Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

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

Routing Suggestions:

- ❑ Physician/Provider
- ❑ Office Manager
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Sign up to our *eNews* electronic mailing list

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

Medicare B Update!

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

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

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32232-5270

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

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

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

Who Receives the *Update?*

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

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

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

We use the same mailing address for *all* correspondence, and cannot designate that the *Update!* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Registration department. Please remember that address changes must be done using the appropriate Form CMS-855.

Clear Identification of State-Specific Content

Articles common to both states appear at the beginning of the publication. Within common articles, references to phone numbers, addresses, reimbursement amounts, past publications, etc., are state-specific as appropriate. Content specific to Connecticut is next, followed by content specific to Florida. Connecticut and Florida local coverage determination (LCD) summaries are combined into one section. Articles in this section applies to both Connecticut and Florida unless otherwise noted.

Publication Format

The *Update!* is arranged into distinct sections.

NOTE: Since the Update! is being published more frequently, the Carrier Medical Director and Medical Review sections will appear on an "as needed" basis.

Following the table of contents, a letter from the carrier medical director (as needed), and an administrative information section, the *Update!* provides content applicable to both states, as noted previously. Within this section, information is categorized as follows.

- The **claims** section provides claim submission requirements and tips, plus correspondence (appeals and hearings) information.
- The **coverage/reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by specialty *categories* (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **electronic media claim** (EMC) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **general information** section includes fraud and abuse, provider registration, and Medicare Secondary Payer topics, plus additional topics not included elsewhere.

Educational resources. Important **addresses, phone numbers**, and **websites** will *always* be in state-specific sections.

Advance Beneficiary Notices

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

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

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

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

Patient Liability Notice

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

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

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

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

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

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

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

OR

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

CLAIMS

Revisions to Form CMS-1500 Submission Requirements

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

Provider Types Affected

Physicians, nonphysician practitioners, and suppliers who bill Medicare contractors (Part A/B Medicare administrative contractors (A/B MACS), carriers, durable medical equipment regional contractors (DMERCS) and DME Medicare administrative contractors (DME MACs) for their services using the Form CMS-1500.

Background

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare and Medicaid programs for claims from physicians and suppliers. The language contained in the *Medicare Claims Processing Manual*, Chapter 26, regarding the Form CMS-1500 is being updated to reflect current processing guidelines and incorporate recent data collection decisions made by CMS.

Key Points

Change request (CR) 5489 makes the following updates to the CMS-1500 requirements:

- The requirement to submit the provider's Social Security Number in Box 25 has been removed;
- The requirement to report the PIN of the skilled nursing facility in Box 23 has been removed; and
- Clarification language was added to Box 17a, indicating the qualifier 1G precedes the unique physician identification number (UPIN).

In addition, language has been added regarding the completion of Item 25 (the provider of service or supplier federal tax identification number). Medicare providers are not required to complete this item for crossover claim purposes, since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the coordination of benefits (COB) outbound claim. However, tax identification information is used in the determination of accurate national provider identification (NPI) reimbursement. Thus, reimbursement of claims submitted without tax identification information may be delayed.

Additional Information

CR 5489 is the official instruction issued to your Medicare contractor. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1215CP.pdf* on the CMS website. The revised Chapter 26, section 10.4, of the *Medicare Claims Processing Manual* is attached to CR 5489.

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

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

MLN Matters Number: MM5489 — Related Change Request (CR) #: 5489
Related CR Release Date: March 30, 2007 — Effective Date: April 1, 2007
Related CR Transmittal #: R1215CP — Implementation Date: April 30, 2007

Clarification of MM5488 Article Regarding Coding on CMS-1500

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

Provider Types Affected

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

What You Need to Know

This special addition article (SE0716) clarifies MM5488 (Temporary Addition to the Administrative Simplification Compliance Act (ASCA) Exception List for Medicare Secondary Payer (MSP) Claims — Released March 9, 2007). MM5488 related to change request (CR) 5488, which informed Medicare carriers and A/B MACS that a temporary waiver to a requirement of the Administrative Simplification Compliance Act (ASCA) is being granted for the co-payments in MSP claims.

Specifically, SE0716 notifies physicians and providers that your claims may be processed in error if you identify the primary payer's primary payment in block 29 of the Form CMS1500. You must only identify and enter the **beneficiary payment amount** in this block.

Clarification of MM5488 Article Regarding Coding on CMS-1500, continued

Background

CR 5488 instructed CMS contractors (carriers and A/B MACs) who use the Medicare multi-carrier system (MCS) for claims processing, to grant a temporary ASCA waiver (until July 1, 2007) for electronic media claim (EMC) MSP claims to allow processing of these claims for reimbursement of a beneficiary for co-payment paid to the provider when the primary payer is an employer managed care organization (MCO).

Therefore, until July 1, 2007, carriers and A/B MACs will allow for co-payment reimbursement claims to be submitted on paper and to send reimbursement directly to the beneficiary.

In clarifying MM5488, this special addition article (SE0716) notifies physicians and providers, that in order for this temporary exception to be implemented, you must only identify the beneficiary payment amount in block 29 of the Form CMS 1500. You must not identify the primary payer's primary payment in this block, or your claims may be processed in error.

Additional Information

You might want to review CR 5488 at *http://cms.hhs.gov/transmittals/downloads/R1194CP.pdf* or MM5488 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5488.pdf* on the CMS website.

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

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

MLN Matters Number: SE0716
Related Change Request (CR) #: 5488
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Supplemental to *MLN Matters* Article MM5391—Revisions to Incomplete or Invalid Claim Instructions

When change request (CR) 5391 is implemented on May 23, 2007, claims that are not completed as instructed by the *Medicare Claims Processing Manual* (Pub.100-04), Chapter 1, Sections 80.3.2.1.1 through 80.3.2.1.3, will be returned as unprocessable. In accordance with CR 5391, **contractors have been instructed not to search their internal files** to satisfy missing or inaccurate required or conditional data elements.

Data analysis indicates providers are routinely not submitting their telephone numbers in the required fields. For instance, Item 33 requires the name, address, ZIP code, **and telephone number** of the provider. Previously, First Coast Service Options, Inc. (FCSO) would have been able to obtain the missing, but required, telephone number from its internal files. With the implementation of CR 5391, FCSO will have to return such a claim as unprocessable. All information (including the telephone number) **must** be provided either on the claim or the electronic equivalent.

Please review the *Medicare Claims Processing Manual* (100-04), Chapter 26, at *http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf*, for detailed item-by-item Form CMS 1500 completion instructions to prevent these avoidable claim rejections.

MLN Matters article MM5391 was published in the April 2007 *Medicare B Update!*, pages 7-8.

Source: Publication 100-04, Chapter 26, CR 5391, MM5391

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.

AMBULANCE

Revision to the Specialty Care Transport Definition—Ground Ambulance Services

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

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Medicare administrative contractors [MACs] and carriers), for ambulance services to Medicare beneficiaries

Provider Action Needed

Providers and suppliers are reminded that the Centers for Medicare & Medicaid Services (CMS) expanded the interpretation of "inter-facility" to include both hospitals and skilled nursing facilities (SNFs) in the December 1, 2006 (71 FR 69716) final rule.

Background

In the February 27, 2002, *Federal Register* (67 FR 9100), a final rule was published with comment period entitled "Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Non-emergency Ambulance Services" that implemented the ambulance fee schedule. In that rule, CMS defined special care transport (SCT) at Section 414.605. In the December 1, 2006, final rule (71 FR 69716), CMS expanded the definition of "inter-facility" to include both hospitals and SNFs.

In addition, CMS further clarified the kinds of facilities included as origin or destination points for "inter-facility" transport for SCT purposes. Therefore, for purposes of SCT payment, CMS considers a "facility" to include:

- Only an SNF or a hospital that participates in the Medicare program, or
- A hospital-based facility that meets the requirements for provider-based status.

Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children's hospitals, psychiatric hospitals, critical access hospitals (CAHs), inpatient acute-care hospitals, and sole community hospitals (SCHs).

Note: Contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

Additional Information

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

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

For complete details regarding this change request (CR) please see the official instruction (CR 5533) 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/R68BP.pdf* on the CMS website.

Providers may review the federal regulations for the ambulance fee schedule located at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/04_CFRAFS.asp#TopOfPage* on the CMS website.

MLN Matters Number: MM5533
Related Change Request (CR) #: 5533
Related CR Release Date: March 30, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R68BP
Implementation Date: April 30, 2007

CARDIAC SERVICES

Ventricular Assist Devices

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], Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5516 which announces that, effective March 27, 2007, new facility criteria are established and hospitals must receive certification from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under their Disease Specific Certification Program for Ventricular Assist Devices (VADs). The new criteria apply to hospitals that implant VADs for the destination therapy indication.

CAUTION – What You Need to Know

Currently approved hospitals will have until March 27, 2009, to become certified by the JCAHO or they will be removed from the approved list.

GO – What You Need to Do

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

Background

A VAD is an implantable device used to assist a damaged or weakened heart in pumping blood. These devices are used for support of blood circulation 1) post-cardiotomy, 2) as a bridge to a heart transplant, or 3) as destination therapy. Destination therapy is defined as use of a device as the end result of treatment (i.e., permanent transplantation), instead of a "bridge" to transplantation. Destination therapy is an indication for patients that are not heart transplant eligible, and therefore, they expect to require use of the VAD through the end of life.

Through the *National Coverage Determination (NCD) Manual* (Publication 100-03), Section 20.9, "Artificial Hearts and Related Devices") issued on October 14, 2003 (CR 2958, Transmittal 2; *http://www.cms.hhs.gov/Transmittals/Downloads/R2NCD.pdf*), Medicare began coverage of the destination therapy indication. The 2003 decision established hospital criteria and an application process through which hospitals were required to submit information to the Centers for Medicare & Medicaid Services (CMS). If approved, the hospital(s) were listed as an approved VAD destination therapy hospital on the CMS website (*http://www.cms.hhs.gov/MedicareApprovedFacilitie/VAD/list.asp#TopOfPage*). At that time, Medicare contractors were instructed to use this VAD Destination Therapy Facilities website to determine which hospitals in their area were Medicare approved for VADs as destination therapy.

CR 5516 announces that, effective March 27, 2007, new facility criteria are established. Included in the facility criteria are requirements that:

- Facilities must have at least one member of the VAD team with experience implanting at least 10 VADs (as bridge to transplant or destination therapy) or artificial hearts over the course of the previous 36 months;
- Facilities must be a member of the Interagency Registry for Mechanically Assisted Circulatory Support (INTERMACS); and
- By March 27, 2009, all facilities must meet the updated CMS facility criteria and be credentialed by the JCAHO under their Disease Specific Certification Program for VADs (standards dated February 2007).

The VAD destination therapy facilities website will be continuously updated by CMS to maintain a current list of approved facilities. Medicare contractors will continue to use this website to determine which hospitals are covered by Medicare when VADs are implanted as destination therapy.

Additional Information

The official instruction, CR 5516, issued to your carrier, intermediary, or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R68NCD.pdf* on the CMS website.

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

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

MLN Matters Number: MM5516
Related Change Request (CR) #: 5516
Related CR Release Date: April 13, 2007
Effective Date: March 27, 2007
Related CR Transmittal #: R68NCD
Implementation Date: May 14, 2007

COMPETITIVE ACQUISITION PROGRAM

Competitive Acquisition Program for Part B Drugs

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

Provider Types Affected

Approved CAP vendors billing the designated carrier

Background

This article and related change request (CR) 5546 provide additional details, information, and instructions for the implementation of the Competitive Acquisition Program (CAP) as outlined in *MLN Matters* articles 4064, 4309, 5079, 5332 and CR 4306. (The Web addresses for these articles are listed in the *Additional Information* section of this article.)

Key Points of CR 5546

The following are the key points listed in the revised Chapter 17, Section 100 of the *Medicare Claims Processing Manual*, which is attached to CR 5546:

Old Rules

- **Under the MMA,** payment to the approved CAP vendor for a drug **was** conditioned upon the administration of the drug to the Medicare beneficiary.
- From July 1, 2006, through March 31, 2007, proof that the drug was administered **was** established by matching the participating CAP physician's claim for drug administration with the approved CAP vendor's claim for the drug in the Medicare claims processing system by means of a prescription order number on both claims. **When the claims matched** in the claims processing system, the approved CAP **vendor was paid.**

New Rules

- Title 2, Section 108(a) of the Tax Relief and Health Care Act of 2006 (TRHCA), requires the Centers for Medicare & Medicaid Services (CMS) to pay an approved CAP vendor's CAP drug claim upon its receipt and to implement a **post payment review process** by April 1, 2007.
- The post payment review process is required to **assure that drugs supplied under the CAP were administered to a beneficiary**. CMS must establish a mechanism to recoup, offset or collect **any** overpayments to the approved CAP vendor. If upon post payment review, Medicare cannot substantiate drug administration, Medicare will treat that as an overpayment to the CAP vendor and take appropriate recovery action for the drug payment to the CAP vendor.
- CMS is implementing CAP claims processing changes in order to comply with TRHCA by April 1, 2007. Pending CAP claims submitted prior to April 1, 2007, but not processed by that date, and all new CAP claims submitted on or after April 1 will be paid upon receipt and will be subject to the post payment review process.

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 1-888-760-6950 (CT).

For complete details regarding this CR, please see the official instruction (CR 5546) issued to your Medicare carrier. This instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1207CP.pdf* on the CMS website.

The following addresses link to the MLN articles listed in the Background section of this article. The articles may be accessed on the CMS website by visiting:

MM4064 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf*
MM5332 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5332.pd*;
MM5079 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pd*;
MM4309 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf*

MLN Matters Number: MM5546
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MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)

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. This information was previously published in the February 2007 Medicare B Update! pages 10-11.

Note: This article was revised on January 5, 2007, to change codes that were incorrectly posted. Code G9358 was changed to G8358 and code Q4095 was changed to Q4085. All other information remains the same.

Provider Types Affected

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

Background

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

Key Points

You may wish to **review Attachment 1** of the CR 5459, which is located at *http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf* on the CMS website. 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 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* at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4219.pdf* on the CMS site.)
- Oncology **demonstration 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.
- G codes G0377 and G8348 through G8368 will be added to the 2007 HCPCS file.
- Q codes Q4083, Q4084, Q4085, and Q4086 will be added, even though they are not on the 2007 HCPCS file. Note that corresponding average sale price (ASP) amounts will be reflected in updated 2007 ASP pricing files to be posted to the CMS website.
- Incorrect diagnostic supervision indicators were assigned to some codes and these codes and correct indicators are listed in the attachment to CR 5459.
- Corrected multiple procedure codes of 0 and diagnostic family imaging indicators of 99 have been assigned to codes G0389, G0389-TC, *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 codes *44180*, *44186*, *73223*, *73223*-26, *76775*, *76775*-TC, *76775*-26, *93503*, *93539*, *93540*, *93541*, *93542*, *93543*, *93544*, *93545*, *95060*, *95065*, G0389, G0389-TC, and G0389-26.
- As a result of the Tax Relief and Health Care Act of 2006, effective January 1, 2007, 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 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 G codes are added to the MPFSDB with a status indicator of M: G8348, G8349, G8350, G8351, G8352, G8353, G8354, G8355, G8356, G8357, G8358, G8359, G8360, G8361, G8362, G8363, G8364, G8365, G8366, G8367, and G8368.

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

- 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, i.e., Q4083 (Hyalgan/supartz inj per dose), Q4084 (Synvisc inj per dose), Q4085 (Euflexxa inj per dose), and Q4086 (Orthovisc inj per dose).
- Procedure status "I" is assigned to J7319, effective January 1, 2007.
- Effective January 1, 2007, the HCPCS codes Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, and Q9964 will be assigned to procedure status indicator E.
- As a courtesy to the public, CMS has established RVUs for a number of codes, even though the codes are either bundled or not valid for Medicare purposes. These 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 *http://www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf* on the CMS website.

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

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

MLN Matters Number: MM5459 *Revised*
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Medicare Physician Fee Schedule Payment Policy Indicators

The information that follows provides definitions of the national policy indicators for each procedure code (and modifier, where applicable) on the Medicare physician fee schedule database (MPFSDB).

Procedure Code/Modifier

The *CPT* or HCPCS procedure code and, where applicable, procedure code modifier.

Code Status

Provides the fee schedule status of each code.

A Active code. These codes are separately paid under the physician fee schedule if covered. There will be relative value units (RVUs) and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

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.

D Deleted/discontinued codes.

E Excluded from physician fee schedule by regulation. These codes are for items and/or services that the Centers for Medicare & Medicaid Services (CMS) chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F Deleted/discontinued codes. (Code not subject to a 90 day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator was effective with the 2002 fee schedule as of January 1, 2002.

G Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.) This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

H Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the data base with the H status.

I Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code *not* subject to a 90-day grace period.)

J Anesthesia services (no relative value units or payment amounts for anesthesia codes on the database, only used to facilitate the identification of anesthesia services.)

L Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

M Measurement codes, used for reporting purposes only.

N Noncovered service. These codes are carried on HCPCS as noncovered services.

P Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule.

If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service).

If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Act.

R Restricted coverage. Special coverage instructions apply.

T There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.

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. (Examples are ambulance services and clinical diagnostic laboratory services.)

Global Surgery

Provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

000 Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

010 Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative

Medicare Physician Fee Schedule Payment Policy Indicators, continued

period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

090 Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

MMM Maternity codes; usual global period does not apply.

XXX Global concept does not apply

YYY Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post service time.)

Preoperative, Intraoperative, and Postoperative Percentages

- Preoperative percentage (**pre op**) – modifier 56
  Provides the percentage for the preoperative portion of the global package.
- Intraoperative percentage (**intra op**) – modifier 54
  Provides the percentage for the intraoperative portion of the global package including postoperative work in the hospital.
- Postoperative percentage (**post op**) – modifier 55
  Provides the percentage for the postoperative portion of the global package that is provided in the office after discharge from the hospital.

The total of preoperative, intraoperative, and postoperative percentages will usually equal one. Any variance is slight and results from rounding.

Professional Component/Technical Component Indicator (PC/TC)

0 Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The total RVUs include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

1 Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests (e.g., pulmonary function tests), or therapeutic radiology procedures (e.g., radiation therapy). These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes.

The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.

The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.

2 Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test.

An example of a professional component only code is *93010, Electrocardiogram; interpretation and report*. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

3 Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only.

An example of a technical component code is *93005, Electrocardiogram, tracing only, without interpretation and report*. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes.

The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

4 Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

5 Incident to codes: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision.

Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.

6 Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for

Medicare Physician Fee Schedule Payment Policy Indicators, continued

which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.

7 **Physical therapy service**: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist.

8 **Physician interpretation codes**: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code *85060*. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.

No payment is recognized for code *85060* furnished to hospital outpatients or non- hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

9 Concept of a professional/technical component does not apply.

Multiple Procedure – Modifier 51

Indicates which payment adjustment rule for multiple procedures applies to the service.

0 No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.

1 Standard payment adjustment rules in effect before January 1, 1996 for multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

2 Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

3 Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified on page 15.

Multiple endoscopy rules are applied to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure).
If an endoscopic procedure is reported with only its base procedure, carriers do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

4 Subject to 25 percent reduction of the TC diagnostic imaging (**effective for services January 1, 2006, thru December 31, 2006**)
Subject to 25 percent reduction of the TC diagnostic imaging reduction (**effective for services January 1, 2007, and after**)

9 Concept does not apply.

Bilateral Surgery – Modifier 50

Provides an indicator for services subject to a payment adjustment.

0 150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier 50 or with modifiers RT and LT, base payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).

The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.

2 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the

Medicare Physician Fee Schedule Payment Policy Indicators, continued

procedure being performed as a bilateral procedure. If procedure is reported with modifier 50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), base payment for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).

The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

3 The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier 50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules.

Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.

9 Concept does not apply.

Assistant at Surgery

Provides an indicator for services where an assistant at surgery is never paid for per the Medicare Carriers Manual.

0 Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

1 Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.

2 Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.

9 Concept does not apply.

Co-Surgeons – Modifier 62

Provides an indicator for services for which two surgeons, each in a different specialty, may be paid.

0 Co-surgeons not permitted for this procedure.

1 Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.

2 Co-surgeons permitted; no documentation required if two specialty requirements are met.

9 Concept does not apply.

Team Surgeons – Modifier 66

Provides an indicator for services for which team surgeons may be paid.

0 Team surgeons not permitted for this procedure.

1 Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report.

2 Team surgeons permitted; pay by report.

9 Concept does not apply.

Physician Supervision of Diagnostic Procedures

Provides levels of physician supervision required for diagnostic tests payable under the physician fee schedule.

General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

01 Procedure must be performed under the general supervision of a physician.

02 Procedure must be performed under the direct supervision of a physician.

03 Procedure must be performed under the personal supervision of a physician.

04 Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.

05 Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.

06 Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American

Medicare Physician Fee Schedule Payment Policy Indicators, continued

Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under state law.

21 Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.

22 May be performed by a technician with on-line real-time contact with physician.

66 May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure.

6A Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.

77 Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.

7A Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.

09 Concept does not apply.

Diagnostic Imaging Family Indicator

01 Family 1 Ultrasound (Chest/Abdomen/Pelvis – Non Obstetrical

02 Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)

03 Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/ Neck)

04 Family 4 MRI and MRA (Chest/Abd/Pelvis)

05 Family 5 MRI and MRA (Head/Brain/Neck)

06 Family 6 MRI and MRA (spine)

07 Family 7 CT (spine)

08 Family 8 MRI and MRA (lower extremeties)

09 Family 9 CT and CTA (lower extremeties)

10 Family 10 Mr and MRI (upper extremeties and joints)

11 Family 11 CT and CTA (upper extremeties)

Facility Pricing

Codes that have reduced fees when performed in a facility setting are not identified in the tables that follow. However, these codes are annotated with an asterisk (*) in the *2007 Medicare Physician and Nonphysician Practitioner Fee Schedule* book. Facility fees are calculated at a national level with a reduced practice expense, because of reduced physician overhead associated with services provided in a facility.

Place of service codes to be used to identify facilities:

21 inpatient hospital

22 outpatient hospital

23 emergency room

24 ambulatory surgical center - ASC is only treated as a facility setting when an ASC list procedure is performed in an ASC

26 military treatment facility

31 skilled nursing facility

34 hospice

41 ambulance - land

42 ambulance air or water

51 inpatient psychiatric facility

52 psychiatric facility partial hospitalization

53 community mental health center

56 psychiatric residential treatment facility

61 comprehensive inpatient rehabilitation facility

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PREVENTIVE SERVICES

Update to Medicare Claims Processing Manual Regarding Colorectal Screening Services

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 for screening and diagnostic colorectal services to Medicare contractors (fiscal intermediaries [FIs], carriers, Part A/B Medicare administrative contractors [A/B MACs]).

Background

The Centers for Medicare & Medicaid Services (CMS) is aware that Chapter 18, Section 60.1 of the *Medicare Claims Processing Manual* (Publication 100-04) needed clarification regarding application of the annual Part B deductible for **diagnostic** colorectal services. Section 5113 of the Deficit Reduction Act (DRA) of 2005 **waived** the requirement for the annual Part B deductible for **screening** colorectal services, **NOT diagnostic** colorectal services. CR 5541 clarifies that portion of the manual.

Key Points

The following are the key points of the revised portion of Chapter 18, Section 60.1 of the *Medicare Claims Processing Manual*, which is attached to CR 5541 (the Web address for CR 5541 is provided in the *Additional Information* section of this article).

Prior to January 1, 2007, deductible and coinsurance apply to HCPCS codes G0104, G0105, G0106, G0120, and G0121. **On or after January 1, 2007**, the annual Part B deductible is waived for the listed HCPCS coded **screening services**. **Coinsurance still applies.**

- **Coinsurance and deductible applies to the diagnostic colorectal service codes *45330, 45378,* and *74280*.**

Additional Information

You may see the official instruction (CR 5541) issued to your Medicare carrier, FI, or A/B MAC by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1217CP.pdf* on the CMS website.

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

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

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RADIOLOGY

Radiopharmaceutical Code Allowances

First Coast Service Options, Inc. (FCSO) has evaluated the pricing for HCPCS code A9500, A9502, A9503, A9505 and A9516. The carrier priced payment allowances are effective for services rendered on/after January 1, 2007.

Procedure Code/Descriptor	Par Fee	Non-Par Fee	Limiting Charge
A9500 – Tc99m Sestamibi/Cardiolite diagnostic, per study dose up to 40 MCI	$121.69	$115.61	$132.95
A9502 – Tc99m Tetrofosmin/Myoview diagnostic, per study dose, up to 40 MCI	$119.70	$113.72	$130.78
A9503 – Tc99m Medronate/MPI MDP diagnostic, per study dose, up to 30 MCI	$54.93	$52.18	$60.01
A9505 – Tl201 Thallous Chloride, per MCI	$88.40	$83.98	$96.58
A9516 – I-123 Sodium Iodide capsule(s) diagnostic, per 100 UCI	$92.99	$88.34	$101.59

THERAPUETIC SERVICES

Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumors

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 (fiscal intermediaries [FIs], Medicare administrative contractors [MACs] and carriers)

What Providers Need to Know

Effective for claims with dates of service on or after March 20, 2007, the use of osmotic blood brain barrier disruption is not considered reasonable and necessary when it is used as part of a treatment regimen for brain tumors in Medicare patients.

Background

This article and change request (CR) 5530 states that Medicare does not currently have a national coverage determination (NCD) for osmotic blood brain barrier disruption (BBBD) as part of a treatment regimen for brain tumors. The Centers for Medicare & Medicaid Services (CMS) accepted a formal request for **noncoverage** of BBBD used for this indication.

CMS determined that the use of osmotic blood brain barrier disruption is not reasonable and necessary when it is used as part of a treatment regimen for brain tumors.

Be aware that the BBBD process includes all items and services necessary to perform the procedure, including hospitalization, monitoring, and repeated imaging procedures.

This NCD does not alter in any manner the coverage of anti-cancer chemotherapy.

Additional Information

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

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

CR 5530 is the official instruction issued to your Medicare FI, carrier or MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R67NCD.pdf* on the CMS website.

MLN Matters Number: MM5530
Related Change Request (CR) #: 5530
Related CR Release Date: April 6, 2007
Effective Date: March 20, 2007
Related CR Transmittal #: R67NCD
Implementation Date: May 7, 2007

GENERAL COVERAGE

Common Working File Duplicate Claim Edit for the Technical Component of Radiology and Pathology Laboratory Services Provided to Hospital Patients

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 29-30.

Note: This article was revised on April 20, 2007, to show that important new information on this issue is available in *MLN Matters* article MM5468 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5468.pdf*). In essence, according to MM5468, qualifying independent laboratories may continue to bill Medicare for the technical component (TC) of physician pathology services furnished to Medicare patients of a covered hospital stay during calendar year 2007. Be sure to view MM5468 for details.

Provider Types Affected

Radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the TC of **radiology** laboratory services provided to Medicare fee-for-service hospital inpatients. Also affected are independent laboratories billing Medicare carriers for the TC of **pathology** laboratory services provided to Medicare fee-for-service hospital patients.

Provider Action Needed

Effective April 1, 2007, CMS will install systems edits to prevent improper payments to radiology suppliers, physicians and nonphysician practitioners for the TC of radiology laboratory services during an inpatient stay. The system edits will also apply to independent laboratories for the TC of pathology laboratory services provided to beneficiaries during a covered inpatient hospital stay or provided on the same date of service as an outpatient service. This change applies to claims with dates of service on or after January 1, 2007, where the claim is received on or after April 1, 2007. Please be sure billing staff are aware of these changes.

Common Working File Duplicate Claim Edit for the Technical Component of Radiology and Pathology Laboratory Services Provided to Hospital Patients, continued

Background

Current Medicare billing practices allow either the hospital or the supplier performing the technical component (TC) of physician pathology laboratory services to bill the carrier for these services. This policy has contributed to the Medicare program paying twice for the TC service, first through the prospective payment system (PPS) to the hospital and again to the supplier that bills the carrier, instead of the hospital, for the TC service.

Effective for claims received on or after April 1, 2007, for services on or after January 1, 2007, CMS will install systems edits to prevent additional improper payments to radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the TC of **radiology** laboratory services during an inpatient stay. The edits will also apply to independent laboratories for the TC of pathology services provided to beneficiaries during an inpatient stay or for the same date of service as an outpatient service.

Key Points

- Effective for claims received on or after April 1, 2007, Medicare will reject/deny a Part B TC or globally billed radiology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay. Such services will also be rejected/denied when they match with a date of service of a hospital inpatient previously processed by Medicare.
- Effective for claims received on or after April 1, 2007, Medicare will reject/deny reject a Part B TC or globally billed pathology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay when billed by a physician/supplier. Such services will also be rejected/denied when they match with a date of service of a hospital outpatient bill (bill types 13x and 85x previously processed by Medicare.
- If providers submit a TC of a radiology or pathology service with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay the carrier will use remittance advice reason code 109 "Claim not covered by this payer/contractor." when denying a service line item.
- Where Medicare systems detect that a Part B TC or globally billed radiology or physician pathology service has been paid and Medicare subsequently receives a hospital inpatient bill for the same date of service, the Medicare carrier will adjust a TC of a radiology or physician pathology service line item and recoup the payment made for that service from the physician/supplier. The Medicare carrier will also adjust a TC of a pathology service for an outpatient claim. The same remittance advice reason code of 109 will be used in such cases.
- Effective for claims received on or after April 1, 2007, the carrier will deny an incoming Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (noncovered level of care) from and through dates plus one day on a posted hospital inpatient bill. Again, the carrier will use remittance advice reason code 109. In addition, the Medicare carrier will recoup payment made to the physician/supplier if a subsequent hospital inpatient bill is received for those same services.
- Carriers will not search their files to either retract payment or retroactively pay claims prior to the implementation of CR 5347. However, they will adjust claims if they are brought to their attention.

Implementation

This change will be implemented on April 2, 2007.

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.

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

For complete details regarding this CR, 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/R1221CP.pdf* on the CMS website.

MLN Matters Number: MM5347 *Revised*
Related Change Request (CR) #: 5347
Related CR Release Date: April 18, 2007
Effective Date: April 1, 2007
Related CR Transmittal #: R1221CP
Implementation Date: April 2, 2007

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

GENERAL INFORMATION

Medicare Fee-For-Service National Provider Identifier Implementation Contingency Plan

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 contractors (carriers, fiscal intermediaries, [FIs], including regional home health intermediaries [RHHIs], Medicare administrative contractors [MACs], durable medical equipment regional carriers [DMERCs], and DME Medicare administrative contractors [DME MACs])

Provider Action Needed

STOP – Impact to You

As early as July 1, 2007, Medicare fee-for-service (FFS) contractors may begin rejecting claims that do not contain a national provider identifier (NPI) for the primary providers.

CAUTION – What You Need to Know

Change Request 5595, from which this article is taken, announces that (effective May 23, 2007) Medicare FFS is establishing a contingency plan for implementing the NPI. In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007.

GO – What You Need to Do

If you have not yet done so, you should obtain your NPI now. You may apply online at *https://nppes.cms.hhs.gov/* on the CMS website**.** You should also make sure that your billing staffs begin to include your NPI on your claims as soon as possible.

Background

The 1996 Health Insurance Portability and Accountability Act (HIPAA) required that each physician, supplier, and other health care provider conducting HIPAA standard electronic transactions, be issued a unique national provider identifier (NPI). CMS began to issue NPIs on May 23, 2005; and to date, has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only,
- Medicare legacy only, or
- An NPI and legacy combination.

On April 2, 2007, the Department of Health & Human Services (DHHS) provided guidance to covered entities regarding contingency planning for NPI implementation. **As long as covered entities, including health plans and covered health providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs, they may establish contingency plans to facilitate the compliance of their trading partners.** (You may find this guidance on the CMS website at: *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf*.)

In CR 5595, from which this article is taken, Medicare FFS announces that it is establishing a contingency plan that follows this DHHS guidance. For some period after May 23, 2007, Medicare FFS will:

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

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

As part of this plan, Medicare FFS has been assessing health care provider submission of NPIs on claims. As soon as the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is determined sufficient (and following appropriate notice to providers), Medicare will begin rejecting claims that do not contain an NPI for primary providers following appropriate notification. (*See Important Information* below.)

In May 2007, Medicare FFS will evaluate the number of submitted claims containing a NPI. If this analysis demonstrates a sufficient number of submitted claims contain a NPI, Medicare will begin to reject claims without NPIs on July 1, 2007. If, however, there are not sufficient claims containing NPIs in the May analysis, Medicare FFS will assess compliance in June 2007 and determine whether to begin rejecting claims in August 2007.

CMS also recognizes that the National Council of Prescription Drug Programs (NCPDP) format only allows for reporting of one identifier. Thus, NCPDP claims can contain either the NPI or the legacy number, but not both, until May 23, 2008.

In addition, in regards to the 835 remittance advice transactions and 837 coordination of benefits (COB) transactions, Medicare FFS will do the following until May 23, 2008:

- If a claim is submitted with an NPI, the NPI will be sent on the associated 835 remittance advice; otherwise, the legacy number will be sent on the associated 835.
- If a claim is submitted with an NPI, the associated 837 COB transaction will be sent with both the NPI and the legacy number; otherwise, only the legacy number will be sent.

By May 23, 2008, the X12 270/271 eligibility inquiry/response supported by CMS via the Extranet and Internet must contain the NPI.

Important Information

CR 5595 also provides specific important information that you should be aware of:

- Once a decision is made to require NPIs on claims, Medicare FFS will notify (in advance) providers and

Medicare Fee-For-Service National Provider Identifier Implementation Contingency Plan, continued

Medicare contractors about the date that claims without NPIs for primary providers will begin to be rejected. **That date will supersede all dates announced in previous CRs and *MLN Matters* articles.**

- In editing NPIs, Medicare considers billing, pay-to and rendering providers to be primary providers who must be identified by NPIs, or the claims will be rejected once the decision is made to reject.
- All other providers (including referring, ordering, supervising, facility, care plan oversight, purchase service, attending, operating and "other" providers) are considered to be secondary providers. Legacy numbers are acceptable for secondary providers until May 23, 2008. If a secondary provider's NPI is present, it will only be edited to assure it is a valid NPI.

Additional Information

You may read CR 5595 by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1227CP.pdf* on the CMS website. You may also learn more about the NPI at *http://cms.hhs.gov/NationalProvIdentStand/* 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* on the CMS website.

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

MLN Matters Number: MM5595
Related Change Request (CR) #: 5595
Related CR Release Date: April 24, 2007
Effective Date: May 23, 2007
Related CR Transmittal #:R1227CP
Implementation Date: May 23, 2007

CMS Clarifies Guidelines For National Provider Identifier Deadline Implementation

The Centers for Medicare & Medicaid Services (CMS) announced that it is implementing a contingency plan for covered entities (other than small health plans) who will not meet the May 23, 2007, deadline for compliance with the national provider identifier (NPI) regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The final rule establishing the NPI as the standard unique health provider identifier for health care providers was published in 2004 and requires all covered entities to be in compliance with its provisions by May 23, 2007, except for small health plans, which must be in compliance by May 23, 2008.

"The enforcement guidance released today clarifies that covered entities that have been making a good faith effort to comply with the NPI provisions may, for up to 12 months, implement contingency plans that could include accepting legacy provider numbers on HIPAA transactions in order to maintain operations and cash flows." said CMS Acting Administrator Leslie V. Norwalk, Esq.

The NPI is an identifier that will be used by covered entities to identify health care providers, eliminating the current need for multiple identifiers for the same provider. The NPI replaces all "legacy" identifiers that are currently being used, such as Medicaid provider IDs, individual plan provider IDs, UPINs, etc., and will be required for use on health care claims and other HIPAA transactions.

CMS made the decision to announce this guidance on its enforcement approach after it became apparent that many covered entities would not be able to fully comply with the NPI standard by May 23, 2007.

This guidance would protect covered entities from enforcement action if they continue to act in good faith to come into compliance, and they develop and implement contingency plans to enable them and their trading partners to continue to move toward compliance. HHS recognizes that transactions often require the participation of two covered entities and that non-compliance by one covered entity may put the second covered entity in a difficult position.

The enforcement process is complaint driven and will allow covered entities to demonstrate good faith efforts and employ contingency plans. If a complaint is filed against a covered entity, CMS will evaluate the entity's "good faith efforts" to comply with the standards and would not impose penalties on covered entities that have deployed contingencies to ensure that the smooth flow of payment continues. Each covered entity will determine the specifics of its contingency plan. Contingency plans may not extend beyond May 23, 2008, but entities may elect to end their contingency plans sooner. Medicare will announce its own contingency plan shortly.

CMS encourages health plans to assess the readiness of their provider communities to determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance. Likewise, we encourage health care providers that have not yet obtained NPIs to do so immediately, and to use their NPIs in HIPAA transactions as soon as possible. Applying for an NPI is fast, easy and free. Visit the National Plan/Provider Enumeration System (NPPES) website at *https://nppes.cms.hhs.gov/*.

A critical aspect of implementing the NPI is the ability for covered entities to match a provider's NPI with the many legacy provider identifiers that have been used to process administrative transactions.

CMS plans to make data available from the NPPES system that will assist covered entities in developing these "crosswalks."

CMS Clarifies Guidelines For National Provider Identifier Deadline Implementation, continued

Further information concerning this issue is available on the CMS website at *http://www.cms.hhs.gov*. The site also contains contingency plan guidance for the industry in a document titled "Guidance on Compliance with the HIPAA National Provider Identifier Rule."

To view this guidance, visit *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf* on the CMS website. A press release on this topic is also available at *http://www.cms.hhs.gov/apps/media/press_releases.asp* on the Web.

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

Source: Provider Education Resources Listserv, Message 200704-03
Provider Education Resources Listserv, Message 200704-08

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Provider Education for Handling Issues Related to Deceased Providers

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

Provider Types Affected

Those submitting claims on behalf of physicians and providers who died before obtaining a national provider identifier (NPI), where such submitted claims that were received by a Medicare contractor (carrier, Part A/B Medicare administrative contractors [A/B MAC], durable medical equipment [DMERC] and/or DME Medicare administrative contractors, [DME/MAC]) after May 23, 2007.

Background

This article and related change request (CR) 5508 addresses NPI issues related to deceased providers. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Secretary of the Department of Health & Human Services adopt standards providing for a standard unique health identifier for each health care provider for use in the health care system and to specify the purpose for which the identifiers may be used.

All entities covered under HIPAA must comply with the requirements of the NPI final rule no later than May 23, 2007. Among these requirements are the following:

- Any health care provider who is an entity covered under HIPAA must obtain an NPI.
- Health care providers meeting the definition of health care provider referenced in the NPI final rule but not covered entities are eligible to obtain NPIs as well.
- Health care providers covered under HIPAA must use NPIs to identify themselves and their subparts (if applicable) on all standard transactions adopted under HIPAA.

Because deceased providers may not have NPIs, this article discusses what representatives of those providers need to do in order to submit claims that need to be paid.

Key Points of CR 5508

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

- A representative of the estate of a proprietor cannot apply for an NPI for that provider posthumously.
- If a provider dies before obtaining an NPI and claims for that provider are received by a Medicare contractor after May 23, 2007, and **Medicare (the Medicare contractor, the Medicare online survey and certification reporting system [OSCAR], of the national supplier clearinghouse [NSC]) has not been notified of the death**, the **claims will reject when received by Medicare due to the absence of the provider's NPI.**
- At that point, the claim submitter would be expected to contact the Medicare contractor to which the claims were submitted to discuss payment of the claims and report the provider's death. Toll free number of the Medicare contractors are available at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.
- The state in which a provider furnishes care will continue to be responsible for notification of Medicare of the death of a provider following existing procedures. Since some states send such notifications on a quarterly basis, CMS is implementing the following procedures to enable affected claims to be paid more promptly:
- Because Medicare will reject an electronic claim received without an NPI after May 23, 2007, in cases where the provider died prior to obtaining an NPI, the provider's representative will need to submit the claim on paper.
- A representative of the estate should then contact the claim processing contractor, who will notify the provider that they must submit the claims on paper and that they must annotate the claim to state that the provider is deceased in Item 19.

Additional Information

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

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

You may view the official instruction (CR 5508) issued to your Medicare carrier, DME/MAC, DMERC and/or A/B MAC by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1216CP.pdf* on the CMS website.

MLN Matters Number: MM5508
Related Change Request (CR) #: 5508
Related CR Release Date: March 30, 2007
Effective Date: May 23, 2007
Related CR Transmittal #: R1216CP
Implementation Date: April 30, 2007

Change in the Amount in Controversy Requirement for Federal District Court Appeals

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) 5518, which notifies Medicare contractors of an increase in the amount in controversy required to sustain federal district court appeal rights beginning January 1, 2007.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an annual reevaluation, beginning in 2005, of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or federal district court review. Therefore, CR 5518 updates the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 29, Sections 330.1 and 345.1) to announce the amount in controversy requirements for ALJ or federal district court appeals during 2007.

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2006 was $100. The amount in controversy requirement increased to $110 for requests made on or after January 1, 2006. CR 5518 announces that for ALJ hearing requests made on or after January 1, 2007, the amount that must remain in controversy did not change and remains at $110.

The amount remaining in controversy requirement for federal district court review prior to January 1, 2006, was $1,000. That amount increased to $1,090 on or after January 1, 2006. CR 5518 announces that for federal district court review requests made on or after January 1, 2007, the amount that must remain in controversy is increased to $1,130.

Additional Information

The official instruction, CR 5518, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1211CP.pdf* on the CMS website.

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

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

MLN Matters Number: MM5518
Related Change Request (CR) #: 5518
Related CR Release Date: March 30, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R1211CP
Implementation Date: July 2, 2007

Medicare Physician Fee Schedule Fact Sheet Available In Print Format

The Medicare Physician Fee Schedule Fact Sheet, which provides general information about the Medicare physician fee schedule, is now available in print format. To place an order for the fact sheet, visit the Medicare Learning Network at *http://www.cms.hhs.gov/mlngeninfo* on the Centers for Medicare & Medicaid Services website and select "MLN Product Ordering Page" under the "Related Links Inside CMS" Section.

Source: Provider Education Resources Listserv, Message 200704-01

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

Part C Plan Type Display on Medicare Common Working File—CR 5538 Rescinds And Fully Replaces CR 5349

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

Provider Types Affected

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

Provider Action Needed

Be aware of the expanded list of Medicare Advantage (MA) plan type descriptions that are being displayed by Medicare CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in private fee-for-service (PFFS) plans. A plan directory, which is quite descriptive, is now available at *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/*.

Background

The CWF displays information on the Medicare Part C (now known as Medicare Advantage) contract number in which a beneficiary is enrolled, including the plan type description associated with the contract, and currently, CWF displays the label "HMO" for these contracts. In many of these cases, the "HMO" label is incorrect because the list of possible plan type descriptions has grown much larger since the creation of the Medicare Advantage (MA) programs.

This situation has especially become problematic for Medicare beneficiaries who are enrolled in MA PFFS contracts because PFFS contracts are labeled as "HMO" in CWF. Consequently, some providers are not recognizing that they can offer services to those beneficiaries enrolled in a MA PFFS contract.

To address this issue, the Health Plan Management System (HPMS) will modify the existing HMO address file exchange process with CWF in order to supply the list of available contract numbers and their corresponding plan type descriptions. With this new data, CWF can correctly display one of the following plan type descriptions: HMO, PPO, POS, indemnity, or FFS demonstration. The following table provides additional information to providers regarding these plan type descriptions:

Plan Type Description	Brief Guidance on Treating Patient	Additional Information
HMO	Call plan for authorization.	Managed Care plan with a provider network. Limited or no out-of-network coverage with the exception of emergency services.
PPO	You may treat the patient.	Has a network of providers. In return for higher cost sharing, members can go out of the plan network for all plan services, including supplemental benefits.
POS	You may treat the patient subject to plan rules. Contact the plan for details.	A limited out-of-network option offered by HMO plans. Contact plan for details.
Indemnity	You may treat the patient.	If this is a PFFS plan, you must follow the PFFS plan's terms and conditions of payment. If this is a Medical Savings Account (MSA) plan, the member may pay you directly.
FFS Demo	You may treat the patient.	Beneficiaries remain in original Medicare and are entitled to all fee-for-service benefits. There are no changes to Medicare FFS billing instructions or claims processing.

Additional Information

The official instruction, CR 5538, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1219CP.pdf* on the CMS website.

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

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

MLN Matters Number: MM5538 — Related Change Request (CR) #: 5538
Related CR Release Date: April 13, 2007 — Effective Date: July 1, 2007
Related CR Transmittal #: R1219CP — Implementation Date: July 2, 2007

New Web Page Regarding Medicare Advantage and Part D Plans

The Centers for Medicare & Medicaid Services (CMS) announces the launch of a new section on the CMS website to house contract and enrollment data about Medicare Advantage (MA) and Part D plans. The new section may be found at: *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/*.

This section provides: a) a plan directory, and b) an MA claim processing contact directory. These directories contain basic information about the contract as well as contact information for the plan itself. CMS will update these directories on a monthly basis. Also, CMS is providing this data in three formats: a PDF document sorted by contract name, a PDF document sorted by contract number, and an Excel® version.

Source: Provider Education Resources Listserv, Message 200703-22

Centers For Medicare & Medicaid Services Launches DOQ-IT University

New Interactive Learning Tool Educates Physicians in the Adoption and Implementation of Electronic Health Records and Care Management Practices

The Centers for Medicare & Medicaid Services (CMS) announced the national launch of DOQ-IT (Doctor's Office Quality Information Technology) University, or DOQ-IT U, to support health information technology (HIT) in physicians' offices.

DOQ-IT U is an interactive, Web-based tool designed to provide solo and small-to-medium sized physician practices with the education for successful HIT adoption, including lessons on culture change, vendor selection and operational redesign, along with clinical processes. The nationally available e-learning system is available at no charge.

"CMS is pleased to launch DOQ-IT University, the first of its kind e-learning platform, to provide assistance to physicians across the United States in the adoption and implementation of electronic health records and care management practices," said CMS Acting Administrator Leslie V. Norwalk, Esq. "DOQ-IT U's interactive platform, self-paced curriculum, and associated tools provide physicians with easy access to the resources they need to help ensure that patients receive the highest quality of care at all times."

DOQ-IT U will provide lessons in assessment, planning and implementation methodologies that will be disease and population specific, incorporating clinical decision support and evidence-based medicine guidelines. This e-learning platform will be utilized to provide physicians with a self-paced curriculum and associated tools, based on adult learning principles, available at their convenience. Additional features, such as surveys, utilization tracking, and continuing medical education/continuing education unit (CME/CEU) offering/issuing capabilities will also be included in the near future.

The first learning sessions (modules), available now, focus on physician office workflow redesign, culture change, and communication necessary for successful electronic health record (EHR) adoption, implementation of care management, and the incorporation of a strong patient self-management component to clinical care. Disease specific modules, starting with diabetes, will include a patient self-management component, which is critical to successfully managing patients with chronic disease.

DOQ-IT U is being developed and managed by the Quality Improvement Organization (QIO) program, under contract to CMS. A QIO is present in each U.S. state, territory, and the District of Columbia.

A technical advisory panel (TAP) composed of leading medical experts from the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), the American Board of Internal Medicine (ABIM), Healthcare Information and Management Systems Society (HIMSS), American Health Information Management Association (AHIMA), private payers, and patient self-management experts, has been convened and will provide content, consultation and evaluation of the care management/DOQ-IT U modules.

For more information, please see CMS' DOQ-IT U website at: *http://elearning.qualitynet.org*.

Source: Provider Education Resources Listserv, Message 200704-18

Medicare Announces Measure Specifications for the Physician Quality Reporting Initiative

The Centers for Medicare and Medicaid Services (CMS) announced the posting of detailed specifications for the 74 measures included in the 2007 Physician Quality Reporting Initiative (PQRI).

PQRI establishes a financial incentive for physicians and other health practitioners to participate in a voluntary quality-reporting program. Eligible professionals who successfully report data for a designated set of quality measures may earn a bonus payment, subject to a cap, of 1.5 percent of total allowed charges for covered Medicare physician fee schedule services provided during the reporting period of July 1, 2007, to December 31, 2007.

"CMS is committed to becoming an active purchaser of high quality, efficient health care, and the PQRI program is an important step in that transformation," said CMS Acting Administrator Leslie V. Norwalk.

The 2007 PQRI quality measures relate to important processes of care that are linked to improved health care quality outcomes. They are evidence and consensus based measures that reflect the work of national organizations involved in quality measure development, consensus endorsement, and adoption. These include the American Medical Association Physician Consortium for Performance Improvement, the National Committee for Quality Assurance, the National Quality Forum, the AQA Alliance, and other physician and nonphysician professional organizations. The professional organizations are also assisting CMS in providing PQRI education and assistance to their members.

Medicare Announces Measure Specifications For The Physician Quality Reporting Initiative, continued

The specifications have been posted well in advance of the statutory deadline of July 1, 2007. This is to help eligible professionals to identify measures applicable to their practices and to prepare for submission of quality data in advance of the July 1, 2007, start date of the program. CMS anticipates a small number of additional specification changes, which may expand the applicability of the measures to additional eligible professionals.

The PQRI measures apply to services that eligible professionals provide to Medicare beneficiaries in their offices and other settings. CMS is implementing an extensive outreach and education plan to assist eligible professionals to understand the program and the measures and to implement processes to efficiently capture the quality data that is to be reported under the PQRI program.

The measure specifications document and other programmatic information are available at *http://www.cms.gov/pqri/* Questions should be submitted through the website.

Source: Provider Education Resources Listserv, Message 200704-05

Special Open Door Forum On Registry-Based Reporting For The Physician Quality Reporting Initiative

The Centers for Medicare & Medicaid Services (CMS) will host a special open door forum on the use of registries for reporting data on quality measures to the Physician Quality Reporting Initiative (PQRI).

This special open door forum will take place from 1:00 p.m. – 5:00 p.m., EDT, on Monday, May 14, 2007, in the CMS auditorium, 7500 Security Blvd., Baltimore, MD. A toll-free number will be available for those who will participate by telephone.

Division B, Title 1-Medicare Improved Quality and Provider Payments, Section 101 (b) of the Tax Relief and Health Care Act (TRHCA) of 2006, states that "As part of the publication of proposed and final quality measures for 2008... the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database), as identified by the Secretary." This special open door forum will build on the broad overview of the 2007 PQRI program presented on two recent national provider conference calls by giving providers and organizations that use or produce registries and other members of the public the opportunity to discuss the potential use of registries for reporting data on quality measures to PQRI.

For the most up to date information on PQRI, please visit *http://www.cms.hhs.gov/PQRI*.

To participate in the special open door forum in person or by phone, you will need to register on this website: *http://registration.intercall.com/go/cms2*.

Registration will close at 4:00 p.m. EDT on Wednesday May 9, 2007. Please be sure to register prior to this time.

For those who will be unable to attend, the special open door forum will be recorded. A replay option will be available beginning the close of business May 18, 2007, and will be accessible for three days. You may visit the following website *http://www.cms.hhs.gov/center/hospital.asp* to download an audio recording.

If you have questions or require special accommodations, please contact Diane Stern at diane.stern@cms.hhs.gov at 1-410-786-1133.

Source: Provider Education Resources Listserv, Message 200704-27

National Colorectal Cancer Awareness Month Is Over

Don't Forget to Follow-Up!

National Colorectal Cancer Awareness Month is over, but that doesn't mean the messages to your patients should stop until next year. Remind patients who have taken home a fecal occult blood test kit to use it. Follow up with patients on all screening results, even negative ones—everyone likes to hear good news. Remember, the appropriate follow-up for a positive fecal occult blood test result is a colonoscopy, not another fecal occult blood test.

Follow the Guidelines to Guide Next Steps When Polyps Are Found

A recent survey by the National Cancer Institute found that gastroenterologists and surgeons are performing surveillance colonoscopies at more frequent intervals than those recommended by evidence-based guidelines. For example, 24 percent of gastroenterologists and 54 percent of surgeons recommended a colonoscopy, either alone or with another procedure, at least every five years after the identification of a small, benign, hyperplastic polyp (Mysliwiec et al., 2004). Medical guidelines do not recommend any follow-up colonoscopy for hyperplastic polyps because their presence has not been shown to increase the risk of colorectal cancer. In contrast, adenomatous polyps ARE associated with cancer and people who have multiple polyps of this kind should be screened at shorter intervals.

Guidelines for surveillance after polypectomy were recently updated—here are references to two publications featuring these guidelines:

- Winawer, Zauber, Fletcher et al. Guidelines for Colonoscopy Surveillance after Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society. *Gastroenterology* 2006; 130:1872-1885.

National Colorectal Cancer Awareness Month Is Over, continued

- Winawer, Zauber, Fletcher et al. Guidelines for Colonoscopy Surveillance after Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society. *CA Cancer J Clin* 2006; May-Jun; 56(3):143-59

For More Information

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

The Centers for Medicare & Medicaid Services (CMS) website also has a "Prevention" website, which contains a section on colorectal cancer screening. From the CMS home page, *http://www.cms.hhs.gov*, select "Medicare" and scroll down to "Prevention" to find the colorectal cancer screening section.

Thank You for the Great Work!

Thank you for helping CMS spread the word regarding the importance of colorectal cancer screening. We are interested in knowing if the information we have provided over the last few weeks has been helpful, and if it has influenced your colorectal cancer screening practices. Please e-mail CMS at: *Prevention@cms.hhs.gov*

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

Source: Provider Education Resources Listserv, Message 200703-27

See How Well Your County or State Has Done in Providing Colorectal Cancer Screening to People with Medicare

Click on the following link: *http://www.mrnc.org/crcreport2/*

The Carolinas Centers for Medical Excellence, Inc., the Quality Improvement Organization for North and South Carolina, calculated national, state, and county colorectal cancer screening rates using Medicare claims data from 1998-2004. The data indicate that over half (52 percent) of those eligible for screening had at least one test in the seven-year period.

Other highlights from the data:

- Although the largest group of people eligible for screening was composed of persons between the ages 65-74 (41 percent of those eligible), the rate of screening was highest among people ages 75-84 (59 percent screened).
- Test use was highest among Caucasians (53 percent), followed by Asians (46 percent), African Americans (45 percent), persons of Hispanic descent (45 percent), and Native Americans (35 percent).
- There was considerable disparity between the test rates for those eligible for only Medicare (54 percent) and persons eligible for both Medicare and Medicaid (43 percent).
- Persons eligible for Medicare due to a disability also had lower test rates (45 percent) than those eligible because of age (54 percent).
- Among the four covered tests, fecal occult blood test was the most commonly used test with a rate of 34 percent. Colonoscopy had the second highest use rate (31 percent), followed by sigmoidoscopy (14 percent) and barium enema (6 percent).
- Test use varied across states. In 2004, Rhode Island Medicare consumers had the highest test use (26 percent had one of the tests) and the lowest in Wyoming (13 percent).

CMS Needs Your Help

No part of the Medicare population has high rates of use of colorectal cancer screening tests. The Centers for Medicare & Medicaid Services (CMS) needs your help to get the word out to your Medicare patients and their caregivers about the benefits of colorectal cancer screening. We hope that you will encourage your eligible Medicare patients to take advantage of this potentially life saving benefit.

For More Information

For information and resources to help you discuss colorectal cancer screening with your patients, visit the following American Cancer Society website: *http://www.cancer.org/colonmd?utm_source=CMSlistserve&utm_medium=email&utm_term=colon&utm_content=colonMD*

Medicare-Covered Colorectal Cancer Screening Tests/Procedures:

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

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

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

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

Source: Provider Education Resources Listserv, Message 200703-20

Important News About the Medicare DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) has announced that the Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Final Regulation is now on display at the Office of the Federal Register. CMS has also announced the first 10 metropolitan areas in which competition will occur as well as the first items to be competitively bid. Visit the CMS website at *http://www.cms.hhs.gov/competitiveacqfordmepos/* to view the rule and obtain additional information.

Source: Provider Education Resources Listserv, Message 200704-06

Initial Registration Is now Open for Suppliers Interested in Competitive Bidding for DMEPOS

The initial registration process is now open and available to all suppliers interested in participating in the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Bidding Program. Interested suppliers will submit their bids using an Internet application. To help ensure the privacy of all bids, all suppliers must complete initial registration in the Internet application to get a USER ID and password. **Suppliers need to complete this initial registration process early.** We strongly recommend that they do so well before the bid window opens to avoid a delay in being able to submit bids. Bidding is currently scheduled to open in late April 2007.

The initial registration process requires the **authorized official**, as identified in Section 15 of the CMS 855S, to complete the information required in the Internet application. The authorized official's information must match the information on file at the National Supplier Clearinghouse. The USER ID and password will be mailed to the authorized official if his/her submitted information matches exactly the data on file for last name, date of birth, Social Security number and supplier number. The USER ID and password will be delivered in 2 separate mailings to the authorized official at the correspondence address (Section 2A.2) listed on the CMS 855S. An authorized official only needs **one** USER ID and password in order to submit bids for any company for which he/she was listed as the authorized official on the CMS 855S. To complete this initial registration and obtain a USER ID and password, please go to *https://applications.cms.hhs.gov*.

Suppliers must have the USER ID and password before they can enter a bid into the competitive bidding Internet application. However, the USER ID and password cannot be used until the bidding window opens, which is expected in late April 2007.

Please read the user guide for the Individuals Authorized Access to CMS Computer Services (IACS) application before attempting initial registration. This guide can be found on the Competitive Bidding Implementation Contractor's website at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home*. If you have any questions about the initial registration process, please contact the Competitive Bidding Implementation Contractor (CBIC) helpdesk on 1-877-577-5331. The helpdesk will be available:

Monday – Friday: 6:00 a.m. – 9:00 p.m. ET
Saturday: 9:00 a.m. – 3:00 p.m. ET

An *MLN Matters* article regarding this registration process will be forthcoming. Additional information on the DMEPOS Competitive Bid Program can be found in *MLN Matters* article MM5574 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf*. Information on accreditation for suppliers can be found in *MLN Matters* article SE0713 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf*.

Important Note: For added security, when suppliers use their USER IDs and passwords to access the Competitive Bid Submission System for the first time, they will need to complete a brief authentication process. The information required for this process must also match the information in the National Supplier Clearinghouse file**.** If you successfully completed the initial registration and received your USER ID and password, please enter your information exactly as you did for initial registration when completing the Competitive Bid Submission System authentication process. Failure to do so may delay your ability to use the system.

Source: Provider Education Resources Listserv, Message 200704-16

Get Accredited for DMEPOS Competitive Bidding!

Important DMEPOS Competitive Bidding Announcement

In order to participate in the Medicare DMEPOS Competitive Bidding Program, suppliers must meet quality standards and be accredited by a CMS-approved Deemed Accreditation Organization.

Suppliers that are interested in bidding under the new program must be aware of two key deadlines:

- Suppliers must be accredited or be pending accreditation to submit a bid. CMS cannot accept a bid from any supplier that is not accredited or has not applied for accreditation.
- To be awarded a contract, suppliers will need to be accredited. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers must be accredited before this date to be awarded a contract. Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

Bidding is expected to open in late April 2007. For a list of the CMS-approved Deemed Accreditation Organizations and information about the Medicare DMEPOS Competitive Bidding program, visit *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/*.

To view a special edition *MLN Matters* article on this topic, visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf*.

Source: Provider Education Resources Listserv, Message 200704-25

Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies Competitive Bidding Program

The Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Final Regulation is now published at the *Federal Register* at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/Downloads/CMS-1270-F.pdf*

CMS has also announced the first 10 metropolitan areas in which competition will occur, as well as the first items to be bid competitively. Visit the CMS website at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/* to view the rule and for additional information.

Source: CMS JSM/TDL-07364, dated April 26, 2007

Initial Supplier Registration for Competitive Bidding Program for DMEPOS is Now Open

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

Provider Types Affected

All suppliers of durable medical equipment (DME) that wish to participate in the Medicare Competitive Bidding Program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Provider Action Needed

STOP – Impact to You

Suppliers wishing to participate in the program must register and obtain a user identification (USER ID) number and password in order to submit their bids electronically to Medicare.

CAUTION – What You Need to Know

Without the USER ID and password, suppliers will not be able to submit electronic, on-line bids. Further, incorrect information could delay issuance of your USER ID and password.

GO – What You Need to Do

Register for the USER ID early in order to confirm that correct information is on file with Medicare and the National Supplier Clearinghouse (NSC) so you can avoid any delays in submitting bids. The background and additional information sections of this article provide important information about the registration process.

Background

The Centers for Medicare & Medicaid Services (CMS) will be using an on-line system to accept bids for the Medicare DMEPOS Competitive Bidding Program. . To take advantage of this opportunity, bidders must first complete an on-line registration process. The name of the on-line registration program is the Individuals Authorized Access to CMS Computer Services (IACS) system. To complete the initial registration and obtain a USER ID and password, please go to *https://applications.cms.hhs.gov*. The on-line registration will be available up to 14 days prior to the close of the bidding window.

The process will require the supplier to have its authorizing official, the person identified in Section 15 on the CMS-855S application form, register and receive a USER ID and password. The authorized official's information must match the information on file at the NSC.

If an organization has one authorizing official but many NSC numbers, the organization needs to submit only one (1) registration request to obtain access to the IACS system. During the registration process, the bidding organization will have to report one of its NSC numbers—the correspondence address associated with that NSC number will be used for mailing the IACS system USER ID and Password.

If an organization has multiple authorizing officials for the same NSC number, only one authorizing official needs to obtain access to the IACS system.

An authorizing official only needs one USER ID and password in order to submit bids for every company for which he/she was listed as such on the CMS-855S.

Potential registrants should first read the CMS document entitled, "Individuals Authorized Access to CMS Computer Services (IACS): Competitive Bid Submission System/Durable Medical Equipment (CBSS/DME) User Guide." You may view this guide on the Competitive Bidding Implementation Contractor's (CBIC) website at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home*. If you have any questions about the initial registration process, please contact the competitive bidding implementation contractor's helpdesk at 1-877-577-5331. The helpdesk will be available Monday – Friday 6:00 a.m. – 9:00 p.m. prevailing Eastern Standard Time and on Saturday 9:00 a.m. – 3:00 p.m. prevailing Eastern Standard Time.

Suppliers are required to register through IACS and get USER IDs and passwords before access to the CBSS/DME will be granted. The bidding window is not scheduled to open until late April 2007; however, suppliers planning to bid are strongly urged to register now, so any issues with USER IDs and passwords can be resolved before the bidding window opens. The issues could include:

- Incorrect authorized official information maintained by the national supplier clearinghouse (NSC) as identified in Section 15 of your CMS-855S.
- Incorrect authorized official date of birth or social security number.
- NSC number does not match the authorizing official information.
- Incorrect correspondence address maintained by the NSC as listed on your CMS-855S in Section 2A.2.

The USER ID and password will be mailed to the authorized official if his/her submitted information matches exactly the data on file for last name, date of birth, Social Security number and supplier number. The USER ID and password will be delivered in two separate mailings to the authorized official at the correspondence address (Section 2A.2) listed on the CMS 855S.

It may take up to 15 days for the NSC to correct authorized official information. Correcting a correspondence address may take up to 45 days. These timeframes for correcting NSC data may be longer depending on the number of requests received by the NSC. This underscores the need to start early.

Initial Supplier Registration for Competitive Bidding Program for DMEPOS is Now Open, continued

Important note: For added security, when suppliers use their USER IDs and passwords to access the competitive bid submission system for the first time, they will need to complete a brief authentication process. The information required for this process must also match the information in the national supplier clearinghouse file. If you successfully completed the initial registration and received your USER ID and password, please enter your information exactly as you did for initial registration when completing the competitive bid submission system authentication process. Failure to do so may delay your ability to use the system.

Additional Information

Detailed instructions on how to register for CMS application access may be found in the Guide at *http://www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home*.

Remember that **this first step is the registration to gain access** to online bidding materials—it is not the actual bidding process.

The competitive bidding implementation contractor (CBIC) help desk can help you with any problems or questions you have regarding the IACS registration process. The Help Desk number is 1-877-577-5331.

You may also want to review a related *MLN Matters* article that covers accreditation requirements for suppliers wishing to participate in the Competitive Bidding Program. That article, SE0713, is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf* on the CMS website.

Periodically, you may also want to visit *http://cms.hhs.gov/CompetitiveAcqforDMEPOS/01_overview.asp* to stay abreast of developments for this program.

MLN Matters Number: SE0717
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Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Accreditation Information for Suppliers of 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

All suppliers of durable medical equipment (DME) that wish to participate in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) program.

Provider Action Needed

This special edition (SE) article, SE0713, provides the information that DME suppliers need to comply with Section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). That MMA section requires the Secretary of the Department of Health & Human Services (HHS) to establish and implement quality standards for DMEPOS suppliers. All DMEPOS suppliers wishing to bill Medicare for DMEPOS provided to Medicare patients must comply with these standards to receive Medicare Part B payments. In addition, Section 1847 (b)(2)(A)(i) of the Social Security Act requires DMEPOS suppliers meet these standards before being awarded a contract under the upcoming Medicare DMEPOS Competitive Bidding Program.

Background

Section 302 of the MMA required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers of DMEPOS must comply with the quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. Covered items include (Section 1834 [a] [13] and [h] [4]):

- Medical supplies
- Home dialysis supplies and equipment
- Therapeutic shoes
- Parenteral and enteral nutrient, equipment and supplies
- Electromyogram devices
- Salivation devices
- Blood products
- Transfusion medicine
- Prosthetic devices, orthotics.

The standards will be applied prospectively and are published at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS* on the Centers for Medicare & Medicaid Services (CMS) website. Also, note that Section 1847(b)(2)(A)(i) of the Act requires DMEPOS suppliers to meet the quality standards before being awarded a contract under the Medicare DMEPOS Competitive Bidding Program.

Please note that suppliers must be accredited or be pending accreditation to submit a bid. CMS cannot accept a bid from any supplier that is not accredited or has not applied for accreditation. Additionally, to be awarded a contract, suppliers must be accredited. **The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers must be accredited before this date in order to be awarded a contract.** Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

The quality standards are separated into two sections and have three appendices, as follows:

- Section I includes the business standards that apply to all suppliers and focus on standards for administration, financial management, human resource management,

Accreditation Information for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, continued

consumer services, performance management product safety, and information management.
- Section II contains product-specific service standards, including intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver, and follow-up service.
- Appendix A deals with respiratory equipment, supplies, and services.
- Appendix B deals with manual wheelchairs and power mobility devices, including complex rehabilitation and assistive technology.
- Appendix C deals with custom fabricated, custom fitted and custom made orthotics, prosthetic devices, somatic, ocular and facial prosthetics, and therapeutic shoes and inserts.

In order to participate in Medicare Part B, DMEPOS suppliers will need to be accredited and in compliance with these standards. The accreditation will be phased in and to accommodate the suppliers who wish to participate in the Medicare Competitive Bidding Program for DMEPOS, CMS will require accreditation organizations to prioritize their surveys of suppliers to accredit suppliers in the selected metropolitan statistical areas (MSAs) where the bidding program will begin. To provide additional information on the accreditation surveys, suppliers should note that:

- All surveys are performed on site at the supplier location.
- All surveys are unannounced.
- Accreditation cannot be transferred upon merger, acquisition or sale – CMS, the national supplier clearinghouse (NSC) and the accreditation organization must be notified when these events occur.
- The accreditation organization and the NSC will be coordinating efforts so that the supplier number can be revoked when accreditation is revoked.

Status of Accreditations

- Almost 5,000 suppliers are already accredited (329 of those are in the 20 MSAs proposed in the NPRM for the Competitive Bidding Program).
- One thousand surveys have been scheduled since the start of 2007.
- Ten (10) Accreditation Organizations were deemed by CMS in Nov. 2006. Those organizations are listed at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf* on the CMS website.

Suppliers can contact the deemed accrediting organizations directly based on the information provided at that website.

Additional Information

The CMS complete listing of all DME resources is available at *http://www.cms.hhs.gov/center/dme.asp* on the CMS website.

The CMS Web page for the Competitive Bidding Program is *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS*.

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Related Change Request (CR) #: N/A
Related CR Release Date: N/A
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Implementation Date: N/A

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.

LOCAL COVERAGE DETERMINATIONS

Unless otherwise indicated, articles apply to both Connecticut and Florida.

This section of the *Medicare B Update!* features summaries of new and revised local coverage determinations developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's medical policies and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text LCDs on our provider education websites, *http://www.connecticutmedicare.com or http://www.floridamedicare.com*. Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each policy, and are based on the date of service (unless otherwise noted in the policy). Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to *http://www.connecticutmedicare.com or http://www.floridamedicare.com* , click on the "eNews" link on the navigational menu and follow the prompts.

More Information

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

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

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Advance Notice Statement

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

NEW LCD

J0129: Abatacept—New LCD

Abatacept is indicated for reducing signs and symptoms, inducing major clinical response, slowing the progression of structural damage, and improving physical function in adult patients with moderate to severe active rheumatoid arthritis who have had an inadequate response to one or more disease-modifying antirheumatic drugs (DMARDS), such as methotrexate or tumor necrosis factor (TNF) antagonists. Abatacept may be used as monotherapy or concomitantly with DMARDS other than TNF antagonists. It should not be administered concomitantly with TNF antagonists and it is not recommended for use concomitantly with anakinra.

This local coverage determination (LCD) was developed after evaluation of data identified abatacept as one of two drugs which were a factor in causing a 277 percent increase in re-imbursements for HCPCS code J3590 (unlisted biological drugs). A new HCPCS code for Abatacept (J0129) became effective January 1, 2007. The LCD provides coverage guidelines for the administration of abatacept.

Effective Date

This LCD will be effective for services rendered on or after June 30, 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.

REVISIONS TO LCDS

EPO: Epoetin alfa—LCD Revision

This local coverage determination (LCD) was last updated March 8, 2007. Since that time, the U. S. FDA (Food and Drug Administration) notified health care professionals of new safety information for erythropoiesis-stimulating agents (ESAs) Aranesp® (darbepoetin alfa), Epogen® (epoetin alfa), and Procrit® (epoetin alfa), drugs used to treat certain causes of anemia. Four new studies in patients with cancer found a higher chance of serious and life-threatening side effects or death with the use of ESAs. These research studies were evaluating an unapproved dosing regimen, a patient population for which ESAs are not approved, or a new unapproved ESA. In another study, patients scheduled for orthopedic surgery had a higher rate of deep venous thrombosis when treated with ESA at the approved dose. This new information is consistent with risks found in two clinical studies in patients with chronic renal failure treated with an unapproved regimen of an ESA that were reported in November 2006.

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

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

With this decision, the LCD for epoetin alfa (EPO, Procrit), will be revised as follows:

- Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD:
  - Removed the indication for anemia of malignancy not due to concurrent chemotherapy.
  - Revised the FDA-approved covered indications to read exactly per the FDA-approved label.
- Under the “Utilization Guidelines” section of the LCD:
  - Added a statement about endpoints for administering EPO for anemia associated with concurrent chemotherapy.
- Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD for HCPCS code J0885:
  - Removed ICD-9-CM codes 205.00-205.91, 206.00-206.91, 207.00-208.91 and 285.22 as these ICD-9-CM codes are no longer supported as medically necessary.

EPO: Epoetin alfa—LCD Revision, continued

- Added a dual diagnosis requirement for the following ICD-9-CM codes:

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

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

In evaluating the new coding requirements as noted above, FCSO determined that there were not appropriate ICD-9-CM codes for the covered off-label indication anemia associated with the management of hepatitis C. Therefore, FCSO has added ICD-9-CM codes 571.40, 571.41 and 571.49 as medically necessary for this off-label indication. The coding instructions found in the coding guideline for this indication were updated with this revision.

- The coding guideline was revised accordingly for all other revisions mentioned in this article.

FCSO is continuing to evaluate all other off-label coverage found in the epoetin alfa LCD. FCSO will communicate to physicians and allied providers if and when such off-label indications are removed from the local policies.

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

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

Effective Date

These revisions to the LCD are effective for services rendered on or after May 3, 2007.

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

J2505: Pegfilgrastim (Neulasta®)—LCD Revision

This local coverage determination (LCD) was last revised on October 1, 2006. Since that time, the LCD has been revised. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to correct wording related to the administration of Neulasta. The following sentence, "The administration should not occur within 14 days before, **or** 24 hours after, administration of cytotoxic chemotherapy," was revised to read per the product label. The revised sentence reads as follows: "The administration should not occur within 14 days before, **and** 24 hours after, administration of cytotoxic chemotherapy."

Effective Date

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

0145T: Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries—LCD Revision

This local coverage determination (LCD) was last revised on January 1, 2007. Since that time, the "ICD-9 Codes that Support Medical Necessity" section of the LCD for *CPT* code *71275* has been revised to add ICD-9-CM code 441.2 (Thoracic aneurysm without mention of rupture).

Effective Date

This LCD revision is effective for services rendered on or after April 23, 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.

ADDITIONAL INFORMATION

Corrected Pricing for *CPT* Codes *0145T-0151T*

Effective for services processed on or after February 5, 2007, for dates of service on or after January 1, 2007. First Coast Service Options, Inc. (FCSO) has established the 2007 global, techinical (TC) and professional (26) component pricing for the category III *CPT* codes:*0145T – 0151T* (Cardiac computed tomography [CCT] and Cardiac computed tomographic angiography [CCTA]). 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).

Please Note: Providers will have to determine payment amounts by comparing the MPFS/carrier-priced amounts to the cap amounts for the TC and global portion of imaging services. The lower amount will be paid.

Connecticut

CODE/MOD	PAR	NON-PAR	LMTG CHG	CODE/MOD	PAR	NON-PAR	LMTG CHG
0145T	640.70	608.67	699.96	*0148T* 26	98.17	93.26	107.25
0145T TC	542.53	515.40	592.71	*0149T*	640.70	608.67	699.96
0145T 26	98.17	93.26	107.25	*0149T* TC	542.53	515.40	592.71
0146T	640.70	608.67	699.96	*0149T* 26	98.17	93.26	107.25
0146T TC	542.53	515.40	592.71	*0150T*	640.70	608.67	699.96
0146T 26	98.17	93.26	107.25	*0150T* TC	542.53	515.40	592.71
0147T	640.70	608.67	699.96	*0150T* 26	98.17	93.26	107.25
0147T TC	542.53	515.40	592.71	*0151T*	150.00	142.50	163.87
0147T 26	98.17	93.26	107.25	*0151T* TC	100.00	95.00	109.25
0148T	640.70	608.67	699.96	*0151T* 26	50.00	47.50	54.62
0148T TC	542.53	515.40	592.71				

Florida

	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
0145T	532.78	566.14	603.83	506.14	537.83	573.64	582.06	618.51	659.68
0145T TC	441.32	471.98	506.43	419.25	448.38	481.11	482.14	515.64	553.28
0145T 26	91.47	94.16	97.41	86.90	89.45	92.54	99.93	102.87	106.42
0146T	532.78	566.14	603.83	506.14	537.83	573.64	582.06	618.51	659.68
0146T TC	441.32	471.98	506.43	419.25	448.38	481.11	482.14	515.64	553.28
0146T 26	91.47	94.16	97.41	86.90	89.45	92.54	99.93	102.87	106.42
0147T	532.78	566.14	603.83	506.14	537.83	573.64	582.06	618.51	659.68
0147T TC	441.32	471.98	506.43	419.25	448.38	481.11	482.14	515.64	553.28
0147T 26	91.47	94.16	97.41	86.90	89.45	92.54	99.93	102.87	106.42
0148T	532.78	566.14	603.83	506.14	537.83	573.64	582.06	618.51	659.68
0148T TC	441.32	471.98	506.43	419.25	448.38	481.11	482.14	515.64	553.28
0148T 26	91.47	94.16	97.41	86.90	89.45	92.54	99.93	102.87	106.42
0149T	532.78	566.14	603.83	506.14	537.83	573.64	582.06	618.51	659.68
0149T TC	441.32	471.98	506.43	419.25	448.38	481.11	482.14	515.64	553.28
0149T 26	91.47	94.16	97.41	86.90	89.45	92.54	99.93	102.87	106.42
0150T	532.78	566.14	603.83	506.14	537.83	573.64	582.06	618.51	659.68
0150T TC	441.32	471.98	506.43	419.25	448.38	481.11	482.14	515.64	553.28
0150T 26	91.47	94.16	97.41	86.90	89.45	92.54	99.93	102.87	106.42
0151T	150.00	150.00	150.00	142.50	142.50	142.50	163.88	163.88	163.88
0151T TC	100.00	100.00	100.00	95.00	95.00	95.00	109.25	109.25	109.25
0151T 26	50.00	50.00	50.00	47.50	47.50	47.50	54.62	54.62	54.62

E&M Home and Domiciliary Visits—Implementation Delayed

This local coverage determination (LCD) was introduced as a draft in 2006 and addresses evaluation and management services in certain settings. The draft LCD, set for implementation on April 30, 2007, has considerable changes based on many comments received during the comment period. There are still concerns among certain physicians that the LCD may have some unintended consequences.

Effective Date Delayed Until Further Notice

Because of these concerns, First Coast Service Options, Inc. (FCSO) has elected to delay the effective date of this LCD until further notice. Based on FCSO medical policy review of recent comments received, and planned future discussions with physicians and allied providers, FCSO will present this LCD to the June 2007 Carrier Advisory Committee (CAC) meeting for the next LCD cycle and repost a revised LCD with a new notice period and effective date after the LCD cycle is completed.

Please monitor our websites at *http://www.connecticutmedicare.com* or *http://www.floridamedicare.com* for the draft LCD to be posted for notice and comment on or after May 21, 2007.

Operative Tissue Ablation and Reconstruction of Atria (Maze Procedure)

Background: Prior to *Current Procedural Terminology (CPT)* 2007, any procedures performed for surgical reconstruction and tissue ablation of the atria were reported with *CPT* code *33253. CPT* Code *33253* described a comprehensive procedure that required cardiopulmonary bypass, cardioplegic arrest, and extensive biatrial incisions with connection to the atrioventricular (AV) annulus. The electrophysiology of atrial fibrillation combined with electrical isolation ablative techniques that do not require cardiac incision have allowed the development of simpler surgical approaches that are significantly different from that described by *CPT* code *33253*.

Effective for dates of service on or after January 1, 2007, *CPT* codes *33254-33256* and *33265-33266* were established to describe this range of development and modification of the maze procedures for the treatment of atrial fibrillation. These procedure codes should be billed with stand-alone procedures.

CPT definitions:

33254 *Operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure)*
33255 *Operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure); without cardiopulmonary bypass*
33256 *with cardiopulmonary bypass*
33265 *Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (e.g., modified maze procedure), without cardiopulmonary bypass*
33266 *operative tissue ablation and reconstruction of atria, extensive (e.g., maze procedure), without cardiopulmonary bypass*

Billing and Coding

CPT guidelines were also added indicating that if an operative (nonthoracic) electrophysiologic procedure is performed concurrently with another procedure that requires a median sternotomy or cardiopulmonary bypass (e.g. coronary artery bypass surgery, or valve replacement/repair) only unlisted *CPT* code *33999* (*Unlisted procedure; cardiac surgery*) can be reported.

Recognizing that the majority of maze procedures are performed concomitantly with other procedures, and the delay in processing claims with *CPT* code *33999* (unlisted, cardiac surgery), First Coast Service Options, Inc. is providing the following guidance:

- Effective date - Effective for claims processed on or after May 4, 2007, for services rendered on or after January 1, 2007.
- Form CMS-1500 – Report either "Limited" or "Extensive" in item 19 on the Form CMS-1500 (or its electronic equivalent).

  Limited Maze – operative ablation and reconstruction – Surgical isolation of triggers of supraventricular dysrhythmias by operative ablation that isolates the pulmonary veins or other anatomically defined triggers in the left or right atrium

  Extensive Maze – operative ablation and reconstruction includes:
  - the services included in limited Maze, **and**
  - additional ablation of atrial tissue to eliminate sustained supraventricular dysrhythmias. This must include operative ablation that involves the right atrium, the atrial septum, or left atrium in continuity with the atrioventricular annulus.

Entering the type of procedure ("Limited" or "Extensive") in item 19, and *CPT* code *33999* (unlisted procedure; cardiac surgery) in item 24d of the Form CMS-1500 (or its electronic equivalent), will facilitate the payment for services without having to send documentation.

CONNECTICUT ONLY - NEW LCDS

93965: Non-Invasive Evaluation of Extremity Veins—New LCD

Non-invasive vascular diagnostic studies utilize ultrasonic Doppler and physiologic principles to assess irregularities in blood flow in the venous system. The display may be a two-dimensional image with spectral analysis and color flow or a plethysmographic recording that allows for quantitative analysis.

The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reported. The appropriate assignment of a specific ultrasound *CPT* code is not solely determined by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure. If an examination is performed with hand-carried equipment, the quality of the exam, printout, and report must be in keeping with accepted national standards.

A duplex scan is an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectral analysis and/or color flow velocity mapping or imaging.

The accuracy of non-invasive vascular diagnostic studies depends on the knowledge, skill and experience of the technologist and the physician performing the interpretation of the study. Consequently, the technologist and the physician must maintain proof of training and experience.

All non-invasive vascular diagnostic studies must be: (1) performed by a qualified physician, or (2) performed under the general supervision of a qualified physician by a technologist who has demonstrated minimum entry level competency by being credentialed in vascular technology, and/or (3) performed in a laboratory accredited in vascular technology.

This new local coverage determination (LCD) was developed to provide a consistent diagnosis list of medically necessary ICD-9-CM codes between First Coast Service Options, Inc. (FCSOs) active Florida B and A non-invasive evaluation of extremity veins LCDs. This LCD incorporates indications and limitations, credentialing requirements, documentation guidelines, utilization guidelines and ICD-9-CM codes that support medical necessity for procedure codes *93965*, *93970* and *93971*.

Effective Date

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

95860: Electromyography and Nerve Conduction Studies—New LCD

The new local coverage determination (LCD) for electromyography and nerve conduction studies was presented at the Connecticut Carrier Advisory Committee (CAC) meeting on February 6, 2007.

Electrodiagnostic medicine includes a variety of electrodiagnostic studies, including nerve conduction studies, needle electromyography, and neuromuscular junction testing. These studies are useful when evaluating tumors involving an extremity, the spinal cord, and/or peripheral nervous system, and in neurotrauma, low-back pain, spondylosis and cervical and lumbosacral disc diseases.

This LCD was developed to include indications and limitations of coverage, documentation requirements, utilization guidelines, ICD-9-CM codes that support medical necessity, and coding guidelines.

Effective Date

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

95925: Somatosensory Testing—New LCD

The new local coverage determination (LCD) for somatosensory testing was presented at the Connecticut Carrier Advisory Committee (CAC) meeting on February 6, 2007.

Short-latency somatosensory evoked potentials (SEPs) are non-invasive studies performed by the repetitive, submaximal, electrical stimulation of a sensory or mixed sensorimotor peripheral nerve. The evoked potential response depends on the functional integrity of the nerve that is stimulated.

This LCD was developed to include indications and limitations of coverage, documentation requirements, utilization guidelines, ICD-9-CM codes that support medical necessity, and coding guidelines.

Effective Date

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

CONNECTICUT ONLY - LCD REVISIONS

97001: Physical Medicine and Rehabilitation—LCD Revision

The local coverage determination (LCD) for physical medicine and rehabilitation was last revised on January 16, 2007. Since that time, the LCD has been revised. A request was received asking that First Coast Service Options, Inc. (FCSO) revise the language found in the LCD for *CPT 97532*. After reviewing the literature submitted with this request, FCSO has revised the language found in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, under general physical and occupational therapy guidelines, for *CPT 97532* to read as follows:

- Development of cognitive skills to improve attention, memory or problem solving, may be medically necessary for patients having neurological conditions such as head injury or trauma, stroke, muscular dystrophy and/or multiple sclerosis or other neurological diseases. It is not appropriate for patients with chronic, progressive or stable brain conditions who do not have potential for improvement of or restoration of current cognitive function. Reassessment of the patient's progress should occur every 2-3 months showing significant and measurable improvement. These procedures may be medically necessary when included in a patient's individual treatment plan aimed at improving or restoring specific functions which were impaired by an identified illness or injury and when the improved functional physical/cognitive abilities of the patient that are expected to be achieved are specified in the plan. If at anytime during the treatment period it becomes obvious that continued cognitive rehabilitation is not likely to be effective, that the service is no longer needed, or that all realistic attainable goals have been met, then the treatment should be discontinued. The patient must have the capacity to learn from instructions.

Effective Date

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

THERSVCS: Therapy and Rehabilitation Services (formerly Physical Medicine and Rehabilitation—97001)—LCD Revision

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on April 17, 2007.

Therapy services provided to the beneficiary must be restorative or for the purpose of designing and teaching a maintenance program required in connection with a specific disease state. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program. This requirement applies to all rehabilitative services.

Therefore, revision of the LCD will provide coverage guidelines for occupational and speech therapy services in addition to the existing guidelines for physical therapy. The physical therapy portion of this LCD is being revised to add *CPT* codes *97542* (*Wheelchair management [e.g., assessment, fitting, training], each 15 minutes)* and *97750* (*Physical performance test or measure [e.g., musculoskeletal, functional capacity], with written report each 15 minutes).*

In addition, the LCD Title and Contactor's Determination Number were changed to "Therapy and Rehabilitation Services (THERSVCS)".

Effective Date

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

Sign up to our *eNews* electronic mailing list

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

FLORIDA ONLY - LCD RETIRED

95934: H-Reflex Study—Retired LCD

This local coverage determination (LCD) was last revised on October 4, 2005. Since that time, this LCD is being retired as it has been incorporated into the Electromyography and Nerve Conduction Studies LCD (95860).

Effective Date

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

78472: Cardiac Blood Pool Imaging—Retired LCD

This local coverage determination (LCD) was last revised October 18, 2005. Since that time, this LCD is being retired as it has been incorporated into the Cardiovascular Nuclear Imaging Studies LCD (78460).

Effective Date

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

FLORIDA ONLY - LCD REVISIONS

62310: Epidural—LCD Revision

This local coverage determination (LCD) was last revised on October 1, 2006. Since that time, the LCD was revised to include the addition of ICD-9-CM code range 338.11-338.19 for acute postoperative pain management.

In addition, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was updated to include "Acute pain management in the postoperative surgical patient for patients who have undergone major abdominal, thoracic, orthopedic, or obstetrics and gynecological operations."

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

78460: Cardiovascular Nuclear Imaging Studies (formerly Myocardial Perfusion Imaging)—LCD Revision

The two types of radionuclide studies commonly used for cardiac evaluation are myocardial perfusion imaging and ventriculography. Myocardial perfusion imaging is used primarily for the evaluation of coronary artery disease. Ventriculography is sometimes referred to as multiple gated acquisition scanning (MUGA) and is primarily used to evaluate valvular disease and cardiomyopathies. Either type of study may be obtained at rest or stress. Stress may be provided by exercise or with pharmacologic agents. A variety of radionuclides may be used, including Technetium tc-99M sestamibi, thallium 201 and Technetium tc-99M tetrofosmin.

Myocardial perfusion imaging, a cardiac radionuclide imaging procedure that evaluates blood flow to the cardiac muscle, is usually performed with exercise ECG testing for detecting coronary artery disease and determining prognosis. A gamma camera is used to record images in planar or tomographic (single photon emission computed tomography) (SPECT) projections. Use of dual radiopharmaceuticals permits concurrent studies at rest and after stress, which is then compared and interpreted by a nuclear physician. Since the radiopharmaceutical accumulates in the myocardium in relation to blood flow, ischemic and infarcted myocardium can be detected.

This LCD revision included updating the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD and incorporating the Cardiac Blood Pool Imaging (78472) LCD. In addition, the name was changed to "Cardiovascular Nuclear Imaging Studies" and the coding guidelines were updated and combined.

Effective Date

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

93965: Non-Invasive Evaluation of Extremity Veins—LCD Revision

This local coverage determination (LCD) was last revised on September 18, 2006. Since that time, the LCD has been revised. The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to include the following ICD-9-CM codes: 427.31, 451.82, 518.81, 782.5, 785.0, 799.02 and 996.62 as medically necessary for procedure codes *93965*, *93970* and *93971*.

Effective Date

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

95860: Electromyography and Nerve Conduction Studies (formerly Nerve Conduction Studies)—LCD Revision

The local coverage determination (LCD) for nerve conduction studies (NCS) covered *CPT* codes *95900-95904* and was last updated on October 01, 2006. Since that time, the LCD was completely struck out due to a major revision that included additional *CPT* codes for H-reflex studies, neuromuscular junction, and electromyography, and the LCD Title and Contractor's Determination Number were changed to "Electromyography and Nerve Conduction Studies (95860)." The LCD was presented at the February 2007 Carrier Advisory Committee (CAC) meeting.

This major revision to the LCD also included changes/additions to the indications and limitations of coverage that included credentialing/supervision requirements, documentation requirements, utilization guidelines, and ICD-9-CM codes that support medical necessity. In addition, coding guidelines were added to the LCD for recommended maximum number of EMG/NCS for specific indications.

Effective Date

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

95925: Somatosensory Testing—LCD Revision

The local coverage determination (LCD) for somatosensory testing was last updated on November 08, 2005. Since that time, the following revisions were made to the LCD and presented at the February 2007 Carrier Advisory Committee (CAC) meeting:

- Credentialing guidelines were added under the "Documentation Requirements" section of the LCD.
- Utilization Guidelines were added to the LCD.
- References under the "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections of the LCD were updated.
- Verbiage under the "Coding Guidelines" section of the LCD concerning intraoperative testing was revised to read, "It is not expected that intraoperative testing would be necessary for routine lumbar or cervical root decompression."
- The "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to add ICD-9-CM code 198.3 for *CPT* codes *95925*, *95926*, and *95927*.

Effective Date

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

PULMDIAGSVCS: Pulmonary Diagnostic Services—LCD Revision

The local coverage determination (LCD) for pulmonary diagnostic services was last revised January 1, 2007.

Pulmonary diagnostic tests are important in clinical situations in which the patient has a history or symptom suggestive of lung disease or when risk factors for lung disease (eg, exposure to toxic substances) are present. Pulmonary diagnostic testing may include pulmonary function tests (eg, spirometry, lung volume determination and diffusion capacity tests), pulmonary stress tests (eg, six-minute walk test, carbon monoxide diffusing capacity) and lung compliance studies (eg, plethysmography, volume and pressure measurements).

The LCD was revised to include credentialing requirements for providers performing pulmonary diagnostic services, a noncoverage statement for screening and patient initiated spirometry, information that must be included in the documentation, and a statement related to frequency of services.

Effective Date

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

THERSVCS: Therapy and Rehabilitation Services—LCD Revision

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on January 16, 2007. Since that time, the LCD has been revised. A request was received asking that First Coast Service Options, Inc. (FCSO) revise the language found in the LCD for procedure code *97532*. After reviewing the literature submitted with this request, FCSO has revised the language found in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, under general physical and occupational therapy guidelines, for *97532* to read as follows:

- Development of cognitive skills to improve attention, memory or problem solving, may be medically necessary for patients having neurological conditions such as head injury or trauma, stroke, muscular dystrophy and/or multiple sclerosis or other neurological diseases. It is not appropriate for patients with chronic, progressive or stable brain conditions who do not have potential for improvement of or restoration of current cognitive function. Reassessment of the patient's progress should occur every 2-3 months showing significant and measurable improvement. These procedures may be medically necessary when included in a patient's individual treatment plan aimed at improving or restoring specific functions which were impaired by an identified illness or injury and when the improved functional physical/cognitive abilities of the patient that are expected to be achieved are specified in the plan. If at anytime during the treatment period it becomes obvious that continued cognitive rehabilitation is not likely to be effective, that the service is no longer needed, or that all realistic attainable goals have been met, then the treatment should be discontinued. The patient must have the capacity to learn from instructions.

Effective Date

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

THERSVCS: Therapy and Rehabilitation Services—LCD Revision

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on April 17, 2007.

Therapy services provided to the beneficiary must be restorative or for the purpose of designing and teaching a maintenance program required in connection with a specific disease state. There must be an expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program.

The LCD has been revised to include *CPT* code *97750* (*Physical performance test or measurement [eg, musculoskeletal, functional capacity], with written report, each 15 minutes*). *CPT* codes that would be inappropriate to bill with *CPT* code *97750* are also identified.

Effective Date

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

CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

May 2007 – June 2007

Medicare Executive Circle (MEC) Meeting
For membership information, please leave a message on our registration hotline at (203) 634-5527

When: May 16, 2007
Time: 11:30 a.m. – 3:30 p.m.
Type of Event: In-Person Meeting

2007 Medifest – Day 1 (fee-based event)
4 one-and-a-half hour sessions with 4 classes to choose from per session
When: June 6, 2007
Where: Marriott Hartford Rocky Hill
Time: 8:00 a.m. – 5:15 p.m.

2007 Medifest – Day 2 Specialty Classes (fee-based event)
1 three-hour session with 3 classes to choose from
When: June 7, 2007
Where: Marriott Hartford Rocky Hill
Time: 9:00 a.m. – 12:00 p.m.

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

When: June 27, 2007
Time: 11:00 a.m. – 12:30 p.m.
Type of Event: Teleconference

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

Please Note:

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

Hartford Marriott Rocky Hill
100 Capital Blvd
Rocky Hill, Connecticut 06067
Please contact hotel for directions and/or reservations (860) 257-6000

Select one class per session (time slot).

Day 1
Medifest
June 6, 2007
Cost $100.00

General Session 8:00 am to 8:30 am

8:45 AM - 10:15 AM SESSION 1

- ☐ Form CMS-1500
- ☐ Medical Review/Data Analysis
- ☐ Office Reimbursement Efficiency
- ☐ Provider Enrollment

10:30 AM – 12:00 PM SESSION 2

- ☐ ANSI 101
- ☐ Global Surgery
- ☐ Primary Care/Preventative Services
- ☐ Self-Help Techniques/Web Site Navigation

1:00 PM – 3:30 PM SESSION 3

- ☐ Evaluation & Management (E/M) Coding
- ☐ Fraud & Abuse
- ☐ Medicare Secondary Payer (MSP)
- ☐ Office Reimbursement Efficiency

3:45 PM – 5:15 PM SESSION 4

- ☐ Appeals & Overpayments
- ☐ Evaluation & Management (E/M) Coding
- ☐ Medicare Easy Remit Print
- ☐ Self-Help Techniques/Web Site Navigation

Day 2
Medifest Specialty Seminars
June 7, 2007
Cost $97.00

9:00 AM - 12:00 PM

- ☐ Cardiology
- ☐ E/M Documentation-Advanced
- ☐ Independent Diagnostic Testing Facility

FAXED REGISTRATION INSTRUCTIONS

1. Fax registration form to (203) 639-3069
2. A confirmation and invoice will be faxed to you.
3. Make checks payable to: **FCSO Account # 700242**
4. Mail the forms (after you have faxed them) and payment to: **First Coast Service Options, Inc.**
   PO Box 406443
   Atlanta, GA 30384-6443
5. Bring your Medifest confirmation notice to the event.

CONFIRMATION INFORMATION

Faxed registration: A confirmation notice will be faxed or emailed to you within 14 days of receiving your registration form. If you do not receive a confirmation notice (not the confirmation form generated from your fax machine, but the confirmation notice provided by Provider Outreach & Education), please contact us at **(203) 634-5527. On-line registration:** When registering on-line for an education event, you will automatically receive your confirmation via email.

Registrant's Name: _____
Telephone Number: _____
Email Address: _____
Fax Number: _____
Provider's Name: _____
Street Address: _____
City, State, ZIP Code: _____

FLORIDA EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

May 2007 – August 2007

Hot Topics Teleconference – Updates to the Medicare Program

When: May 10, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

2007 Medifest Symposium (Medicare Part A and B)

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

Hot Topics Teleconference – Topics to be determined

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

Ask the Contractor Teleconference – Topics to be determined

When: August 16, 2007
Time: 11:30 a.m. – 1:30 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: _____

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

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

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

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

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

Attention: Correspondence

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

Attention: Financial Services

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

Attention: Fraud and Abuse

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

Attention: Freedom of Information (FOIA)

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

Attention: Medical Review

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

Attention: MSP

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

Attention: Pricing/ Provider Maintenance

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

Attention: Resolutions

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

MAILING ADDRESS EXCEPTIONS

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

Redeterminations/Appeals

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

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

Hearings

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

Post Office Box for Appeals/Hearings:

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

Electronic Media Claims/EDI

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

Post Office Box for EDI:

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

Claims

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

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

CONNECTICUT MEDICARE PHONE NUMBERS

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

Provider Services
Medicare Part B
1-888-760-6950

Interactive Voice Response
1-866-419-9455

Electronic Data Interchange (EDI)
Enrollment
1-203-639-3160, option 1

PC-ACE® PRO-32
1-203-639-3160, option 2

Marketing and Reject Report Issues
1-203-639-3160, option 4

Format, Testing, and Remittance Issues
1-203-639-3160, option 5

Electronic Funds Transfer Information
1-203-639-3219

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

Durable Medical Equipment
HealthNow NY
DMERC Medicare Part B
1-800-842-2052

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

Quality of Care
Peer Review Organization
1-800-553-7590

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

American Association of Retired Persons (AARP)
1-800-523-5800

To Report Lost or Stolen Medicare Cards
1-800-772-1213

Health Insurance Counseling Program
1-800-994-9422

Area Agency on Aging
1-800-994-9422

Department of Social Services/ConnMap
1-800-842-1508

ConnPace/ Assistance with Prescription Drugs
1-800-423-5026

MEDICARE WEBSITES

PROVIDER
Connecticut
http://www.connecticutmedicare.com
Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov

BENEFICIARIES
Centers for Medicare & Medicaid Services
http://www.medicare.gov

Florida Medicare Part B Mail Directory

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

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

Fair Hearing Requests
Medicare Hearings
Post Office Box 45156
Jacksonville FL 32232-5156

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

Status/General Inquiries
Medicare Part B Correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

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

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims
Palmetto GBA Medicare
DMERC Operations
P. O. Box 100141
Columbia, SC 29202-3141

ELECTRONIC MEDIA CLAIMS (EMC)

EMC Claims, Agreements and Inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

MEDICARE PART B ADDITIONAL DEVELOPMENT

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

MISCELLANEOUS

Provider Participation and Group Membership Issues; Written Requests for UPINs, Profiles & Fee Schedules:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider Education:
For Educational Purposes and Review of Customary/Prevailing Charges or Fee Schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For Education Event Registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting Charge Issues:
For Processing Errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For Refund Verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare Claims for Railroad Retirees:
MetraHealth RRB Medicare
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and Abuse
First Coast Service Options, Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Florida Medicare Phone Numbers

PROVIDERS

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

BENEFICIARY

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

For Education Event Registration (*not* toll-free)**:**
1-904-791-8103

EMC

Format Issues & Testing:
1-904-354-5977 option 4
Start-Up & Front-End Edits/Rejects:
1-904-791-8767 option 1
Electronic Funds Transfer
1-904-791-8016
Electronic Remittance Advice, Electronic Claim Status, & Electronic Eligibility:
1-904-791-6895
PC-ACE Support:
1-904-355-0313
Marketing:
1-904-791-8767 option 1
New Installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608
Help Desk:
(Confirmation/Transmission):
1-904-905-8880 option 1

DME, ORTHOTIC OR PROSTHETIC CLAIMS

Palmetto GBA Medicare
1-866-270-4909

MEDICARE PART A

Toll-Free:
1-866-270-4909

Medicare Websites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

ORDER FORM — 2007 PART B MATERIALS

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

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

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

Please write legibly

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

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____ FAX Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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

Medicare B Update!

First Coast Service Options, Inc.
P.O. Box 2078 Jacksonville, FL 32231-0048 (Florida)
P.O. Box 44234 Jacksonville, FL 32231-4234 (Connecticut)

*** ATTENTION BILLING MANAGER ***