arthropathy associated with other disorders classified elsewhere	*	*	–
714.0-714.9	Rheumatoid arthritis and other inflammatory polyarthropathies	*	*	–
715.00-715.98	Osteoarthrosis and allied disorders (complexity except as listed below)	*	*	–
715.09	Osteoarthritis and allied disorders, multiple sites	X	X	–
715.11	Osteoarthritis, localized, primary, shoulder region	X	X	–

Outpatient Therapy Cap Exception Process for 2007, continued

ICD-9-CM Cluster	ICD-9-CM (Cluster) Description	PT	OT	SLP
715.15	Osteoarthritis, localized, primary, pelvic region and thigh	X	X	–
715.16	Osteoarthritis, localized, primary, lower leg	X	X	–
715.91	Osteoarthritis, unspecified id gen. or local, shoulder	X	X	–
715.96	Osteoarthritis, unspecified if gen. or local, lower leg	X	X	–
716.00-716.99	Other and unspecified arthropathies	*	*	–
717.0-717.9	Internal derangement of knee	*	*	–
718.00-718.99	Other derangement of joint (complexity except as listed below)	*	*	–
718.49	Contracture of joint, multiple sites	X	X	–
719.00-719.99	Other and unspecified disorders of joint (complexity except as listed below)	*	*	–
719.7	Difficulty walking	X	X	–
720.0-724.9	Dorsopathies	*	*	–
725-729.9	Rheumatism, excluding back (complexity except as listed below)	*	*	–
726.10-726.19	Rotator cuff disorder and allied syndromes	X	X	–
727.61-727.62	Rupture of tendon, nontraumatic	X	X	–
730.00-739.9	Osteopathies, chondropathies, and acquired musculoskeletal deformities (complexity except as listed below)	*	*	–
733.00	Osteoporosis	X	X	–
741.00-742.9 and 745.0-748.9 and 754.0-756.9	Congenital anomalies	*	*	*
780.31-780.39	Convulsions	*	*	*
780.71-780.79	Malaise and fatigue	*	*	*
780.93	Memory loss	*	*	*
781.0-781.99	Symptoms involving nervous and musculoskeletal system (complexity except as listed below)	*	*	*
781.2	Abnormality of gait	X	X	–
781.3	Lack of coordination	X	X	–
783.0-783.9	Symptoms concerning nutrition, metabolism, and development	*	*	*
784.3-784.69	Aphasia, voice and other speech disturbance, other symbolic dysfunction	*	*	X
785.4	Gangrene	*	*	–
786.00-786.9	Symptoms involving respiratory system and other chest symptoms	*	*	*
787.2	Dysphagia	*	*	X
800.00-828.1	Fractures (complexity except as listed below)	*	*	–
806.00-806.9	Fracture of vertebral column with spinal cord injury	X	X	–
810.11-810.13	Fracture of clavicle	X	X	–
811.00-811.19	Fracture of scapula	X	X	–
812.00-812.59	Fracture of humerus	X	X	–
813.00-813.93	Fracture of radius and ulna	X	X	–
820.00-820.9	Fracture of neck of femur	X	X	–
821.00-821.39	Fracture of other and unspecified parts of femur	X	X	–
828.0-828.1	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum	X	X	–
830.0-839.9	Dislocations	X	X	–
840.0-848.8	Sprains and strains of joints and adjacent muscles	*	*	–
851.00-854.19	Intracranial injury, excluding those with skull fracture	X	X	X
880.00-884.2	Open wound of upper limb	*	*	–

Outpatient Therapy Cap Exception Process for 2007, continued

ICD-9-CM Cluster	ICD-9-CM (Cluster) Description	PT	OT	SLP
885.0-887.7	Traumatic amputation, thumb(s), finger(s), arm and hand (complete)(partial)	X	X	–
890.0-894.2	Open wound lower limb	*	*	–
895.0-897.7	Traumatic amputation, toe(s), foot/feet, leg(s) (complete)(partial)	X	X	–
905.0-905.9	Late effects of musculoskeletal and connective tissue injuries	*	*	*
907.0-907.9	Late effects of injuries to the nervous system	*	*	*
941.00-949.5	Burns	*	*	*
952.00-952.9	Spinal cord injury without evidence of spinal bone injury	X	X	X
953.0-953.8	Injury to nerve roots and spinal plexus	X	X	*
959.01	Head injury, unspecified	X	X	X

- Medicare contractors will allow automatic process exceptions for diagnoses in the table above or any other diagnosis for which therapy services are appropriate when the beneficiary needs therapy services above the therapy cap (due to the occurrence of any condition or complexity that is appropriately documented).
- For the therapy HCPCS codes subject to the cap limits in your claims to be excepted, you must include the modifier KX to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record. In CY 2007, when claims contain a modifier KX, contractors will override edits that indicate that a therapy service has exceeded the financial limitation, and will pay for the service if it is otherwise covered and payable.
- Contractors will not use the modifier KX as the sole indicator of services that do exceed caps in 2007, because, there will be services with modifier KX that do not represent services that exceed the cap.
- Contractors will require that the documentation for outpatient therapy services include objective, measurable patient function information, either by using one of the four recommended (but not required) measurement tools:
  - National Outcomes Measurement System (NOMS) by the American Speech-Language Hearing Association,
  - Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO),
  - Activity Measure – Post Acute Care (AM-PAC), or
  - OPTIMAL by the American Physical Therapy Association),

  or by including other information as described in the *Medicare Benefit Policy Manual* (Publication 100-02), Chapter 15 (Covered Medical and Other Health Services), Section 220.3C (Documentation Requirements for Therapy Services – Evaluation/Re-Evaluation and Plan of Care).
- If one of these instruments is not in the patient's medical record, the record must contain documentation to indicate objective, measurable beneficiary physical function including, for example: 1) Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or 2) Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or 3) Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.

The automatic exceptions process for therapy claims reporting the modifier KX does not preclude these claims from being subject to review. The contractor may review claims when they are potentially fraudulent, where there is evidence of misrepresentation of facts, or where there is a pattern of aberrant billing.

Note: Claims for services above the cap, which are denied, are considered benefit category denials, and the beneficiary is liable. Further, providers do not need to issue an ABN for these benefit category denials.

Be aware that contractors do not have to search their files to either retract payment for claims already paid or to retroactively pay claims, but will reopen and/or adjust claims brought to their attention.

Final note: The CR 5478 also relocates some information. Comprehensive Outpatient Rehabilitation Facilities (CORF) policies for 1) Group therapy services and 2) Therapy students, are the same as other Part B outpatient services policies for group therapy services and therapy students; and can now be found in the *Medicare Benefit Policy Manual*, Chapter 15, Section 230.

Additional Information

You can find more information about the outpatient therapy cap exception process for 2007 by going to CR 5478. CR 5478 is actually issued in three separate transmittals, one for each manual being revised. The attachments to each of the transmittals include the updates to the *Medicare Claims Processing Manua*l, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation) for 2007; the *Program Integrity Manual*, Chapter 3 (Verifying Potential

Outpatient Therapy Cap Exception Process for 2007, continued

Errors and Taking Corrective Actions), Section 3.4.1.1.1 (Exception From the Uniform Dollar Limitation ["Therapy Cap"]), and the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 220.3C (Documentation Requirements for Therapy Services – Evaluation/Re-Evaluation and Plan of Care). You are encouraged to be familiar with these important manual sections. You can find these transmittals on the CMS website at:

The *Medicare Claims Processing Manual* transmittal – *http://www.cms.hhs.gov/transmittals/downloads/R1145CP.pdf*.

The *Medicare Benefit Policy Manual* transmittal – *http://www.cms.hhs.gov/transmittals/downloads/R63BP.pdf*.

The *Medicare Program Integrity Manual* transmittal – *http://www.cms.hhs.gov/transmittals/downloads/R181PI.pdf*.

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).

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Related CR Transmittal Number: R1145CP, R181PI, R63BP
Implementation Date: On or after January 29, 2007

Elimination of the Manual Process for Therapy Cap Exceptions

Background

The Centers for Medicare & Medicaid Services (CMS) through change request (CR) 4364 implemented exceptions to the therapy financial limitation. Two processes were created to handle requests for exceptions to therapy services exceeding $1740 for calendar year (CY) 2006. These two processes were described as:

1. **The automatic process** allowed providers to automatically submit claims using modifier **KX** for patients with specific diagnoses that met medical necessity criteria.
2. **The manual process** required the provider to submit a request prior to services being provided. The request was sent via medical review for patients who required additional therapy services beyond the therapy cap. Authorization was granted for those services that met documentation and medical necessity requirements, but did not meet the criteria for the automatic process.

Effective January 1, 2007, CR 5478 announces several changes to the therapy cap and the exceptions process. The purpose of this article is to address one of the changes, which discontinues the manual process for CY 2007 for the therapy cap exceptions. Contractors will no longer accept or grant exceptions via the manual request for exceptions to the therapy cap in CY 2007. All exceptions to the CY 2007 therapy cap of $1780 must meet the criteria under the automatic process as outlined in CR 5478 dated December 29, 2006.

Reminder to Providers Included in the Progressive Corrective Action Process

Providers (Part A and Part B) included in the progressive corrective action (PCA) process may submit rehabilitation therapy claims using modifier **KX.** Use of modifier **KX** shall be interpreted as the therapist's attestation that services provided above the cap are medically necessary. If the clinician attests that the requested services are medically necessary by using modifier **KX** on the claim detail line, the contractor may make the determination that the claim is medically necessary. That determination is binding on the contractor in the absence of:

- potential fraud; or
- evidence of misrepresentation of facts presented to the contractor, or
- a pattern of aberrant billing by a provider.

Should such evidence of potential fraud, misrepresentation, or aberrant billing patterns by a provider be found, claims are subject to medical review regardless of whether modifier **KX** was used on the claim. Although the services may meet the criteria for exception from the cap due to condition or complexity, they are still subject to review to determine that the services are otherwise covered and appropriately provided. This includes providers that are currently under a progressive corrective action (PCA) medical review.

Source: CMS Pub. 100-04, Transmittal 1145, CR 5478

Outpatient Therapy Cap Exceptions Clarifications

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 January 12, 2007. Recent legislation extended the therapy cap exceptions for calendar year 2007. For details on the 2007 exceptions and process, see the *MLN Matters* article MM5478 on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5478.pdf*. *MLN Matters* article MM5478 is included on page 13 of this publication.

Provider Types Affected

Providers, physicians, and nonphysician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries [RHHIs], Part A/B Medicare administrative contractors [A/B MACs], and carriers) under the Part B benefit for therapy services.

Provider Action Needed

CR 4364, released February 15, 2006, described the exception process to the caps set on outpatient therapy services (physical therapy and occupational therapy). CR 5271, upon which this article is based, clarifies questions (below) that have arisen about this exception process. Thus, the article is meant primarily for informational purposes. It also reminds you that the exception process stops after December 31, 2006.

Background

A brief history may be beneficial at this point. The Balanced Budget Act of 1997 placed financial limitations on Medicare covered therapy services (therapy caps), which were implemented in 1999 and again for a short time in 2003. Congress placed moratoria on these caps for 2004 and 2005, but the moratoria are no longer in place, and the caps were reimplemented on January 1, 2006. However, Congress, through the Deficit Reduction Act has provided that (only for calendar year 2006) exceptions to caps may be made when provision of additional therapy services is determined to be medically necessary. **This process ends on December 31, 2006.**

Review of This Exception Process

Section 1833(g)(5) of the Social Security Act provides that, **for services provided during calendar year 2006**, FIs, RHHIs, and carriers can, in certain circumstances, grant an exception to the therapy cap when requested by the individual enrolled under the Part B benefit (or by a person acting on behalf of that individual).

Exception Processes fall into two categories:

1. Automatic process exceptions

Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if they meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 5, (as revised by CR 5271) for exception from the therapy cap for 2006.

2. Manual process exceptions

Medicare beneficiaries may be request an exception using the manual process for exception from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the criteria for automatic exceptions.

Clarifications to Questions Generated from CR 4364

Your FI, RHHI, or carrier:

1. Will grant exceptions for any number of medically necessary services for 2006 that meet the automatic process exception criteria, if the beneficiary meets the conditions described in *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR 4364).
2. Will grant an exception to the therapy cap, by approving any number of additional therapy treatment days, when these additional treatment days are deemed medically necessary based on documentation that you have submitted for services provided in 2006.
3. Will utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance in which you do not submit all required documentation with the exception request in 2006.
4. Must reply as soon as practicable to a request for exception for services provided in 2006. They will grant an exception to the therapy cap, approving the number of treatment days that you or the beneficiary request (not to exceed 15 future treatment days), if they do not make a decision within 10 business days of receipt of any request and appropriate documentation.
5. Will allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.
6. Will follow the manual description for allowing exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process in 2006.
7. Will allow automatic process exceptions when complexities occur in combination with other conditions that **may or may not be on the list** in the *Medicare Claims Processing Manual* in 2006.

Outpatient Therapy Cap Exceptions Clarifications, continued

8. Will, when a patient is being treated under the care of two physicians for separate conditions, accept as appropriate documentation either 1) A combined plan of care certified by one of the physicians/NPPs, or 2) Two separate plans of care certified by separate physicians/NPPs.

9. Will update the list of exceptions in 2006 according to the changes provided in this transmittal. You should be aware that they may expand (but not contract) this list if their manual process exception decisions lead them to believe further exceptions should be allowed.

10. Will not require the additional documentation that is encouraged but not required in the manuals.

11. Will interpret a referral or an order or a plan of care dated after an evaluation, as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.

12. Will not deny payment for reevaluation **only** because an evaluation or reevaluation was recently done, as long as documentation supports the need for re-evaluation. A reevaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.

13. Will require clinicians to write progress reports at least during each progress report period. Note that required elements of the progress report that are written into the treatment notes or in a plan of care, acceptably fulfill the requirement for a progress report. In these instances, a separate progress report is not required.

14. Will require, on pre or postpay medical review of documentation, that when the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each progress report period and sign the progress report.

15. Will continue to use Medicare summary notice (MSN) message 38.18 on all Medicare MSN forms, both in English and in Spanish. This message reads: "ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are $1,740 for PT and SLP combined and $1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE."

16. Will continue to enforce local coverage determinations (LCDs).

Final Note: *You should keep in mind that claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable.*

Additional Information

You can find more information about outpatient therapy cap exceptions by going to CR 5271, issued in three transmittals. As attachments to those transmittals, you will find updated manual sections for:

- The *Medicare Claims Processing Manual*, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services, section 10.2, The Financial Limitation. This is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1106Cp.pdf*.
- The *Medicare Program Integrity Manual*, Chapter 3, Verifying Potential Errors and Taking Corrective Actions, Section 3.4.1.1.1, Exception from the Uniform Dollar Limitation ("Therapy Cap"). This is available at *http://www.cms.hhs.gov/Transmittals/downloads/R171PI.pdf*.
- The *Medicare Benefit Policy Manual*, Chapter 15, Section 220.3, Documentation Requirements for Therapy Services. This is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R60BP.pdf*.

These manual revisions include numerous additional changes clarifications.

If you have any questions, please contact your FI, RHHI, A/B MAC, or carrier 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).

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Therapy Caps Exception Process

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 January 12, 2007. Recent legislation extended the therapy cap exceptions for calendar year 2007. For details on the 2007 exceptions and process, see the *MLN Matters* article MM5478 on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5478.pdf*. *MLN Matters* article MM5478 is included on page 13 of this publication.

Provider Types Affected

Providers, physicians, and nonphysician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) under the Part B benefit for therapy services

Key Points

- Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims).

  Outpatient rehabilitation services include:

  - **Physical therapy –** including outpatient speech-language pathology: Combined annual limit for 2006 is $1,740; and
  - **Occupational therapy –** annual limit for 2006 is $1,740.

- In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, **exceptions to therapy caps for services provided during calendar year 2006**, if these services meet certain qualifications as medically necessary services (Section 1833(g)(5) of the Social Security Act).
- The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.
- Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:

  - Meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR 4364) for exception from the therapy cap; or
  - Meet specific criteria for exception, in addition to those listed in the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.

- Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

  You may submit a request, with supporting documentation, for a specific number (not to exceed 15 future treatment days for each discipline of occupational therapy, physical therapy, and speech language pathology services) of additional therapy visits.

- Please refer to the *Additional Information* section of this article for more detailed information about the therapy caps exception process.

Background

Financial limitations on Medicare-covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997. These caps were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005.

The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to these dollar limitations of $1,740 for each cap in 2006 may be made when provision of additional therapy services is determined to be medically necessary.

Additional Information

Billing Guidelines

- **Modifier KX –** You must include modifier KX on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
- **Separate requests –** You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received **before** the cap is exceeded because the patient is liable for denied services based on caps.
- **Subsequent requests during the same episode of care –** To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of

Therapy Caps Exception Process, continued

additional therapy treatment days, not to exceed 15, **each time** the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.

- When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using t modifier KX. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

ICD-9 Codes That Qualify for the Automatic Therapy Cap Exception Process Based Upon Clinical Condition or Complexity

CR 4364 transmittal that contains these codes is the one that revises the *Medicare Claims Processing Manual*, available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf.*

You may wish to bookmark that link so you may easily reference these codes.

Documentation

Providers who believe that it is medically necessary for their patient to receive therapy services in excess of the therapy cap limitations (and the patient does not fall into the automatically excepted categories mentioned above) must submit documentation, sufficient to support medical necessity, in accordance with the revised *Medicare Benefit Policy Manual*, Pub.100-02 Chapter 15, Section 220.3; and the revised *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Sections 10.2 and 20, with the request for treatment days in excess of those payable under the therapy cap.

These manual sections contain important definitions, as well as examples of acceptable documentation, and are attached to CR 4364. CR 4364 is in three parts, one each for the revised manuals, i.e.:

- The *Medicare Benefit Policy Manual*, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R47BP.pdf*.
- The *Medicare Claims Processing Manual*, located at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf*.
- The *Medicare Program Integrity Manual*, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf*.

The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

1. **Evaluation and Certified Plan of Care** – 1-2 documents.
2. **Certification** – Physician/NPP approval of the plan required 30 days after initial treatment-or delayed certification.
3. **Clinician-signed Interval Progress Reports** (when treatment exceeds ten treatment days or 30 days) – These must be sufficient to explain the beneficiary's current functional status and need for continued therapy with the request for therapy visits in excess of those payable under the therapy cap. This is not required to be provided daily in treatment encounter notes or for an incomplete interval when unexpected discontinuation of treatment occurs.
4. **Treatment Encounter Notes** – The treatment encounter note is acceptable if it records the name of the treatment; intervention, or activity provided; the time spent in services represented by timed codes; the total treatment time; and the identity of the individual providing the intervention. These may substitute for progress reports if they contain the requirements of interval progress reports at least once every ten treatment days or once in the interval.
5. For therapy caps exceptions purposes, records justifying services over the cap, either included in the above or as a separate document.

Please see the revised Section 220.3 of the *Medicare Claims Processing Manual* located at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf* for more details about the types of documentation required and explanations of what that documentation should contain.

When reviewing documentation, Medicare contractors will:

- Consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary.
- Consider a dictated document to be completed on the day it is dictated if the identity of the qualified professional is included in the dictation.
- Consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing purposes) if it includes a diagnosis, subjective and/or objective condition, and prognosis. This information may be included in or attached to a plan. The inclusion of this information in the documentation does not necessarily constitute a billable evaluation or reevaluation unless it represents a service.
- Accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.

Therapy Caps Exception Process, continued

Medicare Contractor Decisions

If determined to be medically necessary, your Medicare contractor will grant additional treatment days for occupational therapy, physical therapy, and speech language pathology.

It is preferable that the request for exception be received before the therapy cap is actually exceeded. However, your Medicare contractor will approve additional therapy treatment days retroactively if they are deemed medically necessary, in the exceptional circumstance where a timely request for exception from the therapy cap is not received before the therapy cap is surpassed.

Your Medicare contractor may also approve additional therapy visits already provided when the request is accompanied by documentation supporting medical necessity of the services.

Please note that outpatient therapy services appropriately provided by assistants or qualified personnel will be considered covered services only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment. Claims for services above the cap that are not deemed medically necessary will be denied as a benefit category denial.

Note: If your Medicare contractor does *not* make a decision within ten business days of receipt of the request and documentation, then the decision for therapy cap exception is considered to be deemed approved as medically necessary for the number of future visits requested (not to exceed 15).

Notification

You will be notified as to whether or not an exception to the cap has been made (and if so, for how many additional future visits) as soon as practicable once the contractor has made its decision.

This notification is not an initial determination and, therefore, does not carry with it administrative appeal rights. For examples of the standard letters from the *Medicare Program Integrity Manual*, 100-8, Section 3.3.1.2, please refer to the Attachments to CR 4364. The examples include:

- Letter #1 – Approved
- Letter #2 – Negative Decision-Medical Necessity
- Letter #3 – Denied-Insufficient Documentation

Revised Medicare Summary Notice (MSN) Messages

The MSN messages (17.13; 38.18) are revised to inform beneficiaries about the therapy caps and approved medically necessary exceptions. These notices are also part of CR4 364.

Once again, there are three transmittals that comprise CR 4364. They are:

- The *Medicare Benefit Policy Manual* revision on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R47BP.pdf*.
- The *Medicare Claims Processing Manual* revision, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf*.
- The *Medicare Program Integrity Manual* revision, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf*.

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

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

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GENERAL INFORMATION

Medicare Fee-for-Service Implementation of the National Provider Identifier

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

Provider Types Affected

All Medicare fee-for-service (FFS) providers who bill Medicare.

Background

The Centers for Medicare & Medicaid Services (CMS) is publishing this special edition (SE) article to remind providers that **on May 23, 2007,** the national provider identifier (NPI) will replace health care provider identifiers that are in use today in HIPAA standard transactions. Health care providers should remember that getting an NPI is free and easy. **Time is running out!** It is estimated that, once a provider obtains an NPI, it may take up to 120 days to implement the NPI in current business practices. The following key points will assist Medicare providers as they transition from the application stage to the implementation stage to ensure NPI readiness.

Applying for an NPI

Visit the official CMS source for NPI-related information, including how to apply for an NPI, as well as free educational products, on the CMS website at *http://www.cms.hhs.gov/NationalProvIdentStand/.*

Key Points

The following are the critical content areas for the Medicare FFS health plan implementation of the NPI.

Medicare Legacy Numbers

After the compliance date, Medicare providers must begin submitting their NPIs instead of their Medicare legacy identifiers on claims they send to Medicare. A provider's taxpayer identification number (TIN), which is the provider's social security number or employer identification number, will continue to be used when a provider needs to be identified as a taxpayer in HIPAA standard transactions. The implementation guides for each of the standard transactions indicate when it is necessary to identify a provider as a taxpayer.

- A related *MLN Matters* article, MM4023, may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf.*

Electronic File Interchange

Health industry organizations that are approved by CMS as electronic file interchange organizations (EFIOs) can submit NPI application data for health care providers, including Medicare providers, in electronic files to the National Plan and Provider Enumeration System (NPPES) after obtaining the permission of the health care providers to do so. This process is called electronic file interchange (EFI). For health care providers who are approached by (EFIOs), EFI is an alternative to having to apply for their NPIs via the Web-based or paper application process. Providers who are enumerated via EFI, receive their NPI notifications from the EFIO that had them enumerated. These notifications are not generated from national plan and provider enumeration system (NPPES).

Designation of Subparts

CMS reminds Medicare providers to visit Medicare's subparts expectation paper (entitled, "Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA," and located at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf* on the CMS NPI Web page) for suggestions on how to determine their subparts.

Remember: No health plan, not even Medicare, can instruct a provider on how to enumerate subparts. This is a business decision that the organization provider must make considering its unique business operations.

Durable Medical Equipment Enumeration Requirement

As mentioned in the paper entitled, "Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA" (see link in preceding paragraph), Medicare DME suppliers are required to obtain an NPI for every location. The only exception to this requirement is the situation in which a Medicare DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI (the individual's NPI) regardless of the number of locations the DME supplier may have.

Submitting your NPI on Medicare Electronic Claims

Until further notice, CMS recommends that Medicare providers submit claims using both the NPI and legacy number. Claims submitted with **only an NPI** may be rejected/returned as unprocessable if Medicare systems are unable to properly match the incoming NPI with a legacy number. The provider will then need to resubmit the claim with the appropriate legacy number.

Medicare Fee-for-Service Implementation of the National Provider Identifier, continued

A related *MLN Matters* article, MM5378, may be viewed on the CMS website at *http://www.cms.hhs.gov/mlnmattersarticles/downloads/mm5378.pdf*.

Required Use of the NPI on Medicare Paper Claims

Medicare, as a health plan, will require the use of the NPI on its paper claims. The paper claim forms used by Medicare have been revised to accommodate use of the NPI. There will be transition periods for each of the revised forms. While the NPI cannot be used on the current paper claim forms, providers may begin using the NPI on the revised forms once the transition period for each form begins.

- The *MLN Matters* article related the transition from UB-92 to UB 04 may be viewed on the CMS website at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf*.
- The *MLN Matters* article related to the transition from CMS 1500 (12/90) to CMS 1500 (08/05) may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf*.

Required Use of Taxonomy Codes on Intuitional Provider Claims

Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a **taxonomy code** on all claims submitted to their FI. Taxonomy codes shall be reported by these facilities whether or not the facility has applied for NPIs for each of their subparts. Institutional providers that do not currently bill Medicare for services performed by their subparts are not required to use taxonomy codes on their claims to Medicare.

A recent *MLN Matters* article, MM5243, discusses this requirement in more detail and may be viewed on the CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5243.pdf*.

National Council of Prescription Drug Plan Claims

The National Council of Prescription Drug Plan (NCPDP) format was designed to permit a prescription drug claim to be submitted with either an NPI or a legacy identifier, but no more than one identifier may be reported for a provider (retail pharmacy or prescribing physician) per claim. From October 1, 2006, through May 22, 2007, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have this information). (Refer to *MLN Matters* article MM4023 at the link provided earlier in this article.)

Medicare Remittance Advice Print Software

The 835-PC-print and Medicare remit easy print software were modified to enable either the NPI or a Medicare legacy number, or both, if included in the 835. (Refer to *MLN Matters* article MM4023.)

Communicating Your NPI to Medicare

Medicare providers should know that there is no "special process" or any need to call to communicate NPIs to the Medicare program. NPIs may be shared with the Medicare program by using them on your claims along with your legacy identifier. Secondly, for providers applying for Medicare enrollment, an NPI must be reported on the CMS-855 enrollment application (along with a photocopy of the NPI notification received by the provider from the NPPES or from an EFIO). **Existing Medicare providers must provide their NPIs when making any changes to their Medicare provider enrollment information.**

Sharing NPIs

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business, and with health plans that request their NPIs. In fact, as outlined in current regulation, all providers, including Medicare providers, that are HIPAA covered providers **must** share their NPI with other providers, health plans, clearinghouses, and any entity that may need those NPIs for use in standard transactions, including the need to identify an ordering or a referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their NPIs for them.

Additional Information

NPI Questions

CMS continues to update our Frequently Asked Questions (FAQs) to answer many of the NPI questions we receive on a daily basis. Visit the following link to view all NPI FAQs: *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser//std_alp.php?p_sid=Qjr3YRYh&p_lva=&p_li=&p_page=1&p_cv=&p_pv=&p_prods=0&p_cats=&p_hidden_prods=&prod_prods=&prod_lvl1=0&p_search_text=NPI&p_new_search=1&p_search_type=answers.search_nl*

Providers should remember that the NPI enumerator can **only** answer/address the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter (i.e., for those providers enumerated via paper or web-based applications)
- Trouble accessing NPPES
- Forgotten password/user ID
- Need to request a paper application

Medicare Fee-for-Service Implementation of the National Provider Identifier, continued

- Need clarification on information that is to be supplied in the NPI application

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI enumerator at *CustomerService@NPIenumerator.com*.

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

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National Provider Identifier—Time is Running Out

NPI: Get It. Share It. Use It

Failure to prepare could result in a disruption in cash flow. Will you be ready to use your NPI? Time is running out! To date, over 1.6 million providers have obtained a national provider identifier (NPI). Now, only 120 days are left to implement the NPI into business practices prior to the compliance date. A recent survey of the health care industry, conducted by the Workgroup for Electronic Data Interchange (WEDI), indicates that providers should have already obtained an NPI and be focusing on implementation and testing with health plans and clearinghouses. If you have not obtained your NPI by now you should do so immediately so that you can begin the implementation and testing process

Reminder to Supply Legacy Identifiers on NPI Application

The Centers for Medicare & Medicaid Services (CMS) continues to urge providers to include legacy identifiers, as well as associated provider identifier type(s), on their NPI applications. This will help all health plans, including Medicare, to get ready for May 23, 2007. If reporting a Medicaid legacy number, include the associated state name. If providers have already been assigned NPIs, CMS asks them to go back into the NPPES and update their information with their legacy identifiers if they did not include those identifiers when they applied for NPIs. Providers should make sure that these legacy identifiers are the ones used to bill for services and should be sure that the NPPES is updated with this information for all health plans. This information is critical for health plans and health care clearinghouses in the development of crosswalks to aid in the transition to the NPI.

MLN Matters Article Available

A Special Edition *MLN Matters* article is posted on the CMS website with important implementation information for Medicare providers, as well as information that may be helpful for all health care providers. You may view this article by visiting *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf* on the CMS website.

Upcoming WEDI Events

WEDI will host the WEDI NPI Industry Forum on February 12, 2007, an audio-cast on the impact of the NPI on standard transactions on February 28, 2007, as well as a question and answer session on March 21, 2007. Visit the WEDI website for more details at *http://www.wedi.org/npioi/index.shtml* on the Web. Please note that there is a charge to participate in WEDI Events.

Still Confused?

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

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

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

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

Source: Provider Education Resources Listserv, Message 200701-11

Enhance the Multi-Carrier System to Avoid Duplicate Payments When a Full Claim Adjustment is Performed

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

Provider Types Affected

Physicians and other providers who bill Medicare carriers or Part A/B Medicare administrative contractors (A/B MACS) for services.

Provider Action Needed

In CR 5424, from which this article was taken, CMS announces the enhancement of the Multi-Carrier System (MCS). MCS is the system that Medicare carriers and A/B MACS use to process Part B claims for physician care and other outpatient services to avoid duplicate payments when performing a full claim adjustment. CR 5424 rescinds and fully replaces CR 3878. This article is mainly for informational purposes.

Background

In the MCS system, when a claim is adjusted because of an overpayment, an accounts receivable (A/R) is created and a demand letter sent by the carrier or A/B MAC to the provider. When a claim is adjusted because of an underpayment, payment is automatically sent to the provider.

If the claim adjustment (that created the overpayment) later turns out to be incorrect, the carrier or A/B MAC must adjust the claim again. This could happen for many reasons. The two most common are: problems with the original overpayment identification and an appeal decision favorable to the provider. When the claim adjustment occurs a second time (to allow for correct history), the MCS system will automatically issue payment to the provider. In many cases, this second payment is duplicative. This then requires an offset from the provider to collect the duplicate payment.

The MCS system maintainer has designed full claim adjustment to act as a full claim void and replace in accordance with the collective understanding of the requirements for HIPAA. This design was developed using a process that if an adjustment creates an overpayment, an AR is created and a subsequent adjustment assumes that the A/R has either been recouped or will be recouped.

Example:

- A claim is processed and $100 is paid to the provider.
- It is determined that there is an overpayment of $100.
- The claim is adjusted to show the denial (-$100) and an A/R for $100 is created.
- The claim payment total from the first adjustment is $0 = $100 - $100.
- The A/R has not yet been collected and the provider appeals.
- The appeal decision is in the provider's favor.
- A second adjustment is performed to show the claim as paid. (+ $100)
- The second adjustment calculates its payment based on the previous adjustment.
- Since the previous adjustment reads $0.00 (because the claim was denied) the second adjustment calculated a payment of $100 to the provider.
- The claim payment total from the second adjustment is $100 = $0 + $100
- A $100 check is issued because MCS cannot suppress the check.
- Since the A/R was never collected, the provider has been paid twice.

Medicare carriers and A/B MACs have, to date, used a manual system to avoid duplicate payments. But now, the MCS system will have the ability to suppress duplicate payments when a full claim adjustment is performed on a previous overpayment adjustment.

Additional Information

You may find the official instruction, CR 5424, issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R260OTN.pdf* on the CMS website.

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

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: MM5424
Related Change Request (CR) #: 5424
Related CR Release Date: January 12, 2007
Effective Date: April 1, 2007
Related CR Transmittal #: R260OTN
Implementation Date: April 2, 2007

The New HHS National Clearinghouse for Long-Term Care Information Website

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

Provider Types Affected

Physicians and providers and their staff who provide services to Medicare beneficiaries.

Provider Action Needed

This special edition article is for informational purposes and may assist providers when counseling their patients regarding long-term care. The article announces that the U.S. Department of Health & Human Services (HHS) has developed a consumer website to help beneficiaries carefully prepare a safe and secure strategy for their future healthcare needs. Resources on the new website include a long-term care planning kit and detailed information on what long term care needs are; step-by-step planning; and financial preparation. The free long-term planning kit and resources to start the planning process may be found at *http://www.longtermcare.gov*. The planning kit may also be ordered by phone by calling 1-866-PLAN-LTC (1-866-752-6582). TTY users should call 800-427-5605.

Background

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to inform you that the national clearinghouse for long-term care information is a new user-friendly consumer website that provides in-depth objective information on understanding, planning, and paying for long-term care. This important website is a collaborative effort between the Administration on Aging (AoA), the Centers for Medicare & Medicaid Services (CMS), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and it was developed as part of the Deficit Reduction Act (DRA) of 2005 (Section 6021 (d)) which allocated funds to the U.S. Department of Health and Human Services (HHS) to help Americans take an active role in planning for their future.

Located at *http://www.longtermcare.gov*, the clearinghouse website features information and tools to help people better understand the risks for and the costs of long-term care, and it is part of ongoing efforts to increase public awareness about the importance of advance planning for future long-term care needs. Given that one of the biggest barriers to planning is misinformation about long-term care, the clearinghouse website is designed to provide people with the trusted information and resources they need to take an active role in planning for possible future health care needs.

With an emphasis on the importance of future planning, the website provides a number of resources and interactive tools to help people prepare for their future healthcare needs including:

- Objective information on **specific long-term care planning options**, including the pros and cons of private financing options such as personal savings, long-term care insurance, reverse mortgages, and other options.
- In-depth information on the **availability and limitations of Medicaid** in all states, including eligibility and estate recovery requirements.
- **State-specific long-term care insurance partnership programs** under Medicaid.
- **Planning resources** that include an interactive savings calculator, information on the costs of care across the United States, and examples illustrating how individuals have planned successfully.
- **State and national contact information** for a range of long-term care programs and planning services.

The website also includes the long-term care planning kit, initially developed for the "Own Your Future" Campaign. Information regarding this campaign is in *MLN Matters* article SE0671, located on the CMS site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0671.pdf*.

A survey showed that consumers who received the long-term care planning kit were twice as likely to take some type of planning action, including evaluating their existing coverage, talking to a financial planner, buying long-term care insurance, or considering a reverse mortgage, as those who did not receive the planning kit. The planning kit may be ordered or downloaded on the clearinghouse website at *http://www.longtermcare.gov*, as well as calling 1-866-PLAN-LTC. It may also be ordered or downloaded at *http://www.aoa.gov/ownyourfuture*.

Additional Information

For more information about the "Own Your Future" campaign and the national clearinghouse for long-term care information, please visit *http://www.longtermcare.gov*.

MLN Matters Number: SE0680
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Rules of Behavior Governing Medicare Eligibility Inquiries

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

Provider Types Affected

All providers and suppliers, including their third party billing agents or clearinghouses, who submit eligibility inquiries to Medicare

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. If you, or your biller, do not adhere to these rules of behavior and/or other CMS data privacy and security rules, you could incur revocation of access to the data as well as other penalties.

CAUTION – What You Need to Know

CR 5431, from which this article is taken, restates your responsibilities in obtaining, disseminating, and using beneficiary's Medicare eligibility data; and also delineates CMS' expectations for provider and clearinghouse use of the HIPAA 270/271 Extranet application.

GO – What You Need to Do

Read the key points from CR 5431 in the Background section, below, and make sure that your staffs read the manual section (*Medicare Claims Processing Manual* (100-04), Chapter 31 (ANSI X12N Formats Other than Claims or Remittance), Section 10.3 (Eligibility Rules of Behavior), attached to CR 5431. (See Additional Information, below, for instructions in locating CR 5431.)

Background

Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

CR 5431, upon which this article is based, restates your responsibilities in obtaining, disseminating, and using beneficiary's Medicare eligibility data; and outlines CMS' expectations for providers and clearinghouses who use the HIPAA 270/271 Extranet application.

In October 2005, CMS began offering to Medicare providers and clearinghouses, the HIPAA 270/271 beneficiary eligibility transaction, real-time, via the CMS AT&T communication Extranet; and in June 2006, began to pilot an Internet application for eligibility information. Over time, this application will be available to an increasing number of Medicare providers.

Please keep in mind that the Medicare Electronic Data Interchange (EDI) enrollment process (which collects the information needed to successfully exchange EDI transactions between Medicare and EDI trading partners, and establishes the data exchange expectations for both), must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party (a billing agent or clearinghouse).

First, here are the key points, from the CR, that address your responsibilities in dealing with beneficiary eligibility data.

- The HIPAA privacy rule mandates the protection and privacy of all health information, and specifically defines the authorized uses and disclosures of "individually-identifiable" health information. CMS is committed to maintaining the integrity and security of health care data in accordance with the applicable laws and regulations.
- You should always remember that Medicare eligibility data is to be used for Medicare business only, and that providers and their staffs are expected to use, and disclose, this protected health information according to the CMS regulations.
- Authorized purposes for requesting beneficiary Medicare eligibility information include:
  - To verify eligibility, after screening the patient to determine Medicare Part A or Part B eligibility.
  - To determine beneficiary payment responsibility with regard to deductible/co-insurance.
  - To determine eligibility for services such as preventive services.
  - To determine if Medicare is the primary or secondary payer.
  - To determine if the beneficiary is in the original Medicare plan, Part C plan (Medicare Advantage) or Part D plan.
  - To determine proper billing.

Conversely, examples of unauthorized purposes for requesting beneficiary Medicare eligibility information include:

- To determine eligibility for Medicare without screening the patient to determine if they are Medicare eligible; or
- To acquire the beneficiary's health insurance claim number.

In dealing with Medicare beneficiary eligibility information, you and your employees/staff must:

- Ensure sufficient security measures exist to associate a particular transaction with a particular staff member or employee before requesting the information;
- Cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry;
- Promptly inform CMS or one of CMS's contractors (e.g., your carrier, fiscal intermediary (FI), or Part A/B Medicare administrative contractor [A/B MAC]) if you identify misuse of "individually-identifiable" health information accessed from the CMS database; and
- Limit each inquiry for Medicare beneficiary eligibility data to that for a patient that you are currently treating/serving, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

Penalties

- HHS may impose civil money penalties on a HIPAA-covered entity of $100 per failure to comply with a Privacy Rule requirement (not to exceed $25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year).

Rules of Behavior Governing Medicare Eligibility Inquiries, continued

- Further, a person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA or a trading partner agreement under 42 U.S.C 1320d-6 faces a fine of $50,000 and up to one-year imprisonment (increasing to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm).
- Under the False Claims Act, anyone who knowingly submits, or causes another person or entity to submit, false claims for payment of government funds is liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

CR 5431 also discusses CMS' expectations for providers and clearinghouses that use the HIPAA 270/271 Extranet application. A synopsis of this discussion follows.

For Providers

In order to access and use this system, you will need to 1) Register, on line, in IACS (individual authorized access to CMS computer services) and provide your social security number and e-mail address so that the system can identify you and communicate with you through email, if necessary; and 2) Adhere to basic desktop security measures and to the CMS computer systems security requirements in order to ensure the security of Medicare beneficiary personal health information.

You will also be required to adhere to the security requirements for users of CMS computer systems and to the basic desktop security measures to ensure the security of Medicare beneficiary personal health information. You must not:

- Disclose or lend your identification number and/or password to someone else. They are for your use only and serve as your electronic signature. This means that you may be held responsible for the consequences of unauthorized or illegal transactions.
- Browse or use CMS data files for unauthorized or illegal purposes.
- Use CMS data files for private gain or to misrepresent yourself or CMS.
- Make any disclosure of CMS data that is not specifically authorized.

As mentioned earlier, violation of these security requirements could result in termination of system access privileges and /or disciplinary/adverse action up to and including legal prosecution.

For Clearinghouses

CMS allows the release of eligibility data to third parties (providers' authorized billing agents or clearinghouses) for the purpose of preparing an accurate Medicare claim or determining eligibility for specific services.

In order to receive such access on behalf of providers, billing agents/clearinghouses must adhere to the following rules:

- Such entities may not submit an eligibility inquiry except as a health care provider's authorized, and through a business associate contract with the provider.
- Each provider that contracts with a billing agent/clearinghouse must sign a valid EDI enrollment form and be approved by a Medicare contractor before eligibility data can be sent to the third party.
- Each billing agent/clearinghouse must sign appropriate agreement(s) (i.e. Rules of Behavior, Trading Partner Agreement and Attestation Form) directly with CMS and/or one of CMS's contractors.
- The billing agent/clearinghouse must be able to associate each inquiry with the provider or billing service making the inquiry.

Additional Information

You can find more information about the rules of behavior with respect to obtaining, disseminating, and using beneficiary's Medicare eligibility data by going to CR 5431, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1149CP.pdf* and reading the attached *Medicare Claims Processing Manual* (100-04), Chapter 31 (ANSI X12N Formats Other than Claims or Remittance), Section 10.3(Eligibility Rules of Behavior).

If you have any questions, please contact your carrier, fiscal intermediary (FI), regional home health intermediary (RHHI), A/B MAC, durable medical equipment regional carrier (DMERC) or DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

MLN Matters Number: MM5431
Related Change Request (CR) Number: 5431
Related CR Release Date: January 5, 2007
Related CR Transmittal Number: R1149CP
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Annual Medicare Contractor Provider Satisfaction Survey: Make Your Voice Heard!

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

Provider Types Affected

All Medicare FFS providers, especially those receiving the 2007 Medicare Contractor Provider Satisfaction Survey.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is publishing this special edition (SE) article to alert providers that in early January 2007 CMS will disseminate the 2007 Medicare Contractor Provider Satisfaction Survey (MCPSS) to a new sample of Medicare providers. If you receive the survey, CMS encourages you to respond because your input is NEEDED and will be used to support claims processing improvement by Medicare fee-for-service (FFS) contractors and to reform the Medicare program.

Background

The 2007 MPCSS survey is designed so that it **can be completed in about 15 minutes** and providers can submit their responses via a secure website, mail, fax, or over the telephone. CMS will ask providers to respond by February 2007.

The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location.

The MCPSS focuses on seven major aspects of the provider-contractor relationship:

- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement.

Respondents are asked to rate their experience working with Medicare FFS contractors using a scale of 1 to 6, with "1" representing "not at all satisfied" and "6" representing "completely satisfied."

Additional Information

More information about the MCPSS and results of the 2006 survey are available at *http://www.cms.hhs.gov/MCPSS/* on the CMS website.

MLN Matters Number: SE0702 Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

January Flu Shot Reminder

It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because the flu viruses change each year. Encourage your Medicare patients who haven't already done so to get their annual flu shot and don't forget to immunize yourself and your staff.

Protect yourself, your patients, and your family and friends. Get Your Flu Shot. It's Not Too Late!

Remember – Influenza vaccination is a covered Medicare Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pd*.

Source: Provider Education Resources Listserv, Message 200701-01

Overview of Medicare Preventive Services

The *Medicare Learning Network's* newest educational video program, *An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* provides an overview of preventive services covered by Medicare and information on risk factors associated with various preventable diseases, and highlights the importance of prevention, detection, and early treatment of disease. The program is a great resource to help physicians, providers, suppliers, and other health care professionals involved in providing preventive services to Medicare beneficiaries learn more about the preventive benefits covered by Medicare.

The video program runs approximately 75 minutes in length and is suitable for viewing by an individual or for a larger audience such as at a conference or training session. The Centers for Medicare & Medicaid Services (CMS) has approved this educational video program for .1 International Association for Continuing Education and Training (IACET) CEUs for successful completion.

To order your copy today, go to the *Medicare Learning Network* Product Ordering page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS website. Available in DVD or VHS format.

Source: CMS Learning Resource, Message 200701-05

Medicare Physician Fee Schedule Fact Sheet now Available

The *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 200701-07

January is National Glaucoma Awareness Month

Please join the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of glaucoma and the glaucoma screening benefit provided by Medicare. Nearly 3 million Americans have glaucoma, the second leading cause of blindness in the world. Often progressing silently, with no symptoms, it is estimated that many people that do have the disease don't know it. With glaucoma, by the time a problem is noticed permanent damage has already occurred. With early detection and treatment, however, blindness may be prevented.

Medicare Coverage

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

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

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure (IOP) measurement; and
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

What Can You Do?

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

For More Information

- For more information about Medicare's coverage of glaucoma screening, visit the CMS website *http://www.cms.hhs.gov/GlaucomaScreening/*.
- CMS has also developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.
- The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS website.
- The CMS website provides information for each preventive service covered by Medicare. Go to *http://www.cms.hhs.gov*, select "Medicare", scroll down to the "Prevention" heading.
- For information to share with your Medicare patients, visit *http://www.medicare.gov* on the Web.
- For more information about National Glaucoma Awareness Month, please visit *http://www.preventblindness.org/*.

Source: Provider Education Resources Listserv, Message 200701-03

GENERAL MEDICAL REVIEW

X STOP® Interspinous Process Decompression System

X STOP® is a titanium metal implant designed to fit between the spinous processes of the vertebrae in the lower back. It is designed to remain safely in place without being permanently affixed to the bony or ligamentous structures of the spine. The oval spacer fits between the spinous processes and has wings, which are designed to prevent the implant from moving. The X STOP procedure is used for patients who cannot tolerate conventional spinal procedures (e.g., comorbidities, debilitated patients) and in lieu of such procedures.

The X STOP interspinous process decompression system received pre-market approval from the Food and Drug Administration (FDA) on November 21, 2005. The Centers for Medicare & Medicaid Services (**CMS) is approving the X STOP interspinous process decompression system for new technology add-on payment for FY 2007** for inpatient or outpatient settings. However, CMS remains interested in seeing whether the clinical evidence from the **five-year** follow-up study required by the FDA demonstrates that X STOP **continues** to be effective.

X STOP interspinous process decompression system is used in the treatment of lumbar spinal stenosis, which is described as a condition that occurs when the spaces between bones in the spine become narrowed due to arthritis and other age-related conditions. This narrowing, or stenosis, causes nerve root compression, thereby causing symptoms including pain, numbness, and weakness. It particularly causes symptoms when the spine is in extension, as occurs when a patient stands fully upright or leans back. The X STOP device is inserted between the spinous processes of adjacent vertebrae in order to provide a minimally invasive alternative to invasive surgery (spinal fusion, laminectomy or laminotomy) when conservative treatment (exercise and physical therapy) has failed. It works by limiting the spine extension that compresses the nerve roots while still preserving as much motion as possible. The device is inserted in a relatively simple, primarily outpatient procedure, using local anesthesia with or without sedation. However, in some circumstances, the physician may prefer to admit the patient for an inpatient stay. The device is portrayed as providing "a new minimally invasive, stand-alone alternative treatment for lumbar spinal stenosis.''

In situations where there is no national coverage determination (NCD) or local coverage determination (LCD), services are evaluated individually based on Medicare's general medical reasonableness and necessity criteria. Claims for XSTOP will be given individual consideration on a case-by-case basis until appropriately designed and powered studies are published and evaluated.

The provider should document that the patient has co-morbidities (such as cardiopulmonary disease, specifically chronic obstructive pulmonary disease, coronary artery disease or congestive heart failure) or that the patient is overly debilitated, such that they would be unable to tolerate general anesthesia or a conventional spinal procedure.

Providers should not interpret the process of individual consideration as synonymous with coverage and payment by Medicare. This means only that the claims will be reviewed against the background of the presently available evidence and specific patient circumstances.

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

Provider Billing

Please utilize the unlisted *CPT* code *22899* when billing X STOP® for 2006 service dates and *CPT* codes *0171T* and *0172T* for 2007 service dates.

Note: Code *0172T* is an add-on code. If you implant the X STOP in two lumbar levels, you must bill the primary code *0171T* and the subsequent level code *0172T* on the same claim.

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).

CORRECTIONS

2007 ICD-9-CM Coding Changes—Correction

The local coverage determinations (LCDs) impacted by the Annual 2007 ICD-9-CM update (effective October 1, 2006), were published in the October 2006 *Medicare B Update!* (pages 37-38). One of the procedure codes listed in the article for the Epoetin alfa (EPO) LCD was incorrect. The article indicated, "Add diagnoses 238.72, 238.73, 238.74, and 238.75 for procedure code J0585". The procedure code should reflect J0885.

REVISIONS TO LCDS

J9000: Antineoplastic Drugs—LCD Revision

This local coverage determination (LCD) for antineoplastic drugs was last updated on December 19, 2006. Since that time, a revision was made to add an additional off-label indication and ICD-9-CM code range for irinotecan (J9206), based on The United States Pharmacopeia Drug Information (USP DI).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the following off-label indication was added to irinotecan (J9206):

- Treatment of epithelial ovarian cancer for platinum-resistant or platinum-refractory patients.

Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, the following diagnosis range was added to irinotecan (J9206):

183.0-183.9	Malignant neoplasm of ovary and other uterine adnexa

Effective Date

This revision is effective for claims processed on or after January 22, 2007, for services rendered on or after November 30, 2006 for HCPCS code J9206. The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after this effective date.

J9041: Bortezomib (Velcade®)—LCD Revision

This local coverage determination (LCD) for bortezomib (Velcade®) had an original effective date of January 1, 2006. Since that time, the following revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD:

- Added approved Food and Drug Administration (FDA) indication for treatment of patients with mantle cell lymphoma who have received at least one prior therapy.
- Removed off-label treatment of relapsed or refractory B-cell non-Hodgkin's lymphoma for mantle cell lymphoma.
- Added off-label indication of induction therapy for multiple myeloma patients in combination with one or more drugs.

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.

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

This local coverage determination (LCD) for the list of Medicare noncovered services was last updated on January 1, 2007. Since that time, Medicare has issued a national coverage determination (NCD) and deemed Cavernous nerves electrical stimulation with penile plethysmography not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures. A revision has been made to add *CPT* code *55899* (*Cavernous nerves electrical stimulation with penile plethysmography*) under the "National Noncoverage Decisions" section of the LCD. This revision is based on CMS Publication 100-03, *Medicare National Coverage Determinations*, Transmittal 61, change request 5294.

Effective Date

This revision is effective for claims processed on or after January 8, 2007 for services rendered on or after August 24, 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.

VISCO: Viscosupplementation Therapy For Knee—LCD Revision

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised January 1, 2007. The revision consisted of the 2007 HCPCS update.

Since that time, change request 5459 issued by the Centers for Medicare & Medicaid Services (CMS), dated December 22, 2006, assigned HCPCS code J7319 hyaluronan (sodium hyaluronate) or derivative, intra-articular injection, per injection] a status indicator of I (inactive). New HCPCS codes were assigned for all recognized synthetic hyaluronic preparations used for viscosupplementation therapy for the knee(s).

The LCD has been revised to replace HCPCS code J7319 and J3590 with HCPCS codes Q4083, Q4084, Q4085, and Q4086. The new HCPCS codes and their descriptors are as follows:

Q4083 Hyaluronan or derivative, Hyalgan® or Supartz®, for intra-articular injection, per dose

Q4084 Hyaluronan or derivative, Synvisc®, for intra-articular injection, per dose

Q4085 Hyaluronan, or derivative, Euflexxa™, for intra-articular injection, per dose

Q4086 Hyaluronan, or derivative, Orthovisc®, for intra-articular injection, per dose

Effective Date

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

97001: Physical Medicine and Rehabilitation—LCD Revision

The local coverage determination (LCD) for physical medicine and rehabilitation was last revised on December 9, 2006. Since that time the LCD has been revised. CMS issued change request (CR) 5478, dated December 29, 2006 for Outpatient Therapy Cap Exception Process for CY 2007. Based on instructions found in this CR, the LCD was revised to remove language pertaining to the Manual Process Exceptions. In addition, the "Documentation Requirements" section of the LCD was updated based on the revised language found in the *Medicare Benefit Policy Manual*, Pub 100-2, Chapter 15, sections 220-230.
Note: This revision is effective **January 16, 2007** for services rendered on or after **January 1, 2007.**

In addition to the above revision, this LCD was also revised based on instructions issued in CR 5421, dated December 15, 2006. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add national noncoverage language issued with this CR for infrared therapy devices. This noncoverage language pertains to *CPT 97026*. The "ICD-9 Codes that **Do Not** Support Medical Necessity" section of the LCD was revised to include the ICD-9-CM codes issued as noncovered with this CR. These include:

250.60-250.63	354.4	354.5	354.9	355.1	355.2	355.3
355.4	355.6	355.71	355.79	355.8	355.9	356.0
356.2	356.3	356.4	356.8	356.9	357.0-357.7	674.10
674.12	674.14	674.20	674.22	674.24	707.00-707.09	707.10-707.19
870.0-879.9	880.00-887.7	890.0-897.7	998.31	998.32.		

Note: This revision will be effective **January 16, 2007** for services rendered on or after **October 24, 2006.**

The full-text for this LCD may be viewed on the provider education website *http://wwwconnecticutmedicare.com* on or after this effective date.

Sign up to our *eNews* electronic mailing list

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

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

2007 Medifest Symposium

Date	Location
April 17 & 18, 2007	Marriott Hartford 100 Capital Boulevard Rocky Hill, CT 06067

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

- Changes in the Medicare program for 2007
- NPI compliance and implementation
- CMS-1500 08/05 revisions and implementation
- Specialty classes (To be determined)
- CPT coding
- ICD-9-CM coding
- Appeals
- Primary care
- 'Incident to' provision, locum tenens and reciprocal billing rules
- E/M coding
- Global surgery
- Provider enrollment
- SNF consolidated billing
- Medicare Secondary Payer

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

This event will provide you with the opportunity to network with other professionals, visit with exhibitors featuring the latest product and service offerings, and 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.

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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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).

CORRECTIONS

2007 ICD-9-CM Coding Changes—Correction

The local coverage determinations (LCDs) impacted by the annual 2007 ICD-9-CM update (effective October 1, 2006), were published in the October 2006 *Medicare B Update!* (pages 45-47). One of the procedure codes listed in the article for the epoetin alfa (EPO) LCD was incorrect. The article indicated, "Add diagnoses 238.72, 238.73, 238.74, and 238.75 for procedure code J0585". The procedure code should reflect J0885.

NEW LCDS

90802: Interactive Psychiatric Services—New LCD

This information was previously published in the January 2007 Medicare B Update! page 78 in the General Medical Review section. This article has been revised to include information regarding the retirement of two LCDs.

The interactive psychiatric techniques are utilized primarily to evaluate children and/or adults who do not have the ability to interact through ordinary verbal communication. It involves the use of physical aids and nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication. An interactive technique may include the use of inanimate objects such as toys and dolls for a child, physical aids and non-verbal communication to overcome barriers to therapeutic interaction, or an interpreter for a person who is deaf or in situations where the patient does not speak the same language as the provider of care. If a patient is unable to communicate by any means, the interactive codes should not be billed.

This new local coverage determination (LCD) has been developed to provide indications and limitations of coverage and/or medical necessity and documentation requirements for *CPT* codes *90802*, *90810*, *90811*, *90812*, *90813*, *90814*, *90815*, *90823*, *90824*, *90826*, *90827*, *90828*, *90829* and *90857*.

In addition, the LCD for interactive individual psychotherapy (90810) and the LCD for interactive group psychotherapy (90857) are being retired as they have been incorporated in this new LCD.

Effective Date

This new LCD and the retired LCDs are 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.

REVISIONS TO LCDS

J9000: Antineoplastic Drugs—LCD Revision

This local coverage determination (LCD) for antineoplastic drugs was last updated on December 19, 2006. Since that time, a revision was made to add an additional off-label indication and ICD-9-CM code range for irinotecan (J9206), based on The United States Pharmacopeia Drug Information (USP DI).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the following off-label indication was added to Irinotecan (J9206):

- Treatment of epithelial ovarian cancer for platinum-resistant or platinum-refractory patients.

Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, the following diagnosis range was added to irinotecan (J9206):

183.0-183.9 Malignant neoplasm of ovary and other uterine adnexa

Effective Date

This revision is effective for claims processed on or after January 22, 2007, for services rendered on or after November 30, 2006 for HCPCS code J9206. The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after this effective date.

J9041: Bortezomib (Velcade®)—LCD Revision

This local coverage determination (LCD) for bortezomib (Velcade®) had an original effective date of January 1, 2006. Since that time, the following revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD:

- Added approved Food and Drug Administration (FDA) indication for treatment of patients with mantle cell lymphoma who have received at least one prior therapy.
- Removed off-label treatment of relapsed or refractory B-cell non-Hodgkin's lymphoma for mantle cell lymphoma.
- Added off-label indication of induction therapy for multiple myeloma patients in combination with one or more drugs.

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

This local coverage determination (LCD) for the list of medicare noncovered services was last updated on January 1, 2007. Since that time, Medicare has issued a national coverage determination (NCD) and deemed Cavernous nerves electrical stimulation with penile plethysmography not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures. A revision has been made to add *CPT* code *55899* (Cavernous nerves electrical stimulation with penile plethysmography) under the "National Noncoverage Decisions" section of the LCD. This revision is based on CMS Publication 100-03, Medicare National Coverage Determinations, Transmittal 61, Change Request 5294.

Effective Dates

This revision is effective for claims processed on or after January 8, 2007 for services rendered on or after August 24, 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.

THERSVCS: Therapy and Rehabilitation Services—LCD Revision

The local coverage determination (LCD) for physical medicine and rehabilitation was last revised on December 9, 2006. Since that time the LCD has been revised. CMS issued change request (CR) 5478, dated December 29, 2006 for outpatient therapy cap exception process for calendare year 2007. Based on instructions found in this CR, the LCD was revised to remove language pertaining to the Manual Process Exceptions. In addition, the "Documentation Requirements" section of the LCD was updated based on the revised language found in the *Medicare Benefit Policy Manual*, Pub 100-2, Chapter 15, sections 220-230.

Note: This revision is effective **January 16, 2007** for services rendered on or after **January 1, 2007.**

In addition to the above revision, this LCD was also revised based on instructions issued in CMS CR 5421, dated December 15, 2006. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add national noncoverage language issued with this CR for Infrared Therapy Devices. This noncoverage language pertains to *CPT 97026*. The "ICD-9 Codes that **Do Not** Support Medical Necessity" section of the LCD was revised to include the ICD-9-CM codes issued as noncovered with this CR. These include:

250.60-250.63	354.4	354.5	354.9	355.1	355.2	355.3
355.4	355.6	355.71	355.79	355.8	355.9	356.0
356.2	356.3	356.4	356.8	356.9	357.0-357.7	674.10
674.12	674.14	674.20	674.22	674.24	707.00-707.09	707.10-707.19
870.0-879.9	880.00-887.7	890.0-897.7	998.31	998.32.		

Note: This revision will be effective **January 16, 2007** for services rendered on or after **October 24, 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.

VISCO: Viscosupplementation Therapy For Knee—LCD Revision

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised January 1, 2007. The revision consisted of the 2007 HCPCS update.

Since that time, change request 5459 issued by the Centers for Medicare & Medicaid Services (CMS), dated December 22, 2006, assigned HCPCS code J7319 [hyaluronan (sodium hyaluronate) or derivative, intra-articular injection, per injection] a status indicator of I (inactive). New HCPCS codes were assigned for all recognized synthetic hyaluronic preparations used for viscosupplementation therapy for the knee(s).

The LCD has been revised to replace HCPCS code J7319 and J3590 with HCPCS codes Q4083, Q4084, Q4085, and Q4086. The new HCPCS codes and their descriptors are as follows:

Q4083 Hyaluronan or derivative, Hyalgan® or Supartz®, for intra-articular injection, per dose

Q4084 Hyaluronan or derivative, Synvisc®, for intra-articular injection, per dose

Q4085 Hyaluronan, or derivative, Euflexxa™, for intra-articular injection, per dose

Q4086 Hyaluronan, or derivative, Orthovisc®, for intra-articular injection, per dose

Effective Date

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

Sign up to our *eNews* electronic mailing list

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

FLORIDA EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

February 2007 – May 2007

Ask the Contractor Teleconference (ACT) – Provider Enrollment

When: February 15, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

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

Hot Topics Teleconference – Topics to be determined

When: April 12, 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

March 13-15, 2007

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

Registrant's Name: _____

March 13 – 15, 2007
Jacksonville Marriott
4670 Salisbury Road
Jacksonville, FL 32256
Please contact hotel for directions and/or reservations (904) 296-2222

PLEASE MARK ONLY ONE CLASS PER TIME SLOT.
Cost $205.00

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 (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 (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

March 15, 2007
Cost $126.00

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, Jacksonville Registration Form

Jacksonville Marriott
4670 Salisbury Road Jacksonville, FL 32256
Please contact hotel for directions and/or reservations (904) 296-2222

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)	$205.00
Medifest Specialty (Day 3)	$126.00

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
Jacksonville Marriott
4670 Salisbury Road
Jacksonville, FL 32256
(904) 296-2222

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 ***