Medicare B Update!
A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue…

Features

To receive quick, automatic notification when new publications and other items of interest are posted to our provider education websites, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com*, click on the "Join our Electronic Mailing List FCSO eNews" link and follow the prompts. The *FCSO eNews* is sent at least every other week, more frequently as required.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

FIRST COAST SERVICE OPTIONS, INC.
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 Web sites: *http://www.connecticutmedicare.com* and *http://www.floridamedicare.com*.

Routing Suggestions:

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

_____

TABLE OF CONTENTS

Medicare B Update!

Vol. 5, No. 1
January 2007

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

Third party Web sites: This document contains references to sites operated by third parties. Such references are provided for your convenience only. FCSO does not control such sites, and is 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.

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

The Provider Outreach & Education Publications team will begin distributing the *Medicare B Update!* on a monthly basis. We are making this change to better serve our customers by making valuable information available in a more timely manner. The previous quarterly publications have become 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 eletronic access.

For additional copies, providers may purchase a separate annual subscription in hardcopy or CD-ROM format (see order form on page 66). 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.

New Patient Liability Notice

Form CMS-R-131 is the new 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 new ABNs are designed to be more beneficiary-friendly, more readable and understandable, with patient options more 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, following the guidance in CMS Program Memoranda (PM) AB-02-114 and AB-02-168, which may be found on the CMS website at *http://cms.hhs.gov/manuals/pm_trans/AB02114.pdf* and *http://cms.hhs.gov/manuals/pm_trans/AB02168.pdf*.

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/medicare/bni*.

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

Medically Unlikely Edits

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

Provider Types Affected

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

Background

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

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

Key Points

- CR 5402 states that Medicare contractors will deny the claim line or RTP claims with units of service that exceed MUE criteria and pay the other services on the claim as part of initial claims processing activities.
- The MUEs that will be implemented by this notice are based on anatomic considerations. CMS believes that most MUEs based on anatomic considerations are not controversial, but CMS will allow and require an appeals process for those claim line items that are denied as a result of an MUE edit.
- An appeals process will not be allowed or required for claims that are RTP'ed as a result of an MUE edit. Instead, providers should resubmit corrected claims.
- This set of MUEs that is based on anatomical considerations addresses approximately 2,800 codes.
- Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"), and this provision can neither be waived nor subject to an advanced beneficiary notice (ABN).

Additional Information

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

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

For complete details regarding CR 5402 please see the official instruction issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R178PI.pdf* on the CMS website.

MLN Matters Number: MM5402
Related Change Request (CR) #: 5402
Related CR Release Date: December 8, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R178PI
Implementation Date: January 2, 2007

Quarterly Update to Correct Coding Initiative Edits, Version 13.0, Effective January 1, 2007

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

Provider Types Affected

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

Background

This article and related change request (CR) 5422 provide a reminder for physicians to take note of the quarterly updates to the coding initiatives. The latest package of Correct Coding Initiative (CCI) edits, version 13.0, effective January 1, 2007, will be available via the CMS Data Center (CDC).

Physicians may view the current CCI edits and the current mutually exclusive code (MEC) edits at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/* on the Centers for Medicare & Medicaid Services (CMS) website.

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology* (*CPT*) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice. The latest package of CCI edits, version 13.0, is effective on January 1, 2007. This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables:

- Column 1/Column 2 Correct Coding Edits table
- MEC Edits table.

Additional Information

The CCI and MEC file formats will be maintained in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 20.9, which may be found at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

You may see the official instruction (CR 5422) issued to your Medicare carrier or A/B MAC by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1124CP.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: MM5422
Related Change Request (CR) #: 5422
Related CR Release Date: December 8, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1124CP
Implementation Date: January 2, 2007

AMBULATORY SURGICAL CENTER

2007 Update of HCPCS Codes and Payments for Ambulatory Surgical Centers

Provider Types Affected

Ambulatory surgical centers (ASCs) submitting claims to Medicare carriers or fiscal intermediaries (FIs) for ASC services provided to Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 5211, which updates the 2007 HCPCS codes and ASC payment rates, effective for services furnished on or after January 1, 2007.

Background

Section 5103 of the Deficit Reduction Act of 2005 (DRA) limits ASC payments to:

- The lesser of the Medicare hospital outpatient prospective payment system (OPPS) payment amount; or
- The ASC payment amount for services furnished on or after January 1, 2007.

Also, section 1833(i)(1) of the Social Security Act requires that the list of payable ASC procedures be updated as least every two years.

CR 5211, from which this article is taken, implements the required biennial ASC update, which includes changes made by the American Medical Association for the calendar year (CY) 2007 *Common Procedural Terminology* (*CPT*). These changes include replacing the ASC 2-digit payment group code designation next to the ASC-approved Healthcare Common Procedure Coding System (HCPCS) codes with a "yy" designation for these codes, which will be defined as "the procedure is approved to be performed in an ambulatory surgical center."

CR 5211 also revises the manner in which ASC payment groups are defined. The number of ASC payment groups that carriers and FIs currently use to identify ASC payment amounts for individual HCPCS codes is being expanded in order to accommodate the new payment amounts that will be assigned to certain ASC services in CY 2007 under the DRA requirement. The ASC payment groups will now be called ASC PRICER groups

The additional ASC PRICER groups reflect the DRA-driven payment amounts, which will be included in the ASC PRICER files that carriers, and certain FIs, use to process ASC facility claims.

And lastly, CR 5211 includes payment file retrieval instructions that your carriers and FIs will use to access the final payment files on, or after, the specified retrieval date provided in CMS's notification.

You should be aware that final ASC payment rates are established after publication of the OPPS final rule and the code change update will be published as part of the OPPS final rule in the federal register. This publication usually occurs in late October. Shortly after publication, you can reach this rule through a link at *http://www.cms.hhs.gov/center/asc.asp* on the CMS website.

Also note that your carriers and FIs will continue to use the wage index values contained in transmittal 51, dated February 4, 2004, to calculate payment amounts for all type of service "F" HCPCS codes until further notice. This transmittal is available at *http://www.cms.hhs.gov/Transmittals/downloads/R51OTN.pdf* on the CMS website.

Additional Information

For complete details, please see CR 5211, the official instruction issued to your carrier/intermediary regarding this change, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1134CP.pdf* on the CMS website. The "2007 ASC Approved HCPCS Codes and Payment Rates" Changes are available at *http://www.cms.hhs.gov/ASCPayment/01_Overview.asp* on the CMS website.

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

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

MLN Matters Number: MM5211
Related Change Request (CR) #: 5211
Related CR Release Date: December 20, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1134CP
Implementation Date: January 2, 2007

The List of Procedures Approved in an Ambulatory Surgical Center

An inclusive list of surgical procedures that may be reimbursed when billed by an ASC, effective for services rendered on or after January 1, 2007, is available on the Centers for Medicare & Medicaid Services website at *http://www.cms.hhs.gov/ascpayment/01_overview.asp*. From that page, click the link entitled "2007 ASC Approved HCPCS Codes and Payment Rates [ZIP 143KB] - updated 12/22/06," and open the file provided. An ASC's facility charge for a procedure *other than* one on this list is not a benefit of Medicare, although the physician's fee may be covered.

Calculating Payment

ASC payment rates are calculated as follows. The calculations are rounded to the fourth decimal place at each step. The payment rates may be accessed at *http://www.cms.hhs.gov/ascpayment/01_overview.asp*.

1. Separate each group's payment rate into its labor (.3445) and nonlabor (.6555) components.
   - To determine the payment rate that is subject to the labor adjustment for procedure codes in PRICER groups 6 and 8, first subtract the $150 intra-ocular lens (IOL) allowance from each group's composite payment rate. (This is because IOLs are not subject to adjustment for labor costs, therefore the IOL allowance must be subtracted from the composite payment rate before applying the wage index adjustment, and then added back in the calculation as described in step 5).
2. Identify the appropriate wage index value for the ASC's location. The wage index values can be accessed at *http://www.cms.hhs.gov/Transmittals/Downloads/AB03116.pdf*. Locate the wage index value for your county listed under the appropriate metropolitan statistical area (MSA).
3. Multiply the labor component (payment rate multiplied by .3445 - Step 1) by the wage index value.
4. Add the adjusted labor component (Step 3) to the nonlabor component (payment rate multiplied by .6555 - Step 1) to determine the total adjusted payment rate.
   - For procedure codes in PRICER Groups *other than* 6 and 8, stop here.
5. For PRICER Groups 6 and 8, add the $150 IOL allowance to the total adjusted payment rate (Step 4) to determine the total adjusted composite rate for the procedures in these groups.

This provides the ASC payment rate for the ASC. Round the final amount to the nearest dollar. Note that coinsurance (and deductible if applicable) is deducted from the payment amount.

Source: Publication 100-04, Transmittal 1134, Change Request 5211
CMS Internet Only Manual, Publication 100-04, Chapter 14, Section 40.2

CARDIAC SERVICES

Cardiac Output Monitoring by Thoracic Electrical Bioimpedance

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

Provider Types Affected

Physicians who bill Part A/B Medicare administrative contractors (A/B MACs), or Medicare carriers for services to Medicare beneficiaries.

Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered the Medicare coverage policy for thoracic electrical bioimpedance (TEB) for drug-resistant hypertension and decided to retain current coverage as written in section 20.16 of the *National Coverage Determinations (NCD) Manual*.

Effective for dates of service on and after November 24, 2006, the current policies for cardiac output monitoring by TEB listed at section 20.16 of the NCD Manual will remain the same. Medicare A/B MACs and carriers will continue to make reasonable and necessary determinations for the use of TEB related to drug-resistant hypertension only. All other coverage and non-coverage policies at section 20.16 remain in effect.

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) including the revised section of 20.16 of the NCD manual, please see the official instruction (CR 5414) issued to your Medicare A/B MAC or carrier. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R63NCD.pdf* on the CMS website.

MLN Matters Number: MM5414
Related Change Request (CR) #: 5414
Related CR Release Date: December 15, 2006
Effective Date: November 24, 2006
Related CR Transmittal #: R63NCD
Implementation Date: January 16, 2007

COMPETITIVE ACQUISITION PROGRAM

Medicare Part B Drug Competitive Acquisition Program: Do Not Bill a Prescription Order Number More Than Once

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

Provider Types Affected

Physicians participating in the Competitive Acquisition Program (CAP) for Part B drugs and biologicals

Provider Action Needed

STOP – Impact to You

A CAP prescription order number must **only be used on one claim line.** It should not be reused on another claim line on the same claim, and it should not be reused on any other claim.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has found some CAP claims are being processed incorrectly when CAP prescription order numbers are reused when billing for CAP drugs.

GO – What You Need to Do

The prescription order number is intended to be a unique identifier, and it should not be reused

Background

This special edition article is being released by the CMS to provide a clarification on billing for drugs under the CAP for Part B drugs and biologicals.

CAP Claims Processing

In order for the CAP vendor's drug claim to be processed and paid, physicians must submit:

- A corresponding drug administration claim; and
- A no-pay claim line for the drug.

The vendor's drug claim and the physician's claim are then matched in the claims processing system by the prescription order number, and the vendor is paid for the drug that was administered.

A physician's no-pay claim line consists of:

- The CAP drug's Health Care Procedure Coding System (HCPCS) code,
- A billed amount (which must not equal zero), and
- The number of HCPCS billing units that were administered.

The CAP prescription order number is:

- A unique number generated by the approved CAP vendor;
- Used to match CAP claims in the payment system; and
- Associated with a line on an electronic claim.

CMS has found that some CAP claims are being processed incorrectly due the following:

- Drugs ordered under one, unique prescription order number are being billed on multiple claim lines; and
- The prescription order number is being reused with the modifier 76. (See the Additional Information Section of this article for a definition of modifier 76.)

Note: A CAP prescription order number must only be used on ONE claim line. It should not be reused on another claim line on the same claim, and it should not be reused on any other claim.

CAP Billing Example

If a CAP vendor has shipped a drug using one prescription order number but the drug is administered in several doses, the total amount administered should be identified in the number of billing units.

Example:

The approved CAP vendor has shipped 20 heparin units of J1642 heparin sodium (heparin lock flush) under the prescription order number QXXXJ1642YYYYY. (Note: HCPCS code J1642 has the descriptor: Inj heparin sodium per 10 u.)

- The patient's IV lines required two 10 unit heparin flushes during the course of the office visit.
- Since the HCPCS code defines J1642 as 10 units of heparin and a total of 20 units of heparin were administered, this situation would be:

- Billed as 2 billing units of J1642 on a line containing a J1 no-pay CAP modifier, and
- Associated with prescription order number QXXXJ1642YYYYY.

Medicare Part B Drug Competitive Acquisition Program: Do Not Bill a Prescription Order Number More Than Once, continued

Additional Information

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

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

For additional information about CAP billing refer to the billing tip sheet at *www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/cap_billtips.pdf* on the CMS website.

Physician billing information on the CAP may be found at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp* on the CMS website.

In addition, you may find MM4064 (MMA- Competitive Acquisition Program (CAP) for Part B Drugs – Coding, Testing, and Implementation) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm4064.pdf* on the CMS website.

You may also find SE0672 (Clarification of Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0672.pdf* on the CMS website.

Modifier 76 (Repeat procedure by same physician): The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier 76 to the repeated service.

Note: When it is medically necessary to repeat a service, the first service should be reported in the usual manner. The repeat service should be reported on the next line with modifier 76 appended to the procedure code. In the event it is medically necessary to repeat a procedure more than twice, report the second line with the modifier 76 and the appropriate number of units in the units field. If a service is repeated more than once, additional documentation should be provided in the narrative field of the claim to support the medical necessity of the repeat services. The patient's medical records must always document the medical necessity of performing repeat procedures and be available to the carrier upon request

MLN Matters Number: SE0677 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

Competitive Acquisition Program—Claim Processing for Not Otherwise Classified Drugs

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

Provider Types Affected

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

Impact on Providers

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

Background

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

Process To Add NOC Drugs To a Cap Vendor's Drug List

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

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

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

If approved, changes will become effective at the beginning of the following quarter. CMS will post the changes on the

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

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

Cap NOC Claims Submission Requirements

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

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

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

Returned Cap NOC Claims

For the following three situations, if:

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

Then:

- Claims will be returned to physicians with a reason code of 16 (Claim/service lacks information needed for adjudication) and remark code MA130 (Your claim contain incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable).
- Remark code N350 (Missing/incomplete/invalid description of a service for a NOC code or unlisted procedure) will also appear in the first situation.
- Remark code N56 (Procedure code billed is not correct/valid for the services billed or the date of service billed) will appear in the second and third situations.

Implementation

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

Additional Information

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

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

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

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

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

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

MLN Matters Number: MM5259
Related Change Request (CR) #: CR5259
Related CR Release Date: August 18, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1034CP
Implementation Date: January 2, 2007

Drugs Obtained Outside of the CAP for Beneficiaries with Medicare

In certain rare situations, participating Competitive Acquisition Program (CAP) providers may mistakenly obtain drugs for Medicare beneficiaries outside of the CAP vendor because they determined the beneficiary had another insurer that was primary to Medicare.

The Centers for Medicare & Medicaid Services (CMS) has created modifier M2 to use in this situation. Effective for dates of service on or after January 1, 2007, modifier M2 will allow the claim to process and pay at the current average sales price (ASP) rate.

Effective for dates of service on or after January 1, 2007, modifier J3 will no longer be accepted for this purpose.

Source: Publication 100-04, Transmittal 57/1088, Change Request 5332
CMS JSM/TDL 07161, December 22, 2006

CONSOLIDATED BILLING

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

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

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (fiscal intermediaries [FIs], carriers, durable medical equipment regional carriers [DMERC], regional home health intermediaries [RHHIs], DME Medicare administrative contractors [DME MACs] and Part A/B Medicare administrative contractors [A/B MACs]) for medical supply or therapy services.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2007. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the *Additional information* section of this article.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA). As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes. Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physicians.
- Supplies provided incidental to physician service.
- Supplies used in institutional settings.

Medicare periodically publishes routine update notifications, which contain updated lists of nonroutine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, 2007, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

Key Points

CR 5356 provides the annual HH consolidated billing update effective January 1, 2007. The following tables describe the *CPT*/HCPCS codes and the specific changes to each that this notification is implementing on January 2, 2007.

Table 1: Non Routine Supplies

Code	Description	Action	Replacement Code or Code Being Replaced
A4213	Syringe, sterile, 20 CC or greater	Add	
A4215	Needle, sterile, any size, each	Add	
A4348	Male external catheter with integral collection compartment, extended wear, each (e.g., 2 per month)	Delete	
A4359	Urinary suspensory without leg bag	Delete	
A4244	Alcohol or peroxide, per pint	Add	

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement, continued

Code	Description	Action	Replacement Code or Code Being Replaced
A4245	Alcohol wipes, per box	Add	
A4246	Betadine or phisohex solution, per pint	Add	
A4247	Betadine or iodine swabs/wipes, per box	Add	
A4461	Surgical dressing holder, nonreusable, each	Add	Replaces code: A4462
A4462	Abdominal dressing holder, each	Delete	Replacement code: A4461 and A4463
A4463	Surgical dressing holder, reusable, each	Add	Replaces code: A4462
A4932	Rectal thermometer, reusable, any type, each	Add	
A6412	Eye patch, occlusive, each	Add	

Table 2: Therapies

Code	Description	Action	Replacement Code or Code being Replaced
97020	Application microwave	Delete	Replacement Code: *97024*
97024	Application of a modality to one or more areas: diathermy (e.g., microwave)	Redefine	Replaces code: *97020*
97504	Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes	Delete	Replacement code: *97760*
97520	Prosthetic training, upper and/or lower extremity(ies), each 15 minutes	Delete	Replacement code: *97761*
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	Delete	Replacement code: *97762*
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	Add	Replaces code: *97504*
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	Add	Replaces code: *97520*
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	Add	Replaces code: *97703*

Additional Information

For complete details regarding this CR please see the official instruction issued to your Medicare FI, carrier, A/B MAC, DMERC, RHHI, or DME MAC. That instruction may be viewed by going to the CMS website *http://www.cms.hhs.gov/Transmittals/downloads/R1082CP.pdf*.

A complete historical listing of codes subject to HH consolidated billing may be found on the CMS website at *http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp*.

To review the Medicare regulations discussed in this article see the Medicare Claims Processing Manual Chapter 10, Section 10.1.25 on the CMS website at *http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf*.

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

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

MLN Matters Number: MM5356
Related Change Request (CR) Number: 5356
Related CR Release Date: October 27, 2006
Related CR Transmittal Number: R1082CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

DIAGNOSTIC IMAGING PROCEDURES

Disclosure of the Payment Cap for the Technical Component of Imaging Services

Note: As a result of legislative change to the update factor for the 2007 Medicare physician fee schedule (CR 5448), the "Payment Cap for the Technical Component of Imaging Procedures" listing has been revised. This instruction supersedes the information published in the December 2006 *Medicare B Update!* (pages 15-23)

Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of imaging services. Effective January 1, 2007, payment for the TC of imaging services including the TC portion of the global imaging service will be capped based on the outpatient prospective payment system (OPPS).

To determine if the payment is to be capped, the MPFS amount is compared to the cap amount for the TC and global portion of imaging services. CMS performed this comparison and the list on the following pages represents the allowances for the imaging services, which will be paid, based on the OPPS.

Source: CMS Pub 100-04/1083, Change Request 5357
CMS Pub 100-04/1131, Change Request 5448

Connecticut Payment Cap for the Technical Component of Imaging Procedures for Disclosure

PROC	MOD	PAR	NONPAR	LMT CHG
70336		416.43	395.61	478.89
70336	TC	340.88	323.84	392.01
70480		297.49	282.62	342.11
70480	TC	232.02	220.42	266.82
70482		436.45	414.63	501.92
70482	TC	362.86	344.72	417.29
70486		289.99	275.49	333.49
70486	TC	231.81	220.22	266.58
70496		453.30	430.63	521.29
70496	TC	363.98	345.78	418.58
70498		453.30	430.63	521.29
70498	TC	363.98	345.78	418.58
70540		495.74	470.95	570.10
70540	TC	427.03	405.68	491.08
70542		542.79	515.65	624.21
70542	TC	460.35	437.33	529.40
70543		720.22	684.21	828.25
70543	TC	610.29	579.78	701.83
70544		487.00	462.65	560.05
70544	TC	425.51	404.23	489.34
70545		520.32	494.30	598.37
70545	TC	459.28	436.32	528.17
70546		703.43	668.26	808.94
70546	TC	611.70	581.12	703.46
70547		486.55	462.22	559.53
70547	TC	425.51	404.23	489.34
70548		519.98	493.98	597.98
70548	TC	458.94	435.99	527.78
70549		703.43	668.26	808.94
70549	TC	611.70	581.12	703.46
70551		500.50	475.47	575.57
70551	TC	424.96	403.71	488.70
70552		549.56	522.08	631.99
70552	TC	458.62	435.69	527.41
70553		727.10	690.75	836.16
70553	TC	607.03	576.68	698.08
71250		290.28	275.77	333.82
71250	TC	231.25	219.69	265.94
71260		369.29	350.83	424.68
71260	TC	305.79	290.50	351.66
71270		433.21	411.55	498.19
71270	TC	362.88	344.74	417.31
71275		463.56	440.38	533.09
71275	TC	365.39	347.12	420.20
71550		500.24	475.23	575.28
71550	TC	426.26	404.95	490.20
71551		548.62	521.19	630.91
71551	TC	460.14	437.13	529.16
71552		726.23	689.92	835.16
71552	TC	611.04	580.49	702.70
72125		290.28	275.77	333.82
72125	TC	231.25	219.69	265.94
72126		368.06	349.66	423.27
72126	TC	305.79	290.50	351.66
72127		427.95	406.55	492.14
72127	TC	362.88	344.74	417.31
72128		290.28	275.77	333.82
72128	TC	231.25	219.69	265.94
72129		368.06	349.66	423.27
72129	TC	305.79	290.50	351.66
72130		427.95	406.55	492.14
72130	TC	362.88	344.74	417.31
72131		290.28	275.77	333.82
72131	TC	231.25	219.69	265.94
72132		368.06	349.66	423.27
72132	TC	305.79	290.50	351.66
72133		427.61	406.23	491.75
72133	TC	362.54	344.41	416.92
72141		506.84	481.50	582.87
72141	TC	425.19	403.93	488.97
72142		557.23	529.37	640.81
72142	TC	458.62	435.69	527.41
72146		506.39	481.07	582.35
72146	TC	424.74	403.50	488.45
72147		557.02	529.17	640.57
72147	TC	458.85	435.91	527.68
72148		500.73	475.69	575.84
72148	TC	424.74	403.50	488.45
72149		550.01	522.51	632.51
72149	TC	458.62	435.69	527.41
72156		738.35	701.43	849.10
72156	TC	607.37	577.00	698.48
72157		737.80	700.91	848.47
72157	TC	607.26	576.90	698.35
72158		727.43	691.06	836.54
72158	TC	607.37	577.00	698.48
72191		457.85	434.96	526.53
72191	TC	365.28	347.02	420.07
72192		287.36	272.99	330.46
72192	TC	231.59	220.01	266.33
72193		364.81	346.57	419.53
72193	TC	305.79	290.50	351.66
72194		424.92	403.67	488.66
72194	TC	362.65	344.52	417.05
72195		500.91	475.86	576.05
72195	TC	426.49	405.17	490.46
72196		548.51	521.08	630.79
72196	TC	460.03	437.03	529.03
72197		724.61	688.38	833.30
72197	TC	609.42	578.95	700.83
72270		258.37	245.45	297.13
72270	TC	190.94	181.39	219.58
73200		287.25	272.89	330.34
73200	TC	231.47	219.90	266.19
73202		425.03	403.78	488.78
73202	TC	362.76	344.62	417.17
73206		457.63	434.75	526.27
73206	TC	365.06	346.81	419.82
73218		495.74	470.95	570.10
73218	TC	427.03	405.68	491.08
73219		543.68	516.50	625.23
73219	TC	460.80	437.76	529.92
73220		720.22	684.21	828.25
73220	TC	610.29	579.78	701.83
73221		495.63	470.85	569.97
73221	TC	426.92	405.57	490.96
73222		543.57	516.39	625.11
73222	TC	460.69	437.66	529.79
73223		720.66	684.63	828.76
73223	TC	609.85	579.36	701.33
73700		287.25	272.89	330.34
73700	TC	231.47	219.90	266.19
73702		425.03	403.78	488.78
73702	TC	362.76	344.62	417.17
73706		462.66	439.53	532.06
73706	TC	365.17	346.91	419.95
73718		495.74	470.95	570.10
73718	TC	427.03	405.68	491.08
73719		542.79	515.65	624.21
73719	TC	460.35	437.33	529.40
73720		719.78	683.79	827.75
73720	TC	610.29	579.78	701.83
73721		495.30	470.53	569.59
73721	TC	426.59	405.26	490.58
73722		543.23	516.07	624.71
73722	TC	460.35	437.33	529.40
73723		719.78	683.79	827.75
73723	TC	609.85	579.36	701.33
74150		292.24	277.63	336.08
74150	TC	231.59	220.01	266.33
74160		370.96	352.41	426.60
74160	TC	305.89	290.60	351.77
74170		434.43	412.71	499.59
74170	TC	362.86	344.72	417.29
74175		462.33	439.21	531.68
74175	TC	365.28	347.02	420.07
74181		500.36	475.34	575.41
74181	TC	426.38	405.06	490.34
74182		548.62	521.19	630.91
74182	TC	460.14	437.13	529.16
74183		724.61	688.38	833.30
74183	TC	609.42	578.95	700.83
74260		133.20	126.54	153.18
74260	TC	107.72	102.33	123.88
74283		210.45	199.93	242.02
74283	TC	107.41	102.04	123.52
74350		165.04	156.79	189.80
74350	TC	126.63	120.30	145.62
75552		508.27	482.86	584.51
75552	TC	425.73	404.44	489.59
75553		564.73	536.49	649.44
75553	TC	459.59	436.61	528.53
75554		523.84	497.65	602.42
75554	TC	426.38	405.06	490.34
75555		520.74	494.70	598.85
75555	TC	426.38	405.06	490.34
75635		489.24	464.78	562.63
75635	TC	365.93	347.63	420.82
75660		535.06	508.31	615.32
75660	TC	466.64	443.31	536.64
75705		579.98	550.98	666.98

Connecticut Payment Cap for the Technical Component of Imaging Procedures for Disclosure

PROC	MOD	PAR	NONPAR	LMT CHG
75705	TC	466.98	443.63	537.03
75733		536.95	510.10	617.49
75733	TC	467.20	443.84	537.28
75860		527.05	500.70	606.11
75860	TC	466.54	443.21	536.52
75870		526.06	499.76	604.97
75870	TC	466.54	443.21	536.52
75893		494.81	470.07	569.03
75893	TC	466.87	443.53	536.90
75962		495.04	470.29	569.30
75962	TC	466.76	443.42	536.77
75966		536.62	509.79	617.11
75966	TC	466.43	443.11	536.39
75978		494.26	469.55	568.40
75978	TC	466.32	443.00	536.27
76376		56.73	53.89	65.24
76376	TC	45.87	43.58	52.75
76377		156.16	148.35	179.58
76377	TC	114.00	108.30	131.10
76380		164.80	156.56	189.52
76380	TC	115.07	109.32	132.33
76506		109.29	103.83	125.68
76506	TC	74.64	70.91	85.84
76812		164.54	156.31	189.22
76812	TC	71.38	67.81	82.09
76857		94.34	89.62	108.49
76857	TC	74.52	70.79	85.70
76885		112.11	106.50	128.93
76885	TC	74.53	70.80	85.71
76936		261.49	248.42	300.71
76936	TC	157.39	149.52	181.00
76942		123.90	117.71	142.48
76942	TC	89.51	85.03	102.94
76965		226.90	215.56	260.94
76965	TC	156.62	148.79	180.11
77011		368.64	350.21	423.94
77011	TC	306.76	291.42	352.77
77012		364.16	345.95	418.78
77012	TC	305.13	289.87	350.90
77014		158.75	150.81	182.56
77014	TC	115.07	109.32	132.33
77021		418.88	397.94	481.71
77021	TC	340.99	323.94	392.14
77031		302.42	287.30	347.78
77031	TC	220.94	209.89	254.08
77054		150.03	142.53	172.53
77054	TC	126.96	120.61	146.00
77078		100.84	95.80	115.97
77078	TC	88.30	83.88	101.54
77080		99.28	94.32	114.17
77080	TC	87.87	83.48	101.05
77084		422.75	401.61	486.16
77084	TC	341.10	324.05	392.26
77421		102.62	97.49	118.01
77421	TC	82.41	78.29	94.77
78075		242.05	229.95	278.36
78075	TC	203.59	193.41	234.13
78190		208.39	197.97	239.65
78190	TC	150.28	142.77	172.82
78206		380.09	361.09	437.10
78206	TC	330.70	314.16	380.30
78456		234.79	223.05	270.01
78456	TC	181.16	172.10	208.33
78458		227.80	216.41	261.97
78458	TC	181.27	172.21	208.46
78465		565.37	537.10	650.18
78465	TC	486.84	462.50	559.87
78496		140.00	133.00	161.00
78496	TC	112.74	107.10	129.65
78607		412.30	391.69	474.14
78607	TC	348.75	331.31	401.06
78630		297.01	282.16	341.56
78630	TC	262.24	249.13	301.58
78647		308.31	292.89	354.56
78647	TC	262.23	249.12	301.56
78710		289.68	275.20	333.13
78710	TC	256.14	243.33	294.56
78730		56.32	53.50	64.77
78730	TC	45.65	43.37	52.50
78803		355.77	337.98	409.14
78803	TC	299.55	284.57	344.48
78804		500.99	475.94	576.14
78804	TC	446.33	424.01	513.28
78806		343.30	326.13	394.79
78806	TC	299.23	284.27	344.11
78807		356.21	338.40	409.64
78807	TC	299.88	284.89	344.86
93880		215.31	204.54	247.61
93880	TC	183.84	174.65	211.42
93886		234.94	223.19	270.18
93886	TC	183.95	174.75	211.54
93888		107.46	102.09	123.58
93888	TC	73.98	70.28	85.08
93890		170.72	162.18	196.33
93890	TC	116.42	110.60	133.88
93892		177.72	168.83	204.38
93892	TC	116.09	110.29	133.50
93893		178.05	169.15	204.76
93893	TC	116.42	110.60	133.88
93925		215.06	204.31	247.32
93925	TC	184.38	175.16	212.04
93926		137.96	131.06	158.65
93926	TC	117.07	111.22	134.63
93930		208.20	197.79	239.43
93930	TC	183.62	174.44	211.16
93931		133.21	126.55	153.19
93931	TC	116.75	110.91	134.26
93970		219.08	208.13	251.94
93970	TC	183.30	174.13	210.79
93971		139.49	132.52	160.41
93971	TC	116.09	110.29	133.50
93975		278.69	264.76	320.49
93975	TC	183.95	174.75	211.54
93976		245.17	232.91	281.95
93976	TC	183.30	174.13	210.79
93978		151.02	143.47	173.67
93978	TC	116.42	110.60	133.88
93979		139.60	132.62	160.54
93979	TC	116.20	110.39	133.63
93981		138.29	131.38	159.03
93981	TC	115.22	109.46	132.50
93990		130.29	123.78	149.83
93990	TC	117.07	111.22	134.63
G0365		197.04	187.19	226.60
G0365	TC	184.16	174.95	211.78

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
70336		350.67	374.12	401.11	333.14	355.41	381.05	403.27	430.24	461.28
70336	TC	280.27	301.64	326.11	266.26	286.56	309.80	322.31	346.89	375.03
70480		251.01	266.84	284.98	238.46	253.50	270.73	288.66	306.87	327.73
70480	TC	190.04	204.07	220.03	180.54	193.87	209.03	218.55	234.68	253.03
70482		365.84	389.84	417.29	347.55	370.35	396.43	420.72	448.32	479.88
70482	TC	297.42	319.51	344.68	282.55	303.53	327.45	342.03	367.44	396.38
70486		244.45	260.30	278.49	232.23	247.29	264.57	281.12	299.34	320.26
70486	TC	190.28	204.59	220.93	180.77	194.36	209.88	218.82	235.28	254.07
70496		381.88	406.74	435.28	362.79	386.40	413.52	439.16	467.75	500.57
70496	TC	298.72	321.15	346.76	283.78	305.09	329.42	343.53	369.32	398.77
70498		381.88	406.74	435.28	362.79	386.40	413.52	439.16	467.75	500.57
70498	TC	298.72	321.15	346.76	283.78	305.09	329.42	343.53	369.32	398.77
70540		411.38	437.40	466.79	390.81	415.53	443.45	473.09	503.01	536.81
70540	TC	347.42	371.60	398.78	330.05	353.02	378.84	399.53	427.34	458.60
70542		451.60	480.06	512.27	429.02	456.06	486.66	519.34	552.07	589.11
70542	TC	374.86	401.15	430.76	356.12	381.09	409.22	431.09	461.32	495.37
70543		599.85	638.10	681.49	569.86	606.20	647.42	689.83	733.81	783.71
70543	TC	497.49	532.73	572.48	472.62	506.09	543.86	572.11	612.64	658.35
70544		406.23	433.97	465.71	385.92	412.27	442.42	467.16	499.07	535.57
70544	TC	349.10	375.24	405.06	331.64	356.48	384.81	401.46	431.53	465.82
70545		433.67	463.52	497.69	411.99	440.34	472.81	498.72	533.05	572.34
70545	TC	376.89	405.16	437.44	358.05	384.90	415.57	433.42	465.93	503.06
70546		581.35	617.21	657.44	552.28	586.35	624.57	668.55	709.79	756.06
70546	TC	495.94	529.35	566.64	471.14	502.88	538.31	570.33	608.75	651.64
70547		405.88	433.60	465.32	385.59	411.92	442.05	466.76	498.64	535.12
70547	TC	349.10	375.24	405.06	331.64	356.48	384.81	401.46	431.53	465.82
70548		433.19	462.89	496.85	411.53	439.75	472.01	498.17	532.32	571.38
70548	TC	376.41	404.53	436.59	357.59	384.30	414.76	432.87	465.21	502.08
70549		581.35	617.21	657.44	552.28	586.35	624.57	668.55	709.79	756.06
70549	TC	495.94	529.35	566.64	471.14	502.88	538.31	570.33	608.75	651.64
70551		419.26	447.60	480.11	398.30	425.22	456.10	482.15	514.74	552.13
70551	TC	348.86	375.12	405.11	331.42	356.36	384.85	401.19	431.39	465.88
70552		461.42	492.41	527.99	438.35	467.79	501.59	530.63	566.27	607.19
70552	TC	376.77	405.31	437.94	357.93	385.04	416.04	433.29	466.11	503.63
70553		611.93	653.93	702.35	581.33	621.23	667.23	703.72	752.02	807.70
70553	TC	500.24	539.10	583.76	475.23	512.14	554.57	575.28	619.97	671.32
71250		244.95	260.94	279.32	232.70	247.89	265.35	281.69	300.08	321.22
71250	TC	190.04	204.47	220.98	180.54	194.25	209.93	218.55	235.14	254.13
71260		310.42	331.22	355.11	294.90	314.66	337.35	356.98	380.90	408.38
71260	TC	251.42	270.59	292.54	238.85	257.06	277.91	289.13	311.18	336.42
71270		363.69	388.23	416.41	345.51	368.82	395.59	418.24	446.46	478.87
71270	TC	298.25	320.92	346.87	283.34	304.87	329.53	342.99	369.06	398.90
71275		388.63	411.94	438.33	369.20	391.34	416.41	446.92	473.73	504.08
71275	TC	297.17	317.78	340.93	282.31	301.89	323.88	341.75	365.45	392.07
71550		416.24	442.72	472.72	395.43	420.58	449.08	478.68	509.13	543.63
71550	TC	347.43	372.01	399.73	330.06	353.41	379.74	399.54	427.81	459.69
71551		457.52	486.51	519.39	434.64	462.18	493.42	526.15	559.49	597.30
71551	TC	375.10	401.67	431.65	356.35	381.59	410.07	431.37	461.92	496.40
71552		603.04	639.79	681.13	572.89	607.80	647.07	693.50	735.76	783.30
71552	TC	495.82	529.50	567.14	471.03	503.02	538.78	570.19	608.92	652.21
72125		244.95	260.94	279.32	232.70	247.89	265.35	281.69	300.08	321.22
72125	TC	190.04	204.47	220.98	180.54	194.25	209.93	218.55	235.14	254.13
72126		309.31	330.08	353.95	293.84	313.58	336.25	355.71	379.59	407.04
72126	TC	251.42	270.59	292.54	238.85	257.06	277.91	289.13	311.18	336.42
72127		358.84	383.32	411.43	340.90	364.15	390.86	412.67	440.82	473.14
72127	TC	298.25	320.92	346.87	283.34	304.87	329.53	342.99	369.06	398.90
72128		244.95	260.94	279.32	232.70	247.89	265.35	281.69	300.08	321.22
72128	TC	190.04	204.47	220.98	180.54	194.25	209.93	218.55	235.14	254.13

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

CODE/MOD		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
72129		309.31	330.08	353.95	293.84	313.58	336.25	355.71	379.59	407.04
72129	TC	251.42	270.59	292.54	238.85	257.06	277.91	289.13	311.18	336.42
72130		358.84	383.32	411.43	340.90	364.15	390.86	412.67	440.82	473.14
72130	TC	298.25	320.92	346.87	283.34	304.87	329.53	342.99	369.06	398.90
72131		244.95	260.94	279.32	232.70	247.89	265.35	281.69	300.08	321.22
72131	TC	190.04	204.47	220.98	180.54	194.25	209.93	218.55	235.14	254.13
72132		309.31	330.08	353.95	293.84	313.58	336.25	355.71	379.59	407.04
72132	TC	251.42	270.59	292.54	238.85	257.06	277.91	289.13	311.18	336.42
72133		358.37	382.68	410.59	340.45	363.55	390.06	412.13	440.08	472.18
72133	TC	297.77	320.29	346.02	282.88	304.28	328.72	342.44	368.33	397.92
72141		425.44	454.17	487.16	404.17	431.46	462.80	489.26	522.30	560.23
72141	TC	349.45	376.02	406.41	331.98	357.22	386.09	401.87	432.42	467.37
72142		468.59	499.85	535.74	445.16	474.86	508.95	538.88	574.83	616.10
72142	TC	376.77	405.31	437.94	357.93	385.04	416.04	433.29	466.11	503.63
72146		425.08	453.79	486.76	403.83	431.10	462.42	488.84	521.86	559.77
72146	TC	349.10	375.64	406.01	331.64	356.86	385.71	401.46	431.99	466.91
72147		468.83	500.36	536.64	445.39	475.34	509.81	539.15	575.41	617.14
72147	TC	377.36	406.20	439.24	358.49	385.89	417.28	433.96	467.13	505.13
72148		419.85	448.50	481.40	398.86	426.07	457.33	482.83	515.77	553.61
72148	TC	349.10	375.64	406.01	331.64	356.86	385.71	401.46	431.99	466.91
72149		461.77	492.78	528.38	438.68	468.14	501.96	531.04	566.70	607.64
72149	TC	376.77	405.31	437.94	357.93	385.04	416.04	433.29	466.11	503.63
72156		622.56	665.03	714.02	591.43	631.78	678.32	715.94	764.78	821.12
72156	TC	500.72	539.74	584.60	475.68	512.75	555.37	575.83	620.70	672.29
72157		622.33	664.91	714.07	591.21	631.66	678.37	715.68	764.65	821.18
72157	TC	500.83	540.00	585.05	475.79	513.00	555.80	575.95	621.00	672.81
72158		612.40	654.57	703.19	581.78	621.84	668.03	704.26	752.76	808.67
72158	TC	500.72	539.74	584.60	475.68	512.75	555.37	575.83	620.70	672.29
72191		383.43	406.65	432.95	364.26	386.32	411.30	440.94	467.65	497.89
72191	TC	297.29	318.04	341.38	282.43	302.14	324.31	341.88	365.75	392.59
72192		242.44	258.55	277.10	230.32	245.62	263.25	278.81	297.33	318.67
72192	TC	190.52	205.11	221.83	180.99	194.85	210.74	219.10	235.88	255.10
72193		306.33	327.06	350.88	291.01	310.71	333.34	352.28	376.12	403.51
72193	TC	251.42	270.59	292.54	238.85	257.06	277.91	289.13	311.18	336.42
72194		355.55	379.52	406.98	337.77	360.54	386.63	408.88	436.45	468.03
72194	TC	297.65	320.03	345.57	282.77	304.03	328.29	342.30	368.03	397.41
72195		417.18	443.99	474.41	396.32	421.79	450.69	479.76	510.59	545.57
72195	TC	348.02	372.90	401.02	330.62	354.25	380.97	400.22	428.83	461.17
72196		457.64	486.77	519.84	434.76	462.43	493.85	526.29	559.79	597.82
72196	TC	375.22	401.93	432.10	356.46	381.83	410.50	431.50	462.22	496.91
72197		604.83	643.68	687.87	574.59	611.50	653.48	695.55	740.23	791.05
72197	TC	497.62	533.39	573.88	472.74	506.72	545.19	572.26	613.40	659.96
72270		220.51	234.74	251.23	209.48	223.00	238.67	253.59	269.95	288.91
72270	TC	157.64	170.07	184.39	149.76	161.57	175.17	181.29	195.58	212.05
73200		241.73	257.40	275.36	229.64	244.53	261.59	277.99	296.01	316.66
73200	TC	189.80	203.95	220.08	180.31	193.75	209.08	218.27	234.54	253.09
73202		355.43	379.26	406.53	337.66	360.30	386.20	408.74	436.15	467.51
73202	TC	297.54	319.77	345.12	282.66	303.78	327.86	342.17	367.74	396.89
73206		383.66	407.17	433.85	364.48	386.81	412.16	441.21	468.25	498.93
73206	TC	297.53	318.56	342.27	282.65	302.63	325.16	342.16	366.34	393.61
73218		411.38	437.40	466.79	390.81	415.53	443.45	473.09	503.01	536.81
73218	TC	347.42	371.60	398.78	330.05	353.02	378.84	399.53	427.34	458.60
73219		452.31	480.81	513.06	429.69	456.77	487.41	520.16	552.93	590.02
73219	TC	375.22	401.53	431.15	356.46	381.45	409.59	431.50	461.76	495.82
73220		599.85	638.10	681.49	569.86	606.20	647.42	689.83	733.81	783.71
73220	TC	497.49	532.73	572.48	472.62	506.09	543.86	572.11	612.64	658.35
73221		411.50	437.66	467.24	390.92	415.78	443.88	473.22	503.31	537.33
73221	TC	347.54	371.86	399.22	330.16	353.27	379.26	399.67	427.64	459.10

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
73222		452.43	481.07	513.51	429.81	457.02	487.83	520.29	553.23	590.54
73222	TC	375.34	401.79	431.60	356.57	381.70	410.02	431.64	462.06	496.34
73223		600.21	638.48	681.88	570.20	606.56	647.79	690.24	734.25	784.16
73223	TC	497.14	532.35	572.08	472.28	505.73	543.48	571.71	612.20	657.89
73700		241.73	257.40	275.36	229.64	244.53	261.59	277.99	296.01	316.66
73700	TC	189.80	203.95	220.08	180.31	193.75	209.08	218.27	234.54	253.09
73702		355.43	379.26	406.53	337.66	360.30	386.20	408.74	436.15	467.51
73702	TC	297.54	319.77	345.12	282.66	303.78	327.86	342.17	367.74	396.89
73706		388.00	411.44	438.02	368.60	390.87	416.12	446.20	473.16	503.72
73706	TC	297.41	318.30	341.82	282.54	302.38	324.73	342.02	366.04	393.09
73718		411.38	437.40	466.79	390.81	415.53	443.45	473.09	503.01	536.81
73718	TC	347.42	371.60	398.78	330.05	353.02	378.84	399.53	427.34	458.60
73719		451.60	480.06	512.27	429.02	456.06	486.66	519.34	552.07	589.11
73719	TC	374.86	401.15	430.76	356.12	381.09	409.22	431.09	461.32	495.37
73720		599.50	637.73	681.09	569.52	605.84	647.04	689.42	733.39	783.25
73720	TC	497.49	532.73	572.48	472.62	506.09	543.86	572.11	612.64	658.35
73721		411.02	437.02	466.39	390.47	415.17	443.07	472.67	502.57	536.35
73721	TC	347.07	371.23	398.38	329.72	352.67	378.46	399.13	426.91	458.14
73722		451.96	480.44	512.66	429.36	456.42	487.03	519.75	552.51	589.56
73722	TC	374.86	401.15	430.76	356.12	381.09	409.22	431.09	461.32	495.37
73723		599.50	637.73	681.09	569.52	605.84	647.04	689.42	733.39	783.25
73723	TC	497.14	532.35	572.08	472.28	505.73	543.48	571.71	612.20	657.89
74150		246.92	263.09	281.70	234.57	249.94	267.61	283.96	302.55	323.95
74150	TC	190.52	205.11	221.83	180.99	194.85	210.74	219.10	235.88	255.10
74160		311.89	332.72	356.66	296.30	316.08	338.83	358.67	382.63	410.16
74160	TC	251.30	270.33	292.09	238.74	256.81	277.49	289.00	310.88	335.90
74170		363.97	387.95	415.38	345.77	368.55	394.61	418.57	446.14	477.69
74170	TC	297.42	319.51	344.68	282.55	303.53	327.45	342.03	367.44	396.38
74175		387.52	410.81	437.18	368.14	390.27	415.32	445.65	472.43	502.76
74175	TC	297.29	318.04	341.38	282.43	302.14	324.31	341.88	365.75	392.59
74181		416.95	443.87	474.46	396.10	421.68	450.74	479.49	510.45	545.63
74181	TC	348.14	373.16	401.47	330.73	354.50	381.40	400.36	429.13	461.69
74182		457.52	486.51	519.39	434.64	462.18	493.42	526.15	559.49	597.30
74182	TC	375.10	401.67	431.65	356.35	381.59	410.07	431.37	461.92	496.40
74183		604.83	643.68	687.87	574.59	611.50	653.48	695.55	740.23	791.05
74183	TC	497.62	533.39	573.88	472.74	506.72	545.19	572.26	613.40	659.96
74260		110.95	117.43	124.70	105.40	111.56	118.47	127.59	135.04	143.41
74260	TC	87.27	93.10	99.60	82.91	88.44	94.62	100.36	107.06	114.54
74283		184.40	193.99	205.15	175.18	184.29	194.89	212.06	223.09	235.92
74283	TC	88.46	95.30	103.14	84.04	90.53	97.98	101.73	109.59	118.61
74350		140.13	149.26	159.81	133.12	141.80	151.82	161.15	171.65	183.78
74350	TC	104.42	112.58	121.97	99.20	106.95	115.87	120.08	129.47	140.27
75552		425.55	453.62	485.71	404.27	430.94	461.42	489.38	521.66	558.57
75552	TC	348.86	374.72	404.16	331.42	355.98	383.95	401.19	430.93	464.78
75553		472.77	502.64	536.64	449.13	477.51	509.81	543.69	578.04	617.14
75553	TC	375.70	402.97	433.90	356.91	382.82	412.20	432.05	463.42	498.98
75554		438.11	465.65	496.93	416.20	442.37	472.08	503.83	535.50	571.47
75554	TC	348.14	373.16	401.47	330.73	354.50	381.40	400.36	429.13	461.69
75555		435.06	462.61	493.92	413.31	439.48	469.22	500.32	532.00	568.01
75555	TC	348.14	373.16	401.47	330.73	354.50	381.40	400.36	429.13	461.69
75635		411.31	434.59	460.83	390.74	412.86	437.79	473.01	499.78	529.95
75635	TC	296.57	316.48	338.68	281.74	300.66	321.75	341.06	363.95	389.48
75660		449.18	481.71	519.34	426.72	457.62	493.37	516.56	553.97	597.24
75660	TC	385.65	416.30	451.67	366.37	395.49	429.09	443.50	478.74	519.42
75705		491.75	526.11	566.00	467.16	499.80	537.70	565.51	605.03	650.90
75705	TC	386.13	416.94	452.52	366.82	396.09	429.89	444.05	479.48	520.40
75733		450.48	482.95	520.48	427.96	458.80	494.46	518.05	555.39	598.55
75733	TC	385.89	416.42	451.62	366.60	395.60	429.04	443.77	478.88	519.36

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
75860		441.60	473.89	511.22	419.52	450.20	485.66	507.84	544.97	587.90
75860	TC	385.77	416.56	452.12	366.48	395.73	429.51	443.64	479.04	519.94
75870		441.01	473.40	510.88	418.96	449.73	485.34	507.16	544.41	587.51
75870	TC	385.77	416.56	452.12	366.48	395.73	429.51	443.64	479.04	519.94
75893		412.15	443.79	480.38	391.54	421.60	456.36	473.97	510.36	552.44
75893	TC	386.25	417.20	452.97	366.94	396.34	430.32	444.19	479.78	520.92
75962		412.74	444.68	481.67	392.10	422.45	457.59	474.65	511.38	553.92
75962	TC	386.37	417.46	453.42	367.05	396.59	430.75	444.33	480.08	521.43
75966		450.84	483.73	521.83	428.30	459.54	495.74	518.47	556.29	600.10
75966	TC	385.89	416.82	452.57	366.60	395.98	429.94	443.77	479.34	520.46
75978		411.91	443.67	480.43	391.31	421.49	456.41	473.70	510.22	552.49
75978	TC	386.01	417.08	453.02	366.71	396.23	430.37	443.91	479.64	520.97
76376		47.50	50.52	53.95	45.13	47.99	51.25	54.62	58.10	62.04
76376	TC	37.25	39.80	42.65	35.39	37.81	40.52	42.84	45.77	49.05
76377		136.32	147.16	160.13	129.50	139.80	152.12	156.77	169.23	184.15
76377	TC	96.40	105.42	116.13	91.58	100.15	110.32	110.86	121.23	133.55
76380		140.61	148.93	158.49	133.58	141.48	150.57	161.70	171.27	182.26
76380	TC	94.37	101.41	109.45	89.65	96.34	103.98	108.53	116.62	125.87
76506		93.86	99.90	106.92	89.17	94.91	101.57	107.94	114.88	122.96
76506	TC	61.26	65.86	71.11	58.20	62.57	67.55	70.45	75.74	81.78
76812		150.43	161.21	174.42	142.91	153.15	165.70	172.99	185.39	200.58
76812	TC	64.01	72.23	82.39	60.81	68.62	78.27	73.61	83.06	94.75
76857		78.99	83.74	89.11	75.04	79.55	84.65	90.84	96.30	102.48
76857	TC	60.54	64.70	69.37	57.51	61.46	65.90	69.62	74.41	79.78
76885		96.35	102.04	108.62	91.53	96.94	103.19	110.80	117.35	124.91
76885	TC	61.38	66.12	71.56	58.31	62.81	67.98	70.59	76.04	82.29
76936		227.02	240.47	256.17	215.67	228.45	243.36	261.07	276.54	294.60
76936	TC	129.61	139.62	151.12	123.13	132.64	143.56	149.05	160.56	173.79
76942		104.69	110.62	117.33	99.46	105.09	111.46	120.39	127.21	134.93
76942	TC	72.72	77.72	83.32	69.08	73.83	79.15	83.63	89.38	95.82
76965		195.23	207.85	222.56	185.47	197.46	211.43	224.51	239.03	255.94
76965	TC	129.62	140.03	152.07	123.14	133.03	144.47	149.06	161.03	174.88
77011		307.86	327.37	349.53	292.47	311.00	332.05	354.04	376.48	401.96
77011	TC	250.34	268.25	288.50	237.82	254.84	274.07	287.89	308.49	331.77
77012		307.04	328.62	353.58	291.69	312.19	335.90	353.10	377.91	406.62
77012	TC	252.13	272.15	295.24	239.52	258.54	280.48	289.95	312.97	339.53
77014		135.00	143.26	152.75	128.25	136.10	145.11	155.25	164.75	175.66
77014	TC	94.37	101.41	109.45	89.65	96.34	103.98	108.53	116.62	125.87
77021		352.96	376.64	403.90	335.31	357.81	383.70	405.90	433.14	464.48
77021	TC	280.15	301.38	325.66	266.14	286.31	309.38	322.17	346.59	374.51
77031		259.03	276.18	296.16	246.08	262.37	281.35	297.88	317.61	340.58
77031	TC	182.83	197.52	214.49	173.69	187.64	203.77	210.25	227.15	246.66
77054		126.33	135.27	145.62	120.01	128.51	138.34	145.28	155.56	167.46
77054	TC	104.90	113.22	122.81	99.66	107.56	116.67	120.63	130.20	141.23
77078		84.02	89.72	96.23	79.82	85.23	91.42	96.62	103.18	110.66
77078	TC	72.37	77.75	83.87	68.75	73.86	79.68	83.23	89.41	96.45
77080		83.34	89.62	96.91	79.17	85.14	92.06	95.84	103.06	111.45
77080	TC	72.85	78.79	85.67	69.21	74.85	81.39	83.78	90.61	98.52
77084		356.02	379.27	405.97	338.22	360.31	385.67	409.42	436.16	466.87
77084	TC	280.03	301.12	325.21	266.03	286.06	308.95	322.03	346.29	373.99
77421		85.87	91.13	97.08	81.58	86.57	92.23	98.75	104.80	111.64
77421	TC	67.05	71.72	76.96	63.70	68.13	73.11	77.11	82.48	88.50
78075		202.19	215.32	230.28	192.08	204.55	218.77	232.52	247.62	264.82
78075	TC	166.50	178.64	192.42	158.17	169.71	182.80	191.47	205.44	221.28
78190		177.52	188.68	201.57	168.64	179.25	191.49	204.15	216.98	231.81
78190	TC	123.11	132.21	142.57	116.95	125.60	135.44	141.58	152.04	163.96
78206		312.01	330.00	349.86	296.41	313.50	332.37	358.81	379.50	402.34
78206	TC	266.17	282.86	301.17	252.86	268.72	286.11	306.10	325.29	346.35

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
78456		198.49	211.31	226.05	188.57	200.74	214.75	228.26	243.01	259.96
78456	TC	149.01	160.40	173.46	141.56	152.38	164.79	171.36	184.46	199.48
78458		192.12	204.64	219.01	182.51	194.41	208.06	220.94	235.34	251.86
78458	TC	148.89	160.14	173.01	141.45	152.13	164.36	171.22	184.16	198.96
78465		472.78	505.46	542.97	449.14	480.19	515.82	543.70	581.28	624.42
78465	TC	400.54	431.25	466.45	380.51	409.69	443.13	460.62	495.94	536.42
78496		117.81	125.62	134.60	111.92	119.34	127.87	135.48	144.46	154.79
78496	TC	92.72	99.80	107.91	88.08	94.81	102.51	106.63	114.77	124.10
78607		344.09	366.45	391.90	326.89	348.13	372.30	395.70	421.42	450.68
78607	TC	285.11	305.83	329.32	270.85	290.54	312.85	327.88	351.70	378.72
78630		247.34	264.27	283.63	234.97	251.06	269.45	284.44	303.91	326.17
78630	TC	214.99	230.99	249.23	204.24	219.44	236.77	247.24	265.64	286.61
78647		257.04	273.70	292.64	244.19	260.01	278.01	295.60	314.75	336.54
78647	TC	214.16	229.58	247.04	203.45	218.10	234.69	246.28	264.02	284.10
78710		241.97	259.04	278.66	229.87	246.09	264.73	278.27	297.90	320.46
78710	TC	210.74	226.90	245.42	200.20	215.56	233.15	242.35	260.94	282.23
78730		47.26	50.64	54.54	44.90	48.11	51.81	54.35	58.24	62.72
78730	TC	37.49	40.32	43.55	35.62	38.30	41.37	43.11	46.37	50.08
78803		297.07	316.33	338.26	282.22	300.51	321.35	341.63	363.78	389.00
78803	TC	244.79	262.51	282.60	232.55	249.38	268.47	281.51	301.89	324.99
78804		412.30	437.85	466.43	391.69	415.96	443.11	474.14	503.53	536.39
78804	TC	361.61	385.80	412.76	343.53	366.51	392.12	415.85	443.67	474.67
78806		286.99	306.93	329.82	272.64	291.58	313.33	330.04	352.97	379.29
78806	TC	245.98	264.70	286.14	233.68	251.46	271.83	282.88	304.40	329.06
78807		297.42	316.71	338.66	282.55	300.87	321.73	342.03	364.22	389.46
78807	TC	245.26	263.15	283.44	233.00	249.99	269.27	282.05	302.62	325.96
93880		181.42	194.58	209.83	172.35	184.85	199.34	208.63	223.77	241.30
93880	TC	151.97	164.07	178.04	144.37	155.87	169.14	174.77	188.68	204.75
93886		199.32	212.96	228.78	189.35	202.31	217.34	229.22	244.90	263.10
93886	TC	151.85	163.81	177.59	144.26	155.62	168.71	174.63	188.38	204.23
93888		92.54	98.65	105.80	87.91	93.72	100.51	106.42	113.45	121.67
93888	TC	61.14	66.00	71.61	58.08	62.70	68.03	70.31	75.90	82.35
93890		147.53	157.54	169.30	140.15	149.66	160.84	169.66	181.17	194.69
93890	TC	97.10	105.37	115.02	92.24	100.10	109.27	111.66	121.18	132.27
93892		153.76	163.71	175.37	146.07	155.52	166.60	176.82	188.27	201.68
93892	TC	96.62	104.73	114.18	91.79	99.49	108.47	111.11	120.44	131.31
93893		154.23	164.34	176.22	146.52	156.12	167.41	177.36	188.99	202.65
93893	TC	97.10	105.37	115.02	92.24	100.10	109.27	111.66	121.18	132.27
93925		180.07	192.52	206.83	171.07	182.89	196.49	207.08	221.40	237.85
93925	TC	151.37	162.77	175.79	143.80	154.63	167.00	174.08	187.19	202.16
93926		116.15	124.49	134.14	110.34	118.27	127.43	133.57	143.16	154.26
93926	TC	96.38	103.81	112.33	91.56	98.62	106.71	110.84	119.38	129.18
93930		175.32	188.67	204.21	166.55	179.24	194.00	201.62	216.97	234.84
93930	TC	152.21	164.59	178.93	144.60	156.36	169.98	175.04	189.28	205.77
93931		112.32	120.86	130.80	106.70	114.82	124.26	129.17	138.99	150.42
93931	TC	96.74	104.59	113.68	91.90	99.36	108.00	111.25	120.28	130.73
93970		186.33	200.55	217.21	177.01	190.52	206.35	214.28	230.63	249.79
93970	TC	152.56	165.37	180.28	144.93	157.10	171.27	175.44	190.18	207.32
93971		118.53	127.42	137.83	112.60	121.05	130.94	136.31	146.53	158.50
93971	TC	96.62	104.73	114.18	91.79	99.49	108.47	111.11	120.44	131.31
93975		240.69	255.97	273.81	228.66	243.17	260.12	276.79	294.37	314.88
93975	TC	151.85	163.81	177.59	144.26	155.62	168.71	174.63	188.38	204.23
93976		210.08	224.48	241.31	199.58	213.26	229.24	241.59	258.15	277.51
93976	TC	152.56	165.37	180.28	144.93	157.10	171.27	175.44	190.18	207.32
93978		129.73	139.41	150.82	123.24	132.44	143.28	149.19	160.32	173.44
93978	TC	97.10	105.37	115.02	92.24	100.10	109.27	111.66	121.18	132.27
93979		118.41	127.16	137.38	112.49	120.80	130.51	136.17	146.23	157.99
93979	TC	96.50	104.47	113.73	91.67	99.25	108.04	110.97	120.14	130.79

Florida Payment Cap for the Technical Component of Imaging Procedures for Disclosure

		PARTICIPATING FEE SCHEDULE			NONPARTICIPATING FEE SCHEDULE			LIMITING CHARGE		
CODE/MOD		LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
93981		119.01	128.86	140.58	113.06	122.42	133.55	136.86	148.19	161.67
93981	TC	97.58	106.81	117.77	92.70	101.47	111.88	112.22	122.83	135.44
93990		108.98	117.05	126.38	103.53	111.20	120.06	125.33	134.61	145.34
93990	TC	96.38	103.81	112.33	91.56	98.62	106.71	110.84	119.38	129.18
G0365		163.73	175.90	189.90	155.54	167.10	180.41	188.29	202.29	218.38
G0365	TC	151.61	163.29	176.69	144.03	155.13	167.86	174.35	187.78	203.19

January 2007 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective January 1, 2007, and Revisions to April 2006, July 2006 and October 2006 Quarterly ASP Medicare Part B Drug Pricing Files

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5413, which informs Medicare contractors to download the January 2007 average sales price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2006, April 2006, July 2006, and October 2006 files.

Background

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

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

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

ASP Methodology

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

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

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

Exceptions are summarized as follows:

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

January 2007, April 2006, July 2006 and October 2006 ASP Revisions, continued

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

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

On or after December 19, 2006, the revised April, July and October 2006 and January 2007 ASP file and ASP NOC files will be available for retrieval from the CMS ASP Web page, and the payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The revised files are applicable to claims based on dates of service as shown below:

Payment Allowance Limit Revision Date	**Applicable Dates of Service**
April 2006	April 1, 2006 through June 30, 2006.
July 2006	July 1, 2006 through September 30, 2006.
October 2006	October 1, 2006 through December 31, 2006.
January 2007	January 1, 2007 through March 31, 2007.

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

Drugs Furnished During Filling or Refilling an Implantable Pumpor Reservoir

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

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

Additional Information

For complete details, please see the official instruction issued to your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1129CP.pdf* on the CMS website.

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

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

MLN Matters Number: MM5413	Related Change Request (CR) #: 5413
Related CR Release Date: December 15, 2006	Effective Date: January 1, 2007
Related CR Transmittal #: R1129CP	Implementation Date: January 2, 2007

Payment Allowances for the Influenza Virus Vaccine and the Pneumoccocal Vaccine

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

Provider Types Affected

Physicians, nonphysician practitioners, providers and suppliers billing Medicare contractors (Part A/B Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs) and carriers for the influenza and pneumoccocal vaccines.

Background

This article and related change request (CR) 5365 provide the payment allowances for the following influenza virus vaccines: *CPT* codes *90655, 90656, 90657,* and *90658* as well as the pneumoccocal vaccine (*CPT 90732*) when payment is based on 95 percent of the AWP.

Key Points

- Effective September 1, 2006, the Medicare Part B payment allowance for *CPT 90655* is $15.377.
- Effective September 1, 2006, the Medicare Part B payment allowance for *CPT 90656* is $16.574.
- Effective September 1, 2006, the Medicare Part B payment allowance for *CPT 90657* is $6.312.
- Effective September 1, 2006, the Medicare Part B payment allowance for *CPT 90658* is $12.624.
- Effective September 1, 2006, the Medicare Part B payment allowance for *CPT 90732* is $27.028.
- Annual Part B deductible and coinsurance amounts do not apply to these services.
- All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumoccocal vaccination must take assignment on the claim for the vaccine.
- Note that your carrier or FI may also cover *CPT 90660* (FluMist, a nasal influenza vaccine) if they determine its use is medically reasonable and necessary for the beneficiary.
- Please take note of this pricing information to ensure accurate claims processing. Your carrier or FI will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, they will adjust claims brought to their attention.

Implementation

While the implementation of these rates will occur on January 22, 2007, the rates apply to dates of service on or after September 1, 2006.

Additional Information

If you have questions, please contact your Medicare FI, 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).

To view CR 5365, the official instruction issued to your Medicare FI, Carrier or A/B MAC on this issue, visit *http://www.cms.hhs.gov/Transmittals/downloads/R256OTN.pdf* on the CMS website.

MLN Matters Number: MM5365
Related Change Request (CR) #: 5365
Related CR Release Date: December 22, 2006
Effective Date: September 1, 2006
Related CR Transmittal #: R256OTN
Implementation Date: January 22, 2007

DURABLE MEDICAL EQUIPMENT

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

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

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (Part A/B Medicare administrative contractors [A/B MACs], durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], carriers, and/or regional home health intermediariesl [RHHIs]), for services paid under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule.

Provider Action Needed

This article is based on change request (CR) 5417, and it provides specific information regarding the annual update for the 2007 DMEPOS fee schedule. Be sure billing staff are aware of this update.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to:

- Implement fee schedule amounts for new codes; and
- Revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for:

- Durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)); and
- Parenteral and enteral nutrition (PEN) by regulations contained in the *Code of Federal Regulations* (42 CFR 414.102).

Note: DMERCs and DME MACS will use the 2007 PEN fee schedule payment amounts to pay claims for items furnished from January 1, 2007 through December 31, 2007

Deleted HCPCS Codes

The following codes are being deleted from the HCPCS effective January 1, 2007, and are therefore being removed from the DMEPOS and PEN fee schedule files.

A4348
A4359
A4462
A4632
E0164
E0166
E0180
E0701
E0977
E0997 thru E0999
E2320
K0090 thru K0097
K0099 L0100
L0110
L3902
L3914
L6700
L6705
L6710
L6715
L6720
L6725
L6730
L6735 L6740
L6745
L6750
L6755
L6765
L6770
L6775
L6780
L6790
L6795
L6800
L6806 thru L6809
L6825
L6830
L6835
L6840
L6845
L6850
L6855
L6860
L6865
L6867
L6868
L6870
L6872
L6873
L6875
L6880
L7010
L7015
L7020
L7025
L7030
L7035

Added HCPCS

The HCPCS codes listed below are being added to the HCPCS on January 1, 2007:

A4461
A4463
A4559
A4600
A4601
A8000
A9279
E0676
E0936
E2373 thru E2377
E2381 thru E2396
K0733 thru K0737
L1001
L3806
L3808
L3915
L5993
L5994
L6703
L6704
L6706
L6707 thru L6709
L7007 thru L7009
L8690
A8001
A8002
A8003
A8004
L6611
L6624
L6639
L8691
L8695

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

Payment Rates for Oxygen and Oxygen Equipment

As part of this fee schedule update, the Centers for Medicare & Medicaid Services (CMS) is implementing national monthly payment rates for oxygen and oxygen equipment effective for claims with dates of service on or after January 1, 2007. The 2007 national monthly payment rates are listed in the table below. As a result of these changes, CMS is revising the fee schedule amounts for codes E1405 and E1406. Since 1989, the fees for E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

As part of these changes, suppliers must submit claims with both the code for stationary oxygen contents (E0441 or E0442) and the code for portable oxygen contents (E0443 or E0444) when billing for payment for furnishing both stationary and portable oxygen contents for beneficiary-owned gaseous or liquid stationary and portable oxygen equipment.

HCPCS Codes	Amount	Class
E0424, E0439, E1390, and E1391	$198.40	Stationary oxygen equipment (including stationary concentrator, liquid and gaseous equipment) and oxygen contents (stationary and portable)
E0431 and E0434	$31.79	Portable equipment only (gaseous or liquid tanks)
E1392 and K0738	$51.63	Oxygen generating portable equipment (OGPE) only
E0441 and E0442	$77.45	Oxygen contents for beneficiary-owned stationary gaseous or liquid oxygen equipment
E0443 and E0444	$77.45	Oxygen contents for beneficiary-owned portable gaseous or liquid oxygen equipment

The fee schedules for HCPCS code E0461 (Volume control ventilator, without pressure support mode, may Include pressure control mode, used with noninvasive interface [E.G. mask]) are being revised as part of this update to correct calculation errors and are effective for dates of service on or after January 1, 2007.

Gap-Fill Items

The Medicare DMERCS and DME MACs will gap-fill base fee schedule amounts for each state in their region for the following new and revised HCPCS codes that will be subject to the DMEPOS fee schedules in 2007:

- Inexpensive or routinely purchased DME for codes A8002, A8003, A8004, E2373, E2374, E2375, E2376, E2377, E2388, E2389, E2390, E2391, E2392, E2393, E2394, E2395
- Capped rental DME codes of E0639 and E0640
- Prosthetics and orthotics codes of L1001, L3806, L3808, L3915, L5993, L5994, L6611, L6624, L6639
- Surgical dressings codes of A4463
- DME supplies codes of A4559

Additional Information

If you have questions, please contact your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier at their toll-free number which may be found 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 5417) issued to your Medicare A/B MAC, DMERC, DME MAC, FI, RHHI, or carrier. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1125CP.pdf* on the CMS website.

MLN Matters Number: MM5417
Related Change Request (CR) #: 5417
Related CR Release Date: December 8, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1125CP
Implementation Date: January 2, 2007

Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

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

Provider Types Affected

Physicians, suppliers and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME MACs), or Part A/B Medicare administrative contractors (A/B MACs) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

Provider Action Needed

Affected providers may want to be sure their billing staff knows of these changes.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses in calendar year 2007 as required by regulations contained in 42 CFR 405.501 (*http://www.gpoaccess.gov/cfr/retrieve.html*).

For splints and casts, Q-codes are to be used when supplies are indicated for cast and splint purposes. *Current Procedural Terminology (CPT)* codes should be used as indicated in the *CPT* section "Application of Casts and Strapping" for the specified *CPT* procedure codes in the 29XXX series. This payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.

For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. Change request (CR) 5282 instructs your carrier, DMERC, DME MAC, or A/B MAC to compute 2007 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular lenses implanted in a physician's office) using actual charge data from July 1, 2005, through June 30, 2006. Carriers, and A/B MACs will compute 2007 inflation-indexed charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2006.

DMERCs and DME MACs will compute 2007 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2005, through June 30, 2006. For these same codes, they will compute 2007 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2006. These tables are:

Dialysis Supplies Billed With AX Modifier

A4216	A4217	A4248	A4244	A4245	A4246	A4247	A4450	A4452	A6250	A6260	A4651	A4652	A4657
A4660	A4663	A4670	A4927	A4928	A4930	A4931	A6216	A6402					

Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680	A4690	A4706	A4707	A4708	A4709	A4714	A4719	A4720
A4721	A4722	A4723	A4724	A4725	A4726	A4728	A4730	A4736	A4737	A4740	A4750	A4755	A4760
A4765	A4766	A4770	A4771	A4772	A4773	A4774	A4802	A4860	A4870	A4890	A4911	A4918	A4929
E1634													

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639

Dialysis Equipment Billed Without AX Modifier

E1500	E1510	E1520	E1530	E1540	E1550	E1560	E1570	E1575	E1580	E1590	E1592	E1594	E1600
E1610	E1615	E1620	E1625	E1630	E1635	E1636							

Carriers and A/B MACs will make payment for splints and casts furnished in 2007 based on the lower of the actual charge or the payment limits established for these codes. **Carriers, DMERCs and DME MACs** will use the 2007 reasonable charges or the same payment limits to pay claims for items furnished from January 1, 2007 through December 31, 2007. **Those 2007 payment limits are at the end of this article.**

Additional Information

Instructions for calculating:

- Reasonable charges are located in chapter 23 (section 80) of the *Medicare Claims Processing Manual* (Pub. 100-04).
- Customary and prevailing charge are locate in section 80.2 and 80.4 of chapter 23 of the *Medicare Claims Processing Manual* (Pub 100-04)
- The IIC (inflation indexed charge) are located in section 80.6 of chapter 23 of the *Medicare Claims Processing Manual* (Pub. 100-04). The IIC update factor for 2007 is 4.3 percent.

You can find chapter 23 of the *Medicare Claims Processing Manual* (Pub. 100-04) at the following CMS website: *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*.

For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC, or A/B MAC regarding this change. That instruction may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1118CP.pdf*.

If you have any questions, please contact your carrier, DMERC, DME MAC, 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*.

Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses, continued

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).

2007 Payment Limits for Splints and Casts Disclaimer

Code	Payment Limit	Code	Payment Limit	Code	Payment Limit	Code	Payment Limit
A4565	$7.19	Q4013	$13.16	Q4026	$98.64	Q4039	$6.89
Q4001	$40.91	Q4014	$22.21	Q4027	$15.80	Q4040	$17.22
Q4002	$154.63	Q4015	$6.58	Q4028	$49.33	Q4041	$16.71
Q4003	$29.39	Q4016	$11.10	Q4029	$24.16	Q4042	$28.53
Q4004	$101.74	Q4017	$7.61	Q4030	$63.59	Q4043	$8.36
Q4005	$10.83	Q4018	$12.14	Q4031	$12.08	Q4044	$14.27
Q4006	$24.42	Q4019	$3.81	Q4032	$31.79	Q4045	$9.70
Q4007	$5.43	Q4020	$6.08	Q4033	$22.53	Q4046	$15.61
Q4008	$12.21	Q4021	$5.63	Q4034	$56.05	Q4047	$4.84
Q4009	$7.23	Q4022	$10.17	Q4035	$11.27	Q4048	$7.81
Q4010	$16.28	Q4023	$2.83	Q4036	$28.03	Q4049	$1.77
Q4011	$3.61	Q4024	$5.08	Q4037	$13.75		
Q4012	$8.14	Q4025	$31.60	Q4038	$34.44		

MLN Matters Number: MM5382
Related Change Request (CR) Number: 5382
Related CR Release Date: November 24, 2006
Related CR Transmittal Number: R1118CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

FEE SCHEDULES

Legislative Change to the Update Factor for the 2007 Medicare Physician Fee Schedule and Extension of the Participating Enrollment Period

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

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries, which are paid based on the Medicare physician fee schedule (MPFS).

What You Need to Know

This article is based on change request (CR) 5448. The Tax Relief and Health Care Act of 2006 changes the update to the 2007 conversion factor for services paid under the MPFS, and this change is effective for services provided on or after January 1, 2007.

The Tax Relief and Health Care Act of 2006 set the 2007 conversion factor for physician payment at the same level as in 2006 ($37.8975), **reversing** the statutorily mandated 5.0 percent negative update. However, it does not maintain 2007 physician payments at 2006 levels. There are a number of other factors that affect payment rates for 2007.

Other changes adopted in the physician fee schedule final rule that affect 2007 payment rates include changes in the practice expense RVU-setting methodology, refinements to the practice expense RVUs, re-weighting of geographic adjustment factors, limits on payments for imaging services required by the Deficit Reduction Act, and other annual refinements including coding changes.

Both the Centers for Medicare & Medicaid Services (CMS) and your local Medicare contractor will display the resulting new fees on its website no later than December 31, 2006. (FCSO posted the revised 2007 fees on December 20, 2006, including the PAR/NONPAR, and limiting charge rates.) The revised fees under the 2007 MPFS will be effective for services provided on or after January 1, 2007.

The change to the 2007 MPFS will also result in an extension of the participation enrollment period to February 14, 2007. Therefore, the participation enrollment period runs from November 15, 2006, through February 14, 2007. The effective date for any participation change is January 1, 2007.

Physicians who wish to sign an agreement and become participating (Par) physicians can access the Par Agreement (CMS-460 form) from the CD, which was mailed to all physicians last November. Physicians can also request the CMS-460 form from their local Medicare contractor. Existing Par physicians who no longer wish to be Par must notify their Medicare contractor in writing of their decision to terminate their Par agreement. Physicians who change their Par status during the extension period should begin to submit claims based on their new Par status.

Background

Based on the new Tax Relief and Health Care Act of 2006, CR 5448 emphasizes the following:

1) Change to the 2007 MPFS rates.
2) Capability of Medicare contractors to begin processing claims for services paid under the MPFS with the new fees beginning January 2, 2007.
3) Extension of the participation enrollment period to February 14, 2007.

The implementation date of this instruction is January 2, 2007.

Note: Services not paid under the MPFS (e.g., durable medical equipment (DME), clinical lab, etc) are not impacted by this instruction, and claims containing those services were also processed beginning January 2, 2007.

In addition, Medicare contractors will:

- Have hard copies of the new 2007 MPFS to mail to those physicians/practitioners that do not have ready Internet access and request a copy.
- Not charge providers requesting hard copy 2007 MPFS who do NOT have ready Internet access.
- Charge a reasonable fee for mailing hard copies of the 2007 MPFS to providers who do have ready Internet access but want a hard copy for convenience.
- Accept any participation changes made during the extended enrollment period that are received or post-marked by February 14, 2007. All participation changes are effective January 1, 2007.
- Load their updated local Medicare participating physician/supplier directories (MEDPARDs) to their websites within 30 days following the close of the extended enrollment period.

Additional Information

For complete details, please see the official instruction, CR 5448, issued to your contractor regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1131CP.pdf* on the CMS website.

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

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: MM5448
Related Change Request (CR) #: 5448
Related CR Release Date: December 15, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1131CP
Implementation Date: January 2, 2007

CONNECTICUT FEE SCHEDULES

2007 Allowances for Administration of Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines

The following are the 2007 allowances for the administration of pneumococcal pneumonia, hepatitis B, and influenza virus vaccines.

Code	Allowance
G0008	21.78
G0009	21.78
G0010	21.78

Source: Publication 100-20, Transmittal 256, Change Request 5365

2007 Ambulance Fee Schedule

The following are the allowances for the 2007 Ambulance Fee Schedule.

CODE	FEE	CODE	FEE
A0425	6.25	A0430	4297.99 *
A0426	276.64	A0431	3331.36
A0427	438.01	A0431	4997.04 *
A0428	230.53	A0432	403.43
A0429	368.85	A0433	633.97
A0430	2865.32	A0434	749.23

* Rural Rate

Source: Publication 100-04, #1102, CR 5358

2007 Carrier-Priced Fee Schedule Services

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

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

CODE/	MOD	PAR	NON-PAR	L CHG
G0186		639.23	607.27	698.36
G0186		619.08	588.13	676.34 *
R0070		162.83	154.69	177.89
R0075		162.83	154.69	177.89
70557		402.90	382.76	440.17
70557	TC	241.74	229.65	264.10
70558		445.46	423.19	486.67
70558	TC	267.28	253.92	292.00
70559		447.24	424.88	488.61
70559	TC	268.35	254.93	293.17
74300		50.79	48.25	55.49
74300	TC	30.47	28.95	33.29
74301		29.47	28.00	32.20
74301	TC	17.68	16.80	19.32
75952		701.56	666.48	766.45
75952	TC	420.94	399.89	459.88
75953		255.58	242.80	279.22
75953	TC	153.35	145.68	167.53
75954		625.29	594.03	683.13
75954	TC	375.17	356.41	409.87
76350		18.67	17.74	20.40
78282		54.96	52.21	60.04
78282	TC	32.98	31.33	36.03
78414		64.13	60.92	70.06
78414	TC	38.48	36.56	42.04
78459		2592.49	2462.87	2832.30
78459	TC	2506.31	2380.99	2738.14
78491		1014.70	963.97	1108.56
78491	TC	927.30	880.94	1013.08
78492		1655.65	1572.87	1808.80
78492	TC	1546.66	1469.33	1689.73
78608		1988.66	1889.23	2172.61
78608	TC	1904.79	1809.55	2080.98
78609		1988.66	1889.23	2172.61
78609	TC	1904.79	1809.55	2080.98
78811		2080.56	1976.53	2273.01
78811	TC	1992.52	1892.89	2176.83
78812		2615.51	2484.73	2857.44
78812	TC	2506.31	2380.99	2738.14
78813		2677.25	2543.39	2924.90
78813	TC	2563.96	2435.76	2801.13
78814		2938.88	2791.94	3210.73
78814	TC	2814.59	2673.86	3074.94
78815		3245.14	3082.88	3545.32
78815	TC	3107.83	2952.44	3395.30
78816		3323.58	3157.40	3631.01
78816	TC	3183.01	3023.86	3477.44
79300		230.20	218.69	251.49
79300	TC	138.12	131.21	150.90
86485		21.00	19.95	22.94
91132		75.29	71.53	82.25
91132	TC	45.18	42.92	49.36
91133		94.68	89.95	103.44
91133	TC	56.81	53.97	62.06
93315		398.52	378.59	435.38
93315	TC	239.11	227.15	261.23
93317		263.12	249.96	287.46
93317	TC	157.87	149.98	172.47
93318		278.01	264.11	303.73

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

2007 CT Carrier-Priced Fee Schedule Services, continued

CODE/	MOD	PAR	NON-PAR	L CHG
93318	TC	166.81	158.47	182.24
93501		957.84	909.95	1046.44
93501	TC	787.38	748.01	860.21
93505		340.53	323.50	372.03
93505	TC	93.69	89.01	102.36
93508		831.40	789.83	908.30
93508	TC	582.63	553.50	636.52
93510		1983.73	1884.54	2167.23
93510	TC	1722.03	1635.93	1881.32
93511		1975.95	1877.15	2158.73
93511	TC	1675.75	1591.96	1830.76
93524		2600.30	2470.29	2840.83
93524	TC	2190.81	2081.27	2393.46
93526		2606.96	2476.61	2848.10
93526	TC	2251.08	2138.53	2459.30
93527		2620.21	2489.20	2862.58
93527	TC	2190.81	2081.27	2393.46
93528		2715.97	2580.17	2967.20
93528	TC	2190.81	2081.27	2393.46
93529		2476.26	2352.45	2705.31
93529	TC	2190.81	2081.27	2393.46
93530		1031.88	980.29	1127.33
93530	TC	787.38	748.01	860.21
93531		2726.82	2590.48	2979.05
93531	TC	2251.08	2138.53	2459.30
93555		335.77	318.98	366.83
93555	TC	290.50	275.98	317.37
93556		503.75	478.56	550.35
93556	TC	457.25	434.39	499.55
93561		50.58	48.05	55.26
93561	TC	25.10	23.85	27.42
93562		23.61	22.43	25.79
93562	TC	15.55	14.77	16.99
93571		310.32	294.80	339.02
93571	TC	210.82	200.28	230.32
93620		1713.88	1628.19	1872.41
93620	TC	1028.33	976.91	1123.45
93621		314.63	298.90	343.73
93621	TC	188.78	179.34	206.24
93622		504.42	479.20	551.08
93622	TC	302.66	287.53	330.66
93623		421.00	399.95	459.94
93623	TC	252.60	239.97	275.97
93662		434.37	412.65	474.55
93662	TC	260.62	247.59	284.73
94642		31.40	29.83	34.30
95824		113.25	107.59	123.73
95824	TC	67.95	64.55	74.24
95951		902.15	857.04	985.60
95951	TC	541.29	514.23	591.36
95965		1164.82	1106.58	1272.57
95965	TC	698.90	663.96	763.55
95966		581.41	552.34	635.19
95966	TC	348.85	331.41	381.12
95967		509.03	483.58	556.12
95967	TC	305.42	290.15	333.67

Source: CMS Pub 100-04, Transmittal 1143, Change Request 5459

2007 Clinical Laboratory Fee Schedule

The following are the allowances for the 2007 Clinical Laboratory Fee Schedule services.

CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES
36415	$3.00	80164	$18.93	80201	$16.66	80436	$127.36	82017	$23.57
78267	$10.98	80166	$21.66	80202	$18.93	80438	$70.41	82024	$53.97
78268	$94.11	80168	$22.83	80299	$19.13	80439	$93.88	82030	$36.05
80048	$11.83	80170	$22.90	80400	$45.56	80440	$81.24	82040	$6.37
80051	$9.80	80172	$22.76	80402	$121.46	81000	$4.43	82042	$7.23
80053	$14.77	80173	$20.34	80406	$109.34	81001	$4.43	82043	$8.09
80061	$18.72	80174	$24.05	80408	$175.34	81002	$3.57	82044	$6.39
80061QW	$18.72	80176	$20.52	80410	$112.23	81003	$3.14	82044QW	$6.39
80069	$12.13	80178	$9.24	80412	$460.50	81003QW	$3.14	82045	$47.43
80074	$66.54	80178QW	$9.24	80414	$72.16	81005	$3.03	82055	$15.10
80076	$11.42	80182	$18.93	80415	$78.08	81007	$3.59	82055QW	$15.10
80100	$14.65	80184	$16.01	80416	$184.38	81007QW	$3.59	82075	$16.84
80101	$19.24	80185	$18.52	80417	$61.46	81015	$4.24	82085	$13.56
80101QW	$19.24	80186	$19.23	80418	$809.76	81020	$5.15	82088	$56.94
80102	$18.51	80188	$23.18	80420	$100.64	81025	$8.84	82101	$32.50
80150	$21.06	80190	$23.41	80422	$64.38	81050	$4.19	82103	$18.77
80152	$25.01	80192	$23.41	80424	$70.56	82000	$17.31	82104	$12.72
80154	$25.84	80194	$20.39	80426	$207.40	82003	$28.28	82105	$23.44
80156	$20.34	80195	$19.17	80428	$93.16	82009	$6.31	82106	$23.44
80157	$18.52	80196	$9.92	80430	$109.60	82010	$11.42	82107	$89.99
80158	$25.23	80197	$19.17	80432	$188.73	82010QW	$11.42	82108	$35.60
80160	$24.05	80198	$19.77	80434	$141.30	82013	$15.61	82120	$5.25
80162	$18.55	80200	$22.52	80435	$143.85	82016	$19.37	82120QW	$5.25

2007 CT Clinical Laboratory Fee Schedule, continued

CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES
82127	$19.37	82397	$19.74	82666	$30.01	82978	$19.91	83586	$17.89
82128	$19.37	82415	$17.70	82668	$26.26	82979	$9.62	83593	$36.75
82131	$23.57	82435	$6.42	82670	$39.04	82980	$25.60	83605	$14.92
82135	$16.89	82436	$7.02	82671	$45.13	82985	$21.06	83605 QW	$14.92
82136	$23.57	82438	$6.63	82672	$30.30	82985 QW	$21.06	83615	$8.44
82139	$23.57	82441	$8.12	82677	$33.79	83001	$25.97	83625	$17.88
82140	$20.36	82465	$6.08	82679	$34.88	83001 QW	$25.97	83630	$27.42
82143	$9.61	82465 QW	$6.08	82679 QW	$34.88	83002	$25.88	83631	$27.42
82145	$13.40	82480	$11.01	82690	$24.15	83002 QW	$25.88	83632	$28.24
82150	$9.06	82482	$10.74	82693	$20.82	83003	$23.29	83633	$7.69
82154	$40.29	82485	$28.85	82696	$32.95	83008	$23.45	83634	$16.10
82157	$40.90	82486	$25.23	82705	$7.11	83009	$94.11	83655	$16.91
82160	$34.94	82487	$22.30	82710	$23.47	83010	$17.58	83661	$30.71
82163	$28.68	82488	$29.85	82715	$24.05	83012	$24.02	83662	$26.43
82164	$20.39	82489	$25.84	82725	$18.60	83013	$94.11	83663	$26.43
82172	$21.65	82491	$25.23	82726	$25.23	83014	$10.98	83664	$26.43
82175	$26.51	82492	$25.23	82728	$19.03	83015	$26.31	83670	$12.80
82180	$13.81	82495	$28.34	82731	$89.99	83018	$30.68	83690	$9.62
82190	$20.83	82507	$38.85	82735	$25.91	83020	$17.99	83695	$18.09
82205	$16.01	82520	$21.17	82742	$27.66	83021	$25.23	83698	$47.43
82232	$22.61	82523	$26.11	82746	$20.54	83026	$3.30	83700	$15.73
82239	$23.94	82523 QW	$26.11	82747	$24.20	83030	$11.56	83701	$34.68
82240	$24.31	82525	$17.34	82757	$24.24	83033	$8.33	83704	$44.08
82247	$7.02	82528	$31.45	82759	$30.01	83036	$13.56	83718	$11.44
82248	$7.02	82530	$23.35	82760	$15.64	83036 QW	$13.56	83718 QW	$11.44
82252	$2.84	82533	$22.78	82775	$29.43	83037	$21.06	83719	$16.26
82261	$23.57	82540	$6.48	82776	$11.31	83037 QW	$21.06	83721	$13.33
82270	$4.54	82541	$25.23	82784	$12.99	83045	$6.93	83721 QW	$13.33
82271	$4.54	82542	$25.23	82785	$23.01	83050	$7.73	83727	$24.02
82271 QW	$4.54	82543	$25.23	82787	$11.20	83051	$10.21	83735	$9.36
82272	$4.54	82544	$25.23	82800	$11.83	83055	$6.87	83775	$10.30
82272 QW	$4.54	82550	$9.10	82803	$27.04	83060	$11.56	83785	$34.36
82274	$20.28	82552	$18.71	82805	$39.65	83065	$9.62	83788	$25.23
82274 QW	$20.28	82553	$16.13	82810	$12.20	83068	$11.83	83789	$25.23
82286	$9.62	82554	$16.58	82820	$13.96	83069	$5.51	83805	$24.63
82300	$32.33	82565	$7.16	82926	$7.61	83070	$6.64	83825	$22.72
82306	$41.36	82570	$7.23	82928	$9.15	83071	$8.70	83835	$23.67
82307	$45.02	82570 QW	$7.23	82938	$24.72	83080	$23.57	83840	$22.81
82308	$37.41	82575	$13.20	82941	$24.64	83088	$41.26	83857	$15.01
82310	$7.20	82585	$11.98	82943	$19.97	83090	$23.57	83858	$20.71
82330	$16.26	82595	$9.04	82945	$5.48	83150	$27.04	83864	$27.82
82331	$7.23	82600	$27.11	82946	$21.06	83491	$24.47	83866	$13.76
82340	$8.43	82607	$21.06	82947	$5.48	83497	$15.09	83872	$8.19
82355	$16.17	82608	$20.01	82947 QW	$5.48	83498	$37.95	83873	$24.04
82360	$17.99	82615	$11.41	82948	$4.43	83499	$35.22	83874	$18.04
82365	$18.01	82626	$35.31	82950	$6.64	83500	$31.65	83880	$47.43
82370	$17.51	82627	$31.07	82950 QW	$6.64	83505	$33.96	83880 QW	$47.43
82373	$25.23	82633	$43.28	82951	$17.99	83516	$16.12	83883	$19.00
82374	$6.83	82634	$40.90	82951 QW	$17.99	83518	$11.85	83885	$34.23
82375	$17.22	82638	$17.11	82952	$5.48	83518 QW	$11.85	83887	$33.09
82376	$8.37	82646	$28.85	82952 QW	$5.48	83519	$16.46	83890	$5.60
82378	$26.51	82649	$35.91	82953	$21.16	83520	$18.09	83891	$5.60
82379	$23.57	82651	$36.07	82955	$13.55	83525	$15.98	83892	$5.60
82380	$12.89	82652	$53.78	82960	$8.47	83527	$18.09	83893	$5.60
82382	$24.02	82654	$19.34	82962	$3.27	83528	$22.22	83894	$5.60
82383	$35.01	82656	$16.12	82963	$30.01	83540	$9.05	83896	$5.60
82384	$35.28	82657	$25.23	82965	$10.80	83550	$12.21	83897	$5.60
82387	$29.07	82658	$25.23	82975	$22.13	83570	$12.36	83898	$23.42
82390	$15.01	82664	$48.00	82977	$9.77	83582	$19.80	83900	$46.84

2007 CT Clinical Laboratory Fee Schedule, continued

CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES
83901	$23.42	84154	$25.70	84466	$17.84	85175	$5.47	85576 QW	$30.01
83902	$19.83	84155	$5.12	84478	$8.04	85210	$18.14	85597	$25.12
83903	$23.42	84156	$5.12	84478 QW	$8.04	85220	$24.66	85610	$5.49
83904	$23.42	84157	$5.12	84479	$9.04	85230	$25.02	85610 QW	$5.49
83905	$23.42	84160	$7.23	84480	$19.81	85240	$25.02	85611	$5.51
83906	$23.42	84163	$16.29	84481	$23.67	85244	$28.53	85612	$13.37
83907	$18.66	84165	$15.01	84482	$22.02	85245	$32.06	85613	$13.37
83908	$23.42	84166	$24.92	84484	$13.75	85246	$32.06	85635	$13.76
83909	$23.42	84181	$23.80	84485	$10.49	85247	$32.06	85651	$4.96
83912	$5.60	84182	$25.15	84488	$5.47	85250	$26.60	85652	$3.77
83913	$18.66	84202	$20.05	84490	$10.63	85260	$25.02	85660	$7.26
83914	$23.42	84203	$12.03	84510	$14.53	85270	$25.02	85670	$8.07
83915	$15.58	84206	$23.53	84512	$10.76	85280	$27.04	85675	$9.58
83916	$28.09	84207	$34.32	84520	$5.51	85290	$22.83	85705	$13.45
83918	$23.00	84210	$15.17	84525	$5.25	85291	$12.42	85730	$8.38
83919	$23.00	84220	$13.18	84540	$6.64	85292	$26.46	85732	$9.04
83921	$23.00	84228	$12.22	84545	$7.94	85293	$26.46	85810	$16.32
83925	$27.19	84233	$89.99	84550	$6.31	85300	$15.35	86000	$9.75
83930	$9.24	84234	$90.64	84560	$6.64	85301	$15.11	86001	$7.30
83935	$9.52	84235	$73.12	84577	$4.88	85302	$16.80	86003	$7.30
83937	$41.71	84238	$51.09	84578	$4.54	85303	$19.32	86005	$11.14
83945	$17.99	84244	$30.73	84580	$9.92	85305	$16.20	86021	$21.03
83950	$89.99	84252	$16.26	84583	$7.02	85306	$21.41	86022	$25.66
83970	$57.67	84255	$35.67	84585	$21.66	85307	$21.41	86023	$17.40
83986	$5.00	84260	$24.31	84586	$49.37	85335	$17.99	86038	$16.89
83986 QW	$5.00	84270	$30.36	84588	$47.43	85337	$14.56	86039	$15.60
83992	$20.54	84275	$18.77	84590	$15.03	85345	$6.01	86060	$10.20
84022	$21.76	84285	$32.90	84591	$15.03	85347	$5.95	86063	$8.07
84030	$7.69	84295	$6.72	84597	$13.00	85348	$5.20	86140	$7.23
84035	$5.11	84300	$6.79	84600	$22.45	85360	$11.74	86141	$18.09
84060	$10.32	84302	$6.79	84620	$16.55	85362	$9.62	86146	$35.54
84061	$11.06	84305	$29.70	84630	$15.91	85366	$12.03	86147	$35.54
84066	$13.50	84307	$25.54	84681	$29.07	85370	$15.87	86148	$22.44
84075	$7.23	84311	$9.77	84702	$16.29	85378	$9.97	86155	$22.33
84078	$10.20	84315	$3.50	84703	$10.49	85379	$14.22	86156	$9.36
84080	$20.66	84375	$27.39	84703 QW	$10.49	85380	$14.22	86157	$11.27
84081	$23.09	84376	$7.69	84830	$14.02	85384	$11.87	86160	$16.78
84085	$9.42	84377	$7.69	85002	$6.29	85385	$11.87	86161	$16.78
84087	$14.42	84378	$16.10	85004	$9.04	85390	$7.22	86162	$28.39
84100	$6.63	84379	$16.10	85007	$4.81	85400	$12.36	86171	$13.52
84105	$7.23	84392	$6.64	85008	$4.41	85410	$10.77	86185	$12.50
84106	$5.99	84402	$35.57	85009	$4.88	85415	$24.02	86200	$18.09
84110	$11.80	84403	$36.08	85013	$3.31	85420	$9.13	86215	$18.51
84119	$9.61	84425	$29.67	85014	$3.31	85421	$8.70	86225	$19.20
84120	$20.55	84430	$16.26	85014 QW	$3.31	85441	$5.88	86226	$16.92
84126	$35.59	84432	$22.44	85018	$3.31	85445	$9.52	86235	$25.06
84127	$16.28	84436	$9.61	85018 QW	$3.31	85460	$10.81	86243	$28.68
84132	$6.42	84437	$9.04	85025	$10.86	85461	$9.26	86255	$16.84
84133	$6.01	84439	$12.60	85027	$9.04	85475	$12.40	86256	$16.84
84134	$20.38	84442	$20.66	85032	$6.01	85520	$12.22	86277	$21.99
84135	$26.73	84443	$23.47	85041	$4.02	85525	$16.55	86280	$11.44
84138	$26.46	84443 QW	$23.47	85044	$6.01	85530	$19.81	86294	$27.41
84140	$28.89	84445	$71.05	85045	$5.59	85536	$9.04	86294 QW	$27.41
84143	$31.89	84446	$19.81	85046	$7.80	85540	$12.02	86300	$29.07
84144	$29.15	84449	$25.15	85048	$3.55	85547	$12.02	86301	$29.07
84146	$27.08	84450	$7.22	85049	$5.47	85549	$26.21	86304	$29.07
84150	$34.88	84450 QW	$7.22	85055	$37.41	85555	$9.34	86308	$7.23
84152	$25.70	84460	$7.40	85130	$6.06	85557	$18.66	86308 QW	$7.23
84153	$25.70	84460 QW	$7.40	85170	$5.05	85576	$30.01	86309	$9.04

2007 CT Clinical Laboratory Fee Schedule, continued

CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES
86310	$10.30	86645	$23.54	86777	$20.11	87140	$7.79	87327	$16.76
86316	$29.07	86648	$21.25	86778	$20.12	87143	$17.51	87328	$16.76
86317	$20.95	86651	$18.43	86781	$18.50	87147	$7.23	87329	$16.76
86318	$18.09	86652	$18.43	86784	$17.55	87149	$28.02	87332	$16.76
86318 QW	$18.09	86653	$18.43	86787	$18.00	87152	$7.31	87335	$16.76
86320	$31.32	86654	$18.43	86788	$23.54	87158	$7.31	87336	$16.76
86325	$31.24	86658	$18.20	86789	$20.11	87164	$15.01	87337	$16.76
86327	$31.70	86663	$18.33	86790	$18.00	87166	$15.78	87338	$20.10
86329	$19.62	86664	$21.38	86793	$18.43	87168	$5.96	87339	$16.76
86331	$16.75	86665	$25.35	86800	$20.28	87169	$5.96	87340	$14.43
86332	$34.05	86666	$14.22	86803	$19.94	87172	$5.96	87341	$14.43
86334	$31.21	86668	$14.53	86804	$21.64	87176	$8.22	87350	$16.10
86335	$41.00	86671	$17.13	86805	$73.05	87177	$12.43	87380	$22.94
86336	$21.77	86674	$20.56	86806	$66.49	87181	$1.27	87385	$16.76
86337	$23.20	86677	$20.28	86807	$55.29	87184	$9.63	87390	$24.65
86340	$21.06	86682	$18.17	86808	$41.47	87185	$1.27	87391	$24.65
86341	$27.65	86684	$22.14	86812	$36.06	87186	$12.08	87400	$16.76
86343	$17.41	86687	$11.72	86813	$81.02	87187	$14.48	87420	$16.76
86344	$11.16	86688	$19.57	86816	$38.92	87188	$9.27	87425	$16.76
86353	$68.49	86689	$27.05	86817	$89.95	87190	$7.90	87427	$16.76
86355	$19.97	86692	$23.98	86821	$78.88	87197	$20.99	87430	$16.76
86357	$19.97	86694	$20.11	86822	$51.07	87205	$5.96	87449	$16.76
86359	$19.97	86695	$18.43	86880	$7.50	87206	$7.50	87449 QW	$16.76
86360	$65.65	86696	$27.05	86885	$7.99	87207	$5.73	87450	$13.39
86361	$37.41	86698	$17.46	86886	$7.23	87209	$17.19	87451	$13.39
86367	$19.97	86701	$12.41	86900	$4.17	87210	$5.96	87470	$28.02
86376	$17.54	86701 QW	$12.41	86901	$4.17	87210 QW	$5.96	87471	$49.04
86378	$27.51	86702	$18.88	86903	$13.19	87220	$5.96	87472	$59.85
86382	$23.62	86703	$19.17	86904	$13.28	87230	$27.59	87475	$28.02
86384	$15.91	86703 QW	$19.17	86905	$5.34	87250	$27.32	87476	$49.04
86403	$14.24	86704	$16.84	86906	$10.83	87252	$36.42	87477	$59.85
86406	$14.87	86705	$16.44	86940	$11.46	87253	$28.22	87480	$28.02
86430	$7.93	86706	$15.01	86941	$16.92	87254	$27.32	87481	$49.04
86431	$7.93	86707	$16.16	87001	$18.47	87255	$47.31	87482	$58.33
86480	$86.59	86708	$17.31	87003	$23.52	87260	$16.76	87485	$28.02
86586	$19.97	86709	$15.73	87015	$9.33	87265	$16.76	87486	$49.04
86590	$12.22	86710	$18.94	87040	$13.00	87267	$16.76	87487	$59.85
86592	$5.96	86713	$21.39	87045	$13.18	87269	$16.76	87490	$28.02
86593	$6.16	86717	$17.12	87046	$13.18	87270	$16.76	87491	$49.04
86602	$14.22	86720	$18.43	87070	$10.53	87271	$16.76	87492	$22.93
86603	$17.98	86723	$18.43	87071	$13.18	87272	$16.76	87495	$28.02
86606	$21.03	86727	$17.98	87073	$13.18	87273	$16.76	87496	$49.04
86609	$18.00	86729	$16.69	87075	$13.22	87274	$16.76	87497	$59.85
86611	$14.22	86732	$18.43	87076	$11.29	87275	$16.76	87498	$49.04
86612	$18.03	86735	$18.23	87077	$11.29	87276	$16.76	87510	$28.02
86615	$18.43	86738	$18.51	87077 QW	$11.29	87277	$16.76	87511	$49.04
86617	$21.64	86741	$18.43	87081	$9.26	87278	$16.76	87512	$58.33
86618	$23.80	86744	$18.43	87084	$12.03	87279	$16.76	87515	$28.02
86618 QW	$23.80	86747	$21.00	87086	$11.28	87280	$16.76	87516	$49.04
86619	$18.69	86750	$18.43	87088	$11.31	87281	$16.76	87517	$59.85
86622	$12.48	86753	$17.32	87101	$10.77	87283	$16.76	87520	$28.02
86625	$18.33	86756	$18.01	87102	$11.74	87285	$16.76	87521	$49.04
86628	$16.78	86757	$27.05	87103	$12.60	87290	$16.76	87522	$59.85
86631	$16.52	86759	$18.43	87106	$14.42	87299	$16.76	87525	$28.02
86632	$17.74	86762	$20.11	87107	$14.42	87300	$16.76	87526	$49.04
86635	$16.03	86765	$18.00	87109	$21.50	87301	$16.76	87527	$58.33
86638	$16.94	86768	$18.43	87110	$27.37	87305	$16.76	87528	$28.02
86641	$20.14	86771	$18.43	87116	$15.10	87320	$16.76	87529	$49.04
86644	$20.11	86774	$20.68	87118	$15.29	87324	$16.76	87530	$59.85

2007 CT Clinical Laboratory Fee Schedule, continued

CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES
87531	$28.02	87651	$49.04	88150	$14.76	88283	$95.84	ATP12	$12.62
87532	$49.04	87652	$58.33	88152	$14.76	88285	$26.54	ATP16	$14.77
87533	$58.33	87653	$49.04	88153	$14.76	88289	$48.11	ATP18	$14.87
87534	$28.02	87660	$28.02	88154	$14.76	88371	$31.05	ATP19	$15.45
87535	$49.04	87797	$28.02	88155	$7.78	88372	$31.79	ATP20	$15.95
87536	$118.89	87798	$49.04	88164	$14.76	88400	$7.02	ATP21	$16.45
87537	$28.02	87799	$59.85	88165	$14.76	89050	$6.61	ATP22	$16.95
87538	$49.04	87800	$56.03	88166	$14.76	89051	$7.70	G0027	$9.09
87539	$59.85	87801	$98.07	88167	$14.76	89055	$5.96	G0103	$25.70
87540	$28.02	87802	$16.76	88174	$29.85	89060	$9.99	G0123	$28.31
87541	$49.04	87803	$16.76	88175	$37.01	89125	$6.03	G0143	$28.31
87542	$58.33	87804	$16.76	88230	$162.77	89160	$5.15	G0144	$29.85
87550	$28.02	87804 QW	$16.76	88233	$196.63	89190	$6.64	G0145	$37.01
87551	$49.04	87807	$16.76	88235	$205.74	89225	$4.67	G0147	$15.90
87552	$59.85	87807 QW	$16.76	88237	$176.47	89235	$6.74	G0148	$21.23
87555	$28.02	87808	$16.76	88239	$206.12	89300	$12.45	G0265	$14.11
87556	$49.04	87810	$16.76	88240	$14.11	89300 QW	$12.45	G0266	$14.11
87557	$59.85	87850	$16.76	88241	$14.11	89310	$12.03	G0306	$10.86
87560	$28.02	87880	$16.76	88245	$207.98	89320	$16.84	G0307	$9.04
87561	$49.04	87880 QW	$16.76	88248	$241.96	89321	$16.84	G0328	$20.28
87562	$59.85	87899	$16.76	88249	$241.96	89325	$14.91	G0328 QW	$20.28
87580	$28.02	87899 QW	$16.76	88261	$246.93	89329	$29.30	G0394	$4.54
87581	$49.04	87900	$182.11	88262	$174.14	89330	$13.83	P2038	$7.02
87582	$58.33	87901	$359.69	88263	$209.97	ATP02	$7.28	P3000	$14.76
87590	$28.02	87902	$359.69	88264	$174.14	ATP03	$9.29	P9612	$3.00
87591	$49.04	87903	$682.72	88267	$251.17	ATP04	$9.80	P9615	$3.00
87592	$59.85	87904	$36.42	88269	$232.38	ATP05	$10.93	Q0111	$5.96
87620	$28.02	88130	$21.02	88271	$29.93	ATP06	$10.96	Q0112	$5.96
87621	$49.04	88140	$11.17	88272	$30.33	ATP07	$11.42	Q0113	$7.56
87622	$58.33	88142	$28.31	88273	$30.33	ATP08	$11.83	Q0114	$9.99
87640	$49.04	88143	$28.31	88274	$30.33	ATP09	$12.13	Q0115	$13.83
87641	$49.04	88147	$15.90	88275	$30.33	ATP10	$12.13		
87650	$28.02	88148	$21.23	88280	$35.07	ATP11	$12.34		

Source: Publication 100-04, #1122, CR 5362

2007 DMEPOS Fee Schedule

The following are the allowances for the 2007 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies fee schedule.

PROC/MOD	FEE	PROC/MOD	FEE	PROC/MOD	FEE
A4561	19.43	L8616	86.26	L8685	10737.96*
A4562	48.37	L8617	775.34	L8686	6851.65*
A7040	38.44	L8618	21.53	L8687	13974.36*
A7041	72.24	L8619	6875.06 *	L8688	8916.77*
A7042	172.75	L8621	0.51	L8689	1416.44
A7043	27.37	L8622	0.27	L8695	13.67*
E0749	276.89	L8623	53.12	Q0480	73956.06
E0782	3553.46*	L8624	132.42	Q0481	11931.94
E0783	7971.67*	L8630	375.74*	Q0482	3737.31
E0785	391.07*	L8631	1832.33	Q0483	15396.04
E0786	7775.89*	L8641	390.39*	Q0484	2989.86
L8600	526.86*	L8642	237.49*	Q0485	288.67
L8603	366.27*	L8658	340.39	Q0486	240.26
L8606	180.01*	L8659	1584.56	Q0487	280.30
L8609	5350.13	L8670	465.61*	Q0489	13347.54
L8610	489.59*	L8680	377.18*	Q0490	577.34
L8612	600.15*	L8681	902.36*	Q0491	907.66
L8613	261.32*	L8682	4895.39*	Q0492	73.12
L8614	16014.82*	L8683	4309.07*	Q0493	208.22
L8615	370.34	L8684	569.58	Q0494	176.19

2007 CT DMEPOS Fee Schedule, continued

PROC/MOD	FEE
Q0495	3429.97
Q0496	1231.07
Q0497	384.41
Q0498	421.78
Q0499	137.04

PROC/MOD	FEE
Q0500	25.07
Q0501	419.36
Q0502	533.89
Q0503	1067.80
Q0504	563.46

* Allowable in an ASC

Source: Publication 100-04, Transmittal 1125, CR 5417

2007 DMEPOS—ASC Allowable Fees

The following are the allowances for the 2007 DMEPOS services allowable in an ambulatory surgical center (ASC).

CODE	FEE	CODE	FEE	CODE	FEE
E0782	3553.46	L8613	261.32	L8682	4895.39
E0783	7971.67	L8614	16014.82	L8683	4309.07
E0785	391.07	L8619	6875.06	L8684	569.84
E0786	7775.89	L8630	375.74	L8686	6851.65
L8600	526.86	L8641	390.39	L8687	13974.36
L8603	366.27	L8642	237.49	L8688	8916.77
L8606	180.01	L8658	340.39	L8690	ICIC
L8610	489.59	L8670	465.61	L8691	ICIC
L8612	600.15	L8680	377.18	L8695	13.67
		L8681	902.36	V2785	ICIC

Allowance for Procedure Code R0070

The allowance for the portable X-ray transportation code R0070 has been increased to $162.83 for dates of service on or after January 1, 2007. The ambulance inflation factor (AIF) for 2007 was used to adjust the allowance.

2007 Reasonable Charge Payment

The **procedure status** for the following codes has been changed to **"X**" (Statutory exclusion) These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes.

No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule.

CODE	ALLOWANCE
86850	31.00
86901	23.36
86920	33.93

Source: Publication 100-04, #1131, Change Request 5448

FLORIDA FEE SCHEDULES

2007 Allowances for Administration of Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines

The following are the 2007 allowances for the administration of pneumococcal pneumonia, hepatitis B, and influenza virus vaccines.

Code	LOC 01/02	LOC 03	LOC 04
G0008	18.57	19.45	20.43
G0009	18.57	19.45	20.43
G0010	18.57	19.45	20.43

Source: Publication 100-20, Transmittal 256, Change Request 5365

2007 Ambulance Fee Schedule

The following are the allowances for the 2007 Ambulance Fee Schedule.

CODE	LOC 99	LOC 03	LOC 04
A0425	6.25	6.25	6.25
A0426	222.85	231.67	241.14
A0427	352.85	366.81	381.81
A0428	185.71	193.06	200.95
A0429	297.14	308.89	321.52
A0430	2553.99	2625.23	2701.74
	3830.99	3937.84	4052.61*
A0431	2969.39	3052.21	3141.17
	4454.08	4578.32	4711.76*
A0432	324.99	337.85	351.67
A0433	510.70	530.91	552.62
A0434	603.56	627.44	653.10

*Rural Rate

Source: Source: Publication 100-04, #1102, CR 5358

2007 Carrier-Priced Fee Schedule Services

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

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

	PARTICIPATING			NONPARTICIPATING			LIMITING CHARGE		
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
G0186	578.12	603.49	626.24	549.21	573.32	594.93	631.60	659.31	684.17
G0186	561.64	585.75	607.90	533.56	556.46	577.51	613.59	639.93	664.13*
R0070	105.22	105.22	105.22	99.96	99.96	99.96	114.95	114.95	114.95
R0075	105.22	105.22	105.22	99.96	99.96	99.96	114.95	114.95	114.95
21088	6360.07	6360.07	6360.07	6042.07	6042.07	6042.07	6948.38	6948.38	6948.38
21088	4070.45	4070.45	4070.45	3866.93	3866.93	3866.93	4446.97	4446.97	4446.97*
70557	372.20	382.84	394.73	353.59	363.70	374.99	406.63	418.25	431.24
70557 TC	223.32	229.70	236.84	212.15	218.22	225.00	243.98	250.95	258.75
70558	411.99	424.30	438.10	391.39	403.09	416.20	450.10	463.55	478.62
70558 TC	247.19	254.58	262.86	234.83	241.85	249.72	270.06	278.13	287.17
70559	414.40	427.70	442.64	393.68	406.32	420.51	452.73	467.26	483.58
70559 TC	248.64	256.62	265.58	236.21	243.79	252.30	271.64	280.36	290.15
74300	47.30	50.07	52.37	44.94	47.57	49.75	51.68	54.70	57.21
74300 TC	28.38	30.04	31.43	26.96	28.54	29.86	31.01	32.82	34.34
74301	26.89	28.35	29.58	25.55	26.93	28.10	29.38	30.97	32.32
74301 TC	16.13	17.01	17.74	15.32	16.16	16.85	17.62	18.58	19.38
75952	658.51	719.18	775.00	625.58	683.22	736.25	719.42	785.70	846.69
75952 TC	395.10	431.51	465.01	375.35	409.93	441.76	431.65	471.42	508.02
75953	255.53	301.35	347.48	242.75	286.28	330.11	279.17	329.22	379.62
75953 TC	153.32	180.81	208.49	145.65	171.77	198.07	167.50	197.53	227.78
75954	625.35	738.88	853.75	594.08	701.94	811.06	683.19	807.23	932.72
75954 TC	375.20	443.32	512.25	356.44	421.15	486.64	409.91	484.33	559.63
76350	14.94	16.46	17.46	14.19	15.64	16.59	16.32	17.98	19.08
78282	49.16	51.96	54.28	46.70	49.36	51.57	53.71	56.77	59.30
78282 TC	29.50	31.17	32.56	28.03	29.61	30.93	32.23	34.05	35.57
78414	58.31	61.45	64.02	55.39	58.38	60.82	63.70	67.13	69.94
78414 TC	34.99	36.87	38.41	33.24	35.03	36.49	38.23	40.28	41.96
78459	2165.64	2364.70	2486.95	2057.36	2246.47	2362.60	2365.96	2583.43	2716.99
78459 TC	2086.08	2282.96	2402.69	1981.78	2168.81	2282.56	2279.04	2494.13	2624.94
78491	852.10	920.04	980.76	809.50	874.04	931.72	930.92	1005.14	1071.48
78491 TC	771.34	836.89	894.84	732.77	795.05	850.10	842.69	914.30	977.61

2007 FL Carrier-Priced Fee Schedule Services, continued

	PARTICIPATING			NONPARTICIPATING			LIMITING CHARGE		
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
78492	1387.29	1499.68	1599.85	1317.93	1424.70	1519.86	1515.61	1638.40	1747.84
78492 TC	1286.69	1396.17	1492.98	1222.36	1326.36	1418.33	1405.71	1525.32	1631.08
78608	1663.33	1815.15	1908.78	1580.16	1724.39	1813.34	1817.19	1983.05	2085.34
78608 TC	1585.42	1735.05	1826.04	1506.15	1648.30	1734.74	1732.07	1895.54	1994.95
78609	1663.33	1815.15	1908.78	1580.16	1724.39	1813.34	1817.19	1983.05	2085.34
78609 TC	1585.42	1735.05	1826.04	1506.15	1648.30	1734.74	1732.07	1895.54	1994.95
78811	1740.98	1900.57	1999.50	1653.93	1805.54	1899.53	1902.02	2076.37	2184.45
78811 TC	1658.43	1814.96	1910.14	1575.51	1724.21	1814.63	1811.83	1982.84	2086.83
78812	2188.04	2388.29	2512.11	2078.64	2268.88	2386.50	2390.43	2609.21	2744.48
78812 TC	2086.08	2282.96	2402.69	1981.78	2168.81	2282.56	2279.04	2494.13	2624.94
78813	2239.74	2444.59	2571.24	2127.75	2322.36	2442.68	2446.92	2670.71	2809.08
78813 TC	2134.06	2335.47	2457.95	2027.36	2218.70	2335.05	2331.46	2551.50	2685.31
78814	2458.42	2683.12	2821.93	2335.50	2548.96	2680.83	2685.82	2931.31	3082.96
78814 TC	2342.67	2563.76	2698.22	2225.54	2435.57	2563.31	2559.37	2800.91	2947.81
78815	2714.44	2962.37	3115.40	2578.72	2814.25	2959.63	2965.53	3236.39	3403.57
78815 TC	2586.74	2830.87	2979.34	2457.40	2689.33	2830.37	2826.01	3092.73	3254.93
78816	2780.00	3033.89	3190.57	2641.00	2882.20	3031.04	3037.15	3314.52	3485.70
78816 TC	2649.32	2899.36	3051.42	2516.85	2754.39	2898.85	2894.38	3167.55	3333.68
79300	217.13	229.00	238.41	206.27	217.55	226.49	237.21	250.18	260.46
79300 TC	130.29	137.41	143.04	123.78	130.54	135.89	142.34	150.12	156.27
86485	16.26	17.92	18.95	15.45	17.02	18.00	17.76	19.58	20.70
91132	67.23	71.25	74.55	63.87	67.69	70.82	73.45	77.84	81.45
91132 TC	40.34	42.75	44.80	38.32	40.61	42.56	44.07	46.70	48.94
91133	83.85	88.46	92.15	79.66	84.04	87.54	91.61	96.64	100.67
91133 TC	50.30	53.07	55.30	47.79	50.42	52.54	54.95	57.98	60.42
93315	361.10	379.46	393.96	343.05	360.49	374.26	394.50	414.56	430.40
93315 TC	216.65	227.68	236.37	205.82	216.30	224.55	236.69	248.74	258.23
93317	238.09	249.91	259.13	226.19	237.41	246.17	260.11	273.03	283.10
93317 TC	142.85	149.95	155.48	135.71	142.45	147.71	156.06	163.82	169.86
93318	289.30	303.16	313.66	274.84	288.00	297.98	316.06	331.20	342.67
93318 TC	173.59	181.90	188.19	164.91	172.81	178.78	189.65	198.73	205.60
93501	808.67	866.48	933.49	768.24	823.16	886.82	883.47	946.63	1019.84
93501 TC	650.58	702.42	762.20	618.05	667.30	724.09	710.76	767.39	832.70
93505	306.93	322.23	340.44	291.58	306.12	323.42	335.32	352.04	371.93
93505 TC	78.15	84.84	92.64	74.24	80.60	88.01	85.38	92.69	101.21
93508	707.03	752.38	804.70	671.68	714.76	764.47	772.43	821.98	879.13
93508 TC	478.74	515.23	556.95	454.80	489.47	529.10	523.02	562.89	608.47
93510	1663.53	1786.47	1928.70	1580.35	1697.15	1832.27	1817.41	1951.72	2107.10
93510 TC	1423.14	1536.71	1667.72	1351.98	1459.87	1584.33	1554.78	1678.86	1821.98
93511	1660.91	1782.06	1922.29	1577.86	1692.96	1826.18	1814.54	1946.90	2100.10
93511 TC	1384.72	1495.13	1622.46	1315.48	1420.37	1541.34	1512.81	1633.43	1772.54
93524	2188.15	2347.33	2531.70	2078.74	2229.96	2405.12	2390.55	2564.46	2765.88
93524 TC	1810.79	1955.44	2122.34	1720.25	1857.67	2016.22	1978.29	2136.32	2318.66
93526	2188.52	2350.03	2537.01	2079.09	2232.53	2410.16	2390.96	2567.41	2771.68
93526 TC	1860.79	2009.55	2181.21	1767.75	1909.07	2072.15	2032.91	2195.43	2382.97
93527	2206.62	2366.60	2551.96	2096.29	2248.27	2424.36	2410.73	2585.51	2788.02

2007 FL Carrier-Priced Fee Schedule Services, continued

	PARTICIPATING			NONPARTICIPATING			LIMITING CHARGE		
CODE/MOD	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04	LOC 01/02	LOC 03	LOC 04
93527 TC	1810.79	1955.44	2122.34	1720.25	1857.67	2016.22	1978.29	2136.32	2318.66
93528	2295.40	2458.59	2647.81	2180.63	2335.66	2515.42	2507.72	2686.01	2892.73
93528 TC	1810.79	1955.44	2122.34	1720.25	1857.67	2016.22	1978.29	2136.32	2318.66
93529	2073.49	2228.27	2407.34	1969.82	2116.86	2286.97	2265.29	2434.38	2630.02
93529 TC	1810.79	1955.44	2122.34	1720.25	1857.67	2016.22	1978.29	2136.32	2318.66
93530	876.45	936.87	1007.01	832.63	890.03	956.66	957.52	1023.53	1100.16
93530 TC	650.58	702.42	762.20	618.05	667.30	724.09	710.76	767.39	832.70
93531	2301.28	2466.79	2658.70	2186.22	2343.45	2525.77	2514.15	2694.97	2904.63
93531 TC	1860.79	2009.55	2181.21	1767.75	1909.07	2072.15	2032.91	2195.43	2382.97
93555	280.53	300.16	322.68	266.50	285.15	306.55	306.48	327.92	352.53
93555 TC	239.03	257.46	278.58	227.08	244.59	264.65	261.14	281.28	304.35
93556	418.34	448.18	482.35	397.42	425.77	458.23	457.04	489.64	526.97
93556 TC	375.72	404.35	437.09	356.93	384.13	415.24	410.47	441.75	477.52
93561	44.98	47.67	50.87	42.73	45.29	48.33	49.14	52.08	55.58
93561 TC	21.30	23.34	25.77	20.24	22.17	24.48	23.27	25.50	28.15
93562	20.81	22.38	24.26	19.77	21.26	23.05	22.73	24.45	26.50
93562 TC	13.26	14.56	16.12	12.60	13.83	15.31	14.49	15.91	17.61
93571	264.53	280.32	298.46	251.30	266.30	283.54	289.00	306.25	326.07
93571 TC	173.33	186.60	201.80	164.66	177.27	191.71	189.36	203.86	220.47
93620	1556.61	1646.00	1718.72	1478.78	1563.70	1632.78	1700.60	1798.26	1877.70
93620 TC	933.97	987.60	1031.23	887.27	938.22	979.67	1020.36	1078.95	1126.62
93621	290.83	309.71	325.59	276.29	294.22	309.31	317.73	338.36	355.71
93621 TC	174.50	185.84	195.35	165.78	176.55	185.58	190.64	203.03	213.42
93622	483.19	537.07	588.15	459.03	510.22	558.74	527.89	586.75	642.55
93622 TC	289.91	322.24	352.90	275.41	306.13	335.26	316.73	352.05	385.54
93623	387.91	410.39	428.60	368.51	389.87	407.17	423.79	448.35	468.25
93623 TC	232.75	246.24	257.16	221.11	233.93	244.30	254.28	269.02	280.95
93662	408.17	445.15	479.10	387.76	422.89	455.15	445.93	486.33	523.42
93662 TC	244.91	267.09	287.47	232.66	253.74	273.10	267.56	291.80	314.06
94642	27.50	29.97	31.42	26.13	28.47	29.85	30.04	32.74	34.33
95824	91.60	102.73	107.86	87.02	97.59	102.47	100.07	112.23	117.84
95824 TC	54.96	61.63	64.72	52.21	58.55	61.48	60.04	67.33	70.71
95951	813.06	854.45	886.02	772.41	811.73	841.72	888.27	933.49	967.98
95951 TC	487.83	512.67	531.62	463.44	487.04	505.04	532.95	560.09	580.79
95965	1048.88	1098.16	1135.18	996.44	1043.25	1078.42	1145.90	1199.74	1240.18
95965 TC	629.33	658.90	681.11	597.86	625.96	647.05	687.54	719.85	744.11
95966	534.48	563.79	587.25	507.76	535.60	557.89	583.92	615.94	641.57
95966 TC	320.69	338.28	352.34	304.66	321.37	334.72	350.35	369.57	384.93
95967	469.17	495.54	516.85	445.71	470.76	491.01	512.57	541.38	564.66
95967 TC	281.51	297.32	310.11	267.43	282.45	294.60	307.55	324.82	338.80
99082	1.99	1.99	1.99	1.89	1.89	1.89	2.17	2.17	2.17

Source: Publication 100-04, #1143, Change Request 5459

2007 Clinical Laboratory Fee Schedule

The following are the allowances for the 2007 Clinical Laboratory Fee Schedule services.

CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES
CODE	FEES	80415	$78.08	82120	$4.02	82383	$35.01	82652	$53.78
36415	$3.00	80416	$184.38	82120 QW	$4.02	82384	$33.28	82654	$19.11
78267	$10.98	80417	$61.46	82127	$19.37	82387	$29.07	82656	$16.12
78268	$94.11	80418	$809.76	82128	$19.37	82390	$15.01	82657	$24.35
80048	$11.83	80420	$100.64	82131	$23.57	82397	$19.74	82658	$24.35
80051	$9.80	80422	$64.38	82135	$23.00	82415	$17.70	82664	$48.00
80053	$14.77	80424	$66.56	82136	$23.57	82435	$6.42	82666	$30.01
80061	$18.72	80426	$207.40	82139	$23.57	82436	$4.55	82668	$26.26
80061 QW	$18.72	80428	$93.16	82140	$20.36	82438	$6.83	82670	$39.04
80069	$12.13	80430	$109.60	82143	$9.61	82441	$8.38	82671	$45.13
80074	$66.54	80432	$177.43	82145	$21.72	82465	$6.08	82672	$30.30
80076	$11.42	80434	$141.30	82150	$9.06	82465 QW	$6.08	82677	$33.79
80100	$20.32	80435	$143.85	82154	$40.29	82480	$9.93	82679	$34.88
80101	$19.24	80436	$127.36	82157	$40.90	82482	$8.31	82679 QW	$34.88
80101 QW	$19.24	80438	$70.41	82160	$34.94	82485	$20.02	82690	$21.99
80102	$18.51	80439	$93.88	82163	$28.68	82486	$24.35	82693	$13.75
80150	$21.06	80440	$81.24	82164	$20.39	82487	$20.02	82696	$32.95
80152	$25.01	81000	$4.43	82172	$19.80	82488	$20.02	82705	$7.11
80154	$25.84	81001	$4.43	82175	$26.51	82489	$20.02	82710	$22.12
80156	$20.34	81002	$3.57	82180	$13.81	82491	$24.35	82715	$24.05
80157	$18.52	81003	$3.14	82190	$17.08	82492	$24.35	82725	$12.08
80158	$24.31	81003 QW	$3.14	82205	$16.01	82495	$28.34	82726	$24.35
80160	$24.05	81005	$3.03	82232	$22.61	82507	$38.85	82728	$19.03
80162	$18.55	81007	$3.59	82239	$23.94	82520	$21.17	82731	$89.99
80164	$18.93	81007 QW	$3.59	82240	$24.31	82523	$26.11	82735	$12.62
80166	$21.66	81015	$4.02	82247	$7.02	82523 QW	$26.11	82742	$27.66
80168	$22.83	81020	$5.15	82248	$7.02	82525	$17.34	82746	$20.54
80170	$22.90	81025	$8.84	82252	$2.73	82528	$31.45	82747	$4.30
80172	$22.76	81050	$4.19	82261	$23.57	82530	$23.35	82757	$16.89
80173	$20.34	82000	$17.31	82270	$4.54	82533	$22.78	82759	$30.01
80174	$24.05	82003	$28.28	82271	$4.54	82540	$6.48	82760	$15.64
80176	$16.26	82009	$6.31	82271 QW	$4.54	82541	$24.35	82775	$29.43
80178	$9.24	82010	$9.99	82272	$4.54	82542	$24.35	82776	$11.71
80178 QW	$9.24	82010 QW	$9.99	82272 QW	$4.54	82543	$24.35	82784	$12.99
80182	$18.93	82013	$15.61	82274	$22.22	82544	$24.35	82785	$23.01
80184	$16.01	82016	$19.37	82274 QW	$22.22	82550	$9.10	82787	$4.36
80185	$18.52	82017	$23.57	82286	$9.62	82552	$18.71	82800	$4.88
80186	$19.23	82024	$53.97	82300	$13.25	82553	$13.00	82803	$27.04
80188	$23.18	82030	$18.08	82306	$41.36	82554	$13.00	82805	$39.65
80190	$23.41	82040	$5.73	82307	$45.02	82565	$7.16	82810	$12.20
80192	$23.41	82042	$2.46	82308	$37.41	82570	$7.23	82820	$13.96
80194	$20.39	82043	$2.46	82310	$7.20	82570 QW	$7.23	82926	$7.61
80195	$19.17	82044	$6.39	82330	$19.09	82575	$13.20	82928	$7.32
80196	$9.92	82044 QW	$6.39	82331	$7.23	82585	$11.98	82938	$24.72
80197	$19.17	82045	$47.43	82340	$8.43	82595	$9.04	82941	$24.64
80198	$19.77	82055	$15.10	82355	$16.17	82600	$27.11	82943	$19.97
80200	$22.52	82055 QW	$15.10	82360	$12.22	82607	$21.06	82945	$5.48
80201	$16.66	82075	$16.84	82365	$17.30	82608	$20.01	82946	$21.06
80202	$18.93	82085	$13.56	82370	$17.51	82615	$11.41	82947	$5.48
80299	$19.13	82088	$56.94	82373	$24.35	82626	$35.31	82947 QW	$5.48
80400	$45.56	82101	$41.94	82374	$6.83	82627	$31.07	82948	$4.43
80402	$121.46	82103	$18.77	82375	$17.22	82633	$43.28	82950	$6.64
80406	$109.34	82104	$20.20	82376	$7.94	82634	$40.90	82950 QW	$6.64
80408	$175.34	82105	$23.44	82378	$26.51	82638	$17.11	82951	$17.99
80410	$112.23	82106	$23.44	82379	$23.57	82646	$27.81	82951 QW	$17.99
80412	$460.50	82107	$89.99	82380	$12.89	82649	$35.91	82952	$5.48
80414	$72.16	82108	$35.60	82382	$24.02	82651	$36.07	82952 QW	$5.48

2007 FL Clinical Laboratory Fee Schedule, continued

CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES
82953	$6.63	83520	$18.09	83891	$3.56	84138	$26.46	84443 QW	$23.47
82955	$13.55	83525	$15.98	83892	$3.56	84140	$23.53	84445	$24.31
82960	$8.12	83527	$18.09	83893	$3.56	84143	$31.89	84446	$19.81
82962	$3.27	83528	$22.22	83894	$3.56	84144	$29.15	84449	$21.05
82963	$30.01	83540	$9.05	83896	$3.56	84146	$27.08	84450	$7.22
82965	$7.28	83550	$12.21	83897	$3.56	84150	$34.88	84450 QW	$7.22
82975	$22.13	83570	$12.36	83898	$23.42	84152	$25.70	84460	$7.40
82977	$10.06	83582	$19.80	83900	$46.84	84153	$25.70	84460 QW	$7.40
82978	$19.91	83586	$17.89	83901	$23.42	84154	$25.70	84466	$17.84
82979	$9.62	83593	$36.75	83902	$15.17	84155	$5.12	84478	$8.04
82980	$24.31	83605	$14.92	83903	$23.42	84156	$5.12	84478 QW	$8.04
82985	$21.06	83605 QW	$14.92	83904	$23.42	84157	$5.12	84479	$9.04
82985 QW	$21.06	83615	$8.44	83905	$23.42	84160	$7.23	84480	$19.81
83001	$25.97	83625	$17.88	83906	$23.42	84163	$21.03	84481	$21.97
83001 QW	$25.97	83630	$27.42	83907	$18.66	84165	$15.01	84482	$21.97
83002	$25.88	83631	$27.42	83908	$23.42	84166	$24.92	84484	$13.75
83002 QW	$25.88	83632	$28.24	83909	$23.42	84181	$23.80	84485	$10.01
83003	$23.29	83633	$7.69	83912	$3.56	84182	$25.15	84488	$10.01
83008	$23.45	83634	$11.17	83913	$18.66	84202	$10.67	84490	$10.01
83009	$94.11	83655	$16.91	83914	$23.42	84203	$10.67	84510	$12.22
83010	$17.58	83661	$27.56	83915	$15.58	84206	$18.72	84512	$7.58
83012	$24.02	83662	$26.43	83916	$27.42	84207	$26.00	84520	$5.51
83013	$94.11	83663	$26.43	83918	$21.19	84210	$15.17	84525	$4.02
83014	$10.98	83664	$26.43	83919	$21.19	84220	$7.28	84540	$6.64
83015	$26.31	83670	$12.80	83921	$21.19	84228	$7.94	84545	$9.23
83018	$30.68	83690	$9.62	83925	$27.19	84233	$89.99	84550	$6.31
83020	$17.99	83695	$18.09	83930	$9.24	84234	$90.64	84560	$6.64
83021	$24.35	83698	$47.43	83935	$9.52	84235	$73.12	84577	$17.43
83026	$3.30	83700	$15.73	83937	$28.73	84238	$51.09	84578	$4.54
83030	$11.56	83701	$17.30	83945	$17.99	84244	$30.73	84580	$9.92
83033	$6.50	83704	$29.52	83950	$89.99	84252	$17.81	84583	$7.02
83036	$13.56	83718	$11.44	83970	$57.67	84255	$35.67	84585	$21.66
83036 QW	$13.56	83718 QW	$11.44	83986	$5.00	84260	$21.19	84586	$26.81
83037	$21.06	83719	$16.26	83986 QW	$5.00	84270	$11.17	84588	$47.43
83037 QW	$21.06	83721	$13.33	83992	$20.54	84275	$10.28	84590	$16.20
83045	$4.88	83721 QW	$13.33	84022	$21.76	84285	$32.90	84591	$16.20
83050	$5.86	83727	$24.02	84030	$7.69	84295	$6.72	84597	$9.77
83051	$10.21	83735	$9.36	84035	$5.11	84300	$6.79	84600	$22.45
83055	$6.87	83775	$10.30	84060	$10.32	84302	$6.79	84620	$16.55
83060	$8.12	83785	$34.36	84061	$11.06	84305	$27.55	84630	$15.91
83065	$6.00	83788	$24.35	84066	$13.50	84307	$21.61	84681	$26.81
83068	$11.83	83789	$24.35	84075	$7.23	84311	$9.77	84702	$21.03
83069	$5.51	83805	$24.63	84078	$10.20	84315	$3.50	84703	$10.49
83070	$6.64	83825	$22.72	84080	$20.66	84375	$12.22	84703 QW	$10.49
83071	$9.61	83835	$23.67	84081	$23.09	84376	$7.69	84830	$14.02
83080	$23.57	83840	$22.81	84085	$9.42	84377	$7.69	85002	$6.29
83088	$41.26	83857	$15.01	84087	$11.31	84378	$11.17	85004	$9.04
83090	$23.57	83858	$18.72	84100	$6.63	84379	$11.17	85007	$4.81
83150	$17.30	83864	$27.82	84105	$6.50	84392	$6.64	85008	$4.81
83491	$24.47	83866	$13.76	84106	$5.99	84402	$35.57	85009	$5.19
83497	$18.01	83872	$8.19	84110	$11.80	84403	$36.08	85013	$3.31
83498	$37.95	83873	$24.04	84119	$12.03	84425	$12.22	85014	$3.31
83499	$35.22	83874	$18.04	84120	$20.55	84430	$16.26	85014 QW	$3.31
83500	$31.65	83880	$47.43	84126	$35.59	84432	$22.44	85018	$3.31
83505	$33.96	83880 QW	$47.43	84127	$16.28	84436	$9.61	85018 QW	$3.31
83516	$16.12	83883	$19.00	84132	$6.42	84437	$7.94	85025	$10.86
83518	$11.85	83885	$7.94	84133	$6.01	84439	$12.60	85027	$9.04
83518 QW	$11.85	83887	$33.09	84134	$20.38	84442	$20.66	85032	$6.01
83519	$18.88	83890	$3.56	84135	$26.73	84443	$23.47	85041	$4.20

2007 FL Clinical Laboratory Fee Schedule, continued

CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES
85044	$6.01	85530	$13.25	86294	$27.41	86625	$18.33	86756	$18.01
85045	$5.59	85536	$9.04	86294 QW	$27.41	86628	$11.31	86757	$27.05
85046	$7.80	85540	$12.02	86300	$28.50	86631	$16.52	86759	$18.43
85048	$3.55	85547	$12.02	86301	$28.50	86632	$17.74	86762	$20.11
85049	$6.25	85549	$26.21	86304	$28.50	86635	$16.03	86765	$18.00
85055	$5.86	85555	$9.34	86308	$7.23	86638	$16.94	86768	$16.26
85130	$16.62	85557	$18.66	86308 QW	$7.23	86641	$15.86	86771	$18.33
85170	$5.05	85576	$30.01	86309	$9.04	86644	$20.11	86774	$20.68
85175	$6.35	85576 QW	$30.01	86310	$10.30	86645	$23.54	86777	$20.11
85210	$8.12	85597	$25.12	86316	$28.50	86648	$21.25	86778	$20.12
85220	$24.66	85610	$5.49	86317	$20.95	86651	$18.43	86781	$18.50
85230	$25.02	85610 QW	$5.49	86318	$18.09	86652	$18.43	86784	$11.31
85240	$25.02	85611	$5.51	86318 QW	$18.09	86653	$18.43	86787	$18.00
85244	$28.53	85612	$13.37	86320	$31.32	86654	$18.43	86788	$23.54
85245	$32.06	85613	$13.37	86325	$31.24	86658	$18.20	86789	$20.11
85246	$32.06	85635	$13.76	86327	$31.70	86663	$18.33	86790	$18.00
85247	$32.06	85651	$4.96	86329	$19.62	86664	$21.38	86793	$18.33
85250	$26.60	85652	$3.77	86331	$16.75	86665	$25.35	86800	$22.22
85260	$25.02	85660	$7.71	86332	$34.05	86666	$8.11	86803	$19.94
85270	$25.02	85670	$8.07	86334	$31.21	86668	$14.53	86804	$21.64
85280	$27.04	85675	$6.50	86335	$41.00	86671	$17.13	86805	$73.05
85290	$22.83	85705	$11.17	86336	$21.77	86674	$19.64	86806	$66.49
85291	$12.42	85730	$8.38	86337	$29.92	86677	$20.28	86807	$55.29
85292	$7.28	85732	$9.04	86340	$21.06	86682	$18.17	86808	$41.47
85293	$7.28	85810	$16.32	86341	$27.65	86684	$22.14	86812	$36.06
85300	$8.12	86000	$9.75	86343	$17.41	86687	$11.72	86813	$81.02
85301	$15.11	86001	$7.30	86344	$11.16	86688	$19.57	86816	$38.92
85302	$16.80	86003	$7.30	86353	$68.49	86689	$27.05	86817	$89.95
85303	$19.32	86005	$11.14	86355	$52.70	86692	$23.98	86821	$78.88
85305	$16.20	86021	$21.03	86357	$52.70	86694	$20.11	86822	$51.07
85306	$21.41	86022	$25.66	86359	$52.70	86695	$18.43	86880	$7.50
85307	$21.41	86023	$17.40	86360	$9.77	86696	$27.05	86885	$7.99
85335	$17.99	86038	$16.89	86361	$5.86	86698	$17.46	86886	$7.23
85337	$14.56	86039	$15.60	86367	$52.70	86701	$12.41	86900	$4.17
85345	$6.01	86060	$10.20	86376	$20.33	86701 QW	$12.41	86901	$4.17
85347	$5.95	86063	$8.07	86378	$27.51	86702	$18.88	86903	$8.46
85348	$5.20	86140	$7.23	86382	$23.62	86703	$19.17	86904	$13.28
85360	$11.17	86141	$18.09	86384	$15.91	86703 QW	$19.17	86905	$5.34
85362	$9.62	86146	$23.12	86403	$14.24	86704	$16.84	86906	$10.83
85366	$12.03	86147	$23.12	86406	$14.87	86705	$16.44	86940	$11.46
85370	$14.83	86148	$22.44	86430	$7.93	86706	$15.01	86941	$13.27
85378	$9.97	86155	$22.33	86431	$7.93	86707	$16.16	87001	$18.47
85379	$14.22	86156	$9.36	86480	$86.59	86708	$17.31	87003	$23.52
85380	$14.22	86157	$11.27	86586	$4.47	86709	$15.73	87015	$9.33
85384	$11.87	86160	$16.78	86590	$12.22	86710	$18.94	87040	$14.42
85385	$11.87	86161	$16.78	86592	$5.96	86713	$21.39	87045	$13.18
85390	$6.63	86162	$28.39	86593	$6.16	86717	$17.12	87046	$13.18
85400	$12.36	86171	$14.00	86602	$8.11	86720	$18.43	87070	$12.03
85410	$10.77	86185	$12.50	86603	$17.98	86723	$18.43	87071	$13.18
85415	$13.25	86200	$18.09	86606	$21.03	86727	$17.98	87073	$13.18
85420	$9.13	86215	$18.51	86609	$18.00	86729	$16.69	87075	$13.22
85421	$14.23	86225	$19.20	86611	$8.11	86732	$18.43	87076	$11.29
85441	$5.88	86226	$16.92	86612	$18.03	86735	$18.23	87077	$11.29
85445	$9.52	86235	$25.06	86615	$18.43	86738	$18.51	87077 QW	$11.29
85460	$10.81	86243	$28.68	86617	$21.64	86741	$18.43	87081	$9.26
85461	$9.26	86255	$16.84	86618	$21.05	86744	$18.43	87084	$12.03
85475	$12.40	86256	$16.84	86618 QW	$21.05	86747	$21.00	87086	$11.28
85520	$13.25	86277	$21.99	86619	$18.69	86750	$13.00	87088	$11.31
85525	$13.25	86280	$11.44	86622	$12.48	86753	$17.32	87101	$10.77

2007 FL Clinical Laboratory Fee Schedule, continued

CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES	CODE	FEES
87102	$11.74	87283	$16.76	87517	$59.85	87808	$16.76	89051	$7.70
87103	$12.60	87285	$16.76	87520	$17.79	87810	$16.76	89055	$5.96
87106	$14.42	87290	$16.76	87521	$41.65	87850	$16.76	89060	$9.99
87107	$14.42	87299	$16.76	87522	$59.85	87880	$16.76	89125	$6.03
87109	$21.50	87300	$16.76	87525	$17.79	87880 QW	$16.76	89160	$5.15
87110	$23.73	87301	$16.76	87526	$41.65	87899	$16.76	89190	$6.64
87116	$15.10	87305	$16.76	87527	$58.33	87899 QW	$16.76	89225	$4.67
87118	$15.29	87320	$16.76	87528	$17.79	87900	$182.11	89235	$7.69
87140	$7.79	87324	$16.76	87529	$41.65	87901	$359.69	89300	$12.45
87143	$17.51	87327	$16.76	87530	$59.85	87902	$359.69	89300 QW	$12.45
87147	$7.23	87328	$16.76	87531	$17.79	87903	$682.72	89310	$12.03
87149	$17.79	87329	$16.76	87532	$41.65	87904	$36.42	89320	$16.84
87152	$7.31	87332	$16.76	87533	$58.33	88130	$21.02	89321	$16.84
87158	$7.31	87335	$16.76	87534	$17.79	88140	$11.17	89325	$14.91
87164	$15.01	87336	$16.76	87535	$41.65	88142	$28.21	89329	$29.30
87166	$15.78	87337	$16.76	87536	$98.47	88143	$28.21	89330	$13.83
87168	$5.96	87338	$17.19	87537	$17.79	88147	$14.76	ATP02	$7.28
87169	$5.96	87339	$16.76	87538	$41.65	88148	$14.76	ATP03	$9.29
87172	$5.96	87340	$14.43	87539	$59.85	88150	$14.76	ATP04	$9.80
87176	$8.22	87341	$14.43	87540	$17.79	88152	$14.76	ATP05	$10.93
87177	$12.43	87350	$16.10	87541	$41.65	88153	$14.76	ATP06	$10.96
87181	$1.17	87380	$22.94	87542	$58.33	88154	$14.76	ATP07	$11.42
87184	$9.63	87385	$16.76	87550	$17.79	88155	$8.37	ATP08	$11.83
87185	$1.17	87390	$15.61	87551	$41.65	88164	$14.76	ATP09	$12.13
87186	$12.08	87391	$15.61	87552	$59.85	88165	$14.76	ATP10	$12.13
87187	$14.48	87400	$16.76	87555	$17.79	88166	$14.76	ATP11	$12.34
87188	$8.12	87420	$16.76	87556	$41.65	88167	$14.76	ATP12	$12.62
87190	$7.90	87425	$16.76	87557	$59.85	88174	$29.39	ATP16	$14.77
87197	$20.99	87427	$16.76	87560	$17.79	88175	$34.70	ATP18	$14.87
87205	$5.96	87430	$16.76	87561	$41.65	88230	$162.77	ATP19	$15.45
87206	$7.50	87449	$16.76	87562	$59.85	88233	$196.63	ATP20	$15.95
87207	$8.37	87449 QW	$16.76	87580	$17.79	88235	$205.74	ATP21	$16.45
87209	$25.11	87450	$13.39	87581	$41.65	88237	$176.47	ATP22	$16.95
87210	$5.96	87451	$13.39	87582	$58.33	88239	$206.12	G0027	$9.09
87210 QW	$5.96	87470	$17.79	87590	$17.79	88240	$14.11	G0103	$25.70
87220	$5.96	87471	$41.65	87591	$41.65	88241	$14.11	G0123	$28.21
87230	$27.59	87472	$59.85	87592	$59.85	88245	$190.23	G0143	$28.21
87250	$27.32	87475	$17.79	87620	$17.79	88248	$241.96	G0144	$29.39
87252	$36.42	87476	$41.65	87621	$41.65	88249	$241.96	G0145	$34.70
87253	$28.22	87477	$59.85	87622	$58.33	88261	$246.93	G0147	$14.76
87254	$27.32	87480	$17.79	87640	$41.65	88262	$174.14	G0148	$14.76
87255	$47.31	87481	$41.65	87641	$41.65	88263	$190.23	G0265	$14.11
87260	$16.76	87482	$58.33	87650	$17.79	88264	$174.14	G0266	$14.11
87265	$16.76	87485	$17.79	87651	$41.65	88267	$251.17	G0306	$10.86
87267	$16.76	87486	$41.65	87652	$58.33	88269	$190.23	G0307	$9.04
87269	$16.76	87487	$59.85	87653	$41.65	88271	$20.22	G0328	$22.22
87270	$16.76	87490	$17.79	87660	$17.79	88272	$35.39	G0328 QW	$22.22
87271	$16.76	87491	$41.65	87797	$17.79	88273	$44.89	G0394	$4.54
87272	$16.76	87492	$48.84	87798	$41.65	88274	$48.63	P2038	$7.02
87273	$16.76	87495	$17.79	87799	$59.85	88275	$56.11	P3000	$14.76
87274	$16.76	87496	$41.65	87800	$35.58	88280	$35.07	P9612	$3.00
87275	$16.76	87497	$59.85	87801	$83.30	88283	$95.84	P9615	$3.00
87276	$16.76	87498	$41.65	87802	$16.76	88285	$26.54	Q0111	$5.96
87277	$16.76	87510	$17.79	87803	$16.76	88289	$40.56	Q0112	$5.96
87278	$16.76	87511	$41.65	87804	$16.76	88371	$31.05	Q0113	$7.56
87279	$16.76	87512	$58.33	87804 QW	$16.76	88372	$31.79	Q0114	$9.99
87280	$16.76	87515	$17.79	87807	$16.76	88400	$7.02	Q0115	$13.83
87281	$16.76	87516	$41.65	87807 QW	$16.76	89050	$6.61		

Source: Publication 100-04, #1122, CR 5362

2007 DMEPOS Fee Schedule

The following are the allowances for the 2007 DMEPOS fee achedule.

PROC/MOD	FEE		PROC/MOD	FEE		PROC/MOD	FEE
A4561	20.05		L8619	6869.27	*	Q0480	76182.94
A4562	49.83		L8621	0.52		Q0481	12291.24
A7040	39.61		L8622	0.28		Q0482	3849.84
A7041	74.42		L8623	54.72		Q0483	15859.63
A7042	176.81		L8624	136.38		Q0484	3079.89
A7043	28.16		L8630	281.81	*	Q0485	297.36
E0749	235.36		L8631	1891.22		Q0486	247.49
E0782	4180.54	*	L8641	305.85	*	Q0487	288.74
E0783	7971.67	*	L8642	251.06	*	Q0489	13749.44
E0785	460.08	*	L8658	262.39		Q0490	594.73
E0786	7775.89	*	L8659	1632.25		Q0491	934.97
L8600	522.32	*	L8670	465.61	*	Q0492	75.35
L8603	366.83	*	L8680	388.54	*	Q0493	214.47
L8606	192.56	*	L8681	955.39	*	Q0494	181.49
L8609	5511.23		L8682	5042.80	*	Q0495	3533.29
L8610	535.77	*	L8683	4438.80	*	Q0496	1268.16
L8612	565.08	*	L8684	582.91		Q0497	395.99
L8613	253.00	*	L8685	11061.27	*	Q0498	434.49
L8614	16013.67	*	L8686	7057.99	*	Q0499	141.16
L8615	381.50		L8687	14395.13	*	Q0500	25.82
L8616	88.86		L8688	9185.27	*	Q0501	431.99
L8617	77.61		L8689	1459.07		Q0502	549.96
L8618	22.16		L8695	14.10	*	Q0503	1099.95
						Q0504	580.41

* Allowable in an ASC

Source: Publication 100-04, #1125, CR 5417

2007 DMEPOS—ASC Allowable Fees

The following are the allowances for the 2007 DMEPOS services allowable in an ambulatory surgical center (ASC).

CODE	FEE	CODE	FEE	CODE	FEE
E0782	4180.54	L8613	253.00	L8682	5042.80
E0783	7971.67	L8614	16013.67	L8683	4438.80
E0785	460.08	L8619	6869.27	L8684	582.91
E0786	7775.89	L8630	281.81	L8686	7057.99
L8600	522.32	L8641	305.85	L8687	14395.13
L8603	366.83	L8642	251.06	L8688	9185.27
L8606	192.56	L8658	262.39	L8690	I.C.
L8610	535.77	L8670	465.61	L8691	I.C.
L8612	565.08	L8680	388.54	L8695	14.10
		L8681	955.39	V2785	I.C.

I.C. = Individual Consideration

Allowance for Procedure Code R0070

The allowance for the portable X-ray transportation code R0070 has been increased to $105.22 for dates of service on or after January 1, 2007.

The ambulance inflation factor (AIF) for 2007 was used to adjust the allowance.

2007 Reasonable Charge Payment

The **procedure status** for the following codes has been changed to **"X"** (Statutory exclusion) These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes.

No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule.

CODE	LOC 01	LOC 02	LOC 03	LOC 04	CODE	LOC 01	LOC 02	LOC 03	LOC 04
P9016	102.50	98.86	104.17	104.17	86904	39.47	39.47	39.47	43.08
86850	40.65	40.65	39.47	43.96	86920	48.90	48.90	48.90	48.90
86870	69.90	69.90	69.90	75.00	86922	64.31	64.31	64.31	64.31

Source: Publication 100-04, #1131, Change Request 5448

LABORATORY/PATHOLOGY

New Waived Tests

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5404 which informs carriers and A/B MACS of new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Background

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test they perform. Laboratory claims are currently edited at the CLIA certificate level in order to ensure that the Centers for Medicare & Medicaid Services (CMS) only pays for laboratory tests categorized as waived complexity under CLIA (for facilities with a CLIA certificate of waiver).

New waived tests are approved by the FDA on a flow basis, and the tests are valid as soon as they are approved. The new waived tests announced by CR 5404 are in the following table:

Newly Added CLIA Waived Tests	**Effective Date**	***Current Procedural Terminology* (*CPT*) Code(s) /Modifier**
Immunostics, Inc., hema-screen Specific Immunochemical Fecal Occult Blood Test	June 15, 2006	*82274*QW, G0328QW;
Gryphus Diagnostics BVBlue	June 30, 2006	*87899*QW
ESA Biosciences LeadCare II Blood Lead Testing System (whole blood)	September 18, 2006	*83655*QW.

Note: The *Current Procedural Terminology* (*CPT*) codes for these new waived tests must have the modifier QW to be recognized as a waived test. Also, for 2007, the new *CPT*/HCPCS code *87808*QW (Infectious agent antigen detection by immunoassay with direct optical observation; trichomonas vaginalis) replaces the code *87899*QW that was assigned to the genzyme OSOM trichomonas rapid test.

Additional Information

For complete details, please see the official instruction, CR 5404, issued to your carrier or A/B MAC regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R1115CP.pdf* on the CMS website. The attachment to CR 5404 includes the list of tests granted waived status under CLIA, and the tests mentioned on the first page of the attachment (i.e., *CPT* codes: *81002, 81025, 82270, 82272, G0394, 82962, 83026, 84830, 85013,* and *85651*) do not require a QW modifier to be recognized as a waived test.

New Waived Tests , continued

As mentioned in change Request 5292 (Transmittal 1062, dated September 22, 2006), the HCPCS code G0107 (Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations) will be retired effective January 1, 2007 and has been replaced with *CPT* code *82270* [Blood, occult, by peroxidase activity (e.g., Guaiac) qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection)].

For 2007, the new *CPT*/HCPCS code G0394 is for Blood occult test (e.g., guaiac), feces, for single determination for colorectal neoplasm (i.e., patient was provided three cards or single triple card for consecutive collection). This code does not require a modifier QW.

To view CR 5292 (Transmittal 1062, dated September 22, 2006), please go to *http://www.cms.hhs.gov/Transmittals/downloads/R1062CP.pdf* on the CMS website.

The *MLN Matters* article based on CR 5292 is located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5292.pdf* on the CMS website.

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

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

MLN Matters Number: MM5404 Related Change Request (CR) #: 5404
Related CR Release Date: November 24, 2006 Effective Date: January 1, 2007
Related CR Transmittal #: R1115CP Implementation Date: January 2, 2007

2007 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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

Provider Types Affected

Clinical laboratories billing Medicare carriers, intermediaries, or Part A/B Medicare administrative contractors (A/B MACs)

Provider Action Needed

This article and related CR 5362 contain important information regarding:

- The 2007 annual updates to the clinical laboratory fee schedule
- Mapping for new codes for clinical laboratory tests, and
- Laboratory costs related to services subject to reasonable charge payments.

It is important that affected laboratories understand these changes to ensure correct and accurate payments from Medicare.

Key Points

Update to Fees

In accordance with section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by section 628 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2007 is zero (0) percent.

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA).

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

For a cervical or vaginal smear test (pap smear), section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge.

The 2007 national minimum payment amount is $14.76 ($14.76 plus zero percent update for 2007). The affected codes for the national minimum payment amount include the following *Current Procedure Terminology (CPT)* codes:

88142	*88143*	*88147*	*88148*	*88150*	*88152*	*88153*
88154	*88164*	*88165*	*88166*	*88167*	*88174*	*88175*
G0123	G0143	G0144	G0145	G0147	G0148	P3000

2007 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment, continued

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with section 1833(h)(4)(B)(viii) of the Act.

Access to 2007 Clinical Laboratory Fee Schedule

Internet access to the 2007 clinical laboratory fee schedule data file should be available after November 20, 2006, at *http://www.cms.hhs.gov/ClinicalLabFeeSched* on the Centers for Medicare & Medicaid Services (CMS) website.

Medicaid state agencies, the Indian Health Service, the United Mine Workers, Railroad Retirement Board, and other interested parties should use the Internet to retrieve the 2007 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public Comments

On July 17, 2006, CMS hosted a public meeting to solicit input on the payment relationship between 2006 codes and new 2007 *Current Procedural Terminology* codes. Notice of the meeting was published in the *Federal Register* on May 26, 2006 and on the CMS website on June 19, 2006

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the website *http://www.cms.hhs.gov/ClinicalLabFeeSched*. Additional written comments from the public were accepted until September 26, 2006.

Additional Pricing Information

The 2006 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615).

For dates of service January 1, 2007 through December 2007, the fee for clinical laboratory travel code P9603 is $0.935 per mile and for code P9604 is $9.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. The standard mileage rate for transportation costs was increased by the Federal Government's Treasury Department to 48.5 cents a mile and this amount is incorporated into the fees for travel codes P9603 and P9604.

The 2007 laboratory fee schedule also includes codes that have a 'QW' modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Based on comments and data submitted, codes *83037* and *83037QW* are priced by crosswalking to code *82985*.

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2006 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were determined by Medicare by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping Information

CMS advises the following:

- New code *80178QW* is priced at the same rate as code *80178*.
- New code *82107* is priced at the same rate as code *83950*.
- New code *83698* is priced at the same rate as code *83880*.
- New code *83913* is priced at the same rate as code *83907*.
- New code *84443QW* is priced at the same rate as code *84443*.
- New code *86788* is priced at the same rate as code *86645*.
- New code *86789* is priced at the same rate as code *86644*.
- New code *86901* is priced at the same rate as code *86900*.
- New code *87305* is priced at the same rate as code *87327*.
- New code *87498* is priced at the same rate as code *87496*.
- New code *87640* is priced at the same rate as code *87651*.
- New code *87641* is priced at the same rate as code *87651*.
- New code *87653* is priced at the same rate as code *87651*.
- New code *87808* is priced at the same rate as code *87802*.
- New code *87808QW* is priced at the same rate as code *87808*.
- New code G0394 is priced at the same rate as code *82270*.

2007 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment, continued

Laboratory Costs Subject to Reasonable Charge Payment in 2006

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as prescribed by section 1842(b)(3) of the Act and 42 CFR 405.509(b)(1). The inflation-indexed update for year 2007 is 4.3 percent.

Manual instructions for determining the reasonable charge payment may be found in the *Medicare Claims Processing Manual*, Chapter 23, §80-80.8. If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. The *Medicare Claims Processing Manual*, is located at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

When these services are performed for independent dialysis facility patients, *Medicare Claims Processing Manual*, Chapter 8, section 60.3 instructs the reasonable charge basis applies. However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood Products

P9010	P9011	P9012	P9016	P9017	P9019	P9020
P9021	P9022	P9023	P9031	P9032	P9033	P9034
P9035	P9036	P9037	P9038	P9039	P9040	P9044
P9050	P9051	P9052	P9053	P9054	P9055	P9056
P9057	P9058	P9059	P9060			

Also, the following codes should be applied to the blood deductible, as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, (also available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage*) Chapter 3, Section 20.5-20.54:

P9010	P9011	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058	

Note: Biologic products not paid on a cost or prospective payment basis are paid based on section 1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B Drug Pricing Files.

Transfusion Medicine

86850	*86860*	*86870*	*86880*	*86885*	*86886*	*86890*
86891	*86900*	*86901*	*86903*	*86904*	*86905*	*86906*
86920	*86921*	*86922*	*86923*	*86927*	*86930*	*86931*
86932	*86945*	*86950*	*86960*	*86965*	*86970*	*86971*
86972	*86975*	*86976*	*86977*	*86978*	*86985*	G0267

Reproductive Medicine Procedures

89250	*89251*	*89253*	*89254*	*89255*	*89257*	*89258*
89259	*89260*	*89261*	*89264*	*89268*	*89272*	*89280*
89281	*89290*	*89291*	*89335*	*89342*	*89343*	*89344*
89346	*89352*	*89353*	*89354*	*89356*		

Additional Information

If you have questions, please contact your Medicare fiscal intermediary (FI), 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.

For complete details regarding CR 5362, please see the official instruction issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1122CP.pdf* on the CMS website.

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

Instructions for calculating reasonable charges are located in the *Medicare Claims Processing Manual* (Pub. 100-04) Chapter 23, Sections 80-80.8 at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS website

MLN Matters Number: MM5362	Related Change Request (CR) #:5362
Related CR Release Date: December 8, 2006	Effective Date: January 1, 2007
Related CR Transmittal #: R1122CP	Implementation Date: January 2, 2007

RADIOLOGY

New 2007 Current Procedural Terminology Mammography Codes

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

Provider Types Affected

All physicians and providers who bill Medicare carriers, fiscal intermediaries (FI), or Part A/B Medicare administrative contractors (A/B MACs) for providing mammography services.

Provider Action Needed

STOP – Impact to You

As part of the annual HCPCS update, CMS has assigned new 2007 *Current Procedural Terminology (CPT)* mammography codes for screening and diagnostic mammography services. Effective January 1, 2007, these codes (*77051*, *77052*, *77055*, *77056*, and *77057*) will replace the current *CPT* codes; however the *CPT* code descriptors for the services are unchanged.

CAUTION – What You Need to Know

Failure to submit the correct codes will cause your claims to be returned and not processed.

GO – What You Need to Do

Make sure that your billing staffs are aware of the *CPT* code changes.

Background

Change request (CR) 5327, from which this article was taken, announces the assignment of new *CPT* codes for screening and diagnostic mammography services. As part of the annual HCPCS update, CMS has assigned new 2007 *CPT* mammography codes for screening and diagnostic mammography services. Effective January 1, 2007, these codes (*77051*, *77052*, *77055*, *77056*, and *77057*) will replace the current *CPT* codes; however the *CPT* code descriptors for the services are unchanged. The following table displays the new (and old) replacement codes and their description.

2007 Screening and Diagnostic Mammography *CPT* Codes

New Code	Old Code	Description
77051	*76082*	*Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography. (List separately in addition to code for primary procedure.)*
77052	*76083*	*Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography. (List separately in addition to code for primary procedure.)*
77055	*76090*	*Diagnostic mammography, unilateral*
77056	*76091*	*Diagnostic mammography, bilateral*
77057	*76092*	*Screening mammography, bilateral (two view film study of each breast)*

Be advised that your carriers and FIs will return claims (with dates of service on or after January 1, 2007) that contain the old screening and diagnostic mammography codes. And also effective January 1, 2007, frequency standards for screening mammography will be applied to the new screening *CPT* codes (*77052* and *77057*).

Additional Information

You can find more information about the new 2007 mammography *CPT* codes by going to CR 5327, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1070CP.pdf*.

There, as an attachment to that CR, you will find revised Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services) of the Medicare Claims Processing Manual (100-04).

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

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

MLN Matters Number: MM5327
Related Change Request (CR) Number: 5327
Related CR Release Date: September 29, 2006
Related CR Transmittal Number: R1070CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

SCREENING SERVICES

Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms, Resulting from a Referral from an Initial Preventive Physical Examination

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the December 2006 Medicare B Update! pages 25-27.

Note: This article was changed on December 8, 2006 to add emphasize that this coverage is for a one-time only service and it must also be as a result of a referral from an initial preventive physical exam and is also subject to other limitations as discussed in this article and in CR 5235.

Provider Types Affected

All physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (MACs) for subject services

Background

This article and related CR 5235 highlight the fact that section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for abdominal aortic aneurysms (AAA) under Medicare Part B, effective for services furnished on or after January 1, 2007, as a result of a referral from an initial preventive physical examination (IPPE) and subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test.

Key Points

Effective for dates of service on and after January 1, 2007 Medicare will pay for a one-time ultrasound screening for AAA, for beneficiaries who meet the following criteria:

- Receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (IPPE) (See *MLN Matters* article MM3638 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf* for more details on the IPPE.)
- Receives such ultrasound screening from a provider or supplier who is authorized to provide covered ultrasound diagnostic services.
- Has not been previously furnished such an ultrasound screening under the Medicare program
- Is included in at least one of the following risk categories:
  1. Has a family history of abdominal aortic aneurysm;
  2. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime?
  3. Is a beneficiary, who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process?

Payment

- The Part B deductible for screening AAA is waived effective January 1, 2007, but coinsurance is applicable.
- If the screening is provided in a physician office, the service is billed to the carrier using the HCPCS code G0389: Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening.
- Short Descriptor: Ultrasound exam AAA screen
- Modifiers: TC, 26 (modifiers are optional)
- Payment is under the Medicare Physician Fee Schedule (MPFS).

FIs will pay for the AAA screening only when the services are performed in a hospital, including a CAH, IHS facility, an SNF, RHC, or FQHC and submitted on one of the following types of bills (TOBs): 12x, 13x, 22x, 23x, 71x, 73x, 85x.

Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms, Resulting from a Referral from an Initial Preventive Physical Examination, continued

- The following table describes the payment methodology Medicare will use for AAA Screening:

Facility	Type of Bill	Payment
Hospitals subject to OPPS	12x, 13x	OPPS
Method I and method II critical access hospitals (CAHs)	12x and 85x	101 percent of reasonable cost
IHS providers	13x, revenue code 051x	OMB-approved outpatient per visit all inclusive rate (AIR)
IHS providers	12x, revenue code 024x	All-inclusive inpatient ancillary per diem rate
IHS CAHs	85x, revenue code 051x	101 percent of the all-inclusive facility specific per visit rate
IHS CAHs	12x, revenue code 024x	101 percent of the all-inclusive facility specific per diem rate
SNFs **	22x, 23x	Non-facility rate on the MPFS
RHCs*	71x, revenue code 052x	All-inclusive encounter rate
FQHCs*	73x, revenue code 052x	All-inclusive encounter rate
Maryland hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12x, 13x	94 percent of provider submitted charges or according to the terms of the Maryland waiver

*If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI using TOBs 71x and 73x, respectively, and the appropriate site of service revenue code in the 052x revenue code series. If the screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier under the practitioner's ID following instructions for submitting practitioner claims to the Medicare carrier. If the screening is provided in a provider-based RHC/FQHC, the base provider to the FI under the base provider's ID can bill the technical component of the service, following instructions for submitting claims to the FI from the base provider.
** The SNF consolidated billing provision allows separate part B payment for screening services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a 22x bill type. Screening services provided by other provider types must be reimbursed by the SNF.

Implementation

The implementation date for this instruction is January 2, 2007.

Information regarding advanced beneficiary notices: Medicare contractors will deny an AAA screening service billed more than one in a beneficiary's lifetime.

If a second G0389 is billed for AAA for the same beneficiary or if any of the other statutory criteria for coverage listed in section 1861(s)(2)(AA) of the Social Security Act are not met, the service would be denied as a statutory (technical) denial under section 1861(s)(2)(AA), not a medical necessity denial.

If a provider cannot determine whether or not the beneficiary has previously had an AAA screening, but all of the other statutory requirements for coverage have been met, the provider should issue the ABN-G. Likewise, if all of the statutory requirements for coverage have been met, but a question of medical necessity still exists, the provider should issue the ABN-G.

Additional Information

The official instructions for CR 5235, issued to your Medicare carrier, FI, MAC, FQHC, RHC, SNF, or CAH regarding this change may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1113CP.pdf* on the CMS website. The Medicare Claims Processing Manual, Publication 100-04, Chapter 18, has been updated to include the requirements to implement section 5112 of the DRA of 2005. The new sections of this chapter address the payment and allowable settings for AAA and the sections are attached to CR 5235.

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

MLN Matters Number: MM5235 *Revised*
Related Change Request (CR) #:5235
Related CR Release Date: November 17, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1113CP
Implementation Date: January 2, 2007

SURGERY

Cavernous Nerves Electrical Stimulation with Penile Plethysmograph

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

Provider Types Affected

Physicians and hospitals who bill Medicare fiscal intermediaries (FI) and carriers for performing cavernous nerves electrical stimulation with penile plethysmography in Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

Provider Action Needed

STOP – Impact to You

Effective for claims with dates of service on or after August 24, 2006, Medicare will not pay for performing cavernous nerves electrical stimulation with penile plethysmography in Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

CAUTION – What You Need to Know

Change Request (CR) 5294, from which this article is taken, announces' the results of a national coverage determination (NCD) addressing cavernous nerves electrical stimulation with penile plethysmography performed for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures. It states that CMS, after reviewing the evidence, has determined that this test is not reasonable and necessary for Medicare beneficiaries undergoing these procedures.

GO – What You Need to Do

Make sure that your billing staffs are aware of this NCD.

Background

The direct application of electrical stimulation with penile plethysmography (also referred to as cavernosal nerve mapping) may be performed, in nerve-sparing prostatic and colorectal surgical procedures, to assess the integrity and function of the cavernous nerves.

Through either an open or laparoscopic approach, the surgeon can assess the function of the cavernous nerves by stimulating, with an electrical nerve stimulator, the most distal end of the nerve that can be located. A functioning and stimulated nerve will trigger blood flow either into or out of the penis, which can be detected via a penile plethysmography sensor fitted around the penis and connected to a nerve stimulator control unit. If the nerves are intact, cavernous blood flow will cause slight changes in penile girth, which the sensor can detect. The presence (and degree) of a response may be used to provide the surgeon with a more realistic assessment of the chance of the patient regaining potency and assist in choosing appropriate therapy.

Heretofore, local Medicare carriers/FIs had the discretion to cover this test whenever it was determined to be medically necessary for the individual patient, because a national coverage determination (NCD) or national Medicare coverage policy had not been issued. However, on December 9, 2005, a request for review of this test initiated a national coverage analysis.

CR 5294, from which this article is taken, announces the results of this NCD. It provides that CMS has reviewed the evidence and determined that: 1) Cavernous nerves electrical stimulation with penile plethysmography is not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures, and 2) this test is **noncovered** under Medicare (as specified the Medicare National Coverage Manual (100-03, Section 160.26 (Cavernous Nerves Electrical Stimulation with Penile Plethysmography).

Effective with claims with dates of service on or after August 24, 2006, your FIs and carriers will not pay for these services.

Physicians should use *CPT* code 55899 to bill this for test. Your FIs and carriers will suspend claims containing this code to determine whether this test is the service being billed, and will deny the line item associated with it, using Medicare summary notice 21.11 (This test was not covered by Medicare at the time you received it).

You should be aware that your FIs, A/B MACs and carriers will not search for, and adjust, claims for tests that have been paid prior to January 8, 2007, but they will adjust claims brought to their attention. Further, physicians and hospitals should, as appropriate:

1. Issue the appropriate liability notice for Medicare beneficiaries having this test.
2. Include the following language when issuing an advanced beneficiary notice (ABN):
   - ***Under "Items or Service" Section:*** *Cavernous Nerves Electrical Stimulation with Penile Plethysmography.*
   - ***Under "Because" Section:*** *As specified in section 160.26 of Medicare NCD Manual, Medicare will not pay for this test as it is not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.* and/or
3. Issue a hospital issued notice of noncoverage (HINN).

Cavernous Nerves Electrical Stimulation with Penile Plethysmograph, continued

If a physician does not issue an ABN, the physician is liable for the service.

Additional Information

You can find more information about payment for cavernous nerves electrical stimulation with penile plethysmography by going to CR5294, which is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R61NCD.pdf*.

You will find revised section 160.26 (Cavernous Nerves Electrical Stimulation with Penile Plethysmography) of the *Medicare National Coverage Manual* (Publication 100-03) as an attachment to this CR.

If you have any questions, please contact your FI or carrier at their toll-free number, which may be found **o**n 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: MM5294
Related Change Request (CR) Number: 5294
Related CR Release Date: November 24, 2006
Related CR Transmittal Number: R61NCD
Effective Date: August 24, 2006
Implementation Date: January 8, 2007

THERAPY SERVICES

Infrared Therapy Devices

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

Provider Types Affected

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

Impact on Providers

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

Background

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

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

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

250.60-250.63,
354.4, 354.5, 354.9,
355.1-355.4,
355.6-355.9
356.0, 356.2-356.4, 356.8-356.9,
357.0-357.7,
674.10, 674.12, 674.14, 674.20, 674.22, 674.24,
707.00-707.07, 707.09-707.15, 707.19,
870.0-879.9,
880.00-887.79,
890.0-897.7, or
998.31-998.32.

Infrared Therapy Devices, continued

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

Additional Information

If you have questions, please contact your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier at their toll-free number which may be found 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 5421) issued to your Medicare A/B MAC, FI, DME MAC, RHHI, or carrier. There are actually two transmittals associated with CR 5421. The first is the national coverage determination transmittal, located at *http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf* on the CMS website. In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is at *http://www.cms.hhs.gov/Transmittals/downloads/R1127CP.pdf* on the CMS website.

MLN Matters Number: MM5421	Related Change Request (CR) #: 5421
Related CR Release Date: December 15, 2006	Effective Date: October 24, 2006
Related CR Transmittal #: R1127CP and R62NCD	Implementation Date: January 16, 2007

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 December 4, 2006, to reflect the correct effective and implementation dates as described in CR 5271, which CMS recently revised. While CR 5271 also reflects effective and implementation dates in January 2007 for Medicare system changes, the information in this article clarifies existing processes. Also, this revision reminds providers that the exception to therapy caps ends December 31, 2006. The revision to this article was published in the December 2006 *Medicare B Update!* (pages 27-29).

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.**

Outpatient Therapy Cap Exceptions Clarifications, continued

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.
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.

Outpatient Therapy Cap Exceptions Clarifications, continued

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).

MLN Matters Number: MM5271 – *Revised*
Related Change Request (CR) Number: 5271
Related CR Release Date: November 9, 2006
Related CR Transmittal Number: R60BP, R171PI, R1106CP
Effective Date: December 9, 2006
Implementation Date: December 9, 2006

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.

Revision to the ICD-9-CM Diagnosis List To Qualify for Therapy Cap Exception

The Centers for Medicare & Medicaid Services (CMS) has revised and correct some of the ICD-9-CM diagnosis ranges on the list of conditions and complexities for which exceptions to the outpatient therapy cap may be allowed. This list was previously published in the Third Quarter 2006 *Medicare B Update!* (pages 67-69) as part of the guidelines for therapy cap exception process.

The changes have been bolded and italicized in the following table for easy identification.

250.*00* – 250.93*	**353.*0* – 357.*7***	486*	724.3*	828.0 – 828.1
278.01 – 278.02*	359.0 – 359.9	490 – 496*	724.4*	852.00 – 852.59
290.0 – 290.43*	386.0 – 386.9*	**707.*00* – 707.9***	726.10 – 726.19	853.00 – 853.19
294.0 – 294.9*	401.0 – 401.9*	710.0 – 710.9	727.61 – 727.62	854.00 – 854.19
311*	402.00 – 402.91*	711.00 – 711.99*	733.00	881.0 – 881.2
323.0 – 323.09*	414.00 – 414.9*	713.0 – 713.8*	780.93	882.0 – 882.2
331.0 – 331.9	415.0 – 415.19*	714.0 – 714.9*	781.2	884.0 – 884.2
332.0 – 332.1	416.0 – 416.9*	715.09	781.3	887.0 – 887.7
333.0 – 333.99	**427.0 – 427.*9***	715.11	781.8	897.0 – 897.7
334.0 – 334.9	428.0 – 428.9*	715.15	781.92*	**941.00 – *949.5***
335.0 – 335.9	430 – 432.9	715.16	**784.3 – 784.*9***	***950.00 – 952.9***
336.0 – 336.9	**433.*00* – 434.*91***	715.91	787.2	959.01
337.20 – 337.29	436	715.96	**806.00 – 806.*9***	V43.64
340	437.0 – 437.9	718.44	810.00 – 810.13	V43.65
342.00 – 342.*92*	438.0 – 438.9	718.49	811.00 – 811.19	V43.61
343.0 – 343.9	443.0 – 443.9*	719.7*	812.00 – 812.59	V49.63 – 49.67
344.00 – 344.9	453.0 – 453.9*	721.91	813.00 – 813.93	V49.73 – 49.77
348.9 – 348.9	457.0 – 457.1	723.4	820.00 – 820.9	
349.0 – 349.9	478.30 – 478.5	724.02	**821.*00* – 821.39**	

***** Complexities

To download the "Request for Exception from Therapy Cap" form, from the home page on the provider education website *http://www.floridamedicare.com*, select "Forms" under the "Resources" section on the left navigational menu. On the next screen, click on "Request for Exception from the Therapy Caps" under the "Resource Order Forms" section.

Source: CMS Pub. 100-04, Transmittal 1106, CR 5271

GENERAL COVERAGE

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

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

Provider Types Affected

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

Provider Action Needed
STOP – Impact to You

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

CAUTION – What You Need to Know

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

Medicare Payment for Preadministration-Related Services Associated with IVIG Administration—Payment Extended Through CY 2007, continued

GO – What You Need to Do

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

Background

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

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

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

- The policy and billing requirements concerning the IVIG preadministration-related services payment are the same in 2007 as they were in 2006.
- This IVIG pre-administration service payment is in addition to Medicare's payments to the physician or hospital for the IVIG product itself and for its administration by intravenous infusion.
- Medicare carriers, FIs, or A/B MACs will pay for these services, that are provided in a physician office, under the physician fee schedule; and FIs or A/B MACs will pay for them under the outpatient prospective payment system (OPPS), for hospitals subject to OPPS (bill types: 12x, 13x) or under current payment methodologies for all non-OPPS hospitals (bill types: 12x, 13x, 85x).
- You need to use HCPCS code G0332 -Preadministration-Related Services for intravenous infusion of immunoglobulin, (this service is to be billed in conjunction with administration of immunoglobulin) to bill for this service.
- You can bill for this only one IVIG preadministration per patient per day of IVIG administration.
- The service must be billed on the same claim form as the IVIG product (HCPCS codes J1566 (Injection, immune globulin, intravenous, lyophilized (E.G. powder), 500 mg) and/or J1567 (Injection, immune globulin, intravenous, non-lyophilized (E.G. liquid), 500 mg), and have the same date of service as the IVIG product and a drug administration service.
- Your claims for preadministration-related services will be returned/rejected by your FI, carrier, or A/B MAC if more than one unit of service of G0332 is indicated on the same claim for the same date of service. They will use the appropriate reason/remark code such as:
  - M80-"Not covered when performed during the same session/date as a previously processed service for the patient;"
  - B5-"Payment adjusted because coverage/program guidelines were not met or were exceeded;"
  - M67-"Missing other procedure codes;" and/or
  - 16-"Claim/service lacks information which is needed for adjudication."

Additional Information

You can find the official instruction, CR 5428, issued to your FI, carrier, or A/B MAC by visiting the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1140CP.pdf*.

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

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

MLN Matters Number: MM5428
Related Change Request (CR) Number: 5428
Related CR Release Date: December 22, 2006
Effective Date: January 1, 2007
Related CR Transmittal Number: R1140CP
Implementation Date: January 2, 2007

HIPAA - The Health Insurance Portability and Accountability Act

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

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

Provider Action Needed

CR 5346, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective January 2, 2007. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits transactions.

The remittance advice remark code list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at *http://wpc-edi.com/codes*. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5346, effective on and after January 1, 2007.

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

Additional Information

You may see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest remittance advice remark code and claim adjustment reason code updates by going to CR 5346, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1087CP.pdf* on the CMS website.

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

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

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

Remittance Advice Remark Code Changes

Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
N370	New	Billing exceeds the rental months covered/approved by the payer.	Medicare initiated
N371	New	Alert: title of this equipment must be transferred to the patient. *	Medicare initiated
N372	New	Only reasonable and necessary maintenance/service charges are covered.	Medicare initiated
MA02	Modified	If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.	Modified effective August 1, 2006
M114	Modified	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, contact your local contractor.	Modified effective August 1, 2006
N199	Modified	Additional payment/recoupment approved based on payer-initiated review/audit.	Modified effective August 1, 2006
There are no deactivated remittance advice remark code changes			

*NOTE: Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, in some cases another/other remark code(s), for an adjustment. Newly created informational codes

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

will have "Alert" in the text to identify them as informational rather than explanatory codes. For example, this informational code is sent per state regulation, but does not explain any adjustment:

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

These informational codes will be used only if specific information needs to be communicated but not as default codes

Reason Code Changes

Code	New/Modified/ Deactivated/Retired	Current Narrative	Comment
196	New	Claim/service denied based on prior payer's coverage determination	New as of June, 2006
16	Modified	Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective April 1, 2007: At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	Modified as of February, 2002 and June, 2006
17	Modified	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective April 1, 2007: At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	Modified as of February, 2002 and June, 2006
96	Modified	Non-covered charge(s). This change to be effective April 1, 2007: At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	Modified as of February, 2002 and June, 2006
125	Modified	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective April 1, 2007: At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	Modified as of February, 2002 and June, 2006
43	Retired	Gramm-Rudman reduction.	Modified as of June, 06, and deactivated on July 1, 2006

MLN Matters Number: MM5346
Related Change Request (CR) #: 5346
Related CR Release Date: October 27, 2006
Effective Date: January 1, 2007
Related CR Transmittal #: R1087CP
Implementation Date: January 2, 2007

GENERAL INFORMATION

Confirmation of Competitive Acquisition Program Participation

The regular 2007 Competitive Acquisition Program (CAP) physician election period concluded on December 1, 2006. Physicians who believe that they have elected to participate in the CAP, but have not been contacted by the approved CAP vendor should confirm their status to participate in the CAP with their local carrier (the carrier that processes the physician's Part B claims).

A link to carriers' contact information may be found in the Downloads section of the CAP information for physicians' Web page (*http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage*) under Medicare Carrier Addresses. Corresponding telephone numbers are also listed.

Source: CMS Learning Resource, Message 200612-11

Flu Shot Reminder

As a respected source of health care information, patients trust their doctors' recommendations. If you have Medicare patients who haven't yet received their flu shot, help protect them by recommending an annual influenza and a one-time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – **And don't forget to immunize yourself and your staff.**

Protect yourself, your patients, and your family and friends. – Get Your Flu Shot!

Remember: Influenza vaccination is a covered Medicare Part B benefit.

Note: Influenza vaccine is not a Medicare Part D covered drug.

For information about Medicare's coverage of adult immunizations and educational resources, go to CMS website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf*.

Source: CMS Provider Education Resource 200612-02

Just Five Months Remaining—National Provider Identifier Reminder

NPI: Get It. Share It. Use It.

Only five months remain until the NPI compliance date – are you ready to use your NPI? A recent survey of the health care industry, conducted by the Workgroup for Electronic Data Interchange (WEDI), indicates that providers should be moving from the enumeration stage into the implementation stage to ensure NPI readiness by the compliance date. Remember, it is estimated that it may take up to 120 days to complete the work needed in order to implement the NPI into your current business practices. The following steps will assist you in your preparation:

Enumerate: Have you applied for your NPI(s)?
Not only should individual providers (type 1) have enumerated, but organizations and subparts (type 2) should have enumerated also.

Update: Have you received your software application updates, upgrades and/or changes relevant to NPI?
Be sure that the updates not only addresses the HIPAA transactions, but includes the CMS-1500, UB-04 and/or dental claim form changes.

Communicate: Have you communicated your NPI(s) to your health plans and other organizations you work with? Keep in mind, as outlined in current regulation, all covered providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes – including designation of ordering or referring physician.

Collaborate: Do you know the readiness of your trading partners (such as health plans, TPAs, clearinghouses, etc...)?
It's important to work with your trading partners to know their readiness with NPI and how it impacts you.

Test: Have you started testing the NPI, both internally and externally?
Not only do you need to test the HIPAA transactions such as 837 laims, but if you process 835 remittance advice, be sure to test that your system can process the NPI appropriately. Also, if you submit paper claims, be sure that you've tested the data being printed in the correct fields.

Educate: Have you educated your staff on what the NPI is and the use of it?
It's important that staff that may be using the NPI in day-to-day work, such as verification of eligibility, or other tasks that may need the NPI, be aware of the NPI and the provider identifiers that it replaces. The staff may have to change policies and procedures.

Just Five Months Remaining—National Provider Identifier Reminder, continued

Implement: Have you implemented the NPI into your business practices?
Once testing is complete, changes will go into production. Prior to doing this, you'll need to make sure your trading partners are ready to process with the NPI only.

Given all the steps above, will you be ready by May 23, 2007?

Enumeration Advice for Incorporated Individual Providers

Health care providers who are individuals are eligible for an entity type 1 (individual) NPI. If these individuals incorporate themselves (i.e., if they form corporations) and the corporations are health care providers, the corporations are organization providers that are eligible for an entity type 2 (organization) NPI. If either of these health care providers (the individual or the corporation) are covered providers (i.e. providers that send electronic transactions) under HIPAA, the NPI final rule requires them to obtain NPIs.

Reminder to Supply Legacy Identifiers on NPI Application

CMS continues to urge providers to include legacy identifiers 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 consider going back into the NPPES and updating their information with their legacy identifiers if they did not include those identifiers when they applied for NPIs. This information is critical for health plans and health care clearinghouses in the development of crosswalks to aid in the transition to the NPI.

Common Testing Error Identified

Given recent testing experience, one common testing error found is that claims submitters check that they are submitting an NPI in the 2010AA Billing Provider REF02 segment instead of NM109. The REF segment is situational, but required if it is necessary to report a secondary ID, such as a legacy identifier and a taxpayer identification number. NM109 is where the NPI is to be submitted, but the claim submitter incorrectly submits a legacy identifier instead. Remember to make sure you correctly designate the type of identifier you are submitting to aid in crosswalk development during this testing phase.

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_lvl1=0&p_s.

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
- 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*.

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

Important Information for Medicare Providers

Requirement of Taxonomy Codes on Institutional 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 subparts are not required to use taxonomy codes on their claims to Medicare.

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

Reminder to Submit Claims with Your NPI and your Legacy Number

From October 1, 2006 through May 22, 2007 or until further notice, CMS recommends that Medicare providers submit claims using both the provider's NPI and legacy number or just the provider's legacy number.

Just Five Months Remaining—National Provider Identifier Reminder, continued

If claims are submitted with only an NPI:

- Claims for which Medicare systems are unable to properly match the incoming NPI with a legacy number may be rejected/returned as unprocessable to the provider.

The provider will then need to resubmit the claim with the appropriate legacy number.

Reminder of DME Supplier 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,"* **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 supplier may have.

Communicating NPIs to Medicare

Medicare providers should know that there is no "special process" or need to call to communicate NPIs to the Medicare program. NPIs can 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 enrollment information.

Still Confused?

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

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

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

Getting an NPI Is Free – Not Having One Can Be Costly

Source: CMS Provider Education Resource 200612-08

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

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

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

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

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

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

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

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

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

Additional Information

The official instruction issued to your Medicare contractor on this issue, CR 5378, is available on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R249OTN.pdf*.

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

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

MLN Matters Number: MM5378
Related Change Request (CR) Number: 5378
Related CR Release Date: November 13, 2006
Related CR Transmittal Number: R249OTN
Effective Date: October 1, 2006
Implementation Date: November 20, 2006

New Web-based Training Course for Professional Providers

Understanding the Remittance Advice for Professional Providers Web-based training (WBT) course is now available through the *Medicare Learning Network*. This WBT course is designed to provide professional providers and their billing staff with general remittance advice (RA) information. This course provides instructions to help professional providers interpret the RA received from Medicare and reconcile it against submitted claims. Course participants will receive guidance on how to read electronic remittance advices (ERAs) and standard paper remittance advices (SPRs). The course also provides an overview of software that Medicare provides free to providers for viewing ERAs.

The course takes approximately 90 minutes to complete and participants may receive .2 CEUs for successful completion. To register to take this WBT course participants can go to the *Medicare Learning Network*'s Product Ordering Page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* and click on the course title.

Source: CMS Learning Resource Message 200612-06

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

Private Contracting—Definition of Physician/Practitioner

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

Provider Types Affected

Registered dietitians or nutrition professionals providing services to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5426 which updates the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 15, Section 40.4) to include registered dietitians and nutrition professionals in the list of practitioners who can opt out of Medicare if certain conditions are met, and to provide services through private contracts that would otherwise be covered by Medicare.

Background

Prior to enactment of the Medicare Benefits Improvement and Protection Act of 2000 (BIPA), the Social Security Act (section 1802[b][5][C]) did not include registered dietitians or nutrition professionals among the list of practitioners who may choose to opt out of Medicare.

Private Contracting—Definition of Physician/Practitioner, continued

BIPA (section 105[d]) amended the definition of practitioner included in the Social Security Act (section 1842[b][18][c]) to include registered dietitians or nutrition professionals in the list of practitioners who can opt out of Medicare if certain conditions are met.

CR 5426 amends the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 15, Section 40.4 [Definition of Physician/Practitioner]) to include registered dietitians and nutrition professionals to be consistent with the Social Security Act (Section 1802[b][5][C]). The revised section 40.4 (Pub. 100-02, Chapter 15), which is attached to CR 5426.

Additional Information

The official instruction, CR 5426, issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R62BP.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: MM5426
Related CR Release Date: December 22, 2006
Related CR Transmittal #: R62BP
Related Change Request (CR) #: 5426
Effective Date: November 13, 2006
Implementation Date: April 2, 2007

Quick Reference Information: Medicare Immunization Billing Chart Available to Order

The *Quick Reference Information: Medicare Immunization Billing* chart is now available in hardcopy or as a download from the *Medicare Learning Network*. This two-sided laminated chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals quick information to assist with filing claims for influenza, pneumococcal polysaccharide (PPV), and hepatitis B (HBV) vaccines and their administration.

To download, view and print the chart go to *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf* or a hardcopy of the chart can be ordered through the *Medicare Learning Network* Product Ordering Page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

Source: CMS Learning Resource Message 200612-07

Revisions to Procedures to Establish Good Cause and Qualified Independent Contractor Jurisdictions

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

Provider Types Affected

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

Background

The purpose of CR 5386 is to notify providers and suppliers of the restructured **Part B/DME Qualified Independent Contractor (QIC)** jurisdictions. Under the new jurisdictions, three QICs will process reconsiderations as follows:

- Two QICs will process reconsiderations of carrier and A/B MAC re-determinations effective November 15, 2006 for contractors that process claims in the North jurisdiction and January 1, 2007 for contractors that process claims in the South jurisdiction. Your contractor will reference the appropriate QIC in the Medicare Redetermination Notice (MRN). In order to expedite your request for appeal, please make sure you follow the instructions on your MRN regarding where to submit your request for reconsideration. If you have already submitted a reconsideration request with the incumbent QIC, please do not submit a duplicate request; and
- The third QIC will process all reconsiderations of DMERC and DME MAC re-determinations effective December 1, 2006.

Key Points

- Your contractor will reference the appropriate QIC with jurisdiction in the redetermination letter.
- One QIC will process all reconsiderations of DME claims.

Revisions to Procedures to Establish Good Cause and Qualified Independent Contractor Jurisdictions, continued

- There are two QIC jurisdictions for Part B claims: a North jurisdiction and a South jurisdiction.
- The North QIC jurisdiction includes the following states: Alaska, Arizona, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, District of Columbia, New York, Pennsylvania, New Jersey, Delaware, Maryland, Ohio, Kentucky, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Missouri, Iowa, Washington, Oregon, Nevada, Idaho, Wyoming, Montana, California, Utah, Kansas, Nebraska, North Dakota, South Dakota, Hawaii, American Samoa, Guam, and the Northern Marianas Islands.
- The South QIC jurisdiction is comprised of the following states: Colorado, Connecticut, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, Florida, North Carolina, South Carolina, Virginia, West Virginia, Puerto Rico, and Virgin Islands.

Additional Information

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

The 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 5386) issued to your Medicare A/B MAC, FI, carrier, RHHI, DMERC or DME MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1136CP.pdf* on the CMS website.

For additional supporting information that details the general appeals process in initial determinations please see MLN Matters article MM4019 at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4019.pdf* on the CMS website.

MLN Matters article MM3530, which may be found at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3530.pdf* on the CMS website, provides a detailed explanation of the term "vacate a dismissal" as well as more background information about the second level of appeals process for Medicare Part A and Part B claims called "reconsiderations."

MLN Matters Number: MM5386	Related Change Request (CR) #: 5386
Related CR Release Date: December 22, 2006	Effective Date: January 1, 2007
Related CR Transmittal #: R1136CP	Implementation Date: April 2, 2007

2007 Medicare Contractor Provider Satisfaction Survey (MCPSS)

The Medicare Contractor Provider Satisfaction Survey (MCPSS) is one of the tools CMS will use to measure satisfaction levels with the services provided by Medicare fee-for-service contractors. This annual survey was first implemented in 2006, and Westat, a survey research firm contracted by the Centers for Medicare & Medicaid Services (CMS), administers it.

What's New…

The 2007 MCPSS will be distributed to a new sample of Medicare providers beginning in January. Randomly selected providers will have an opportunity to rate FCSO's performance and tell us how we are doing in our interactions with you.

FCSO urges all Medicare providers who are selected to participate to complete and return their surveys according to the instructions provided. We know your time is valuable and appreciate your willingness to participate. The information you provide will remain confidential.

Remember, Your Feedback Is Very Important…

FCSO takes your feedback very seriously. Verbatim comments from the 2006 survey have been carefully reviewed and we are already making improvements to our processes and services based on your feedback.

Where Can I Get More Information?

If you have questions about the MCPSS and would like to speak to a representative from Westat, please contact: The **MCPSS Provider Helpline at 1-888-863-3561** or visit Westat MCPSS home study Web page at *https://www.mcpsstudy.org/default.asp*.

Additional information about the MCPSS is available on the CMS website at *http://www.cms.hhs.gov/MCPSS/*.

Source: CMS Joint Signature Memorandum 07009, October 16, 2006

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.

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. CR5459 amends those payment files.

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/R1143CP.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 ASP amounts will be reflected in updated 2007 ASP pricing files to be posted to the CMS web site.
- 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.

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

- 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/R1143CP.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	Related Change Request (CR) Number: 5459
Related CR Release Date: December 22, 2006	Effective Date: January 1, 2007
Related CR Transmittal Number: R1143CP	Implementation Date: January 2, 2007

2007 Physician Fee Schedule Payment Policies

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, fiscal intermediaries (FI) and A/B MACs for services, including ambulance and telehealth services.

What you Need to Know

CR 5443, from which this article was taken: 1) Summarizes significant issues contained in the Medicare physician fee schedule regulation for 2007 (including publishing the ambulance inflation factor (AIF) for CY 2007); and 2) Announces the telehealth originating site facility fee for 2007. CR 5443 also discusses several provisions of the recently-enacted Tax Relief and Health Care Act of 2006. You should refer to the **Background** and **Additional Information** sections, below, for more details and information on how to find the background/reference documents.

Background

Tax Relief and Health Care Act of 2006

The Tax Relief and Health Care Act of 2006 set the 2007 conversion factor for physician payment at the same level as in 2006 ($37.8975), reversing the statutorily mandated 5.0 percent negative update. However, it does not maintain 2007 physician payments at 2006 levels. There are a number of other factors that affect payment rates for 2007 and this article discusses several of those factors. The legislation also extends the 1.0 floor on work geographic practice cost indices (GPCIs) through December 31, 2007. Practice expense GPCIs and malpractice GPCIs are not affected by this provision.

Section 202 of this act mandates that Medicare Part B will cover, for 2007 only, the administration of vaccines that are covered under Part D of Medicare. A new G code (G0377) has been created for the administration of Part D vaccines and payment for G0377 will be crosswalked to *CPT* code *90471* for one year. When a physician administers a Part D vaccine, the physician should use 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 the administration. Payment for Part D covered vaccines is made solely by the participating prescription drug plan. Medicare Part B will not pay for the vaccine itself.

Medicare Physician Fee Schedule Regulation for 2007

Section 1848(b)(1) of the Social Security Act requires the Centers for Medicare and Medicaid Services (CMS) to establish (by regulation, before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year.

Accordingly, on November 1, 2006, the Centers for Medicare & Medicaid Services (CMS) released the Medicare physician fee schedule (MPFS) final rule for calendar year 2007. In this rule (effective January 1, 2007) Medicare:

- Will increase physician payment for the time spent talking with Medicare beneficiaries about their health care. The 2007 final rule significantly increases the relative value unit (RVU) work component for the face-to-face visits (evaluation and management or "E&M services"), during which the physician and patient discuss the patient's health status and the steps that can be taken to maintain or improve the patient's health.

2007 Physician Fee Schedule Payment Policies, continued

- Adopts work values for *CPT* codes *97802, 97803, 97804*, G0270, and G0271.
- Expands its preventive services benefits to include:
    - Adding a one-time preventive ultrasound screening for abdominal aortic aneurysms (AAA), for at risk beneficiaries, **only available** as part of the initial preventive physical examination (also referred to as the welcome to Medicare physical).
    - Insuring more accurate and reliable bone mass measurements are performed for Medicare beneficiaries.
    - Exempting the colorectal cancer screening benefit from the Part B deductible.
- Adjusts the methodology for determining practice expense (such as office overhead) RVUs. As part of the methodology, CMS will use a bottom-up methodology for direct costs, use supplementary survey data for indirect costs, and eliminate the nonphysician workpool. This methodology (to be phased over a four-year period), will be more transparent than the existing methodology, allowing specialties and other stakeholders to predict the effects of proposals to improve accuracy of practice expense payments.
- Adds diabetes outpatient self-management training and medical nutrition therapy services to the list of covered and separately payable services included in the federally qualified health center benefit, making these services more available to beneficiaries in both rural and urban underserved areas.
- Caps payment rates for imaging services under the physician fee schedule at the amount paid for the same services when performed in hospital outpatient departments; includes a list of codes to which the outpatient prospective payment system (OPPS) cap would apply; and reduces the payment for certain multiple imaging procedures on contiguous body parts by 25 percent after full payment for the first procedure.

Note: CMS will apply the multiple imaging reductions first, followed by the OPPS imaging cap, if applicable.

The final rule also:

- Finalizes drug manufacturer reporting requirements and addresses a number of technical average sales price (ASP) issues such as the treatment of *bona fide* service fees in the context of the ASP calculation and the definition of nominal sales;
- Codifies the public consultation process for developing payment amounts for new clinical laboratory tests.
- Adopts supplier standards for independent diagnostic testing facilities (IDTFs).
- Continues the temporary intravenous immune globulin preadministration-related services fee into 2007.
- Addresses the final regulations affecting ambulance payment policy under the ambulance fee schedule, which will improve the accuracy of payments for ambulance services and incorporate changes in geographic adjustments based on the most recent census data.
- Announces an ambulance inflation factor (AIF) for CY 2007 of 4.3 percent, and further 1) Clarifies the designation of areas as urban or rural to incorporate changes made by the Office of Management and Budget to the Metropolitan Statistical Areas (MSAs); 2) Replaces the Goldsmith modification (identifying rural census tracts within MSAs) with the most recent version based on rural urban commuting areas; and 3) Discontinues formal annual reviews of "low billers" and air ambulances to determine whether adjustments are needed in the ambulance fee schedule conversion factors.
- Includes a discussion of exceptions to the therapy cap for CY 2006 and 2007 and announces that the 2007 therapy cap is $1,780. (Note that Section 201 of the Tax Relief and Health Care Act of 2006 extended the exceptions process until December 31, 2007.)
- Amends the reassignment of payment regulations to state that an individual supplier furnishing a service has unrestricted access to the billings submitted by the entity receiving Medicare payment for services furnished by that supplier, irrespective of whether the supplier is an employee or independent contractor.
- Announces that the drug add-on adjustment to the end-stage renal diseased (ESRD) composite payment rate for 2007 will increase from 14.5 percent to 15.1 percent.

Lastly, the final rule addresses comments received on the separate notice published June 29, 2006 (Five Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology [CMS-1521-PN]), which is contained in an attachment to CR 5443. Further discussion of the above-summarized items is in that same attachment to CR 5443.

Telehealth originating site facility fee for 2007

Section 1834(m) of the Social Security Act established the Medicare telehealth originating site facility fee payment amount for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare economic index (MEI).

2007 Physician Fee Schedule Payment Policies, continued

The MEI increase for 2007 is 2.1 percent. Thus for calendar year 2007, the payment amount for HCPCS code "Q3014, telehealth originating site facility fee" is 80 percent of the lesser of the actual charge, or $22.94.

Note: The beneficiary is responsible for any unmet deductible amount or coinsurance.

The Medicare telehealth originating site facility fee and MEI increase by applicable time period is shown in the table below.

Medicare Telehealth Originating site Facility Fee and MEI by Time Period

Facility Fee	MEI	Time Period
$20.00	N/A	October 01, 2001 – December 31, 2002
$20.60	3.0%	January 1, 2003 – December, 31, 2003
$21.20	2.9%	January 1, 2004 – December, 31, 2004
$21.86	3.1%	January 1, 2005 – December, 31, 2005
$22.47	2.8%	January 1, 2006 – December, 31, 2006
$22.94	2.1%	January 1, 2007 – December, 31, 2007

Additional Information

You can find more information about the 2007 Physician Fee Schedule Payment Policies by going to CR 5443, located on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R258OTN.pdf*.

Please see, as an attachment to that CR, a document entitled Revisions to Payment Policies and Five-Year Review of Work Relative Value Units Under the Physician Fee Schedules for CY 2007, and Other Changes to Payment Under Part B; Revisions to the Payment Policies of Ambulance Services Under the Fee Schedule for Ambulance Services; Ambulance Inflation Factor Update for CY 2007, for more details on the significant issues discussed in the final rule. You can find the November 1, 2006 CMS press release entitled MEDICARE ANNOUNCES FINAL RULE SETTING PHYSICIAN PAYMENT RATES AND POLICIES FOR 2007, by going to *http://cms.hhs.gov/apps/media/press/release.asp?Counter=2044*; and other information about the physician fee schedule by going to the CMS Physician Center Website at *http://cms.hhs.gov/center/physician.asp*.

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

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

MLN Matters Number: MM5443
Related Change Request (CR) Number: 5443
Related CR Release Date: December 22, 2006
Effective Date: January 1, 2007
Related CR Transmittal Number: R258OTN
Implementation Date: January 2, 2007

Sign up to our *eNews* electronic mailing list

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

Medicare Fee-for-Service and Medicare Advantage Eligibility System Issues

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

Provider Types Affected

Physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Provider Action Needed

Be aware that Medicare reverses fee-for-service (FFS) payments when Medicare Advantage (MA) enrollments with retroactive dates are processed by CMS systems. Also know what action to take when there are conflicts in CMS eligibility data.

Background

In some cases, MA enrollments with retroactive dates are processed by CMS systems. The result is that Medicare may pay for the services rendered twice; once under fee-for-service and second by the MA payment systems in the monthly capitation rate to the plan.

The FFS contractor reverses the FFS payment, recovers from the provider, and the provider then bills the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the Medicare FFS rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary.

FFS Claims Paid in Error

Due to CMS beneficiary eligibility system updates, beneficiaries enrolled in MA organizations may be identified as having been inappropriately paid on a FFS basis. FIs, carriers, and A/B MACs will adjust these claims and seek overpayments. Where such an overpayment is recovered from a provider, the related remittance advice for the claim adjustment will indicate reason code 24, which states: 'Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan'.

Whenever CMS reverses FFS payments as a result of confirmed retroactive enrollment in an MA plan, the provider must bill the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the FFS rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary.

Information on which plan to contact can be determined through an eligibility inquiry or by contacting the beneficiary directly. To associate plan identification numbers with the plan name, go to *http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage* on the CMS website.

The Medicare beneficiary call center representatives at 1-800-MEDICARE have been trained to answer beneficiary inquiries that may arise in these situations."

Eligibility Data Discrepancies: Provider Action

Despite system corrections, there remains a small number (under 1000) of beneficiary eligibility records that have not been updated. CMS is working to correct this. In the interim, if a provider has information from the MA plan that conflicts with information received from an FI, carrier, or A/B MAC in reply to an eligibility inquiry, the provider should call the FI/carrier/MAC provider call center.

The call center representative will check Medicare's Common Working File System and if the conflict is confirmed the provider will be referred to the CMS regional office for resolution.

Additional Information

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

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

MLN Matters Number: SE0681
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

Laboratory Competitive Bidding Demonstration

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 November 27, and December 19, 2006, to specify that the only hospital were those billing with type of bill (TOB) 14x, and to specify that to be terminated, the $100,000 annual ceiling for passive laboratories must be exceeded by $25,000 or more. All other information remains the same. The *MLN Matters* article MM5359 was published in the December 2006 *Medicare B Update!* (pages 45-47).

Provider Types Affected

Physicians and hospitals (TOB 14x only) who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites.

Background

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

Under this statute, Pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

Key Points

This article and CR 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this article and CR 5359 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the ZIP code of the beneficiary's residence.
- Hospital inpatient testing is covered by Medicare Part A and is therefore **exempt** from the demonstration.
- Physician office laboratory (POL) testing and hospital outpatient testing **are not included in the demonstration**, **except** where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.
- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

Required Bidders

Laboratory firms with $100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for "demonstration tests" provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration.

These laboratory firms will be referred to as "required bidders."

Passive Laboratories

Small laboratories or laboratory firms with less than $100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will **not be required** to bid in the demonstration. These laboratories are considered "passive" laboratories." Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of $100,000.

Passive laboratory firms exceeding the annual ceiling of $100,000 by 25,000 or more will be:

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.
- **Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end-stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considers "passive-ESRD" laboratories.** Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration tests provided to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007 through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

Laboratory Competitive Bidding Demonstration, continued

Winners

Both required and non-required bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled "winners."

Nonwinners

Both required and non-required bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled "nonwinners."

Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Nonwinner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, nonwinner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

Although nonwinner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Demonstration Sites

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses metropolitan statistical areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's ZIP code of residence.

CMS will provide the contractors with a list of ZIP codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of Pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Implementation

CR 5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

During the first quarter of 2007, CMS will provide Medicare carriers, FIs, and A/B MACs with a national ZIP code pricing file identifying the ZIP codes included in the first CBA. Also, in that same timeframe, CMS will provide to the carriers, FIs, and A/B MACs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

Claims submitted by nonwinner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code 96 (noncovered charges)
- Remark code M114 (*This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.*)
- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Using these same reason and remark codes, Medicare will reject any laboratory claims with a date of service between April 1, 2007, and March 31, 2010 with a modifier of "90" submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA, regardless of the referring laboratory's participation status.

Medicare will pay claims during the demonstration period submitted by nondemonstration laboratories for beneficiaries residing in the CBA who receive services outside of those areas (e.g., "snow birds") according to the laboratory competitive bidding demonstration.

Nonwinning laboratories should know that advance beneficiary notices (ABNs) and notices of beneficiary exclusion from Medicare benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at nonwinner laboratories.

Laboratory Competitive Bidding Demonstration, continued

Line items for demonstration services and for nondemonstration services may be submitted on the same claim.

A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

Medicare contractors will be prepared to begin processing claims under the laboratory competitive bidding demonstration in the first CBA on April 1, 2007. The tentative start date for the demonstration in the second CBA is April 1, 2008.

Remember: Required and non-required bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

Implementation

The implementation date for this instruction is April 2, 2007.

Additional Information

The official instructions issued to your Medicare carrier, FI, or A/B MAC regarding this change may be found on the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R50DEMO.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: MM5359 – *Revised*
Related Change Request (CR) Number: 5359
Related CR Release Date: November 1, 2006
Related CR Transmittal Number: R50DEMO
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Disclaimer 1. – Please note that the demonstration design described in transmittal # R49DEMO, which provides instructions to Medicare contractors for the implementation of a CMS laboratory competitive bidding demonstration, is a proposed design and has not yet received final approval from the Office of Management and Budget.

Disclaimer 2 – This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

General Medical Review

Articles in this section apply to both Florida and Connecticut.

Correct Billing of HCPCS Code L8680

Correct billing of HCPCS code L8680 (Implantable neurostimulator electrode, each) and "extensions" when billing *CPT* code *63685* (*insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*)

Providers are billing HCPCS code L8680 incorrectly. In the units billed field, the provider should bill the total number of electrodes supplied and not bill HCPCS code L8680 on separate detail lines for each electrode. Billing HCPCS code L8680 on separate detail lines results in unnecessary duplicate denials.

In addition, providers should not bill HCPCS code L8699 for "extensions" when billing *CPT* code *63685*. The "extensions" are bundled in the *63685* procedure.

Note: Ambulatory surgical centers (ASCs) should bill supplies without the SG modifier.

Independent Diagnostic Testing Facilities (IDTFs)—Specialty Manual Revision

The Independent Diagnostic Testing Facilities (IDTFs) Specialty Manual was last revised on November 28, 2006. Since that time, the manual has been revised to include the annual 2007 hCPCS Updates, which include the following:

Deleted Codes	Replacement Codes	Deleted Codes	Replacement Codes
76003	*77002*	*76090*	*77055*
76005	*77003*	*76091*	*77056*
76006	*77071*	*76092*	*77057*
76020	*77072*	*76093*	*77058*
76040	*77073*	*76094*	*77059*
76061	*77074*	*76095*	*77031*
76062	*77075*	*76096*	*77032*
76065	*77076*	*76360*	*77012*
76066	*77077*	*76370*	*77014*
76070	*77078*	*76393*	*77021*
76071	*77079*	*76400*	*77084*
76075	*77080*	*76778*	*76776*
76076	*77081*	*78704*	
76077	*77082*	*78715*	
76078	*77083*	*78760*	
76082	*77051*	*91060*	
76083	*77052*	*92573*	
76086	*77053*	*95078*	
76088	*77054*		

Also, *CPT* codes *76813* and *76814* have been added to the IDTF Manual.

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

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

Effective Date

This revision is effective for services rendered on or after **January 1, 2007**. The full-text of the FCSO Medicare Guidelines for Independent Diagnostic Testing Facilities Specialty Manual may be viewed on the provider education website at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* on or after this effective date.

Intravitreal Bevacizumab (Avastin®) for Neovascular Age-Related Macular Degeneration—Update

This information was previously posted June 13, 2006 at http://www.connecticutmedicare.com and http://www.floridamedicare.com

NOTE: The filing of Avastin claims has changed. Please enter "Intravitreal bevacizumab" and the dose given in Item 19 of CMS-1500 Form or its electronic equivalent. The applicable ICD-9-CM code is 362.52 (exudative senile macular degeneration of retina). FCSO will no longer routinely request medical records as part of the adjudication of these claims effective for claims processed on or after December 19, 2006.

Bevacizumab, FDA-approved for intravenous use in combination with intravenous 5-fluorouracil-based chemotherapy, is indicated for first-line treatment of patients with metastatic carcinoma of the colon or rectum. The United States Pharmacopeia (USP) supports one unlabeled indication: advanced/metastatic non-squamous non-small cell lung cancer.

Early observations indicate that bevacizumab may be useful in the treatment of age-related macular degeneration (AMD). Ophthalmologists have been using intravitreal bevacizumab increasingly in the treatment of wet AMD.

HCPCS code J9035 (Injection, bevacizumab, 10 mg) does not apply to the intravitreal administration, as a pharmacist has processed the agent. Providers billing for intravitreal bevacizumab should use *CPT* code *67028* for the intravitreal injection and HCPCS code J3490 (unclassified drugs) for the bevacizumab. Please enter "Intravitreal bevacizumab" in Item 19 of CMS-1500 Form or its electronic equivalent. The applicable ICD-9-CM code is 362.52 (exudative senile macular degeneration of retina). Documentation in the medical record must support the following:

- The diagnosis of wet AMD (ICD-9-CM code 362.52) with leakage/fluid in the macula has been confirmed by optical coherence tomography (OCT) or fluorescein angiography.
- Actual dose administered in milligrams.

Providers should not submit this information with the claim. First Coast Service Options, Inc. (FCSO) may request it separately with an additional documentation request (ADR) letter.

When billing Part B Medicare, the intravitreal injection and the drug injected should be billed on the same claim. Remember to use the appropriate modifiers when performing the service on both eyes.

- Please enter "Intravitreal bevacizumab" and the dose given in Item 19 of CMS-1500 Form or its electronic equivalent.
- The applicable ICD-9-CM code is 362.52 (exudative senile macular degeneration of retina).

Anytime there is a question whether Medicare's medical reasonableness and necessity criteria would be met; we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed HCPCS codes. If and when a denial should be received, providers may collect from the beneficiary based on the fee schedule. The GA modifier should be billed with *67028* and J3490. For further details about CMS' Beneficiary Notices Initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*.

SG Modifier, ASCs and Physicians

As a result of providers using the SG modifier incorrectly, claims may be rejected or paid incorrectly.

When filing surgical procedures rendered in an ambulatory surgical center (ASC), ASC providers are required to append the SG modifier to the surgical procedure *CPT* code(s). This modifier indicates the charge is for the ASC facility service and is used to determine the appropriate reimbursement rate for the ASC. Failure to use the SG modifier by the ASC will result in reduced payment amounts and additional paperwork to correct the situation.

SG modifier should be used:

- in addition to any other modifiers that may be applicable
- with surgical procedures only.

SG modifier should **not** be used:

- with supply codes billed by the ASC as the reimbursement (supplies are not affected by the ASC payment groups)
- by physicians performing services in the ASC setting.

Vitagel™ Surgical Hemostat

Vitagel™ Surgical Hemostat is approved by the Food and Drug Administration (FDA) for use to control bleeding and facilitate healing while utilizing the patient's own biology. It is composed of microfibrillar collagen and thrombin in combination with the patient's own plasma. This unique combination of components produces a homeostasis by forming a collagen/fibrin scaffold with platelets. It has been shown to be effective in controlling bleeding during orthopedic, cardiac, hepatic and general surgical procedures.

Recently, providers may have received instructions that may result in the incorrect billing of Vitagel™ Surgical Hemostat using *CPT* code *20926* (*Tissue grafts, other [eg, paratenon, fat, dermis*]). Hemostasis is considered to be an integral part of any surgical procedure. Therefore, Vitagel™ Surgical Hemostat is not separately payable by the carrier and should not be billed using *CPT* code *20926*.

90802: Interactive Psychiatric Services—New LCD

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*.

Effective Date

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

Sign up to our *eNews* electronic mailing list

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

Medical Review Table of Contents

Advance Notice Statement

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

REVISIONS TO LCDS

Botulinum Toxins—LCD Revision

The local coverage determination (LCD) for botulinum toxins was last revised on November 30, 2006. Since that time, the LCD has been revised based on the 2007 annual ICD-9-CM update. The "ICD-9 Codes that Support Medical Necessity" section of the LCD for procedure code J0585 has been revised to add ICD-9-CM code 333.79 (Other acquired torsion dystonia).

Effective Date

This revision is effective for claims processed on or after December 22, 2006 for services rendered on or after October 1, 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.

J9000: Antineoplastic Drugs—LCD Revision

The local coverage determination (LCD) for antineoplastic drugs was last updated on October 30, 2006. Since that time, revisions were made to add additional ICD-9-CM codes and indications, as well as update verbiage based on the Food and Drug Administration (FDA) label where applicable for the following drugs:

Docetaxel (J9170)

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following FDA-approved indication was added:

- Docetaxel in combination with cisplatin and fluorouracil is indicated for the induction treatment of patients with inoperable locally advanced squamous cell carcinoma of the head and neck.

Under the "ICD-9 Codes that Support Medical Necessity" section, the following diagnoses were added:

173.0 Other malignant neoplasm of skin of lip

173.1 Other malignant neoplasm of skin, eyelid, including canthus

173.2 Other malignant neoplasm of skin of ear and external auditory canal

173.3 Other malignant neoplasm of skin of other and unspecified parts of face

173.4 Other malignant neoplasm of skin, scalp and skin of neck

This revision is effective for claims processed on or after December 19, 2006,,for services rendered on or after October 17, 2006.

Rituximab (J9310)

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following off-label indication was added:

- For the treatment of refractory thrombotic thrombocytopenic purpura (TTP) for patients who do not respond to plasmapheresis.

Under the "ICD-9 Codes that Support Medical Necessity" section, the following diagnosis was added:

446.6 Thrombotic microangiopathy [use this code for refractory thrombotic thrombocytopenic purpura (TTP)]

This revision is effective for services rendered on or after December 19, 2006.

Trastuzumab (J9355)

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following FDA approved indication was added:

- Trastuzumab, as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel, is indicated for the adjuvant treatment of patients with HER2-overexpressing, node-positive breast cancer.

This revision is effective for services rendered on or after November 16, 2006.

The full text of this LCD is available through our provider education website at *http://www.connecticutmedicare.com* on or after these effective dates.

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised on January 1, 2007. Since that time the LCD has been revised. First Coast Service Options, Inc. (FCSO) placed unlisted procedure code *53899* for RENESSA™ (system for stress urinary incontinence) on the list of noncovered services, a procedure for female stress urinary incontinence (SUI). The RENESSA™ procedure is indicated for the transurethral treatment of SUI due to hyper mobility in women who have failed conservative treatment and who are not candidates for surgical therapy. The RENESSA system is a nonsurgical, in-office treatment and can be performed with local anesthesia or oral sedation or it can be performed under conscious sedation.

This revised LCD was published for notice and comment from September 19, 2006 through November 11, 2006. After reviewing comments submitted, FCSO has made a decision to leave RENESSA on the noncovered list as investigational and not medically necessary. FCSO recognizes RENESSA as an emerging technology with promising data. However, the number of randomized, controlled studies, especially addressing the Medicare population, are minimal to date. When specific coding evolves that better defines the RENESSA procedure (such as a category I or III code) and when additional data is published, Florida Medicare will consider evaluation on an individual consideration basis.

Effective Date

This revised LCD will be 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.connecticutmedicare.com* on or after this effective date.

76070: Bone Mineral Density Studies—LCD Revision

The local coverage determination (LCD) for bone mineral density studies was last revised on April 11, 2006. Since that time, the LCD has been revised to delete reference to ICD-9-CM code E932.0 (Adrenal cortical steroids causing adverse effects in therapeutic use) in the "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-9 Codes that Support Medical Necessity" sections of the LCD as this code is intended to provide supplementary classification and is not mandatory for billing purposes.

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.

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

The local coverage determination (LCD) for computed tomography (CT) of the abdomen *74150* was last revised on June 7, 2005. The local coverage determination (LCD) for computed tomography (CT) of the pelvis *72192* was last revised on October 1, 2006. Since that time, it was determined that the LCDs for CT of the pelvis and CT of the abdomen would be combined. As a result, a major revision was done to combine these LCDs and the contractor's determination number was changed to *72192* (computed tomography of the abdomen and pelvis). National coverage information is italicized on the LCD. The combined computed tomography of the abdomen and pelvis LCD was presented at the October 3, 2006 Carrier Advisory Committee (CAC) meeting and the following changes were made:

- ICD-9-CM codes have been removed from the LCD
- Indications and Limitations of Coverage/Medical Necessity and Documentation Requirements sections have been revised accordingly.

Effective Date

This LCD revision will be 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.connecticutmedicare.com* on or after this effective date.

97001: Physical Medicine and Rehabilitation—LCD and Coding Guideline Revision

This local coverage determination (LCD) was last updated on May 10, 2006 for services performed on or after January 1, 2006. Since that time, the LCD has been revised. Revisions were made to the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of this LCD based on instructions communicated through change request (CR) 5271, transmittals 60, 171 and 1106 dated November 9, 2006. These revisions clarify language pertaining to outpatient therapy CAPS. The coding guideline was revised accordingly, also based on CR 5271.

This revision is effective for services rendered on or after December 9, 2006.

In addition to the above revisions to the LCD and coding guideline, the coding guideline was also modified to include revised language communicated through CR 5253. The revised language encompasses instructions for billing timed and untimed codes, counting minutes for timed codes in 15-minute units and specific limits for HCPCS.

This revision is effective for claims processed on or after January 2, 2007, 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.

ADDITIONAL INFORMATION

99199—Draft LCD for End Diastolic Pneumatic Compression Therapy (Circulator Boot) Not Finalized

A draft local coverage determination (LCD) for procedure code *99199* (*Unlisted special service, procedure or report*) for end-diastolic pneumatic compression therapy (circulator boot) was developed by Medicare and presented to the Connecticut Carrier Advisory Committee (CAC) on October 3, 2006. This draft LCD was developed as a result of an evaluation of the end-diastolic pneumatic compression therapy (circulator noot) device, which was requested by a beneficiary.

There is a national coverage determination (NCD) for durable medical equipment (DME) for pneumatic compression devices with coverage for lymphedema and chronic venous insufficiency with venous stasis ulcers. This draft LCD was presented to the CAC to address utilization in the physician's office, however, because there were limited well controlled studies, and the consensus of the advisory committee was to consider noncoverage in the physician's office, First Coast Service Options (FCSO) has elected not to finalize this LCD at this time. Vasopneumatic devices do have some coverage under the therapy and rehabilitation services LCD, but must meet the physical therapy plan of care.

2007 HCPCS Local Coverage Determination Changes

Connecticut Medicare has revised local coverage determinations (LCDs) impacted by the 2007 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

LCD Title	Changes
APBI Accelerated Partial Breast Irradiation **(Coding Guidelines only)**	Deleted procedure code *76370* Added procedure code *77014*
G0104 Colorectal Cancer Screening	Deleted procedure code G0107 Added procedure code *82270*
NCSVCS The List of Medicare Noncovered Services	Deleted procedure code *0091T*, 0094T*, 0097T*, and 0120T** from the Local Noncoverage Decisions section of the LCD (* investigational) Added procedure codes *22857*, 22865*, 22862*, 19105*, 22526*, 22527*, 0162T*, 0163T*, 0164T*, 0165T*, 0168T, 0173T, 0174T, 0175T, 0176T,* and *0177T*, to the Local Noncoverage Decisions section of the LCD Descriptor change for procedure codes *0090T**, *0093T**, and *0096T** in the Local Noncoverage Decisions section of the LCD
RETISERT Retisert (fluocinolone acetonide intravitreal implant)	Changed procedure code J3490 to J7311 Changed Contractor's Determination Number to J7311

2007 HCPCS Local Coverage Determination Changes, continued

LCD Title	Changes
SKINSUB Skin Substitutes	Deleted procedure codes *15000* and *15001* Added procedure codes *15002*, *15003*, *15004*, and *15005*
VISCO Viscosupplementation Therapy For Knee	Deleted procedure codes J7317 and J7320 Added procedure code J7319
0145T Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries	Descriptor change for procedure code *71275*
17304 Mohs Micrographic Surgery (MMS)	Deleted procedure codes *17304*, *17305*, *17306*, *17307*, and *17310* Added procedure code *17311*, *17312*, *17313*, *17314*, and *17315* Changed contractor's determination number to 17311
22523 Kyphoplasty	Deleted procedure codes *76012* and *76013* Added procedure codes *72291* and *72292*
27096 Sacroiliac Joint Injection **(Coding Guidelines only)**	Deleted procedure code *76005* Added procedure code *77003*
76070 Bone Mineral Density Studies	Deleted procedure codes *76070*, *76071*, *76075*, *76076*, *76077*, and *76078* Added procedure codes *77078*, *77079*, *77080*, *77081*, *77082*, and *77083* Changed Contractor's Determination Number to *77078*
88104 Cytopathology	Descriptor change for procedure codes *88106* and *88107*
91110 Wireless Capsule Endoscopy	Added procedure code *91111*
92499 Computerized Corneal Topography	Changed procedure code *92499* to *92025* Changed contractor's determination number to 92025

Self-Administered Drug (SAD) List

The Center for Medicare and Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Providers may read the instructions in their entirety in the CMS *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered on or after January 19, 2007, the following drug has been added to the Self-Administered Drug (SAD) List.

J3490 Exenatide injection (Byetta®) 5 mcg, 10 mcg

The evaluation of drugs for addition to the SAD list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs. The SAD list may be viewed in its entirety at *http://www.connecticut.medicare.com*.

CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

January 2007 – March 2007

NPI CMS Module 5 – Medicare Implementation

When: January 18, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

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

When: January 24, 2007
Time: 10:30 a.m. – 12:00 p.m.
Type of Event: Teleconference

Ask the Contractor Teleconference (ACT) – New providers/billers offering helpful tips and resources followed by a question and answer period

When: February 7, 2007
Time: 12:00 p.m. – 1:00 p.m.
Type of Event: Teleconference

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

When: March 14, 2007
Time: 1:00 p.m. – 2:30 p.m.
Type of Event: Teleconference

For membership information, visit the POE AG Web page on *http://www.connecticutmedicare.com*. For those without internet access call the Education Hot Line (203) 639-5527.

More events will be planned soon for this quarter. Keep checking our website, *http://www.connecticutmedicare.com*, or listening to information on the FCSO Provider Education Registration Hotline, 1-203-634-5527, for details and newly scheduled events!

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, Zip Code: _____

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

Medical Review Table of Contents

Advance Notice Statement

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

NEW LCDs

92541: Vestibular Function Tests—New LCD

Vestibular function tests are tests of function. The vestibuloocular reflex (VOR) forms the basis for many of the clinical tests used to evaluate balance function. The vestibular system controls reflexes that maintain stable vision and posture. Vestibular tests are used to determine potential causes of balance disturbances. These tests help to determine if there is a problem with the vestibular portion of the brainstem and inner ear. The balance system depends on the inner ear, the eyes and the muscles and joints to send information related to the body's movement and orientation in space. When there are problems with the inner ear or other parts of the balance system, the patient may present with symptoms of vertigo, dizziness, imbalance or other symptoms.

This new local coverage determination (LCD) was developed based on data analysis. This LCD incorporates indications and limitations, documentation guidelines, utilization guidelines, ICD-9-CM codes that support medical necessity and a coding guideline for procedure codes *92541, 92542, 92543, 92544, 92545, 92546* and *92547*.

Effective Date

This new LCD will be 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

Botulinum Toxins—LCD Revision

The local coverage determination (LCD) for botulinum toxins was last revised on November 30, 2006. Since that time, the LCD has been revised based on the 2007 annual ICD-9-CM update. The "ICD-9 Codes that Support Medical Necessity" section of the LCD for procedure code J0585 has been revised to add ICD-9-CM code 333.79 (Other acquired torsion dystonia).

Effective Date

This revision is effective for claims processed on or after December 22, 2006 for services rendered on or after October 1, 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.

J9000: Antineoplastic Drugs—LCD Revision

The local coverage determination (LCD) for antineoplastic drugs was last updated on October 30, 2006. Since that time, revisions were made to add additional ICD-9-CM codes and indications, as well as update verbiage based on the Food and Drug Administration (FDA) label where applicable for the following drugs:

Docetaxel (J9170)

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following FDA-approved indication was added:

- Docetaxel in combination with cisplatin and fluorouracil is indicated for the induction treatment of patients with inoperable locally advanced squamous cell carcinoma of the head and neck.

Under the "ICD-9 Codes that Support Medical Necessity" section, the following diagnoses were added:

173.0 Other malignant neoplasm of skin of lip
173.1 Other malignant neoplasm of skin, eyelid, including canthus
173.2 Other malignant neoplasm of skin of ear and external auditory canal
173.3 Other malignant neoplasm of skin of other and unspecified parts of face
173.4 Other malignant neoplasm of skin, scalp and skin of neck

This revision is effective for claims processed on or after December 19, 2006, for services rendered on or after October 17, 2006.

J9000: Antineoplastic Drugs—LCD Revision, continued

Rituximab (J9310)

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following off-label indication was added:

- For the treatment of refractory thrombotic thrombocytopenic purpura (TTP) for patients who do not respond to plasmapheresis.

Under the "ICD-9 Codes that Support Medical Necessity" section, the following diagnosis was added:

446.6 Thrombotic microangiopathy [use this code for refractory thrombotic thrombocytopenic purpura (TTP)]

This revision is effective for services rendered on or after December 19, 2006.

Trastuzumab (J9355)

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section, the following FDA approved indication was added:

- Trastuzumab, as part of a treatment regimen containing doxorubicin, cyclophosphamide, and paclitaxel, is indicated for the adjuvant treatment of patients with HER2-overexpressing, node-positive breast cancer.

This revision is effective for services rendered on or after November 16, 2006.

The full text of this LCD is available through our provider education website at *http://www.floridamedicare.com* on or after these effective dates.

NCSVCS: The List of Medicare Noncovered Services—LCD Revision

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised on January 1, 2007. Since that time the LCD has been revised. First Coast Service Options, Inc. (FCSO) placed unlisted procedure code *53899* for RENESSA™ (system for stress urinary incontinence) on the list of noncovered services, a procedure for female stress urinary incontinence (SUI). The RENESSA™ procedure is indicated for the transurethral treatment of SUI due to hyper mobility in women who have failed conservative treatment and who are not candidates for surgical therapy. The RENESSA system is a non-surgical, in-office treatment and can be performed with local anesthesia or oral sedation or it can be performed under conscious sedation.

This revised LCD was published for notice and comment from September 19, 2006 through November 11, 2006. After reviewing comments submitted, FCSO has made a decision to leave RENESSA on the noncovered list as investigational and not medically necessary. FCSO recognizes RENESSA as an emerging technology with promising data. However, the number of randomized, controlled studies, especially addressing the Medicare population, are minimal to date. When specific coding evolves that better defines the RENESSA procedure (such as a category I or III code) and when additional data is published, Florida Medicare will consider evaluation on an individual consideration basis.

Effective Date

This revised LCD will be 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.

THERSVCS: Therapy and Rehabilitation Services—Revision to the LCD and Coding Guideline

This local coverage determination (LCD) was last updated on May 10, 2006, for services performed on or after January 1, 2006. Since that time, revisions were made to the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of this LCD based on instructions communicated through change request (CR) 5271, transmittals 60, 171 and 1106 dated November 9, 2006. These revisions clarify language pertaining to outpatient therapy CAPS. The coding guideline was revised accordingly, also based on CR 5271.

This revision is effective for services rendered on or after December 9, 2006.

In addition to the above revisions to the LCD and coding guideline, the coding guideline was also modified to include revised language communicated through CR 5253. The revised language encompasses instructions for billing timed and untimed codes, counting minutes for timed codes in 15-minute units and specific limits for HCPCS.

This revision is effective for claims processed on or after January 2, 2007, 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.

76070: Bone Mineral Density Studies—LCD Revision

The local coverage determination (LCD) for bone mineral density studies was last revised on April 11, 2006. Since that time, the LCD has been revised to delete reference to ICD-9-CM code E932.0 (Adrenal cortical steroids causing adverse effects in therapeutic use) in the "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-9 Codes that Support Medical Necessity" sections of the LCD, as this code is intended to provide supplementary classification and is not mandatory for billing purposes.

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.

ADDITIONAL INFORMATION

99199—Draft LCD for End Diastolic Pneumatic Compression Therapy (Circulator Boot) Not Finalized

A draft local coverage determination (LCD) for procedure code *99199* (*Unlisted special service, procedure or report*) for end-diastolic pneumatic compression therapy (circulator boot) was developed by Medicare and presented to the Florida Carrier Advisory Committee (CAC) on October 14, 2006. This draft LCD was developed as a result of an evaluation of the end-diastolic pneumatic compression therapy (circulator boot) device, which was requested by a beneficiary.

There is a national coverage determination (NCD) for durable medical equipment (DME) for pneumatic compression devices with coverage for lymphedema and chronic venous insufficiency with venous stasis ulcers. This draft LCD was presented to the CAC to address utilization in the physician's office, however, because there were limited well controlled studies, and the consensus of the advisory committee was to consider non-coverage in the physician's office, First Coast Service Options, Inc. (FCSO) has elected not to finalize this LCD at this time. Vasopneumatic devices do have some coverage under the therapy and rehabilitation services LCD, but must meet the physical therapy plan of care.

Self-Administered Drug (SAD) List

The Center for Medicare and Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Providers may read the instructions in their entirety in the CMS *Medicare Benefit Policy* Manual, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered on or after January 19, 2007, the following drug has been be added to the self-administered drug (SAD) list.

J3490 Exenatide injection (Byetta®) 5 mcg, 10 mcg

The evaluation of drugs for addition to the SAD list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs. The SAD list may be viewed in its entirety at *http://www.floridamedicare.com*.

2007 HCPCS Local Coverage Determination Changes

Florida Medicare has revised local coverage determinations (LCDs) impacted by the 2007 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

LCD Title	Changes
APBI Accelerated Partial Breast Irradiation (**Coding Guidelines only**)	Deleted procedure code *76370* Added procedure code *77014*
G0104 Colorectal Cancer Screening	Deleted procedure code G0107 Added procedure code *82270*
J7188 Hemophilia Clotting Factors	Deleted procedure code J7188 Added procedure code J7187 Changed contractor's determination number to J7187
NCSVCS The List of Medicare Noncovered Services	Deleted procedure code *0091T**, *0094T**, *0097T**, *0120T**, and *22899** from the Local Noncoverage Decisions section of the LCD (* investigational) Added procedure codes *22857**, *22865**, *22862**, *19105**, *22526**, *22527**, *0162T**, *0163T**, *0164T**, *0165T**, *0168T*, *0173T*, *0174T*, *0175T*, *0176T*, and *0177T*, to the Local Noncoverage Decisions section of the LCD Descriptor change for procedure codes *0090T**, *0093T**, and *0096T** in the Local Noncoverage Decisions section of the LCD
PULMDIAGSVCS Pulmonary Diagnostic Services	Descriptor change for procedure code *94620*
RETISERT Retisert (fluocinolone acetonide intravitreal implant)	Changed procedure code J3490 to J7311 Changed contractor's determination number to J7311
SKINSUB Skin Substitutes	Deleted procedure codes *15000* and *15001* Added procedure codes *15002*, *15003*, *15004*, and *15005*
11000 Debridement Services (**Coding Guidelines only**)	Deleted procedure codes *15000* and *15001* Added procedure codes *15002*, *15003*, *15004*, and *15005*
17304 Mohs Micrographic Surgery (MMS)	Deleted procedure codes *17304*, *17305*, *17306*, *17307*, and *17310* Added procedure code *17311*, *17312*, *17313*, *17314*, and *17315* Changed contractor's determination number to 17311
22520 Percutaneous Vertebroplasty	Deleted procedure codes *76012* and *76013* Added procedure codes *72291* and *72292*
22523 Kyphoplasty	Deleted procedure codes *76012* and *76013* Added procedure codes *72291* and *72292*
27096 Sacroiliac Joint Injection	Deleted procedure code *76005* Added procedure code *77003*
70370 Dysphagia/Swallowing Diagnosis and Therapy	Descriptor change for procedure code *76536*
70540 Magnetic Resonance Imaging of the Orbit, Face, and Neck	Descriptor change for procedure code *70540*
76070 Bone Mineral Density Studies	Deleted procedure codes *76070*, *76071*, *76075*, *76076*, *76077*, and *76078* Added procedure codes *77078*, *77079*, *77080*, *77081*, *77082*, and *77083* Changed contractor's determination number to 77078
76536 Ultrasound, Soft Tissues of Head and Neck	Descriptor change for procedure code *76536*
91110 Wireless Capsule Endoscopy	Added procedure code *91111*
92499 Computerized Corneal Topography	Changed procedure code *92499* to *92025* Changed contractor's determination number to 92025

2007 HCPCS Local Coverage Determination Changes, continued

LCD Title	Changes
95004 Allergy Skin Tests	Deleted procedure code *95078*
VISCO Viscosupplementation Therapy For Knee	Deleted procedure codes J7317 and J7320 Added procedure code J7319
0145T Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries	Descriptor change for procedure code *71275*

FLORIDA EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

January 2007 – March 2007

NPI CMS Module – 4 & 5

When: January 18, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Ask the Contractor Teleconference (ACT) – Topics to be determined

When: January 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, 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

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: _____

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 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

OCR

Printer Specifications/Test Claims:
1-904-791-8132

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 these 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 Non-Physician 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 who do not have Internet access may purchase a hardcopy or CD-ROM. 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 also that revisions to fees may occur; these revisions will be published 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 ***