Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue…

To receive quick, automatic notification when new publications and other items of interest are posted to our provider education Web sites, subscribe to our *FCSO eNews* mailing list. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, hover over Medicare Providers, select Connecticut or Florida, click on the "eNews" link located on the upper-right-hand corner of the page and follow the prompts.

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

Routing Suggestions:

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

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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 faxed to (904) 361-0723.

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.

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education Web site, *http://www.fcso.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 Web site(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 Enrollment department. Please remember that address changes must be done using the appropriate 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.

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 data interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **general information** section includes fraud and abuse, and Medicare Secondary Payer topics, plus additional topics not included elsewhere.

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

Quarterly Provider Update

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

Providers may access the Quarterly Provider Update by going to the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU listserv to ensure timely notification of all additions to the QPU.

Have You Visited the FCSO Web Site Lately?

In response to feedback we received from you, our valued customers, we recently completed a redesign of the Florida and Connecticut Medicare Web sites. If you haven't visited our Web sites lately, here are some of the things you have missed, hot off the presses!

- A quick 15-second animation that shows you all the latest tips and tools at your disposal to help successfully complete the CMS-855 form (Provider Enrollment Application).
- Information about the latest enhancements and user tools for the provider automated customer service telephone lines.
- The latest list of final Local Coverage Determinations (LCDs).
- The latest information on the National Provider Identifier (NPI).

This information and much more are just a few clicks away! "You can access the Florida or Connecticut Medicare provider Web sites anytime by going to *www.fcso.com*. Once there, select the Medicare Provider's pull-down menu and click either Florida or Connecticut."

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.

Patient Liability Notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131form as part of the Beneficiary Notices Initiative (BNI) 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 Web site 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
Medicare Part B Redeterminations Appeals
PO Box 45010
Jacksonville, FL 32232-5010

OR

Florida
Medicare Part B Redeterminations Appeals
PO Box 2360
Jacksonville, FL 32231-0018

PROVIDER ENROLLMENT

Avoid Rejection of a Pending Provider Enrollment Application

Respond Immediately to a Request for Information

Our goal at First Coast Service Options, Inc. (FCSO) is to help facilitate your enrollment into the Medicare program. In accordance with 42 CFR, section 424.525(a), FCSO may reject an application if the provider fails to furnish all of the information and/or documentation within 60 calendar days from the date of the request. To prevent rejection of your pending enrollment application, we request that you respond immediately to any request for information and/or documentation.

If an application is rejected after this 60-day window, the provider or supplier must complete and submit a new enrollment application, including all supporting documentation, for review and approval. Enrollment applications that are rejected are not afforded appeal rights.

Remember - the sooner you respond to our request, the sooner you will be enrolled.

Source: CMS Publication 100-08, Chapter 10
Code of Federal Regulations, Title 42, section 424.525(a)

Scenarios for Proper Use of CMS-855I Enrollment Application

NPI Is Here. NPI Is Now. Are You Using It?

CMS recently made available a document that will assist physicians and non-physician practitioners in completing form CMS-855I, Medicare Provider Enrollment Application – Physicians and Non-Physician Practitioners. This document contains several enrollment scenarios and indicates where on the CMS-855I the national provider identifier (NPI) is to be reported. It also indicates when the CMS-855R and/or the CMS-855B need to be completed. The document is available from *http://www.cms.hhs.gov/Medicareprovidersupenroll/Downloads/EnrollmentNPI.pdf*.

Need more Information?

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

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

Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your Web browser to view the intended information.

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

Source: CMS Provider Education Resource 200709-21

INFORMATION FOR CONNECTICUT PROVIDERS

Provider Enrollment—Ask-the-Contractor Teleconference

Do you know which provider enrollment form(s) to complete for your practice? Are you looking for guidance on how to ensure that you submit your enrollment form correctly the first time? If you answered "yes," then you don't want to miss out on this training session! This seminar will help take the mystery out of enrolling as a Medicare provider by providing the necessary information and tools to help make your enrollment process as trouble-free as possible.

Topic: Provider Enrollment
When: Wednesday, December 12, 2007
Time: 12:00 noon – 1:00 p.m.

This teleconference is the latest "lunch and learn" installment of educational efforts designed to support and inform the provider community by answering the questions that are on your mind. The session will begin with short presentation followed by an open question and answer period. Attendees are encouraged to submit their questions in advance via e-mail (eventsct@fcso.com) or by leaving a message on the registration hotline (203-634-5527) by December 7, 2007.

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

To participate in this training event, please register by December 10, 2007.

INFORMATION FOR FLORIDA PROVIDERS

Upcoming Webcast for New Graduates Enrolling in Medicare

This webcast is designed for new graduates of academic medical institutions enrolling in the Medicare program for the first time.

Topic: Provider Enrollment Webcast

When: December 6, 2007 – 11:30 a.m. – 12:30 p.m. Eastern Time

Discussion will include the following:

- Individual provider enrollment application (CMS-855I)
- Mandatory requirements to file Medicare claims on behalf of Medicare beneficiaries
- National Provider Identifier (NPI)
- CMS-460 Participation Agreement
- CMS-588 Electronic Funds Transfer Authorization Agreement

The presentation will be followed by an open question and answer period related to the topics of the webcast. Please join us for this very informative session and obtain first-hand answers to your questions from Medicare subject matter experts.

Don't miss out on this great learning opportunity.

Two Easy Ways To Register

Online – Simply log on to your account on our provider training Web site at *http://www.fcsomedicaretraining.com* and select the course you wish to register for. Class materials will be available under "My Courses" no later than one day before the event. **First-time user?** Please set up an account using the instructions located at *http://www.fcsomedicaretraining.com* in order to register for a class and obtain materials.

Fax - Providers without Internet access can leave a message on our Registration Hotline at 904-791-8103 requesting a fax registration form. Class materials will be faxed to you the day of the event.

Provider Enrollment Educational Events

Watch the Provider Outreach & Education section of our Web sites at *http://www.fcso .com* for upcoming events related to provider enrollment.

CLAIMS

2008 Annual Update for the Health Professional Shortage Area Bonus Payment

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 administrative contractors (A/B MACs), carriers, and fiscal intermediaries (FIs) for services provided in health professional shortage areas (HPSAs).

Impact on Providers

This article is based on change request (CR) 5698, which alerts affected physicians, carriers, A/B MACs and FIs that the new HPSA bonus payment information for 2008 will be available soon. This article is informational only for a physician that the 2008 automated bonus payments applies to claims with dates of service on or after January 1, 2008, through December 31, 2008.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Section 413[b]) mandated an annual update to the automated HPSA bonus payment files, and the Centers for Medicare & Medicaid Services (CMS) creates these new automated HPSA bonus payment files annually. The 2008 HPSA bonus payment file will be used for the automated bonus payment for claims with dates of service on or after January 1, 2008, through December 31, 2008. Physicians and providers should review the CMS Web site to determine whether a HPSA bonus will automatically be paid for services provided in their ZIP code area or whether a modifier must be submitted.

In addition, physicians will find annual HPSA bonus payment files, as they become available, and other important HPSA information at *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/* on the CMS Web site.

Additional Information

The official instruction (CR 5698) issued to your Medicare A/B MAC, carrier, or FI is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1320CP.pdf* on the CMS Web site.

For the CMS information about HPSA/PSA (physician scarcity area bonuses), you may visit: *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/* on the CMS Web site.

If you have questions, please contact your Medicare A/B MAC, carrier, or FI at their toll-free number which may be found at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web 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: MM5698
Related Change Request (CR) #: 5698
Related CR Release Date: August 20, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1320CP
Implementation Date: January 7, 2008

Tips to Remember—CMS-1500 (08/05) Paper Claim Form

Effective for claims received on or after July 2, 2007: Providers may submit paper claims using only the revised CMS-1500 (08/05). The CMS-1500 (12/90) version must not be submitted and will be returned to the provider.

National Provider Identifier (NPI) Accommodation

The following changes accommodate the national provider identifier (NPI). For NPI Contingency Plan details, refer to *MLN Matters* article MM5595.

Item 17, 17a & 17b - Referring or Ordering Physician

Items are required when a service has been ordered or referred by a physician.

- Enter a valid unique physician identification number (UPIN) preceded by "1G" in Item 17a. You may report the UPIN until May 23, 2008, based on the NPI Contingency Plan.
- If the referring provider's NPI is available, enter the valid NPI in Item 17b.
- Claims will be returned as unprocessable if the information is invalid or if a valid NPI/UPIN is submitted in the wrong area.
- You are encouraged to submit both the UPIN in Item 17a and the NPI in Item 17b on all claims when required.

Items 24J

Complete this item if billing services rendered by an individual associated with an incorporated entity or a group. A rendering provider identifier is not required when the billing provider is an independent lab, ambulatory surgical center (ASC), independent diagnostic testing facility (IDTF), ambulance supplier, or solo practitioner not associated with a group.

- Enter a valid individual physician's provider identification number (PIN) in the upper shaded portion of Item 24J.
- If the provider's NPI is available, enter the valid NPI in the lower non-shaded portion of Item 24J.
- You are encouraged to submit both your PIN in the upper portion of Item 24J and your NPI in the lower portion of Item 24J on all claims when required.

Item 32a & 32b

Items are only used if you are reporting purchased diagnostic services on your claim. For all purchased diagnostic services, you should complete Item 20 as well.

- Enter the valid NPI, if available, of the rendering service provider from which the services where purchased in Item 32a.
- Enter the PIN of the rendering service provider in Item 32b.
- You are encouraged to submit both the PIN in Item 32a and the NPI in item 32b on all claims for purchased diagnostic services.
- Effective October 1, 2007, do not report the NPI/PIN of service providers outside of your local state.

Item 33a & 33b

- Enter the billing physician's or billing group's PIN in Item 33b.
- Enter the billing provider's NPI, if available, in Item 33a.
- You are encouraged to submit both the PIN in Item 33a and the NPI in item 33b on all claims for purchased diagnostic services.

The following applies to Items 24J, 32a&b, and 33a&b:

Claims will be returned as unprocessable if required elements are not included, the information submitted is invalid, or if a valid NPI/PIN is submitted in the wrong area.

For More Information

See the CMS *Medicare Claims Processing Manua,l* Pub. 100-04, Chapter 26, Section 10. View CMS-1500 revisions on the National Uniform Claim Committee's (NUCC) Web site: *http://www.nucc.org/images/stories/PDF/final_1500_change_log.pdf*

Source: **CMS Internet Only Manual** (IOM) Publication 100-04 *Medicare Claims Processing Manual*, Chapter 1, Sections 10.1.1-10.1.1.2 & 30.2.9, Chapter 13, Section 20.2.4 & Chapter 26, Section 10.4
Change request (CR) 5595 – Medicare Fee for Service (FFS) National Provider Identifier (NPI) Implementation Contingency Plan
CR 5543 – Implementation of Carrier Jurisdictional Pricing Rules for All Purchased Diagnostic Service Claims

AMBULATORY SURGICAL CENTER

Revised Payment System for Ambulatory Surgical Centers in Calendar Year 2008

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

Provider Types Affected

Ambulatory surgical centers (ASCs) billing Medicare contractors (carriers or Part A/B Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS), pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), is implementing significant revisions to the payment system for ASC services beginning with services rendered on or after January 1, 2008.

CAUTION – What You Need to Know

CMS has issued a final rule (available at *http://www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp#TopOfPage* on the CMS Web site) that describes the revised payment system. Beginning in calendar year (CY) 2008, the revised ASC payment system will provide a transition to the revised rates for currently covered ASC services through three years of transitional payments that are based on a blend of the payment rates from the existing system and the revised payment rates calculated according to the methodology of the revised payment system. CMS also has issued a combined OPPS/ASC proposed rule (available at *http://www.cms.hhs.gov/ASCPayment/05_CMS-1392- P(ASC).asp#TopOfPage* on the CMS Web site) that proposes updates to the payment rates and other pertinent rate setting information for CY 2008.

GO – What You Need to Do

Be sure your billing personnel are aware of the new system and the coding requirements of the new system in order to assure prompt and accurate payment. See the rest of this article for details and watch for additional *MLN Matters* articles as the CY 2008 outpatient prospective payment system (OPPS)/ASC final rule with updated payment rates is published and the system is implemented.

Overview

On August 2, 2007, CMS published a final rule, CMS-1517-F (*http://www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp#TopOfPage*), establishing the policies for the revised payment system for ASCs. This final rule was followed by a proposed rule, CMS-1392-P (*http://www.cms.hhs.gov/ASCPayment/05_CMS-1392-P(ASC).asp#TopOfPage*), that proposes the CY 2008 ASC conversion factor and proposed ASC payment rates, in coordination with the proposed hospital OPPS update.

The ASC final rule outlines the policies for the revised ASC payment system to be implemented January 1, 2008. As recommended by the November 2006 Government Accountability Office report on ASC payment, CMS will implement the revised ASC payment system using OPPS relative payment weights as a guide.

There are currently about 4,600 ASCs enrolled in Medicare. Total Medicare expenditures for CY 2006 payments to ASCs are estimated at about $2.5 billion. Medicare ASC expenditures for CY 2008 are expected to be approximately $3 billion.

The final rule greatly expands the types of procedures that are eligible for Medicare payment when performed in the ASC setting and also limits payments for procedures that are performed predominantly in physicians' offices to the amount that would be paid for the nonfacility practice expense (PE) under the Medicare physician fee schedule (MPFS). The proposed rule includes no proposals to change these final ASC payment policies.

Background

Since 1982, Medicare has paid for certain surgical procedures, including cataract removal, lens replacement, and colonoscopies, when performed in freestanding or hospital-based ASCs. Currently, Medicare pays for more than 2,500 surgical procedures on the ASC approved list, based on a simple fee schedule comprised of nine unadjusted prospectively determined payment rates. The rates of the nine payment groups, prior to the "limitation on payments" adjustment, range from $333 to $1,339. Provider payments include a separate adjustment for geographic wage variations. Medicare makes a separate payment to physicians for professional services. ASC payment rates were last rebased in March 1990 using cost, charge, and utilization data from a 1986 survey of ASC costs.

With the passage of the MMA, Congress required CMS to revise the ASC payment system no later than January 1, 2008. In August of 2006, CMS issued a proposed rule encompassing proposed changes to OPPS policies and payment rates for CY 2007 and the proposed new payment methodology for ASCs. The OPPS and CY 2007 ASC provisions were finalized in November 2006, and the CY 2008 ASC policies related to the revised payment system were finalized in the August 2, 2007 final rule.

Provisions in the Final and Proposed Rules

Expanded List of ASC Procedures

In the ASC final rule, CMS expands access to procedures in the ASC setting by providing ASC payment for approximately 790 additional surgical procedures in CY 2008. CMS excludes from Medicare ASC payment only those surgical procedures determined to pose a significant safety risk to beneficiaries or that are expected to require an overnight stay following the procedure in the ASC.

CMS continues to identify surgical procedures as those listed by the American Medical Association (AMA) within the surgical range of *Current Procedural Terminology*

Revised Payment System for Ambulatory Surgical Centers in Calendar Year 2008, continued

(*CPT*) codes. CMS also includes within the scope of surgical procedures those services that are described by alphanumeric Healthcare Common Procedure Coding System (HCPCS) codes (Level II HCPCS codes) or Category III *CPT* codes that directly crosswalk or are clinically similar to procedures in the *CPT* surgical range.

In the OPPS/ASC proposed rule for CY 2008, CMS proposes to make a few revisions to the list of covered surgical procedures by adding several procedures to the list and updating the list of covered ancillary services in coordination with the proposed OPPS update. In addition, based on review of the most recent utilization data, a number of surgical procedures newly added for payment in CY 2008 in the ASC final rule are proposed to be designated as office-based procedures in the proposed rule and, therefore, would be subject to the "office-based" payment methodology that CMS outlined in the final rule.

Revised Payment Rates

The revised ASC payment rates will be based on the ambulatory payment classifications (APCs) used to group procedures under the OPPS. Per the MMA, the revised ASC payment system is budget neutral. That is, the payment rates are intended to ensure that Medicare expenditures under the revised payment methodology for ASCs in CY 2008 will approximate the expenditures that would have occurred in the absence of the revised ASC payment system.

To establish the budget neutrality adjustment for the revised ASC payment system, CMS took into account the expected migration of surgical procedures among ASCs, physicians' offices, and hospital outpatient departments (HOPDs). CMS assumed that approximately 25 percent of the HOPD volume of new ASC surgical procedures will migrate from hospitals to ASCs during the first two years of implementation of the revised ASC payment system and that 15 percent of the volume of new ASC surgical procedures currently provided in physicians' offices will migrate to ASCs during the first four years of the revised ASC payment system. CMS makes no proposal to revise this methodology in the OPPS/ASC proposed rule.

The illustrative budget neutrality adjustment for CY 2008 in the final rule is based on those assumptions and estimated CY 2008 OPPS and MPFS rates and full CY 2005 utilization data. The estimated ASC CY 2008 budget neutrality adjustment factor in the final rule is 67 percent. In the proposed rule, the budget neutrality adjustment factor is somewhat lower, 65 percent, due to proposed changes in OPPS payment rates as a result of APC recalibration, including the proposal to expand the size of the OPPS payment bundles, as well as use of CY 2006 claims and utilization data. Based on the budget neutrality adjustment factor in the proposed rule, the proposed ASC conversion factor for CY 2008 is calculated as 0.65 x $63.693 (proposed CY 2008 OPPS conversion factor) = $41.400.

The standard ASC payment for most ASC covered surgical procedures is calculated as the product of the estimated ASC conversion factor and the ASC relative payment weight (set based on the OPPS relative payment weight) for each separately payable procedure. Per section 626 of the MMA, contractors will pay ASCs based on the lesser of the actual charge or the standard ASC payment rate. Payment rates for surgical procedures that are commonly performed in physicians' offices and for the technical component of covered ancillary radiology procedures cannot exceed the MPFS nonfacility PE amount. Payments to ASCs for covered surgical procedures and certain covered ancillary services are geographically adjusted using the inpatient prospective payment system (IPPS) pre-reclassification wage index values, with 50 percent as the labor-related factor.

Implementation and Updates

There is a four-year transition period for implementation of the rates for procedures on the CY 2007 ASC list of covered procedures. For those procedures, payment will be based on a blend of the revised ASC payment rates and the current ASC rates. Thus, for CY 2008, the payment rates for procedures subject to the transition are comprised of a 25/75 blend, specifically 25 percent of the CY 2008 revised ASC rate plus 75 percent of the CY 2007 ASC rate; in CY 2009, the ratio will change to 50/50; and for CY 2010 it will be 75/25. Beginning in CY 2011, ASC payment rates will be calculated according to the policies of the revised payment system. HCPCS codes newly payable in the ASC setting beginning in CY 2008 will not be subject to this blended transitional payment methodology.

In the annual updates to the ASC payment system, CMS will set ASC relative payment weights equal to the OPPS weights and then scale the ASC weights in order to maintain budget neutrality in the ASC payment system. Without scaling, changes in the OPPS relative payment weights for non-surgical services could cause an increase or decrease in ASC expenditures due to differences in the mix of services provided by HOPDs and ASCs. For CY 2008, the final payment rates will be published in the CY 2008 OPPS/ASC final rule issued later this year. CMS also will publish an additional *MLN Matters* article around this time.

The statute requires a zero percent ASC update through CY 2009. Beginning in 2010, CMS will update the ASC conversion factor by the consumer price index for all urban consumers (CPI-U).

ASC Payment for Device-Intensive Procedures

A modified payment methodology will be used to establish the ASC payment rates for device-intensive procedures, defined as ASC covered surgical procedures that, under the OPPS, are assigned to APCs for which the device cost is greater than 50 percent of the APC's median cost. Payment for the high cost devices is packaged into the associated procedure payments under the revised ASC system, as it is under the OPPS. CMS pays the same amount for the device-related portion of the procedure cost under the revised ASC payment system as under the OPPS. However, payment for the service portion of the ASC rate will be calculated according to the standard rate-setting methodology, using the ASC budget neutrality adjustment. Therefore, using the budget neutrality adjustment factor in the proposed rule, the service portion of the proposed ASC payment for the device-intensive procedure would be about 65 percent of the corresponding OPPS service payment, just like the payment for other surgical procedures under the revised ASC payment system. The sum of the ASC device and service portions constitutes the complete ASC device implantation procedure payment. ASCs will no longer bill separately for these devices.

Revised Payment System for Ambulatory Surgical Centers in Calendar Year 2008, continued

The same policy related to full credit and no cost implantable device replacement that applies to the OPPS will apply to ASC payments. That is, when a replacement device is supplied to the ASC at no cost or with full credit by the manufacturer, Medicare ASC payment for the procedure to implant the device will be reduced by the device portion of the ASC payment to account for the lower cost to the facility to furnish the procedure. Medicare provides the same amount of payment reduction based on the estimated device cost included in the ASC procedure payment that would apply under the OPPS for performance of those procedures under the same circumstances.

In the proposed rule, CMS proposes to reduce the ASC payment by one half of the device offset amount for certain surgical procedures into which the device cost is packaged when an ASC receives a partial credit toward replacement of an implantable device. This partial payment reduction would apply to certain covered surgical procedures in which the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted. The proposed policy mirrors the proposed policy under the OPPS for CY 2008.

Payment for ASC Covered Ancillary Services

CMS will pay separately for certain covered ancillary services that are provided integral to covered surgical procedures in ASCs. The ancillary services must be provided immediately before, during, or after a covered surgical procedure to be considered integral and thereby, eligible for separate payment. Medicare also will provide separate payment to the ASC for drugs and devices that are eligible for pass-through payment under the OPPS.

In the proposed rule, CMS proposes to revise the definitions of "radiology and certain other imaging services" and "outpatient prescription drugs." The proposed revised definitions would exclude those ASC covered ancillary radiology services and covered ancillary drugs and biologicals from designation as "designated health services" subject to physician self-referral prohibitions.

As described above, payment for covered ancillary radiology services is made to ASCs at the lesser of the ASC rate or the amount of the non-facility PE under the MPFS. To ensure that no duplicate payment is made, only ASCs may receive separate payment for the technical component of the covered ancillary radiology services that are separately payable under the OPPS.

Under the revised ASC payment system, Medicare will pay separately for all drugs and biologicals that are separately paid under the OPPS when they are provided integral to covered surgical procedures. Payment will be equal to the OPPS payment rates, without application of the ASC budget neutrality adjustment. In addition, as in the OPPS, the ASC payment rates for these items will not be adjusted for geographic wage differences.

CMS will make separate payment at contractor-priced rates for devices that have pass-through status under the OPPS when the devices are an integral part of a covered surgical procedure. CMS also provides separate payment for brachytherapy sources at the OPPS rates, or contractor-priced rates if OPPS rates are unavailable. CMS is proposing prospectively established payment rates for these sources in CY 2008 for both HOPD and ASC settings.

There is no change to payment policy for corneal tissue acquisition. Payment for corneal tissue acquisition will continue to be made at reasonable cost when corneal transplants are performed in ASCs.

No other providers or suppliers may bill for covered ancillary services provided in ASCs integral to covered surgical procedures. This policy will ensure that packaged or separate payment is made to ASCs for all covered ancillary services integral to the performance of covered surgical procedures, thereby providing appropriate payment to ASCs for those services that are essential to the delivery of safe, high quality surgical care.

Physician Payment for Non-Covered ASC Procedures

ASCs currently receive facility payments under the ASC payment system only for surgical procedures included on a list of ASC covered procedures. They receive no facility payment for any other procedures. Physicians are paid for their PE based on the facility PE relative value units (RVUs) for performing surgical procedures that are on the list. They are paid based on the nonfacility PE, or technical component RVUs, for performing services that are not included on the list.

To make the payments to physicians who furnish noncovered procedures in ASCs more consistent with the policy under the OPPS, and in recognition that under the revised ASC payment system only procedures that have been determined to pose a significant safety risk or are expected to require an overnight stay are excluded from the ASC list, CMS proposes to pay physicians at the facility PE payment amount, rather than the nonfacility PE amount, for furnishing noncovered procedures in ASCs.

New and Revised Billing Procedures
Reporting Separately Payable Ancillary Services

As described above, beginning January 1, 2008, Medicare will make separate payment to ASCs for certain ancillary items and services such as drugs and biologicals, brachytherapy sources, radiological procedures, and pass-through devices when they are provided integral to ASC covered surgical procedures. ASCs must report separately payable ancillary services with an accurate number of units in order for correct payment to be made. ASCs should be mindful of dosages of drugs and biologicals and the units included in the HCPCS code descriptors when reporting units. Inaccurate reporting of units for HCPCS codes may result in under- or overpayment.

For example, a typical dosage for the drug reported by HCPCS code J1260 (Injection, dolasetron mesylate, 10mg) is 100 mg. ASCs using 100 mg in the care of a patient will report a 100 mg dose of dolasetron mesylate as 10 units of HCPCS code J1260. Failure to report the correct number of units will result in under- or overpayment. In the case of J1260, if the ASC were to report only one unit for HCPCS code J1260, when it provided one 100 mg dose, it would receive only one-tenth of the Medicare payment for that drug.

Additionally, ASCs will bill separately for devices that have pass-through status under the OPPS when provided integral to covered surgical procedures and, therefore, will be paid separately under the revised ASC payment system. ASCs should use the appropriate Level II HCPCS codes to report the devices. Only two devices currently have pass-through status under the OPPS: C1821 (Interspinous process

Revised Payment System for Ambulatory Surgical Centers in Calendar Year 2008, continued

distraction device [implantable]) and L8690 (Auditory osseointegrated device, includes all internal and external components). For these two devices only, ASCs should report the code for the device and its charge. The Medicare contractor will determine the payment amount for each of the pass-through devices.

ASCs also will need to report the number of units for brachytherapy sources that are provided integral to covered surgical procedures. Medicare will pay the same amount for the sources under the revised ASC payment system as it pays hospitals under the OPPS if prospective OPPS rates are available. The ASC will report and charge Medicare and the beneficiary coinsurance for all brachytherapy sources that are ordered by the physician for a specific beneficiary, acquired by the ASC, and implanted in the beneficiary in the ASC in accordance with high quality clinical care standards.

In the case where most, but not all, prescribed and acquired sources are implanted in the beneficiary, Medicare will cover the relatively few brachytherapy sources that were ordered and acquired but not implanted due to specific clinical consideration. These non-implanted sources may be billable to Medicare only under the following circumstances:

- The sources were specifically acquired by the ASC for the particular beneficiary according to a physician's prescription that was consistent with standard clinical practice and high quality brachytherapy treatment. The sources that were not implanted in that beneficiary were not implanted in any other patient
- The sources that were not implanted were disposed of in accordance with all appropriate requirements for their handling
- The number of sources used in the care of the beneficiary but not implanted would not be expected to constitute more than a small fraction of the sources actually implanted in the beneficiary.

Reporting Charges for Separately Payable Procedures and Services

Under the revised payment system, ASCs must report charges for all separately payable procedures and services in order to receive correct payment. Medicare contractors will make payment based on the lower of actual charges for separately payable procedures and services, or the ASC payment rate. ASCs should not report separate line item HCPCS codes or charges for procedures, services, drugs, devices, or supplies that are packaged into payment for covered surgical procedures and therefore not paid separately.

Because section 1833(a)(1) of the Social Security Act, as amended by section 626(c) of the MMA, requires ASCs to be paid the lesser of 80 percent of actual charges or the amount that would be paid by Medicare for each separately payable procedure and service, Medicare contractors will compare billed charges to the ASC payment rate at the line-item level. Therefore, it is important that ASCs incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Facilities may not be paid appropriately if they unbundle charges and report those charges for packaged codes as separate line-item charges.

For example, the single charge reported for a device-intensive procedure should include not only the charges associated with the service such as operating room time and recovery room use, but also the charges associated with the implantable device. Unlike the current ASC payment system, the revised payment system packages device payment into the payment for the associated procedure (i.e., the device is not paid separately). If the ASC bills a procedure code for a device-intensive procedure and fails to include charges for the device in establishing the single line item charge for the covered surgical procedure, the procedure charge may be lower than the Medicare payment rate for that procedure code, which includes payment for the device. The contractor would make payment based on the provider's charges, possibly resulting in underpayment.

Following is a hypothetical example that illustrates the revised payment policy:

Correct Reporting								
Example	HCPCS	Description	PI	Units	ASC-Reported Charge	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider	Unadjusted Beneficiary Payment to Provider
Claim 1: Charges for Packaged Device Rolled Into Charges for Separately Payable Procedure	*62361*	Implant spine infusion pump	H8	1	$12,000	$10,000	$10,000 x .80 = $8,000	$10,000 x .20 = $2,000
Because the Medicare payment rate is less than the reported charges for *CPT* code *62361*, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $10,000. In this case, the amount set by Medicare for all costs of the procedure is paid.								

* All payment rates are hypothetical.

Revised Payment System for Ambulatory Surgical Centers in Calendar Year 2008, continued

Incorrect Reporting								
Example	HCPCS	Description	PI	Units	ASC-Reported Charge	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider	Unadjusted Beneficiary Payment to Provider
Claim 2: Charges for Packaged Device Reported on Different Line from Separately Payable Procedure	*62361*	Implant spine infusion pump	H8	1	$2,500	$10,000	$2,500 x .80 = $2,000	$2,500 x .20 = $500
	C1891	Infusion pump, non-programmable, permanent	N1	1	$9,500	N/A	N/A	N/A
Because the reported charges for *CPT* code *62361* are less than the Medicare payment rate, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $2,500. In this case, the ASC will not receive the amount set by Medicare for all costs of the procedure, due to the ASC's incorrect separate reporting of packaged charges.								

* All payment rates are hypothetical.

Billing Bilateral Procedures

Bilateral procedures should be reported as a single unit on two separate lines or with "2" in the units field on one line, in order for both procedures to be paid. While use of the modifier 50 is not prohibited specifically according to CMS billing instructions, the modifier will not be recognized for payment purposes and may result in incorrect payment to ASCs. The multiple procedure reduction of 50 percent will apply to all bilateral procedures subject to multiple procedure discounting.

The following page provides a hypothetical example that illustrates this payment policy:

Correct Reporting								
Example	HCPCS	Description	PI	Units	ASC-Reported Charges	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider with Multiple Procedure Reduction	Unadjusted Beneficiary Payment to Provider with Multiple Procedure Reduction
Claim 1: Bilateral Procedure Reported on Two Lines	*15823*	Revision of Upper Eyelid	A2	1	$1,000	$800	$800 x .80 = $640	$800 x .20 = $160
	15823	Revision of Upper Eyelid	A2	1	$1,000	$800	($800 x .50) x .80 = $320	($800 x .50) x .20 = $80
Because the provider reports the bilateral procedure on two separate lines, and because the multiple procedure reduction applies to *15823*, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $1,200 for both procedures.								

Revised Payment System for Ambulatory Surgical Centers in Calendar Year 2008, continued

Claim 2: Bilateral Procedure Reported on One Line with Two Units	*15823*	Revision of Upper Eyelid	A2	2	$2,000	$800 X 2	[$800 + ($800 x 0.50)] x .80 = $960	[$800 + ($800 x 0.50)] x .20 = $240
Because the provider reports the bilateral procedure using "2" in the units field, and because the multiple procedure reduction applies to *15823*, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $1,200 for both procedures.								
Incorrect Reporting								
Claim 3: Bilateral Procedure Reported on One Line with Bilateral Modifier	*15823* 50	Revision of Upper Eyelid	A2	1	$2,000	$800	$800 x .80 = $640	$800 x .20 = $160
Because the provider reports the bilateral procedure using the bilateral modifier, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $800 for only one of the procedures.								

* All payment rates are hypothetical.

Additional Information

For more information regarding this and other ASC issues, CMS encourages you to use the ASC Web page at *http://www.cms.hhs.gov/ASCPayment* on the CMS Web site.

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COMPETITIVE AQUISITION PROGRAM

Competitive Acquisition Program: 2008 Physician Election and Impact on Carriers

The 2008 Physician Election Period for the Medicare Part B Drug Competitive Acquisition Program (CAP) began on October 1, 2007, and will conclude on November 15, 2007. The CAP is a voluntary program that offers physicians the option to acquire many drugs they use in their practice from an approved CAP vendor, thus reducing the time they spend buying and billing for drugs. The 2008 CAP program period will run from January 1 to December 31, 2008.

Physicians are instructed to submit their CAP election forms to their local carrier. As per change request 4064, local carriers are required to forward a list to the CAP designated carrier of all physicians and practitioners who have elected to participate in the CAP. This list is due on November 22, 2007.

Additional information about the CAP is available at the following Web site:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp

The list of drugs supplied by the CAP vendor, including NDCs, is in the *Downloads* section at:
http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp

To view and download the billing instructions for CAP physicians, see "CAP Physician Billing Tips" in the *Downloads* section of the "Information for Physicians" page: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp*

Source: Provider Education Resources Listserv, Message 200710-01 & 200710-14

Notification of the 2008 Physician Election Period for the Part B Drug Competitive Acquisition Program

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

Provider Types Affected

Physicians participating in the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals and physicians who would like to participate in the program during 2008.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) will hold the 2008 Part B Drug CAP physician election period beginning on October 1, 2007, and concluding on November 15, 2007. **Current participating CAP physicians must re-elect for the 2008 year if they would like to remain in the program.** Interested Medicare physicians may elect to participate in CAP during this timeframe as well. **New Medicare physicians may submit an application for CAP during the fall election period or anytime within 90 days from their enrollment into Medicare.**

CAUTION – What You Need to Know

To participate in CAP in 2008, go to the CAP Web site and view the CAP drug list. Download the Physician 2008 Election Agreement Form, complete the form, and submit it to your local Medicare carrier or Medicare administrative contractor (A/B MAC). All submissions must be postmarked by November 15, 2007. The 2008 Physician Election Agreement will be effective January 1, 2008, through December 31, 2008.

GO – What You Need to Do

Read on for further details.

Background

This article contains information about the Competitive Acquisition Program (CAP). The CAP is mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 303 [d]), which requires the implementation of a CAP for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. You may review the MMA, Section 303(d) at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/303d.pdf* on the CMS Web site.

CAP is an alternative to the average sales price (ASP) system of obtaining drugs for Medicare. The CAP is open to Medicare physicians who administer drugs under the "incident to" provision in their offices. The term "physician" includes individuals who are authorized to provide services under the Social Security Act and who can, within their state's scope of practice, prescribe and order drugs covered under Medicare Part B. Physicians can buy and bill drugs under the ASP system or, through CAP, obtain drugs from an approved CAP vendor that has been selected in a competitive bidding process.

The CAP drug list includes nearly 190 injectable and infused Part B drugs. A list of the CAP drugs is available in the "Downloads" section of the following CMS CAP Web page: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp*. Be sure to select the most recent list of drugs.

This article announces the 2008 annual physician election period.

Annual CAP Physician Election

The 2008 annual fall physician election period for CAP will begin on October 1, 2007, and will conclude on November 15, 2007. To begin participating in CAP effective January 1, 2008, the 2008 Physician Election Agreement form must be postmarked by November 15, 2007, and mailed to your local carrier. Please do not mail election forms before October 1, 2007.

Current participating CAP physicians must re-elect yearly during the annual fall election period if they wish to continue participating in CAP. New Medicare physicians have 90 days to elect into the CAP.

Physicians who are not currently participating in CAP and who do not wish to participate in CAP at this time are not required to take any action.

Physicians/groups must return a completed CAP Physician Election Agreement form by mail to their local carrier or A/B MAC. Include "ATTENTION: CAP PHYSICIAN ELECTION" in the address. The address for your local Medicare carrier or A/B MAC may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/contact_list.pdf* on the CMS Web site.

Additional Information

For additional information on the election process, please review change request 4404 at *http://www.cms.hhs.gov/transmittals/downloads/R932CP.pdf* and its related article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4404.pdf* on the CMS Web site.

For more information on CAP and how to elect to participate in the program, please visit the CAP Web site at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage*.

The Physician Election Guide and Physician Election Agreement Form may be found at the bottom of that page in the "Downloads" section.

Participating CAP Physicians are encouraged to join the dedicated CAP listserv, CMS-CAP-PHYSICIANS-L, in order to receive pertinent and timely information regarding the CAP. Please view the "Related Links Inside CMS" section on the "Information for Physicians" page at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp* on the CMS Web site.

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CONSOLIDATED BILLING

Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Third Quarter 2005 Medicare B Update! pages 44-45.

Note: This article was revised on October 9, 2007, to add additional information on vaccines as well as information on the Part D benefit.

Provider Types Affected

Skilled nursing facilities (SNFs), physicians, suppliers, and providers.

Provider Action Needed

This special edition is an informational article that describes SNF consolidated billing (CB) as it applies to preventive and screening services provided to SNF residents.

Clarification: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their durable medical equipment Medicare administrative contractor [DME MAC]).

Background

When the skilled nursing facility (SNF) prospective payment system (PPS) was introduced in the Balanced Budget Act of 1997 (BBA, P.L. 105-33, section 4432), it changed the way SNFs are paid, and the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. See *MLN Matters* article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf* on the CMS Web site.

Preventive and Screening Services

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's resident (Social Security Act, section 1888[e][2][A][ii]). Since the BBA did not list preventive and screening services among the services identified for exclusion, these services are included within the scope of the CB provision.

However, reimbursement for covered preventive and screening services, such as vaccines and mammographies, is subject to special billing procedures. As discussed in the May 12, 1998 *Federal Register* (63 FR 26296), since preventive services (such as vaccinations) and screening services (such as screening mammographies) do not appear on the exclusion list, they are subject to CB. Accordingly, if an SNF resident receives, for example, a flu vaccine during a covered Part A stay, the SNF itself is responsible for billing Medicare for the vaccine, even if it is furnished to the resident by an outside entity.

Billing for Preventive and Screening Services

Nevertheless, even though the CB requirement makes the SNF itself responsible for billing Medicare for a preventive or screening service furnished to its Part A resident, the SNF would not include the service on its Part A bill, but would instead submit a separate bill for the service. This is because the Part A SNF benefit is limited to coverage of "diagnostic or therapeutic" services (i.e., services that are reasonable and necessary to diagnose or treat a condition that has already manifested itself). (See sections 1861[h] following [7], 1861[b][3], and 1862[a][1] of the Social Security Act.)

Accordingly, the Part A SNF benefit does not encompass screening services (which serve to check for the possible presence of a specific condition while it is still in an early, asymptomatic stage) or preventive services (which serve to ward off the occurrence of a condition altogether). As discussed below, such services are always covered under the applicable Part B benefit (or, in certain circumstances, under the Part D drug benefit), even when furnished to a beneficiary during the course of a covered Part A SNF stay.

Priority of Payments

Priority of payment between the various parts of the Medicare law (title XVIII of the Social Security Act) basically proceeds in alphabetical order: Part A is primary to Part B (see section 1833(d) of the Social Security Act), and both Parts A and B are primary to Part D (see section 1860D-2[e][2][B] of the Social Security Act). In the case of a vaccine, for example, this means that Part B can cover the vaccine only to the extent that it is not already coverable under Part A; similarly, the Part D drug benefit can cover such a vaccine only to the extent that it is not already coverable under either Part A or Part B.

Thus, when an SNF's Part A resident receives a preventive vaccine for which a specific Part B benefit category exists (i.e., pneumococcal pneumonia, hepatitis B, or influenza), the vaccine would be covered under Part B. It would not be covered under Part A (because, as explained above, the scope of the Part A SNF benefit does not

Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services, continued

encompass preventive services), and it also would not be covered under Part D (because Part B already includes a specific benefit category that covers each of these three types of vaccines and, as discussed above, Part B is primary to Part D). Similarly, a preventive vaccine (such as poliomyelitis) for which no Part B benefit category exists would be coverable under the Part D drug benefit when administered to the SNF's Part A resident, rather than being covered under the Part A SNF benefit.

Example of Special Circumstance

However, there are certain limited circumstances in which a vaccine would no longer be considered preventive in nature, and this can affect how the vaccine is covered. For example, while a booster shot of tetanus vaccine would be considered preventive if administered routinely in accordance with a recommended schedule, it would not be considered preventive when administered in response to an actual exposure to the disease (such as an animal bite, or a scratch on a rusty nail). In the latter situation, such a vaccine furnished to an SNF's Part A resident would be considered reasonable and necessary to treat an existing condition and, accordingly, would be included within the SNF's global Part A per diem payment for the resident's Medicare-covered stay.

In terms of billing for an SNF's Part A resident, a vaccine that is administered for therapeutic rather than preventive purposes (such as a tetanus booster shot given in response to an actual exposure to the disease) would be included on the SNF's global Part A bill for the resident's covered stay. Alternatively, if a vaccine is preventive in nature and is one of the three types of vaccines for which a Part B benefit category exists (i.e., pneumococcal pneumonia, hepatitis B, or influenza), then the SNF would submit a separate Part B bill to its fiscal intermediary for the vaccine. (Under section 1888[e][9] of the Social Security Act, payment for an SNF's Part B services is made in accordance with the applicable fee schedule for the type of service being billed.) Finally, if the resident receives a type of preventive vaccine for which no Part B benefit category exists (e.g., poliomyelitis), then the vaccine would not be covered under either Parts A or B, and so would be coverable under the Part D drug benefit.

Additional Information

See *MLN Matters* special edition article SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found *at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf* on the CMS Web site. The Centers for Medicare & Medicaid Services (CMS) MLN Consolidated Billing Web site is at *http://www.cms.hhs.gov/SNFConsolidatedBilling/*. It includes the following relevant information:

- General SNF consolidated billing information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing)
- Therapy codes that must be consolidated in a noncovered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Web site may be found at *http://www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp* on the CMS Web site. It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publication (including transmittals and *Federal Register* notices).

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Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the Third Quarter 2005 Medicare B Update! pages 36-38.

Note: This article was revised on October 9, 2007, to provide clarification regarding "trips for excluded outpatient services". This clarification is intended to state explicitly that the CB exclusion for ambulance trips related to the receipt of excluded outpatient hospital services would apply to the entire ambulance roundtrip (the SNF-to-hospital trip plus the return trip back to the SNF), and not just to the outbound (SNF-to-hospital) portion alone. All other information remains the same.

Provider Types Affected

This special edition article describes SNF consolidated billing (CB) as it applies to ambulance services for SNF residents.

Clarification**:** The SNF CB requirement makes the SNF responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their durable medical equipment Medicare administrative contractor (DME MAC).

Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services, continued

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF residents receive during the course of a covered Part A stay. Payment for this full range of service is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See *MLN Matters* special edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This instruction can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf* on the CMS Web site.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e. based on the reason the ambulance service is needed. This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or "bundling" requirement since 1983. Since the law describes CB in terms of services that are furnished to a "resident" of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary's SNF "resident" status. The events are as follows:

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.).
- A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care.
- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below).
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

Ambulance Trips to Receive Excluded Outpatient Hospital Services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in program memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- Cardiac catheterization
- Computerized axial tomography imaging (CT) scans
- Magnetic resonance imaging (MRI) services
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite)
- Emergency room services
- Radiation therapy
- Angiography
- Lymphatic and venous procedures

Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB purposes with respect to those services,, any associated ambulance trips are, themselves, excluded from CB as well. Therefore, an ambulance trip from the SNF to the hospital for the receipt of such services should be billed separately under Part B by the outside supplier. Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

Other Ambulance Trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888[e][2][A][iii][I]).

Transfers Between Two SNFs

A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15[p][3][iv]). Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the

Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services, continued

ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under section 411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

Roundtrip to a Physician's Office

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27[c]), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate. The preamble to the July 30, 1999, final rule (64 *Federal Register* 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

Additional Information

See *MLN Matters* Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf* on the CMS Web site.

The Centers for Medicare & Medicaid Services (CMS) *MLN* Consolidated Billing Web site is at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* on the CMS Web site.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB)
- Therapy codes that must be consolidated in a noncovered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Web site may be found *at http://www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp* on the CMS Web site.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

MLN Matters Number: SE0433
Revised Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

DRUGS AND BIOLOGICALS

Medical Literature Used to Determine Medically Accepted Indications for Drugs and Biologicals Used in Anti-Cancer Treatment

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

Provider Action Needed

This article is informational only and it is based on change request (CR) 5729, which revises the *Medicare Benefit Policy Manual*, (chapter 15, section 50.4.5 [Unlabeled Use for Anti-Cancer Drugs]).CR 5729 adds 11 peer-reviewed medical journals to the existing list of 15 peer-reviewed medical journals used to determine medically accepted indications for drugs and biologicals used in anti-cancer treatment. Medicare contractors processing Medicare claims use this list of medical journals to determine whether there is supportive clinical evidence for a particular use of a drug in the treatment of Medicare beneficiaries. None of the 15 existing peer-reviewed medical journals are being deleted at this time.

Background

The Social Security Act (Section 1861[t][2][B][ii][II]); *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*) states that "the carrier involved determines, based upon guidance provided by the Secretary to carriers for determining accepted uses of drugs, that such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified for purposes of this sub clause by the Secretary."

Accordingly, chapter 15 of the *Medicare Benefit Policy Manual* (section 50.4.5; (*http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf*) lists 15 peer-reviewed journals that a Medicare contractor must use to determine "whether there is supportive clinical evidence for a particular use of a drug."

Medical Literature used to Determine Medically Accepted Indications for Drugs and Biologicals used in Anti-Cancer Treatment, continued

These 15 peer-reviewed medical journals include:

- American Journal of Medicine
- Annals of Internal Medicine
- The Journal of the American Medical Association
- Journal of Clinical Oncology
- Blood
- Journal of the National Cancer Institute
- The New England Journal of Medicine
- British Journal of Cancer
- British Journal of Hematology
- British Medical Journal
- Cancer
- Drugs
- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology)
- Lancet
- Leukemia

In letters dated May 21, 2003 (2003 letter) and May 4, 2006 (2006 letter) the American Society of Clinical Oncology (ASCO) noted that this list of 15 journals was created in 1993, and it has not been revised since that time. ASCO formally submitted requests for the Centers for Medicare & Medicaid Services (CMS) to revise the list of 15 journals by adding 14 more journals.

CMS staff conducted a review of the journals listed in the ASCO requests. In addition, CMS informally consulted oncology experts from the National Cancer Institute (NCI) at the National Institutes of Health (NIH) and from the Center for Drug Evaluation and Research at the Food and Drug Administration (FDA) to request their opinions about the ASCO-recommended journals. CMS also provided public notice and solicited public comment through a CMS Web site posting from October 27, 2006, through December 26, 2006 (*http://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=9*). The CMS decision memorandum on this issue has also been posted at this Web site. CMS staff integrated the data from its review and from the above sources into its final decision to add the following 11 journals to the current list of 15 journals at section 50.4.5 of the *Medicare Benefit Policy Manual:*

- Annals of Oncology
- Biology of Blood and Marrow Transplantation
- Bone Marrow Transplantation
- Gynecologic Oncology
- Clinical Cancer Research
- International Journal of Radiation, Oncology, Biology, and Physics
- Journal of the National Comprehensive Cancer Network (NCCN)
- Radiation Oncology
- Annals of Surgical Oncology
- Journal of Urology
- Lancet Oncology

Medicare carriers are not required to maintain copies of these publications. If a claim raises a question about the use of a drug for a purpose not included in the FDA-approved labeling or the compendia, the carrier will ask the physician to submit copies of relevant supporting literature.

Additional Information

The official instruction, CR 5729, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R78BP.pdf* on the CMS Web site.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web 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: MM5729
Related Change Request (CR) #: 5729
Related CR Release Date: September 21, 2007
Effective Date: October 22, 2007
Related CR Transmittal #: R78BP
Implementation Date: October 22, 2007

DURABLE MEDICAL EQUIPMENT

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

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

Provider Types Affected

Physicians, providers, and suppliers billing Medicare contractors (carriers, fiscal intermediaries, [FIs], Medicare administrative contractors [A/B MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for splints, casts, dialysis equipment, and certain intraocular lenses.

Provider Action Needed

Affected providers may want to be certain their billing staffs know of these changes.

Background

For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes.

This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: *http://www.gpoaccess.gov/cfr/retrieve.html* on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The *MLN Matters* article related to CR 5382 may be viewed at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf* on the CMS Web site.

For intraocular lenses, payment is made only on a reasonable charge basis for lenses implanted in a physician's office. CR 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 inflation-indexed charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

Dialysis Supplies Billed with AX Modifier

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

Dialysis Supplies Billed without AX Modifier

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

Dialysis Equipment Billed with AX Modifier

E0210NU	E1632	E1637	E1639

Dialysis Equipment Billed without AX Modifier

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

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes. Contractors will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008, through December 31, 2008. Those 2008 payment limits are at the end of this article.

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses, continued

Additional Information

Detailed instructions for calculating:

- Reasonable charges are located in chapter 23 (section 80) of the *Medicare Claims Processing Manual*.
- Customary and prevailing charges are located in section 80.2 and 80.4 of chapter 23 of the *Medicare Claims Processing Manual*.
- The IIC (inflation indexed charge) are located in section 80.6 of chapter 23 of the *Medicare Claims Processing Manual*. The IIC update factor for 2008 is 2.7 percent.

You may find chapter 23 of the *Medicare Claims Processing Manual* at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS Web site.

For complete details regarding this CR please see the official instruction (CR 5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf* on the CMS Web site.

If you have questions, please contact your Medicare FI, carrier, DME MAC, 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 Web 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).

2007 Payment Limits for Splints and Casts

Code	Payment Limit
A4565	$7.38
Q4001	$42.01
Q4002	$158.81
Q4003	$30.18
Q4004	$104.49
Q4005	$11.12
Q4006	$25.08
Q4007	$5.58
Q4008	$12.54
Q4009	$7.43
Q4010	$16.72
Q4011	$3.71
Q4012	$8.36
Q4013	$13.52
Q4014	$22.81
Q4015	$6.76
Q4016	$11.40
Q4017	$7.82
Q4018	$12.47
Q4019	$3.91
Q4020	$6.24
Q4021	$5.78
Q4022	$10.44
Q4023	$2.91
Q4024	$5.22

Code	Payment Limit
Q4025	$32.45
Q4026	$101.30
Q4027	$16.23
Q4028	$50.66
Q4029	$24.81
Q4030	$65.31
Q4031	$12.41
Q4032	$32.65
Q4033	$23.14
Q4034	$57.56
Q4035	$11.57
Q4036	$28.79
Q4037	$14.12
Q4038	$35.37
Q4039	$7.08
Q4040	$17.68
Q4041	$17.16
Q4042	$29.30
Q4043	$8.59
Q4044	$14.66
Q4045	$9.96
Q4046	$16.03
Q4047	$4.97
Q4048	$8.02
Q4049	$1.82

MLN Matters Number: MM5740
Related Change Request (CR) #: 5740
Related CR Release Date: September 28, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1344CP
Implementation Date: January 7, 2008

PATHOLOGY

New Waived Tests

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

Provider Types Affected

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

Provider Action Needed

This article is based on change request (CR) 5715 which informs carriers and A/B MACS of new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Background

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

New waived tests are approved by the FDA on a flow basis, and the tests are valid as soon as they are approved. The new waived tests announced by CR 5715 are in the following table:

CPT Codes	**Effective Date**	**Description**
83001QW	October 21, 2003	Genosis Fertell Female Fertility Test
84443QW	April 2, 2007	Jant Pharmacal Accutest TSH {Whole Blood}
86308QW	April 12, 2007	Signify Mono Whole Blood
86308QW	April 12, 2007	Clearview MONO Whole Blood
82465QW, 83718QW, 84460QW, 80061QW, 84478QW	May 16, 2007	Cholestech LDX (Lipid Profile – ALT (GPT)){Whole Blood}
86318QW	May 16, 2007	Immunostics Detector H. Pylori WB (H. pyloi Antibody Test) {Whole Blood}
86308QW	May17, 2007	Immuno Detector Mono {Whole Blood}
80101QW	May 24, 2007	Innovacon Multi-Clin Drug Screen Test Device
80101QW	May 24, 2007	Jant Pharmacal Accutest MultiDrug ER11 Drug Screen Test Device
87880QW	May 24, 2007	Cardinal Health SP Brand Rapid Test Strep A Dipstick(K010582/A028)
86318QW	May 24, 2007	Cardinal Health SP Brand Rapid Test H. pylori {Whole Blood}(K024350/A15)
82042QW, 82310QW, 82565QW, 82947QW, 82950QW, 82951QW, 82952QW, 84520QW	May 31,2007	Arkay SPOTCHEM EZ Chemistry Analyer (Spotchem II Basicpanel 1) { Whole Blood}
86308QW	May 31, 2007	Cardinal Health SP Brand Rapid Test Mono {Whole Blood}
82247QW, 84075QW, 84157QW, 84450QW, 84460QW	May 31, 2007	Arkay SPOTCHEM EZ Chemistry Analyer (Spotchem II Basicpanel 2) { Whole Blood}
86318QW	June 11, 2007	Fisher Healthcare Sure-Vue H. pylori Test {Whole Blood}
89321QW	June 18, 2007	Fertell Male Fertility Test

New Waived Tests, continued

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

Also, the new waived *CPT*/HCPCS code, *82310QW*, has been assigned for the total calcium test performed using the Arkay SPOTCHEM EZ Chemistry Analyer (Spotchem II Basicpanel 1) { Whole Blood}. The new waived *CPT*/HCPCS code, *82565QW*, has been assigned for the creatinine test performed using the Arkay SPOTCHEM EZ Chemistry Analyer (Spotchem II Basicpanel 1) { Whole Blood}. The new waived *CPT*/HCPCS code, *89321QW*, has been assigned for the semen motility test performed using the Fertell Male Fertility Test.

Your Medicare carrier or MAC will not automatically adjust claims processed prior to the implementation of these changes. However, they will adjust such claims that you bring to their attention.

Additional Information

For complete details, please see the official instruction, CR 5715, issued to your carrier or A/B MAC regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R1346CP.pdf* on the CMS website. The attachment to CR 5715 includes the list of tests granted waived status under CLIA, and the tests mentioned on the first page of the attachment (i.e., *CPT* codes: *81002, 81025, 82270, 82272*, G0394, *82962, 83026, 84830, 85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.

If you have questions, please contact your Medicare carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web 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: MM5715
Related Change Request (CR) #: 5715
Related CR Release Date: September 28, 2007
Effective Date: October 1, 2007
Related CR Transmittal #: R1346CP
Implementation Date: October 1, 2007

RADIOLOGY

Magnetic Resonance Imaging Procedures

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

Provider Types Affected

Independent diagnostic testing facilities and other providers submitting claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for MRI services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Effective January 1, 2007, separate payment is made for the contrast media used in various imaging procedures. The cost of the contrast media is no longer included in the practice expense (PE) relative values units (RVUs) for the procedures.

CAUTION – What You Need to Know

In addition to the *Current Procedural Terminology* (*CPT*) code representing the imaging procedure, the appropriate Healthcare Common Procedure Coding System (**HCPCS) "Q" code (Q9945-Q9954; Q9958-Q9964) can be separately billed** and paid for the contrast medium utilized in performing the service.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes. See the *Background and Key Points* sections of this article for further information.

Background and Key Points

Prior to January 1, 2007, separate payment was not made for contrast media used in certain MRI procedures because the contrast media was included in the payment for the procedure. To read the complete change in the *Medicare Claims Processing*

Magnetic Resonance Imaging Procedures, continued

Manual, Chapter 13 – Radiology Services and Other Diagnostic Procedures, see the *Additional Information* section of this article and click on the official instruction that was issued with change request (CR) 5677. The key points of CR 5677 are:

- Medicare FIs, carriers, and A/B MACs will pay separately for the contrast medium identified with the appropriate HCPCS "Q" code (Q9945-Q9954; Q9958-Q9964) used in performing various MRI procedures.
- Medicare FIs, carriers, and A/B MACs will not search their files for claims affected by this change to retroactively pay claims, but will adjust such claims that you bring to their attention that were denied with dates of service on or after January 1, 2007.

Additional Information

For complete details regarding this CR please see the official instruction (CR 5677) 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/R1339CP.pdf* on the CMS Web site.

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 Web 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: MM5677
Related Change Request (CR) #: 5677
Related CR Release Date: September 21, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R1339CP
Implementation Date: October 22, 2007

Reminder – Billing for Mammography Computer-Aided Detection Add-On Codes

Definition

Computer-aided detection (CAD) technology is an add-on service used to enhance the analysis of diagnostic and screening mammography and aid in the detection of suspicious lesions.

Billing Requirements

CAD add-on codes must be listed separately, but in conjunction with the primary mammography service. This means the CAD codes must be billed on the same date of service and same claim as the primary service mammography code (refer to "Appropriate Coding Combinations"). CAD add-on codes not billed on the same date and same claim as the primary mammography service will be returned as unprocessable.

Appropriate Coding Combinations

CAD Code	Primary Service
*76083**	*76092*, G0202
*77052***	*77057*, G0202
*76082**	*76090*, *76091*, G0204, G0206
*77051***	G0204, G0206, *77055*, *77056*

*Dates of service prior to January 1, 2007
**Dates of Service on or after January 1, 2007

Source: Publication 100-04, Chapter 18, Section 20.2.1

GENERAL COVERAGE

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 September 2007 Medicare B Update! page 19.

Note: This article was revised on September 27, 2007, to include the "bold and italicized" language in the "GO – What You Need to Do" section. Basically, this added language just reminds affected providers of the need to resubmit certain claims on or after October 1, 2007. All other information remains the same.

Provider Types Affected

Radiology suppliers, clinical diagnostic laboratories, and other providers billing Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for the TC of **radiology and pathology** services provided to Medicare fee-for-service hospital inpatients.

Provider Action Needed

STOP – Impact to You

Previously the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5347 that established duplicate claims edits, which included consideration **of the admission and discharge dates of a hospital stay in identifying duplicate claims for radiology and pathology services.**

CAUTION – What You Need to Know

Effective with implementation of CR 5675 on October 1, 2007, claims with dates of service on or after April 1, 2007, **will be paid that provide** radiology and pathology services to Medicare beneficiaries on **the day of admission and the day of discharge during an inpatient hospital stay**.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes. **If providers, radiology suppliers, or clinical diagnostic laboratories had claims with dates of service on or after April 1, 2007, that would have been paid had these edits been in place on April 1, 2007, they should resubmit those claims on or after October 1, 2007. Medicare carriers and A/B MACs will be ready to process resubmitted claims using these new edits as of October 1, 2007. Claims resubmitted on or after October 1, 2007, will not deny as duplicates, since they were not paid initially. For information regarding recoupment/demand letters, see Chapter 4, Section 90.2 of the Medicare Financial Management Manual located at *http://www.cms.hhs.gov/manuals/downloads/fin106c04.pdf* on the CMS Web site.**

Background

This CR is being implemented to avoid denying claims that were legitimately provided to beneficiaries on the admission and discharge dates. The general rule is that the technical component (TC) of radiology services provided during an inpatient stay may be billed only by the admitting hospital. Radiology suppliers that render services to beneficiaries in an inpatient stay may not bill the Medicare carrier for the technical portion of the service.

Also, the TC of physician pathology services provided to a hospital inpatient may be billed only by the admitting hospital. Independent laboratories have been instructed that they may not bill for these services after December 31, 2007 per CR 5468 (Transmittal 1148, issued Jan 5, 2007). The **exception is that imaging and pathology services performed on the admission date and discharge date** by entities other than the admitting hospital **are separately payable.**

Also, note that carriers and A/B MACs will not reprocess claims already processed, but they will adjust previously processed claims if affected providers bring such claims to the attention of their carrier or A/B MAC.

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5675) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1295CP.pdf* on the CMS Web site.

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

CR 5347 implemented a process to prevent payments of the TC of radiology services furnished to an inpatient of a hospital by any entity other than the admitting hospital. This CR may be reviewed by clicking on *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5347.pdf* on the CMS Web site.

MLN Matters Number: MM5675 *Revised*
Related Change Request (CR) #: 5675
Related CR Release Date: July 13, 2007
Effective Date: April 1, 2007
Related CR Transmittal #: R1295CP
Implementation Date: October 1, 2007

ELECTRONIC DATA INTERCHANGE

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

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

What Providers Need to Know

CR 5721, from which this article is taken, announces the latest update of X12N 835 Health Care RARCs and X12N 835 and 837 Health Care CARCs, effective October 1, 2007. Be sure billing staff are aware of these changes.

Background

For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets – Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) – that must be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 coordination-of-benefits (COB), CARC must be used. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change.

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

As mentioned earlier in CR 5634, at least one remark code must be used with the following 5 CARCs:

16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
17 - Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided. (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
125 - Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
A1 - Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Both code lists are updated three times a year, and are posted at *http://wpc-edi.com/codes* on the Internet. Please note that in order to synchronize with the CARC update schedule, the RARC list will be updated in early November, March and July instead of the current schedule of early December, April and August. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5721, to be effective on and after October 1, 2007 for Medicare.

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

Additional Information

You may see the official instruction issued to you're A/B MAC, FI, carrier, DME MAC, or RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5721, located at *http://www.cms.hhs.gov/transmittals/downloads/R1345CP.pdf* on the CMS Web site.

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

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 Web 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).

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

Remittance Advice Remark Code Changes

New Remark Codes

Code	Current Narrative	Medicare Initiated
N380	The original claim has been processed, submit a corrected claim.	No
N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	No
N382	Missing/incomplete/invalid patient identifier.	No
N383	Services deemed cosmetic are not covered	No
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	No
N385	Payment has been adjusted because notification of admission was not timely according to published plan procedures.	No
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.	Yes
N387	You should submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	Yes

Modified Remark Codes

The following codes have been identified as "Informational" codes, and modified to add the word "Alert" in front of the current text.

M4	M6	M9	M17	M27	M32	M39	M70	M118	MA01
MA07	MA08*	MA10	MA13	MA14	MA15	MA18	MA19	MA26	MA28
MA44	MA45	MA59	MA62	MA68	MA72	MA77	N1	N21	N23
N59	N84	N85	N88	N89	N130	N132	N133	N134	N136
N137	N138	N139	N140	N154	N155	N156	N162	N177	N183
N185	N187	N189	N196	N202	N210	N211	N215	N220	N352
N353	N355	N358	N360	N363	N364	N367			

*Code MA08 text has been modified further as follows:

Old Text for MA08	New Text for MA08
You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.	**Alert**: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

Notes: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated. An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.
The above information is sent per state regulation but does not explain any adjustment. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes.

Deactivated Remark Codes

Code	Current Narrative	Notes
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	Deactivated effective 10/1/07. Consider using Reason Code 45
N361	Payment adjusted based on multiple diagnostic imaging procedure rules	Deactivated effective 10/1/07. Consider using Reason Code 59

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

X12 N Health Care Claim Adjustment Reason Code Changes
Explanation of Start, Last Modified, and Stop

- **Start** – Every code has a start date. This is the date when the code was first available in the code list.
- **Last Modified** – When populated, this is the date of the code list release when the definition of the specific code was last modified by the committee. This date represents a point when the definition changed from one wording to another.
- **Stop** – When populated, this date identifies that the code can no longer be used in original business messages after that date. The code can only be used in derivative business messages (messages where the code is being reported from the original business message). For example, a CARC with a stop date of February 1, 2007 would not be able to be used by a health plan in a CAS segment in a claim payment/remittance advice transaction (835) dated after February 1, 2007 as part of an original claim adjudication. The code would still be able to be used after February 1, 2007 in derivative transactions, as long as the original usage was prior to February 1, 2007. Derivative transactions include: secondary or tertiary claims (837) from the provider or health plan to a secondary or tertiary health plan, an 835 from the original health plan to the provider as a reversal of the original adjudication. The deactivated code is usable in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835 transaction.

New Reason Codes

Code	Current Narrative	Notes
202	Payment adjusted due to non-covered personal comfort or convenience services.	Start: 02/28/2007
203	Payment adjusted for discontinued or reduced service.	Start: 02/28/2007
204	This service/equipment/drug is not covered under the patient's current benefit plan	Start: 02/28/2007
205	Pharmacy discount card processing fee	Start: 07/09/2007
206	NPI denial – missing	Start: 07/09/2007
207	NPI denial - Invalid format	Start: 07/09/2007 Stop: 05/23/2008
208	NPI denial - not matched	Start: 07/09/2007
209	Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA)	Start: 07/09/2007
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	Start: 07/09/2007
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	Start: 07/09/2007

Modified Reason Codes

Code	Current Narrative	Notes
59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	Start: 01/01/1995 Last Modified: 02/28/2007
197	Payment adjusted for absence of recertification/authorization. This change effective 1/1/2008: Payment adjusted for absence of precertification/authorization/notification.	Start: 10/31/2006 Last Modified: 07/09/2007
115	Payment adjusted as procedure postponed or canceled. This change effective 1/1/2008: Payment adjusted as procedure postponed, canceled, or delayed.	Start: 01/01/1995 Last Modified: 07/09/2007
85	Interest amount. This change effective 1/1/2008: Patient Interest Adjustment (Use Only Group code PR) Notes: only use when the payment of interest is the responsibility of the patient	Start: 01/01/1995 Last Modified: 07/09/2007

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

Deactivated Reason Codes

Code	Current Narrative	Notes
A2	Contractual adjustment. Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code. The "Stop" date of 1/1/2008 may change.	Start: 01/01/1995 Stop: 01/01/2008 Last Modified: 02/28/2007
207	NPI denial - Invalid format	Start: 07/09/2007 Stop: 05/23/2008

In addition, CR 5721 contains a comprehensive list of deactivated reason codes. These codes have been deactivated prior to publication of CR 5721 and have been included in previous CRs. Because of a policy change, the deactivation date may have moved from a specific version to a specific date. Contractors will not use any of these codes in any original business messages, but these codes may be used in derivative business messages (messages where the code is being reported from the original business message). This list may be viewed by accessing CR 5721 at the Web address cited in the *Additional Information* section (above) of this article.

MLN Matters Number: MM5721
Related Change Request (CR) #: 5721
Related CR Release Date: September 28, 2007
Effective Date: October 1, 2007
Related CR Transmittal #: R1345CP
Implementation Date: October 1, 2007

Medicare Part B NPI Numbers Must Be Submitted

Starting October 15, 2007, informational or warning edits will be returned to submitters who are not sending a national provider identifier (NPI) for primary provider identifiers (i.e., billing, pay-to, and rendering provider fields) on their claims. The edits are listed below and will remain informational until the Centers for Medicare & Medicaid Services (CMS) directs contractors to begin rejecting claims. The edits will be returned via the Batch Detail Control Listing report. If you submit your claims through a billing service or clearinghouse and do not receive the Batch Detail Control Listing report, please contact your billing service or clearinghouse.

If you receive these warning edits, you must take action to correct the error. In the future these errors will cause your claims to reject.

M389 – 2010AA NM108 Billing Provider Identification Code Qualifier Invalid value.
The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim) the edit does not set.

M390 – 2010AB NM108 Billing Provider Identification Code Qualifier Invalid value.
The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim) the edit does not set.

M391 – 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid value.
The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim) the edit does not set.

M392 – 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid value.
The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim) the edit does not set.

For additional information, please contact Medicare EDI at:

Connecticut – (203) 639-3160 option 4.

Florida – (904) 354-5977 option 2, then option 1.

Source: CMS Joint Signature Memorandum 08007, October 2, 2007

Application of Administrative Simplification Compliance Act Enforcement Review Decisions

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 the Railroad Medicare carrier, and other Medicare carriers, Part A/B Medicare administrative contractors (A/B MACs), and/or DME Medicare administrative contractors (DME MACs) for services provided to both Railroad and non-Railroad Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5606, which implements a process to enable the application of the Administrative Simplification Compliance Act (ASCA) enforcement review decisions made by non-Railroad (non-RR) Medicare contractors to the same providers when they bill the Railroad (RR) Medicare carrier (RMC).

CAUTION – What You Need to Know

Due to distribution of RR retirees, many providers submit fewer than 10 claims a month to the RR Medicare carrier (RMC), and these providers have been allowed to continue to submit paper claims to the RMC. The same providers may also treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors. ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. By adding ASCA enforcement review decision information to the file sent from non-RR Medicare contractors to the RMC to share provider data, the RMC can apply decisions that providers are ineligible to submit paper claims to those same providers when they bill the RMC.

GO – What You Need to Do

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

Background

The ASCA requires that providers submit claims to Medicare electronically to be considered for payment, with a limited number of exceptions including an exception that allows providers that submit fewer than 120 claims per year (no more than 10 claims per month or 30 claims per quarter) to Medicare to continue to submit paper claims. See the *Medicare Claims Processing Manual*, chapter 24, sections 90-90.6 *at http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf*.

Due to the dispersion of railroad (RR) retirees in the United States, however, few physicians/practitioners/suppliers treat a large number of RR Medicare beneficiaries. As result, many of these providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and they have been allowed to continue to submit paper claims to the RMC. In addition, the same providers generally treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors.

However, ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. Providers that submit paper claims to multiple Medicare contractors, including both RR and non-RR Medicare contractors, are subject to ASCA enforcement review by each of those contractors.

If a non-RR Medicare contractor:

1) determines that a provider does not meet criteria which would permit that provider to continue to submit Medicare claims on paper and

2) notifies the provider that all paper claims submitted on or after a specific date will be denied, then that same decision is to be applied to that provider if submitting paper claims to the RMC even if that provider would not normally submit 10 or more paper claims to the RMC monthly.

If a provider reports that another Medicare contractor has reversed a decision that the provider is ineligible to submit paper claims, the RMC will ask that provider to submit a copy of the reversal letter from that contractor and to hold all new paper claims until such time as the RMC reviews the reversal letter and can advise the provider by letter that they can submit the paper claims.

Effective with the implementation date of CR 5606, the Medicare Claims System (MCS) maintainer that prepares the provider files for transfer to the RMC will add ASCA enforcement review information when that information is in the non-RR provider files used to prepare the report for the RMC. Once added to the file, information concerning ASCA enforcement decisions made by the non-RR Medicare contractors (such as providers are ineligible to submit paper claims) will be accessible to the RMC so the same decisions can be applied to the same providers when they bill the RMC.

CR 5606 also updates *the Medicare Claims Processing Manual* to eliminate references to claims status and coordination of benefits (COB) Medicare HIPAA contingency plans and changes to reflect transfer of responsibility for Medigap claims to the COB contractor.

Additional Information

The official instruction, CR 5606, issued to your Medicare carrier, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1353CP.pdf* on the CMS Web site.

If you have any questions, please contact your Medicare carrier, A/B MAC, 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 Web 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: MM5606
Related Change Request (CR) #: 5606
Related CR Release Date: October 15, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1583CP
Implementation Date: January 7, 2008

Moving to a Paperless Claim Processing Environment

- Are you still submitting your claims via paper?
- Do you have questions on how to submit your claims electronically?
- Are you unsure of what software to purchase to submit your claims electronically?
- Would you like to receive reimbursement within 14 days?

If you answered yes to any of these questions, this article is for you.

As the Centers for Medicare & Medicaid Services (CMS) continues to seek new and innovative methods of reducing the cost of administering the Medicare program, one immediate focus is on the reduction of paper handling. First Coast Service Options, Inc. (FCSO) is continuing a campaign to help providers help us reduce the volume of paper claim submissions. Generally speaking, for Part B claims submissions, FCSO continues to receive a significant volume of their total claims in a paper format.

We will continue to reinforce the benefits of filing claims electronically and offer any assistance we can to help you make the transition. Continue to look for updates on the Web site, remittance advice and listen for information on the IVR.

ASCA – Required Electronic Submission

FCSO is continuing with the CMS initiative supporting the effort of Administrative Simplification and Compliance Act (ASCA). A number of providers have received letters from our office requiring that documentation be provided to attest to your qualifications relative to meeting one of the exception criteria to be excluded from filing paper. If you were one of those who received a letter, thank you for responding and/or submitting your claims to us electronically. If you have received a letter, we strongly encourage you to respond timely in order to avoid unnecessary paper claim denials (beginning 90 days from the date of the initial letter) as a result of "no reply" situations. To find out more about ASCA, visit the EDI section of the Florida Medicare Part B Web site at: *http://www.floridamedicare.com/EDI/110674.asp*.

1500 Claim Form Changes

There is no better time to convert to electronic claims submission.

As you are aware, the CMS-1500 has changed to accommodate the new national provider identifier (NPI) requirements. The new CMS-1500 is the 08/05 version, which has taken place of the 12/90 version.

Get Paid Faster and More Efficiently

One significant benefit to you, in converting from paper to electronic claims submissions, is the difference in payment schedules between paper claims and electronic claims. As you know, the CMS made a change in 2006 to increase the paper claims payment floor by two (2) additional days, from 27 to 29 days. This will result in checks being mailed two (2) days later than they were previously. At the same time, the CMS removed the contractor performance requirement to process all clean paper claims in 30 days. This could result in additional delays in processing paper claims. If you file electronic claims, you are held to a different payment floor of 14 days. This results in a much faster turn-around on claims payments.

FCSO is committed to helping our providers by keeping them updated on changes as quickly as possible. We would also like to partner with you to make the necessary changes to processes and systems that are mutually beneficial. If you need additional information on what you need to do to convert to electronic claims filing, please contact our EDI department at:

Connecticut – (203) 639-3160 option 4.

Florida – (904) 354-5977 option 2, then option 1.

You may also visit the EDI section of the Connecticut or Florida Part B Web site available at: *http://www.fcso.com* we look forward to working with you on this very important change!

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 Florida Medicare intermediary. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, hover over Medicare Providers, select Connectict or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

NATIONAL PROVIDER IDENTIFIER

Important NPI and Enrollment Information for Physicians and Nonphysician Practitioners

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

Provider Types Affected

Physicians and other practitioners who submit Medicare fee-for-service (FFS) claims to Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs).

Provider Action Needed

STOP – Impact to You

By October 31, 2007, a Medicare system, known as the national provider identifier (NPI) crosswalk, will validate your claims if they contain a legacy number, such as a Medicare provider identification number (PIN), and an NPI. If the NPI/PIN combination in your claim does do not match an NPI/PIN combination in the NPI crosswalk, your claim will reject.

CAUTION – What You Need to Know

The Medicare NPI crosswalk contains legacy numbers, which you identified to the National Plan and Provider Enumeration System (NPPES) as part of the process in obtaining your NPI.

GO – What You Need to Do

Be sure you supplied the correct information to the NPPES and be sure your billing staff submit the correct NPI/PIN number combination when both a legacy number and NPI are submitted on a claim. Your NPI must be compatible with the PIN you received upon Medicare enrollment.

Background

By October 31, 2007, all Medicare carriers (and A/B MACs that service providers who formerly billed carriers) will be rejecting Part B claims if they are unable to "match" a NPI and a PIN combination submitted on a claim to an NPI/PIN combination in the Medicare NPI crosswalk. The NPI/PIN combination may be used to identify the billing, pay-to, or rendering provider (the pay-to provider is identified only if it is different from the billing provider). This applies to claims that are submitted by corporations that physicians and non-physician practitioners have formed, or by physicians and nonphysician practitioners who bill Medicare directly. In this article, we refer to these physicians and non-physician practitioners as "physicians/practitioners."

Past Medicare Enrollment Practices May Have Contributed to the Use of Incompatible NPI/PIN Combinations

One reason a claim will reject is if the NPI and PIN used in combination on the claim does not identify the same entity. For example, the NPI in the "Billing Provider" field might be the *corporation's* NPI, but the PIN used in combination with it might be the *physician/practitioner's* PIN. This pairing may be the result of variations in past Medicare enrollment and PIN assignment procedures. For example, Medicare carriers may have combined the enrollment of a physician/practitioner and his/her corporation into a single enrollment; or, a sole proprietorship may have been enrolled as a corporation because the sole proprietorship was issued an employer identification number (EIN) by the IRS.

These and similar situations may require physician/practitioners who are experiencing claims rejections to ensure their Medicare enrollment information, and that of their corporations (if they are incorporated), is correct. This may require the completion of the appropriate CMS-855 Medicare Provider Enrollment Application.

Physicians/Practitioners Who Are Incorporated

Corporations include professional corporations, most limited liability companies, professional associations, and partnerships. Generally, the corporations that physicians/practitioners form are referred to as groups or group practices. Corporations are not sole proprietorships. When you are billing Medicare through your corporation, both you and your corporation must enroll in Medicare.

If you are a physician/practitioner who has established a corporation, you must obtain an NPI for yourself and an NPI for your corporation. A corporation applies for an NPI as an entity type 2 (organization) and you apply for an NPI as an entity type 1 (individual). If you, or your corporation, is not enrolled in Medicare, and you use the NPI of the non-enrolled entity in combination with the PIN of the enrolled entity (or vice versa), you will encounter claims problems because the combination is incompatible and will not be found in the Medicare NPI crosswalk. If the corporation will be billing Medicare, it may use only its NPI (once it has one), only its PIN (once it has one), or its NPI/PIN in combination (once it has both) to identify itself as the billing/pay-to provider. Your NPI (once you have one), your PIN (once you have one), or your NPI/PIN combination (once you have both) would be used to identify you – the physician/practitioner – as the rendering provider. Until the enrollment application of the non-enrolled entity can be processed, you may want to use only the PIN or only the NPI of the enrolled entity to avoid claims processing problems.

Physicians/Practitioners Who Have Sole Proprietorships

A sole proprietorship is a business whereby all of the business's assets and liabilities are tied directly to the physician/practitioner's (the sole proprietor's) social security account. The sole proprietor and the sole proprietorship are considered a single legal entity: an individual. The sole proprietor's social security number (SSN) serves as the taxpayer identification number (TIN) of the sole proprietorship. Often, the Internal Revenue Service (IRS) issues an EIN to a sole proprietorship to protect the sole proprietor's SSN from being disclosed on W-2s and in transactions, such as claims sent to health plans. Therefore, at the option of the sole proprietor, the EIN (if issued) instead of the SSN could be used as the TIN in submitting a sole proprietorship's Medicare claims. The IRS links that EIN to the sole proprietor's SSN for tax reporting purposes. You/your sole proprietorship must be enrolled in Medicare.

Important NPI and Enrollment Information for Physicians and Nonphysician Practitioners, continued

If you are a physician/practitioner who has a sole proprietorship, you must obtain an NPI for yourself as an entity type 1 (individual). There is no separate NPI for the sole proprietorship. When you/your sole proprietorship are billing Medicare, you may use only your NPI (once you have one), only your PIN (once you have one), or your NPI and PIN in combination (once you have both) to identify yourself as the billing/pay-to provider and as the rendering provider.

Physicians/Practitioners Who Have No Private Practice

You must be enrolled in Medicare in order for the services you render to Medicare beneficiaries to be reimbursed by the Medicare program. If you do not have a sole proprietorship and have not formed a corporation, you do not bill Medicare directly; instead, you reassign your benefits to another entity, usually a group or group practice, and the group or group practice bills Medicare for the services that you perform. That group or group practice must also be enrolled in Medicare, but you are not responsible for the enrollment of the group or group practice. The group or group practice would submit claims in which you would be identified as a rendering provider.

You must obtain an NPI for yourself as an entity type 1 (individual). The group would be responsible for ensuring that you are appropriately identified in the group's claims; that is, the group would ensure that your NPI (once you have one) is used with the compatible PIN (your PIN, once you have one) if using the NPI/PIN combination; or, the group may use only your NPI (once you have one) or only your PIN (once you have one) to identify you as the rendering provider. The group must have its own NPI and would use only the NPI (the group's NPI, once it has one), only the PIN (the group's PIN, once it has one), or the NPI (the group's NPI, once it has one) with the compatible PIN (the group's PIN, once it has one) in combination to identify itself as the billing pay-to provider.

New Product to Assist Physicians/Practitioners in Understanding Medicare Enrollment

All physician/practitioners, including sole proprietors and incorporated physician/practitioners, applying for enrollment in Medicare must have the appropriate NPI(s) and must report those NPIs on the CMS-855 Medicare Provider Enrollment Application. Physician/practitioners must also report the NPI(s) of the corporations, sole proprietorships, groups, or group practices to which they will be reassigning their benefits. Further information on enrollment scenarios is now available at *http://www.cms.hhs.gov/Medicareprovidersupenroll/Downloads/EnrollmentNPI.pdf* on the CMS Web site. General Medicare enrollment information may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll* on the CMS Web site.

If Your Claims Are Rejected

- Check Medicare reject report messages.
- If you use billing companies, clearinghouses, and administrative staff, check to find out if they have been contacted by Medicare carriers or A/B MACs concerning problems in matching NPI/PIN combinations to the Medicare NPI crosswalk.
- Check your information (and that of your corporation, if you formed one) in the NPPES to ensure that the NPI(s) were properly obtained. For example, if you are have a sole proprietorship, you should have an individual PIN and you should have obtained an NPI as an individual (entity type 1), not as an organization (entity type 2).
- Ensure that the NPPES data (for you and your corporation, if you formed one) are correct, and that the NPPES record(s) contains the Medicare legacy identifier(s) *that was assigned to the provider (physician/practitioner or the corporation) to whom the NPPES record belongs.* For example, a physician/practitioner applying for an NPI would list his/her Medicare PIN in the "Other Provider Identifiers" section of the NPI application, but would not list the PIN of the group in which he/she is a member. Medicare uses this information in building the Medicare NPI crosswalk and incorrect reporting will flow into the NPI crosswalk and cause problems down the road. To view or edit your NPPES record, go to *https://nppes.cms.hhs.gov* on the CMS Web site. For assistance, call the NPI Enumerator at 1-800-465-3203.
- If the NPI(s) was properly obtained and the NPPES information is correct and you continue to get informational NPI edits: Ensure that your (and your corporation's, if you formed one) Medicare enrollment information is up to date. If the carrier or A/B MAC asks that you or your corporation re-enroll or update the enrollment information, ensure that a *complete* application is submitted (CMS-855I and, if appropriate, CMS-855R). When completing the CMS-855I or CMS-855R, list your NPI and the NPI of the corporation (group practice) to which benefits will be reassigned (if applicable) in the appropriate places on the CMS-855I and, if the CMS-855R is necessary, on the CMS-855R. Be sure to also list the NPI and the PIN of the corporation (group practice) in the appropriate places on the CMS-855I and, if the CMS-855R is necessary, on the CMS-855R (if PINs have been assigned). The Medicare document referenced earlier will assist you in doing this. Also, make sure that the Medicare enrollment record reflects the correct TIN for use by Medicare in reporting your income to the IRS on the 1099 form. For example, if you are an incorporated physician/practitioner, your Medicare payments need to be associated with your corporation's TIN and not your SSN. If the enrollment record does not reflect this, a CMS-855I must be completed in order to update it.

MLN Matters Number: SE0744
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Medicare Fee-for-Service National Provider Identifier Final Implementation

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

Provider Types Affected

Physicians, providers, and suppliers who submit any HIPAA standard transactions to Medicare contractors (carriers, fiscal intermediaries, [FIs], including regional home health intermediaries [RHHIs], Medicare administrative contractors [A/B MACs], and DME Medicare administrative contractors [DME MACs])

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5728, which describes the policy change brought about as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, that requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions.

Caution – What You Need to Know

Once CMS ends its NPI contingency, the legacy number will NOT be permitted on any inbound electronic and outbound electronic transaction (there are exceptions to the 835 remittance advice (see CR 5452). Medicare contractors will begin rejecting claims, electronic, including direct data entry, that contain legacy provider numbers for any primary provider instead of or in addition to the NPI number. The following HIPAA transactions are also affected:

- X12N 276/277 Claim Status Inquiry/Response – (see CR 5726 for details.)
- X12N 837 Coordination of Benefits (COB) – NPI only will be sent on the 837 coordination of benefits. Legacy numbers are not allowed. An exception will exist for claims that have not cleared the system by the date that CMS ends its NPI contingency plan. Such claims may contain the legacy number and, therefore, the COB transaction will also include the legacy number.

GO – What You Need to Do

No later than May 23, 2008, providers should ensure that all HIPAA transactions sent to Medicare contractors contain only valid NPI numbers (no legacy provider numbers.)

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique NPI to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions. The Centers for Medicare & Medicaid Services (CMS) began to issue NPIs on May 23, 2005. CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers. They are:

- NPI only
- Medicare legacy only
- NPI and legacy combination.

On April 2, 2007, the Department of Health & Human Services (DHHS) provided guidance to covered entities regarding contingency planning for the implementation of the NPI. As long as a health plan is compliant, meaning they can accept and send NPIs on electronic transactions, they may establish contingency plans to facilitate the compliance of their trading partners. As a compliant health plan, Medicare fee-for-service (FFS) established a contingency plan on April 20, 2007, that followed this guidance. CR 5728 directs Medicare contractors to begin rejecting HIPAA inbound claims when directed by CMS, if they contain legacy provider identifiers.

Since paper claims are not HIPAA transactions, these requirements do not apply to paper claims, however, providers should not submit legacy numbers on paper claims once CMS ends its NPI contingency plan.

Additional Information

The official instruction, CR 5728, issued may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1349CP.pdf* on the CMS Web site.

If you have 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 Web 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: MM5728
Related Change Request (CR) #: 5728
Related CR Release Date: October 5, 2007
Effective Date: No later than May 23, 2008
Related CR Transmittal #: R1349CP
Implementation Date: January 7, 2008 and April 7, 2008

Stage 3 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the July 2007 Medicare B Update! pages 47-48.

Note: This article was revised on September 21, 2007, to reflect a change made to the implementation dates in CR 5452. For DME suppliers billing DME MACs, the implementation date remains the same. For other providers who bill Medicare carriers, fiscal intermediaries, including regional home health intermediaries (RHHIs), and/or Part A/B Medicare administrative contractors (A/B MACs), the implementation date is now April 7, 2008. The CR transmittal date, number, and Web address for accessing CR 5452 were also changed. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers who conduct Health Insurance Portability and Accountability Act (HIPAA) standard transactions, such as claims and eligibility inquiries, with Medicare.

Provider Action Needed

STOP – Impact to You

Be aware that Stage 3 of the national provider identifier (NPI) implementation is nearing. This article discusses impact of the NPI Stage 3 implementation on remittance advice transactions.

CAUTION – What You Need to Know

Make sure you have your NPI, know how to use it, and are prepared to receive it back in your remittance advice processes.

GO – What You Need to Do

Read the remainder of this article and be sure your staff are aware of how the NPI implementation impacts the remittance advice transactions you receive.

Background

This article discusses Stage 3 of Medicare's fee-for-service (FFS) processes for the NPI and reflects Medicare processing of claims submitted with NPIs. Submitted NPIs will be cross-walked to the Medicare legacy number(s) for processing. Medicare's internal provider files will continue to be based upon records established in relation to the legacy identifiers. The crosswalk may result in:

Scenario I: Single NPI cross-walked to single Medicare legacy number
Scenario II: Multiple NPIs cross-walked to single Medicare legacy number
Scenario III: Single NPI cross-walked to multiple Medicare legacy numbers

CMS will adjudicate Medicare FFS claims based upon a unique NPI/Legacy combination for Scenarios II and III, but the remittance advice, both electronic and paper, and any output using PC Print or Medicare Remit Easy Print (MREP) will have only NPI as the primary provider identification. The taxpayer identification number (TIN) will be used as the secondary identifier for the Payee. The NPI regulation permits continued use of TIN for tax purposes if the implementation guide allows it.

The companion documents and flat files for both Part A and B will be updated to reflect these changes and the updated documents will be posted at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage* on the CMS Web site.

The following three scenarios refer to Medicare reporting of NPIs in remittance advice processes.

Note that current requirements concerning the reporting of provider names and addresses still apply.

Scenario I – Single NPI cross-walked to single legacy number

- Electronic remittance advice (ERA) – Under this scenario, Medicare will report the NPI at the payee level as the payee primary ID, and the TIN (employer identification number [EIN] social security number [SSN] [EIN/SSN]) in the REF segment as payee additional ID. Medicare will report any relevant rendering provider NPI at the claim level if different from the payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will also report relevant rendering NPI(s) at the service line level if different from the claim level rendering provider NPI. Under this scenario, there will be one remittance advice, and one-check/electronic funds transfer (EFT) per NPI.
- Standard paper remittance (SPR) – Medicare will insert the appropriate payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- PC Print Software – Medicare will show the payee NPI at the header level and add the relevant rendering provider NPI at the claim level if different from the payee NPI.
- MREP Software – Medicare will show the payee NPI at the header level and add any relevant rendering provider NPI at the claim level if different from the payee NPI, and any relevant rendering NPI(s) at the service line level if different from the claim level rendering provider NPI.

Scenario II: Multiple NPIs cross-walked to single Medicare legacy number

- ERA – Under this scenario, Medicare will report the NPI at the payee level as the payee primary ID, and the TIN (EIN/SSN) in the REF segment as payee additional ID. Then add any relevant rendering provider NPI at the claim level if different from the payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add any relevant rendering NPI(s) at the service line level if different from the claim level rendering provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- SPR – Medicare will insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- PC Print Software – Same as Scenario I.
- MREP Software – Same as Scenario I.

Stage 3 National Provider Identifier Changes for Transaction 835, and Standard Paper Remittance Advice, continued

Scenario III: Single NPI cross-walked to Multiple Medicare legacy numbers

- **ERA –** Under this scenario, Medicare will report the NPI at the payee level as the payee primary ID, and the TIN (EIN/SSN) in the REF segment as payee additional ID. Then, Medicare will add any relevant rendering provider NPI at the claim level if different from the payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add relevant rendering NPI(s) at the service line level if different from the claim level rendering provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** – Insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional notes.
- **PC Print Software –** Same as Scenario I.
- **MREP Software –** Same as Scenario I.

Implementation

While these changes are effective for dates of service on or after July 2, 2007, the changes will be implemented as follows:

- For claims submitted to DMERCs and/or DME MACs, the changes will be implemented on July 1, 2007.
- For claims submitted to other Medicare contractors, the implementation will occur on **April 7, 2008**.

Additional Information

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

For complete details regarding this change request (CR) please see the official instruction (CR 5452) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1343CP.pdf* on the CMS Web site. The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* are attached to CR 5452.

MLN Matters Number: MM5452 *Revised*
Related Change Request (CR) #: 5452
Related CR Release Date: September 21, 2007
Effective Date: July 2, 2007
Related CR Transmittal #: R1343CP
Implementation Date for DME suppliers: July 2, 2007.
Implementation Date for other providers: April 7, 2008

What To Do if Claims Are Rejected Due to National Provider Identifier Issues

The NPI is here. The NPI is now. Are you using it?

- Check Medicare reject report messages.
- If you use billing companies, clearinghouses and administrative staff, check to find out if they have been contacted by Medicare contractors concerning problems in matching NPI/PIN combinations to the Medicare NPI crosswalk.
- Check your information in the NPPES to ensure that the NPI(s) were properly obtained. For example, if you are a sole proprietor, you should have an individual PIN and you should have obtained an NPI as an Individual (Entity type 1), not as an Organization (Entity type 2).
- Ensure that the NPPES data are correct, and that the NPPES record(s) contains the Medicare legacy identifier(s) that was assigned to the provider to whom the NPPES record belongs. For example, a physician/practitioner applying for an NPI would list his/her Medicare PIN in the "Other Provider Identifiers" section of the NPI application, but would not list the PIN of the group in which he/she is a member. Medicare uses this information in building the Medicare NPI crosswalk and incorrect reporting will flow into the NPI crosswalk and cause problems down the road. To view or edit your NPPES record, go *to https://nppes.cms.hhs.gov* on the CMS Web site. For assistance, call the NPI Enumerator at 1-800-465-3203.
- If the NPI(s) was properly obtained and the NPPES information is correct and you continue to get informational NPI edits:
- Ensure that your Medicare enrollment information is up to date.
- If you need to re-enroll or update the enrollment information, ensure that a complete application is submitted.
- Also, make sure that the Medicare enrollment record reflects the correct taxpayer identification number (TIN) for use by Medicare in reporting your income to the IRS on the 1099 form.

Important NPI and Enrollment Information for Physicians and Nonphysician Practitioners

By October 31, 2007, all Medicare carriers (and A/B MACs that service providers who formerly billed carriers) will be rejecting Part B claims if they are unable to "match" an NPI and a PIN combination submitted on a claim to an NPI/PIN combination in the Medicare NPI crosswalk. The NPI/PIN combination may be used to identify the billing, pay-to, or rendering provider (the pay-to provider is identified only if it is different from the billing provider). This applies to claims that are

What To Do if Claims Are Rejected Due to National Provider Identifier Issues, continued

submitted by corporations that physicians and nonphysician practitioners (NPP) have formed, or by physicians and NPPs who bill Medicare directly. In this article, we refer to these physicians and NPPs as "physicians/practitioners."

For more information, please refer to the special edition *MLN Matters* article (SE0744) on this subject. You may view the article at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0744.pdf* on the CMS Web site.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page *www.cms.hhs.gov/NationalProvIdentStand* on the CMS Web site. Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your Web browser to view the intended information.

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

Source: Provider Education Resources Listserv, Message 200710-12

Potential Issues Related to Clearinghouse and Billing Service Practices

The NPI is here. The NPI is now. Are you using it?

As part of efforts to fully implement the national provider identifier (NPI), Medicare fiscal intermediaries, carriers, and A/B MACs have begun calling providers who are not sending their NPI on claims or are sending incorrect NPI information. It has come to CMS' attention that:

- Some clearinghouses may be stripping the NPI off the claim prior to its submission to Medicare for claims processing. Clearinghouses may be adding the NPI back onto the remittance advice, so that providers are unaware that NPIs are being removed prior to being sent forward.
- Some billing services (or "key" shops) are not putting the NPI on the claim, contrary to provider instructions.
- Some clearinghouses are not forwarding, to providers, carrier NPI informational claim error messages designed to help the provider understand the problems Medicare is encountering in attempts to crosswalk the NPI to legacy identifiers.

Medicare contractors are turning on edits to begin validating the NPI/legacy pair against the Medicare NPI crosswalk. If the pair on the claim is not found on the crosswalk, the claim will reject. Stripping the NPI submitted by a provider from the claim adversely affects Medicare provider incentive cash flow, payers that receive crossover claims, and the efforts of Medicare to fully implement NPI.

If you are a Clearinghouse or billing service that is stripping or not sending the NPI, Medicare would like to better understand the reasons behind this practice as well as the expected timeframe during which this will continue to occur. Therefore, we ask those willing to discuss this problem with the Centers for Medicare & Medicaid Services staff to please contact Aryeh Langer at *Aryeh.langer@cms.hhs.gov* or Nicole Cooney at *Nicole.cooney@cms.hhs.gov* before October 10, 2007.

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

Source: Provider Education Resources Listserv, Message 200710-04

NPPES and NPI Registry Update

The NPI is here. The NPI is now. Are you using it?

Many of you have noted the recent instability of NPPES and the NPI Registry. CMS has begun implementing changes that should eliminate the instability. We expect that these changes will be completed as soon as possible. NPPES will remain in operation while these changes are being made but the NPI Registry will remain down until all changes have been implemented. We expect the NPI Registry to be back in operation as soon as possible. We apologize for this inconvenience.

The downloadable file is available at *http://nppesdata.cms.hhs.gov/cms_NPI_files.html* on the Web.

Important Information for Medicare Providers

For physicians and nonphysician practitioners who bill Medicare

Your Medicare carrier has contacted, or will be contacting you, about the date Medicare will begin rejecting your claims if the NPI and legacy number pairs used on your Medicare claims are not compatible. If you bill using only the NPI, please skip to the last paragraph.

Some incorporated physicians and nonphysician practitioners have obtained NPIs as follows: an individual (entity type 1) NPI for the physician or nonphysician practitioner and an organization (entity type 2) NPI for the corporation. If you enrolled in Medicare as an individual and obtained a Medicare provider identification number (PIN) as an individual, and you want to use your NPI and your PIN pair in your Medicare claims, be sure you use your individual NPI with your individual PIN. Pairing your corporation's NPI with your individual PIN will result in your claims being rejected. If you wish to bill Medicare with your corporation's NPI, then you must be sure your corporation is enrolled in Medicare so that it can be assigned a PIN. Please contact your servicing Medicare carrier for more information about this enrollment. Until your corporation has been enrolled in Medicare, you may continue to bill by using your individual NPI with your individual PIN to ensure

NPPES and NPI Registry Update, continued

no disruption in your claims being processed and paid. Please note that similar problems may result if you bill Medicare by using your individual NPI with your corporation's PIN (if the corporation is enrolled and has been assigned a PIN). In other words, when billing with the NPI/PIN pair, you must use compatible NPIs and PINs.

NPI-Only Billers: Make sure the NPI you are using is compatible with your Medicare enrollment. For example, if you enrolled in Medicare as an individual, then you should be using an individual (entity type 1) NPI.

Enumeration Tip for DME Suppliers

Medicare has also reported instances of incorrect billing by DME suppliers to DME MACs. DME suppliers must ensure that if they enumerate as individuals in the national supplier clearinghouse (NSC), they must obtain NPIs for themselves as individuals (entity type 1) in NPPES. If they enumerate as organization in the NSC, they must obtain NPIs for the organizations (entity type 2) in NPPES.

Pay Attention: Informational Edits Today—Future Claim Rejections!

We strongly urge Medicare providers to pay attention to the informational edits they may be receiving on the remittance advice (either electronic or paper). These edits are generated to help providers identify problems that will cause claims to reject in the future. A recent MLN Matters article lists these informational edits and their meanings. Visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf* on the CMS Web site to view the article.

Reminder

Medicare carriers and DME MACs will begin transitioning their systems to start rejecting claims when the NPI and legacy provider identifier pair cannot be found on the Medicare crosswalk

Since May 29, 2007, Medicare fiscal intermediaries, as well as Part B CIGNA Idaho and Tennessee, have been validating NPIs and legacy provider identifier pairs submitted on claims against the Medicare NPI crosswalk. Between the period of September 3, 2007, and October 29, 2007, all other Part B carriers and DME MACS will begin to turn on edits to validate the NPI/legacy pairs submitted on claims. If the pair is not found on the Medicare NPI crosswalk, the claim will reject. Contractors have been instructed to inform providers at a minimum of seven days prior to turning on the edits to validate the NPI/legacy pairs against the NPI crosswalk.

If your remittance advice contains informational edits today, we strongly urge you to validate that the NPPES has ALL of the NPI and legacy numbers you intend to use on claims and for billing purposes. If NPPES is correct, and you continue to receive informational edits, you should ensure that your Medicare enrollment information is up to date. If it is not, you may need to submit a completed CMS-855 (Medicare provider enrollment form). When completing the CMS-855, please list all of the NPIs that will be used in place of legacy identifiers. When applying for an NPI, please include ALL of your Medicare legacy numbers. (NPPES can accept only 20 other provider identifiers, but is being expanded to accept more in the future.) If the information is different between Medicare and NPPES, there is a very good chance your claims will reject. NPPES data may be verified at *https://nppes.cms.hhs.gov* on the Web.

Clarification Regarding Provider Response Times for Contractor Inquiries

As stated in CR 5649, transmittal number 1262 dated June 8, 2007, all Medicare providers could receive phone calls and/or letters from their contractors in the event that a claim suspends due to problems with mapping a provider's NPI to a legacy provider identifier. In last month's NPI message, we noted the number of days for a provider to respond to this type of contractor inquiry. To clarify, if the provider does not respond within the timeframe issued during the phone call with, or on the letter they receive from their contractor, the contractor will return the claim as unprocessable. The contractor will ensure that it is in compliance with the *Medicare Program Integrity Manual* (Publication 100-08), chapter 10, section 17.2 regarding the release of information.

Upcoming WEDI NPI Audiocast

The Workgroup for Electronic Data Interchange will host an NPI audio cast on October 17th. Visit *http://www.wedi.org/npioi/index.shtml* on the WEDI website to learn more. Please note that there is a cost to participate in WEDI events.

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? More information and education on the NPI may be found through the CMS NPI page *www.cms.hhs.gov/NationalProvIdentStand* on the CMS Web site. Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

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

Source: Provider Education Resources Listserv, Message 200709-16

PREVENTIVE SERVICES

Preventive Services Brochures for Health Care Professionals Now Available

The following preventive service brochures from the Centers for Medicare & Medicaid Services (CMS) for health care professionals, have been updated and are now available in print and PDF:

- Expanded Benefits
- Diabetes-Related Services
- Cancer Screenings
- Adult Immunizations
- Bone Mass Measurements
- Glaucoma Screenings
- Smoking and Tobacco-Use Cessation Counseling Services.

To download and view online, please visit the MLN Publications Web page located at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp#TopOfPage* and select the title of the brochure from the list.

To order copies of these brochures, please visit the MLN Product Ordering Page located on the CMS Web site at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

Source: CMS Provider Education Resource 200710-02

Updated Adult Immunizations Web-Based Training Course

The Centers for Medicare & Medicaid Services (CMS) has updated the following Web-based training (WBT) course: ***Medicare Preventive Services Series: Part 1 Adult Immunizations***. This WBT course provides information to help fee-for-services providers and suppliers understand Medicare's coverage and billing guidelines for influenza, pneumococcal, and hepatitis B vaccines and their administration. This Web-based training course is the first in a series of three WBT courses developed by CMS as part of a comprehensive provider information program designed to promote awareness and increase utilization of preventive benefits covered by Medicare and to help those who bill Medicare for these service to file claims effectively. CMS has been reviewed and approved as an authorized provider by:

International Association for Continuing Education and Training (IACET)
1620 I Street, NW, Suite 615
Washington, DC 20006

Participants who successfully complete this course may receive .1 IACET CEU. To register, free of charge for this course, please visit the CMS Web site at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

Source: Provider Education Resources Listserv, Message 200710-05

Flu Shot Reminder

Flu Season is upon us! Begin now to take advantage of each office visit as an opportunity to talk with your patients about the flu virus and their risks for complications associated with the flu. Encourage them to get their flu shot. It's their best defense against combating the flu this season. Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies. And don't forget, health care professionals need to protect themselves also. **Get Your Flu Shot. – Not the Flu.**

Remember: Influenza vaccination **is** a covered Part B benefit.
Note: Influenza vaccine is **not** a Part D covered drug.

For information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to the CMS Web site *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf*.

Source: CMS Provider Education Resource 200710-03, 200710-08, 200710-10, 200710-11

Mass Immunizer and Centralized Biller Clarification

The Centers for Medicare & Medicaid Services (CMS) would like to remind Part B providers and suppliers who participate as specialty provider type, mass immunizer, that a mass immunizer is a provider or supplier who enrolls in the Medicare program to offer the influenza vaccination to a large number of individuals. Enrollment for mass immunizers is ongoing.

Mass immunizers who operate as centralized billers are those entities that operate in at least three different payment localities and have received permission from CMS to bill a single Medicare contractor for payment. An annual June 1 application deadline applies only to mass immunizers who are applying for participation as a mass immunizer centralized biller.

For further clarification, please review the *MLN Matters* article MM5511 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf*.

Source: CMS Provider Education Resource 200710-3

Medicare Preventive Services Quick Reference Information Chart

The Centers for Medicare & Medicaid Services (CMS) has developed a new preventive services quick reference chart entitled *The ABCs of Providing the Initial Preventive Physical Examination*, ICN# 006904. Medicare fee-for-service physicians and qualified nonphysician practitioners can use this two-sided laminated chart as a guide when providing the initial preventive physical examination (IPPE) (also known as the "Welcome to Medicare" Physical Exam or the "Welcome to Medicare" Visit). This handy tool identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs (frequently asked questions), suggestions for preparing patients for the IPPE, and lists references for additional information. Currently available in downloadable PDF format, the chart may be viewed on the CMS Medicare Learning Network Publications Web page at

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf.

Source: CMS Provider Education Resource 200709-10

October was National Breast Cancer Awareness Month

In conjunction with National Breast Cancer Awareness Month (NBCAM), the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join with us in helping to promote increased awareness of the importance of early detection of breast cancer, and ensure that all eligible women with Medicare know that Medicare provides coverage of screening mammograms and clinical breast exams for the early detection of breast cancer.

Next to skin cancer, breast cancer is the most common form of cancer diagnosed in women in the United States. *National Breast Cancer Awareness Month* educates women about the importance of early detection. The good news is, more and more women are getting mammograms to detect breast cancer in its earliest stages. As a result, breast cancer deaths are on the decline. This is exciting progress. Yet, while mammography screening remains the best available method to detect breast cancer, there are still many eligible women with Medicare who do not take advantage of early detection at all and others who do not get screening mammograms and clinical breast exams at regular intervals.

Medicare Coverage

Medicare provides coverage of an annual screening mammogram for all female beneficiaries age 40 and older and one baseline mammogram for female beneficiaries between the ages of 35 and 39. Medicare also provides coverage of clinical breast exams, every 12 or 24 months depending on risk level for the disease. (clinical breast exams are covered by Medicare as part of the pelvic screening exam).

How Can You Help?

"Pass the Word." Early detection of breast cancer results in earlier potentially less invasive treatment and an improved chance of survival. CMS needs your help to ensure that all women with Medicare take full advantage of the preventive services and screenings for which they may be eligible.

- Help your patients understand their risk for breast cancer and the benefits of regular screening mammograms and clinical breast exams.
- Encourage your patients to talk about any barriers that may keep them from obtaining mammography services on a routine basis and help them overcome those barriers.
- Make sure that all eligible female patients are aware that Medicare covers mammography screenings every year and regular clinical breast exams.

Please encourage women with Medicare to take full advantage of these vitally important benefits.

For More Information

- For more information about Medicare's coverage of screening mammography, and clinical breast exams, including coverage, coding, billing, and reimbursement, please visit the CMS Medicare Learning Network Web page: *http://www.cms.hhs.gov/Mammography/*
- The *MLN* Preventive Services Educational Products Web Page provides descriptions and ordering information for all provider specific educational products related to preventive services *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*
- For literature to share with your Medicare patients, please visit *http://www.medicare.gov*
- For more information about NBCAM, please visit *www.nbcam.org*

Thank you for joining with CMS in promoting increased awareness of early breast cancer detection and mammography and clinical breast exam services covered by Medicare.

Provider Education Resources Listserv, Message 200709-20

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 Florida Medicare intermediary. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, hover over Medicare Providers, select Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

GENERAL INFORMATION

Clarification—Provider Billing Procedures Related to the Transition to the Coordination of Benefits Contractor

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

Provider Types Affected

Physicians and suppliers submitting claims to Part B Medicare contractors (including carriers, Medicare administrative contractors (A/B MACs), and durable medical equipment MACs (DME MACs).

Provider Action Needed

As instructed in *MLN Matters* article MM5601, all providers that bill their claims to Part B carriers, A/B MACs, or DMACs should, effective with October 1, 2007, begin to include a new Coordination of Benefits Agreement (COBA) Medigap 5-byte COBA ID (range 55000 to 59999) on incoming Medicare paper claims (CMS-1500), or incoming Health Insurance Portability and Accountability Act (HIPAA) 837 professional (version 4010A1), or National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claims to trigger crossovers to those Medigap insurers that are participating in the Centers for Medicare & Medicaid Services (CMS) new COBA Medigap claim-based process.

Providers should be including **only** the new 5-byte COBA Medigap claim-based ID on incoming Medicare claims effective October 1, 2007, for the purpose of triggering crossovers to those Medigap insurers that have been assigned a COBA Medigap claim-based ID that falls in the range of 55000 through 59999. The link to the Medigap billing ID spreadsheet, which providers or their billing vendors should consult for this purpose, remains as *http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf* on the CMS Web site.

Though the number of entities that have requested COBA Medigap claim-based IDs is currently not very large, providers and their billing vendors should continue to consult this listing for purposes of noting changes. Please be assured the list is complete and accurate. Providers or their billing vendors should include only the Medigap COBA IDs on this list (range 55000 through 59999) on Medicare claims for purposes of triggering crossovers to Medigap insurers. Providers or their billing vendors should not include any of the eligibility file-based COBA IDs (ranges 00001-29999; 30000-54999; 60000-69999; 70000-79999; and 80000-89999) on inbound claims to Medicare.

Effective October 1, 2007, if a provider or its billing vendor files a Medicare claim with a COBA ID other than the COBA Medigap IDs on the above-referenced Medigap billing ID list, Medicare will generate an MA19 message on the provider's 835 electronic remittance advice (ERA) or other remittance advice in use. This message indicates: "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer."

As a reminder, all entities that participate in the COBA eligibility file-based crossover process or automatic complementary crossover process may be referenced at *http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf* on the CMS Web site.

Providers should **not** contact those insurers or payers listed as participating in the automatic crossover process for purposes of determining whether CMS has assigned them a COBA Medigap claim-based ID. As aforementioned, providers or their billing vendors should also **not** utilize COBA ID information from this listing on their incoming Medicare claims for the purpose of triggering Medigap claim-based crossovers. **Important:** Not every Medigap insurer is utilizing the automatic crossover process for the purpose of identifying **all** of its covered members or policyholders for crossover purposes and for receiving crossover claims for those Medicare beneficiaries. An example of this scenario is as follows: If the COBC was approached by a new Medigap insurer that specified that it needed to apply for a Medigap claim-based ID (range 55000 to 59999) for various segments of its covered membership, but will utilize the automatic complementary crossover process for the remainder of its Medigap membership, the Coordination of Benefits Contractor (COBC) would, following execution of the COBA crossover agreement with the insurer, assign it two COBA IDs—one for automatic crossover (range 30000 to 54999 for automatic Medigap eligibility file-based crossover) and the other for Medigap claim-based crossover (55000 to 59999). Thus, this Medigap insurer would appear on **both** the listing of automatic crossover insurers as well as the Medigap billing ID listing at the respective URL links on the COB Web site, referenced above.

Background

All supplemental insurers are required to sign a national COBA crossover agreement with CMS' COBC if they participate in CMS' automatic complementary crossover (COBA eligibility file-based crossover) process **or** in the COBA Medigap claim-based crossover process. Providers should know that it is **never** their responsibility to request or obtain new Medigap 5-byte IDs for their patients' Medigap insurers through the signing of a national COBA crossover agreement.

In *MLN Matters* article, MM5662, CMS informed its affected provider community that, during June through August 2007, its COBC would assign a new 5-byte COBA Medigap claim-based identifier (range=55000 to 59999) to a Medigap insurer after it has signed a national crossover agreement with the COBC. Despite repeated outreach communications to the health insurance industry, not all Medigap insurers have, as instructed, contacted the COBC to specify which approach, among three available options, they will exercise to ensure continued receipt of crossover claims on and after October 1, 2007.

Clarification—Provider Billing Procedures Related to the Transition to the Coordination of Benefits Contractor, continued

The three options available to each Medigap insurer for addressing its receipt of Medicare crossovers remain as follows:

- If applicable, continue to participate **fully** in the automatic crossover process (or COBA eligibility file-based crossover process) and discontinue use of any claim-based Medigap IDs
- Continue to participate in part in the automatic crossover process for a segment of the insurer's covered membership but request a COBA Medigap claim-based ID through the COBC to address crossovers for the remaining segments
- Request a new COBA Medigap claim-based crossover ID through the COBC, with the understanding that the Medigap insurer would prefer **not** to participate in the automatic crossover process.

To be clear, if a Medigap insurer is currently participating **fully** in the automatic (or COBA eligibility file-based) crossover process, it merely needs to inform the COBC of this decision. Upon doing so, that Medigap insurer will experience no disruption in its receipt of crossover claims. Based upon its most recent review of trending, CMS has noted that the vast majority of the larger, more commonly known Medigap insurers, which were already participating **fully** in the Medicare automatic crossover process, have informed CMS and the COBC that they plan to continue to participate fully in the automatic crossover process for purposes of fulfilling their mandatory Medigap crossover payment responsibilities on behalf of their Medigap policyholders. In other words, the majority of the larger, more commonly known Medigap insurers have exercised the first option above.

Additional Information

You may find MLN Matters articles MM5061 and MM5662 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5662.pdf* on the CMS Web site.

If you have any questions, please contact your carrier, A/B MAC, or DME MAC at their toll-free number found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web 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: SE0743
Related Change Request (CR) #: CR5601 and CR5662
Related CR Release Date: N/A
Effective Date: October 1, 2007
Related CR Transmittal #: N/A
Implementation Date: N/A

Medicare Billing Information for Rural Providers, Suppliers, and Physicians

The Medicare Billing Information for Rural Providers, Suppliers, and Physicians informational resource, which consists of charts that provide billing information for rural health clinics, federally qualified health centers, skilled nursing facilities, home health agencies, and critical access hospitals, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *www.cms.hhs.gov/mlngeninfo*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: Provider Education Resources Listserv, Message 200710-10

Medicare Summary Notice Message: Revised 38.13

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

Provider Types Affected

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

Provider Action Needed

This article is informational for providers and the article is based on change request (CR) 5722, which outlines a change to MSN message 38.13 that will advise beneficiaries that they may need to pay their provider before receiving their Medicare Summary Notice (MSN) due to the change to quarterly mailing schedule (see CR 5062.)

Background

In an effort to reduce overall operating costs, CR 5062 changed the No-Pay MSN mailing schedule from a monthly schedule to a quarterly schedule. As a result, it is possible that a beneficiary may receive a bill from a provider before receiving the MSN and may not be able to wait for the MSN before provider payment is due. The change to MSN message 38.13 clarifies this potential timing conflict to beneficiaries. The revised MSN message is as follows:

"If you aren't due a payment check from Medicare, your Medicare Summary notices (MSN) will now be mailed to you on a quarterly basis. You will no longer get a monthly statement in the mail for these types of MSNs. You will now get a statement every 90 days summarizing all of your Medicare claims. Your provider may send you a bill that you may need to pay before you get your MSN. When you get your MSN, look to see if you paid more than the MSN says is due. If you paid more, call your provider about a refund. If you have any questions about the bill from your provider, you should call your provider. "

Medicare Summary Notice Message: Revised 38.13, continued

Additional Information

You may review the official instruction issued to you're A/B MAC, FI, carrier, DME MAC, or RHHI regarding this message modification by going to CR 5722, located at *http://www.cms.hhs.gov/transmittals/downloads/R1347CP.pdf* on the CMS Web site.

You may review CR 5062 at *http://www.cms.hhs.gov/transmittals/downloads/R955CP.pdf* on the CMS website. The related *MLN Matters* article (MM5062: Quarterly Medicare Summary Notice (MSN) Printing Cycle) is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5062.pdf* on the CMS Web site.

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 Web 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: MM5722
Related Change Request (CR) #: 5722
Related CR Release Date: September 27, 2007
Effective Date: October 29, 2007
Related CR Transmittal #: R1347CP
Implementation Date: October 29, 2007

Required Use of Tamper-Resistant Prescription Pads for Outpatient Drugs Prescribed to Medicaid Recipients on or After April 1, 2008

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the September 2007 Medicare B Update! page 22.

Note: This article was revised on October 2, 2007, to change the effective date from October 1, 2007, to April 1, 2008. This change was a result of the "Extenders Law", which was signed September 29, 2007, delaying the implementation date for all paper Medicaid prescriptions to be written on tamper-resistant paper. Under the new law, all written Medicaid prescriptions must be on tamper-resistant prescription pads as of April 1, 2008. CMS will issue additional guidance on this implementation delay as it becomes available. All other information remains the same.

Provider Types Affected

This issue impacts all physicians, practitioners, and other providers who prescribe Medicaid outpatient drugs, including over-the-counter drugs, in states that reimburse for prescriptions for such items. Pharmacists and pharmacy staff especially should be aware of this requirement as it may affect reimbursement for prescriptions. The requirement is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

Background

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 was signed into law on May 25, 2007. Section 7002 (b) of that Act addresses the use of tamper-resistant prescription pads and offers guidance to State Medicaid agencies.

On August 17, 2007, the Centers for Medicare & Medicaid Services (CMS), issued a letter to state Medicaid directors with guidance on implementing the new requirement.

Key Points of the CMS Letter to Your State Medicaid Director

- As of April 1, 2008, in order for outpatient drugs to be reimbursable by Medicaid, all written, non-electronic prescriptions must be executed on tamper-resistant pads.
- CMS has outlined three baseline characteristics of tamper-resistant prescription pads, but each state will define which features it will require to meet those characteristics in order to be considered tamper-resistant. **To be considered tamper resistant on April 1, 2008, a prescription pad must have at least one of the following three characteristics:**
- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.
- No later than October 1, 2008, to be considered tamper resistant, states will require that the prescription pad have all three characteristics.
- Several states have laws and regulations concerning mandatory, tamper-resistant prescription pad programs, which were in effect prior to the passage of section 7002(b). CMS deems that the tamper-resistant prescription pad characteristics required by these states' laws and regulations meet or exceed the baseline standard, as set forth above.
- Your state is free to exceed the above baseline standard.
- Each state must decide whether they will accept prescriptions written in another state with different tamper proof standards.
- CMS believes that both e-prescribing and use of tamper-resistant prescription pads will reduce the number of unauthorized, improperly altered, and counterfeit prescriptions.

Situations in Which the New Requirement Does Not Apply

The requirement does not apply:

- When the prescription is electronic, faxed, or verbal (CMS encourages the use of e-prescribing as an effective means of communicating prescriptions to pharmacists).
- When a managed care entity pays for the prescription
- To refills of written prescriptions presented to a pharmacy before April 1, 2008.

Use of Tamper-Resistant Prescription Pads for Outpatient Drugs Prescribed to Medicaid Recipients on/after 4/1/08, continued

- In most situations when drugs are provided in nursing facilities, intermediate care facilities for the mentally retarded, institutions for mental disease, and certain other institutional and clinical facilities.

Note: The letter issued by CMS to state Medicaid directors states that emergency fills are allowed as long as a prescriber provides a verbal, faxed, electronic, or compliant prescription within 72 hours after the date on which the prescription is filled. PLEASE NOTE also that Drug Enforcement Administration (DEA) regulations regarding controlled substances may require a written prescription.

MLN Matters Number: SE0736 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: April 1, 2008
Related CR Transmittal #: N/A
Implementation Date: N/A

Revised Medicare Physician Guide

The revised Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals (Ninth Edition), which offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, fraud, abuse, inquiries, overpayments, and appeals, is now available in print and CD-ROM formats from the Centers for Medicare & Medicaid Services *Medicare Learning Network*.

To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Provider Education Resources Listserv, Message 200709-18

Tips for Correcting Previously Denied Claims

Providers have three options for correcting a denied claim:

1. Resubmit the claim with the correct information.
2. Submit a redetermination request.
3. Contact customer service to perform a clerical reopening.

Important Reminders

- If it has been more than one year from the date of service, it is best if you write or call in to correct the information. If not, a ten percent reduction will be applied to the resubmitted claim, in accordance with Medicare's timely claim filing guidelines.
- If the claim denied as unprocessable, you must resubmit the claim. You cannot request a redetermination on an unprocessable denial. Claims denied as unprocessable are not afforded appeal rights.
- If you are required to bill claims electronically (as most Medicare claims are), do not resubmit the services as a paper claim.
- If you do bill on paper, do not highlight information on the claim or write any special notes or comments.
- Resubmit only the service(s) in question; do not resubmit services already paid.

New Web Site Features and Enhancements

We recently performed a major overhaul of our Web site, but do you know why? One of the primary reasons is to provide you with more timely and relevant content. Our redesign also makes it easier for us to keep the site fresh and dynamic.

In this spirit of continuous improvement, we recently added new pages for Clinical Trials and New Providers, and made the Provider Enrollment and NPI (National Provider Identifier) sections easier to find. We have also added Flash "simulations" to help you with various provider enrollment forms. Initial response to these simulations has been very positive; if you have not checked them, refer to the Provider Enrollment page and look for the Flash icon .

We have added instructions and tips for using our recently updated IVR (interactive voice response) unit, and enhanced the Contacts page to eliminate duplicate, and sometimes contradictory, information.

And we have completely revised the Frequently Asked Questions (FAQ) section to provide more accessible, up-to-date answers to some of your most important Medicare issues.

We are excited about our new look and functionality, and hope you are as well. Keep checking back for even more enhancements on the horizon, including a brand-new search engine!

References

Clinical Trials (Part B)

New Providers

Provider Enrollment

NPI

IVR

Fee Schedule Look-up(Part B)

FAQs (Part B)

Waiver of Deductible and Coinsurance

Physicians and suppliers who routinely waive (do not bill the beneficiary for) coinsurance and deductible amounts may be in violation of Medicare statutes and may be subject to criminal, civil or administrative liability for make false statements and/or filing false claims to the government.

For most covered items and services, federal law provides Medicare B payment for 80 percent of the reasonable charges.

There is no statutory provision that specifically requires physicians or suppliers to bill the additional 20 percent coinsurance and/or deductible amounts due from beneficiaries. However, to preserve the legislative intent that beneficiaries bear some of the cost of their care and to serve as a deterrent to program overutilization, physicians and suppliers are expected to make reasonable efforts to collect these amounts.

As a means to induce patient business, some physicians and suppliers have advertised that Medicare patients will no be billed for coinsurance and deductible amounts. Physicians and suppliers who routinely waive collection of deductibles and coinsurance derive an unfair advantage in attracting patients over those physicians and suppliers who collect these amounts.

In cases where a physician or supplier advertises to Medicare beneficiaries that they will not be billed coinsurance amounts, the physician or supplier may be in violation of federal law. Section 1877(b)(s)(B) of Title XXVII of the Social Security Act specifically prohibits any offer of remuneration in cash or in kind, to induce a person to purchase, lease, or order any item or service paid by Medicare. Section 1877(b)(3) of the same title contains an express exception that excludes from its scope any discount or other reduction in price, if the reduction is properly disclosed and appropriately reflected in actual charge(s) made by the physician or supplier.

The practice of routinely waiving coinsurance amounts and not incorporating that reduction in the charge amount(s) reported to Medicare and/or billed to beneficiaries clearly constitutes a "discount". Whenever that discount is not reported to Medicare, a violation of the anti-kickback statute has occurred. Additionally, a submission of a claim in which the physician's or supplier's charge does not actually reflect what the physician or supplier intends to collect may be considered a violation of both the federal false claims and federal statements statutes.

Routine Waiver of Deductible and Coinsurance Amounts

Physicians are hereby notified that Medicare can and will:

- Develop and recover monies paid with possible penalties on previous claims where waiver of deductible or coinsurance amounts has been discovered.
- Suspend or exclude physicians and suppliers from participating in the program.
- Treat all future instances of routine waivers as criminal in nature, subject to referral to the Office of the Inspector General.

Occasional Waiver of Deductible and Coinsurance Amounts

One important exception to the prohibition against waiving copayments and deductibles is that providers, practitioners, or suppliers may forgive the copayment in consideration of a particular patient's financial hardship. This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Except in such special cases, a good faith effort to collect deductibles and copayments must be made. Otherwise, claims submitted to Medicare may violate the statutes discussed above and other provisions of the law.

Update to Nine-Digit ZIP Code List for Establishing Payment Based on Locality

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

Provider Types Affected

Physicians, providers, and other health care practitioners submitting claims to Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for services paid under the Medicare physician fee schedule (MPFS) and for anesthesia services.

Provider Action Needed

STOP – Impact to You

Change request (CR) 5208, issued March 09, 2007, had attached to it the list of ZIP codes that would require the nine-digit ZIP codes effective for claims with dates of service on or after October 1, 2007. This ZIP code list is being updated by CR 5730. To review the list in CR 5208, go to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5208.pdf* on the CMS Web site.

CAUTION – What You Need to Know

The *Key Points* section of this CR provides the complete updated list of additions and deletions to the ZIP code list identified in CR 5208.

GO – What You Need to Do

Make certain that your billing staffs are aware that Medicare requires the submission of nine-digit ZIP codes to carriers/A/B MACs for services paid under the MPFS and anesthesia services, when the services are provided in those ZIP code areas listed in CR 5208 (except those identified as deleted in this article) as well as those ZIP codes listed in this article as added to the CR 5208 list. The exception occurs when the Place of Service (POS) is "Home," and for any other places of service that your Medicare carrier or A/B MAC currently considers to be the same as "Home." (Currently, there is no requirement for the submission of a ZIP code when the POS is "Home.")

Update to Nine-Digit ZIP Code List for Establishing Payment Based on Locality, continued

Background

Medicare contractors have been directed to determine payment locality for services paid under the MPFS and anesthesia services by using the ZIP code on the claim of where the service was performed. CMS realizes that some ZIP codes fall into more than one payment locality. The CMS ZIP code file uses the convention of the United States Postal Service, which assigns these ZIP codes into dominant counties. In some cases, though the service may actually be rendered in one county, but per the ZIP code it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount.

Key Points

Additions to the ZIP code list in CR 5208 requiring 9-digit zip codes are as follows:

30132	58639	60585	69145	78660
51001	58649	60586	69343	82701
51023	60502	67762	77578	98068
57533	60503	69128	78653	

Deletions to the ZIP code list in CR 5208 requiring 9-digit zip codes are as follows:

01432	19525	62231	68755	77550	78657

Additional Information

For complete details regarding this change request (CR) please see the official instruction (CR 5730) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1337CP.pdf* on the CMS Web site.

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

MLN Matters Number: MM5730
Related Change Request (CR) #: 5730
Related CR Release Date: September 21, 2007
Effective Date: October 22, 2007
Related CR Transmittal #: R1337CP
Implementation Date: October 22, 2007

Florida ZIP Codes Impacted by the Nine–Digit ZIP Code Payment Policy

Effective For All Claims Received On Or After October 1, 2007

Change request (CR) 5208 – Use of Nine-Digit ZIP Codes for Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services establishes that services provided in ZIP code areas crossing more than one payment locality must be presented in a nine-digit format on claims. When reporting MPFS or anesthesia services being rendered in these locations, you must include the standard five-digit ZIP code plus the four-digit extension on all claims submitted to First Coast Service Options, Inc..

Below lists the Florida ZIP codes and localities impacted. It is extracted from the *Medicare Learning Network (MLN) Matters* article MM5208.

ZIP Code	Location
32948	Fellsmere
33440	Clewiston
33917	North Fort Myers
33920	Alva
33955	Punta Gorda
33972	Lehigh Acres
34141	Ochopee or Jerome
34142	Immokalee or Ava Maria
34972	Okeechobee or Basinger or Yeehaw or Yeehaw Junction
34974	Okeechobee

Any claim received on or after October 1, 2007, for services rendered in any of the above localities not containing a nine-digit ZIP code returned as unprocessable.

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

- You may continue to submit claims with five-digit ZIP codes if you provide these services in areas that are not listed above and do not cross payment localities
- There is no current requirement for the submission of a ZIP code when the place of service (POS) is "Home" (POS 12) or any other place of service that your Medicare contractor currently considers to be the same as "Home."

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

Source: CR 5208 – Use of Nine-Digit ZIP Codes for Determining the Correct Payment Locality for Services paid under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services; MM5208 (Table 1); CMS IOM Pub 100-04 *Medicare Claims Processing Manual*, Chapter 1, Sections 10.1.1, 10.1.1, & 80.3.2.1.2; United States Postal Service (USPS) Web site ZIP code Lookup tool (*http://zip4.usps.com/zip4/citytown_zip.jsp*)

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 (LCDs) 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 LCDs 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 Web sites, *http://www.fcso.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 LCD, and are based on the date of service (unless otherwise noted in the LCD). Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new LCDs are posted to the Web site, subscribe to our *FCSO eNews* mailing list. It's very easy to do; go to our Web site *http://www.fcso.com* , hover over Medicare providers, select Florida Part A or B, click on the "eNews" link located on the upper-righ-hand corner of the page and follow the prompts.

More Information

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

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

Local Coverage Determinations - Table of Contents

Advance Beneficiary Notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

ADDITIONAL INFORMATION

Descemet's Stripping Automated Endothelial Keratoplasty—Coding and Billing – Revised Article

An article was previously published in the September 2007 *Medicare B Update! (page 43)* regarding coding and billing for the Descemet's stripping automated endothelial keratoplasty (DSAEK) procedure. The following information is meant to replace/supersede the previous instructions given for reporting the DSAEK procedure:

Lamellar keratoplasty is a term that describes partial thickness corneal tissue replacement. In anterior lamellar keratoplasty (ALK), as opposed to posterior lamellar keratoplasty (PLK), a varying amount of anterior corneal stromal tissue replacement is done, with retention of the recipient Descemet's membrane and endothelium. Posterior lamellar keratoplasty includes any corneal lamellar procedure where the Descemet's membrane and endothelium are excised with or without host corneal stroma. Both DSAEK and deep lamellar endothelial keratoplasty (DLEK) are types of posterior lamellar keratoplasty. DSAEK is a two-tissue removal, namely endothelium and Descemet's membrane. DLEK is a three-tissue removal procedure, including endothelium, Descemet's membrane and stroma removed from the host cornea. There are other terminologies and technique variations that are in use.

DSAEK had been presented to Medicare beneficiaries as a new surgical procedure for corneal transplant with advantages over conventional procedures. Until new codes and RVUs have been assigned by the AMA/RUC to the PLK procedures, First Coast Service Options, Inc. (FCSO) will allow billing and coding of PLK within the keratoplasty range of codes (*65710, 65730, 65750, 65755*) as determined by the operating physician trained in the technique. The procedure must meet the medical necessary and reasonable criteria for a keratoplasty. Also, remember to use the appropriate modifiers when performing the service on both eyes. It is assumed that in the near future the PLK procedures will be addressed by the AMA for unique level I coding, so this decision is temporary in order to allow beneficiary access to ambulatory surgical center (ASC) and facility coverage.

Documentation in the medical record maintained by the performing provider must include the following: patient's history and physical, office/progress notes and operative report. This documentation must also support the medical necessity of the procedure performed.

Note that Medicare does not cover keratoplasty procedures primarily for refractive correction and radial keratotomy. (See the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual System, Pub. 100-03, *Medicare National Coverage Determinations (NCD) Manual*, chapter 1, part 1, section 80.7).
Anytime there is a question whether Medicare's medical reasonableness and necessity criteria would be met, we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed *CPT* codes. For further details about CMS' beneficiary notices initiative, please point your browser to this link: *http://www.cms.hhs.gov/BNI/*. Please note that services that lead up to or are associated with noncovered services are not covered as well.

CONNECTICUT ONLY - REVISIONS TO THE LCDS

J9212: Interferon—Revision to the LCD

This local coverage determination (LCD) was last revised on October 1, 2007. Since that time, it has been brought to the attention of First Coast Service Options, Inc. (FCSO) that the ICD-9-CM code assigned for the indication of chronic granulomatous disease (CGD) did not appropriately describe the disease. CGD has been included in the LCD since its origination as a local medical review policy (LMRP). Research of the 2008 International Classification of Diseases resulted in the identification of an ICD-9-CM code, which would be a more appropriate designation for this indication. Therefore, under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, ICD-9-CM code 205.10 under the subheading of "For J9216 (interferon gamma-1B)" has been deleted and replaced with ICD-9-CM code 288.1.
Additionally, the following revisions were made under the "Limitations" section of the LCD:

- "The following Interferon is considered self-administered and noncovered by Connecticut Medicare: J1830(beta-1B)". This drug is on the Self-administered drug list, therefore, this statement is being deleted from the LCD.
- "The interferon alfa-2B recombinant and ribavirin combination (REBETRON) is considered noncovered by Connecticut Medicare and should be billed utilizing code A9270". Firstly, procedure code A9270 is not appropriate for use when billing Rebetron. Also, research indicates that Rebetron (J3490) is included in the The List of Medicare Noncovered Services (NCSVCS) LCD. Therefore, this statement is being deleted from this LCD.

J9212: Interferon—Revision to the LCD, continued

Effective Date

This revision is effective for services rendered on or after December 31, 2007. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* on or after this effective date.

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

The local coverage determination (LCD) for Computed Tomography of the Abdomen and Pelvis was last revised on March 13, 2007. Since that time, the LCD has been revised in the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections to add the following language in accordance with the Centers for Medicare & Medicaid Services (CMS) change request 2410, dated January 24, 2003:

Treating physician/practitioner ordering of diagnostic tests: The treating physician/practitioner must order all diagnostic tests furnished to a beneficiary who is not an institutional inpatient or outpatient. A testing facility that furnishes a diagnostic test ordered by the treating physician/practitioner may not change the diagnostic test or perform an additional diagnostic test without a new order. This policy is intended to prevent the practice of some testing facilities to routinely apply protocols, which require performance of sequential tests.

Interpreting physician exception for test design: Unless specified in the order, the interpreting physician of a testing facility who furnishes a diagnostic test to a beneficiary who is not a hospital inpatient or outpatient, may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).

Effective Date

This LCD revision is effective for claims processed on or after October 23, 2007 for services rendered on or after January 1, 2003. The full text of this LCD is available through our provider education Web site at *http://www.connecticutmedicare.com* on or after this effective date.

FLORIDA ONLY - REVISIONS TO THE LCDS

J9212: Interferon—Revision to the LCD

This local coverage determination (LCD) was last revised on October 1, 2007. Since that time, it has been brought to the attention of First Coast Service Options, Inc. (FCSO) that the ICD-9-CM code assigned for the indication of chronic granulomatous disease (CGD) did not appropriately describe the disease. CGD has been included in the LCD since its origination as a local medical review policy (LMRP). Review of the 2008 International Classification of Diseases resulted in the identification of an ICD-9-CM code, which would be a more appropriate designation for this indication. Therefore, under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, ICD-9-CM code 205.10 under the subheading of "For J9216 (interferon gamma-1B)" has been deleted and replaced with ICD-9-CM code 288.1.

Effective Date

This LCD revision is effective for services rendered on or after December 31, 2007. The full text of this LCD is available through our provider education Web site at *http://www.floridamedicare.com* on or after this effective date.

70450: Computed Tomography Scans of the Head or Brain—Revision to the LCD

The local coverage determination (LCD) for Computed Tomography Scans of the Head or Brain was last revised on April 11, 2006. Since that time, the LCD has been revised in the "Documentation Requirements" section to add the following language in accordance with the Centers for Medicare & Medicaid Services (CMS) change request 2410, dated January 24, 2003:

Treating physician/practitioner ordering of diagnostic tests: The treating physician/practitioner must order all diagnostic tests furnished to a beneficiary who is not an institutional inpatient or outpatient. A testing facility that furnishes a diagnostic test ordered by the treating physician/practitioner may not change the diagnostic test or perform an additional diagnostic test without a new order. This policy is intended to prevent the practice of some testing facilities to routinely apply protocols which require performance of sequential tests.

Interpreting physician exception for test design: Unless specified in the order, the interpreting physician of a testing facility who furnishes a diagnostic test to a beneficiary who is not a hospital inpatient or outpatient, may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).

70450: Computed Tomography Scans of the Head or Brain—Revision to the LCD, continued

Effective Date

This LCD revision is effective for claims processed on or after October 23, 2007 for services rendered on or after January 1, 2003. The full text of this LCD is available through our provider education Web site at *http://www.floridamedicare.com* on or after this effective date.

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

The local coverage determination (LCD) for Computed Tomography of the Abdomen and Pelvis was last revised on March 13, 2007. Since that time, the LCD has been revised in the "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections to add the following language in accordance with the Centers for Medicare & Medicaid Services (CMS) change request 2410, dated January 24, 2003:

Treating physician/practitioner ordering of diagnostic tests: The treating physician/practitioner must order all diagnostic tests furnished to a beneficiary who is not an institutional inpatient or outpatient. A testing facility that furnishes a diagnostic test ordered by the treating physician/practitioner may not change the diagnostic test or perform an additional diagnostic test without a new order. This policy is intended to prevent the practice of some testing facilities to routinely apply protocols which require performance of sequential tests.

Interpreting physician exception for test design: Unless specified in the order, the interpreting physician of a testing facility who furnishes a diagnostic test to a beneficiary who is not a hospital inpatient or outpatient, may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).

Effective Date

This LCD revision is effective for claims processed on or after October 23, 2007 for services rendered on or after January 1, 2003. The full text of this LCD is available through our provider education Web site at *http://www.floridamedicare.com* on or after this effective date.

CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

November 2007 – December 2007

Hot Topics Teleconference

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

When: November 14, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Provider Outreach & Education Advisory Group Meeting

For membership information, visit the POE AG page in the Provider Outreach & Education section of *www.connecticutmedicare.com*.

When: December 5, 2007
Time: 8:30 a.m. – 10:30 a.m.
Type of Event: Teleconference

Ask-the-Contractor Teleconference (ACT)

Topic is Provider Enrollment.

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

Note: *Dates and times are subject to change prior to event advertisement.*

Two Easy Ways To Register!

Online - Simply log on to your account on our provider training Web site at *www.fcsomedicaretraining.com* and select the course you wish to register for. Class materials will be available under "My Courses" no later than one day before the event. **First-time user?** Please set up an account using the instructions located at *www.connecticutmedicare.com/Education/108651.asp* in order to register for a class and obtain materials.

Fax - Providers without Internet access can leave a message on our Registration Hotline at 203-634-5527 requesting a fax registration form. Class materials will be faxed to you the day of the event.

Tips for Using the FCSO Provider Training Web Site

The best way to search and register for Connecticut events on *www.fcsomedicaretraining.com* is by clicking on the following links in this order:

- "Course Catalog" from top navigation bar
- "Catalog" in the middle of the page
- "Browse Catalog" on the right of the search box
- "CT – Part B" from list in the middle of the page.

Select the specific session you're interested in, click the "Preview Schedule" button at the bottom of the page. On the Instructor-Led Training (ILT) Schedule page, locate the line that has the course you are interested in and click the "Register" link in the Options column.

If you need assistance, please contact our FCSO Medicare training help desk by calling 866-756-9160 or sending an email to *fcsohelp@geolearning.com*.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

FLORIDA EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

November 2007 – December 2007

Hot Topics/Medicare Updates Teleconference

When: November 15, 2007
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

Ask the Contractor Teleconference – Topics to be determined

When: December 13, 2007
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Two Easy Ways To Register

Online – To register for this seminar, please visit our new training Web site at *http://www.fcsomedicaretraining.com*.

- If you are already a registered user of FCSO's Learning Management System (LMS), simply log on, select the specific session you are interested in, and click the "Register" button.
- If you are a **first-time user** of the LMS, you will need to set up an account. To do so, follow these steps:
  - From the welcome page, click on "I need to request an account" just above the log on button.
  - Complete the Request User Account form. (**Note:** Providers who do not yet have an NPI may use 9999.) You will receive your log on information within 72 hours of requesting an account.
  - Once your registration is complete, log on and select "Course Catalog," then select "Catalog." Select the specific session you are interested in, and then click the "Register" button.

Fax – If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to (904) 361-0407. Keep 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.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

More educational events (teleconferences, webcasts, etc.) will be planned to help providers with hot issues. Keep checking our Web site, *http://www.floridamedicare.com* or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events!

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.

Post Office Box for Appeals:

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

Post Office Box for EDI:

Electronic Media Claims/EDI

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

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

Appeals
1-866-535-6790, option 1

Medicare Secondary Payer
1-866-535-6790, option 2

Provider Enrollment
1-866-535-6790, option 4

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
National Government Services
Medicare Part A
1-888-855-4356

Durable Medical Equipment
NHIC
DME MAC Medicare Part B
1-866-419-9458

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

Quality of Care
Qualidign (Peer Review Organization)
1-800-553-7590

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

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

Health Insurance Counseling Program (CHOICES)/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 or 1-860-832-9265 (Hartford area or from out of state)

MEDICARE WEB SITES

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 32231-0018

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
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

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 Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider Change of Address:
Medicare Registration
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment 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:
Palmetto GBA
Railroad Medicare Part B
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

Cigna Government Services
1-866-270-4909

MEDICARE PART A

Toll-Free:
1-866-270-4909

Medicare Web sites

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

Reader Survey—*Medicare B Update!*

We want our readers of the Update! to find it to be a helpful tool that is easy to use and understand. This survey is your opportunity to let us know how we are doing. After the survey closes, we will publish the results and implement suggested enhancements, as appropriate. Thank you for taking the time to complete this survey!

Please complete the questions below and fax to us at 1-904-361-0723 by December 14, 2007.

Please Indicate Your Location: ❑ **Connecticut** ❑ **Florida**

1. What sections of the Update! do you refer to the most?
   - ❑ Local Coverage Determinations (LCD)
   - ❑ Electronic Data Interchange
   - ❑ Fraud & Abuse
   - ❑ Education Resources
   - ❑ Coverage & Reimbursement
   - ❑ Claims
   - ❑ Provider Enrollment
   - ❑ General Information

2. How frequently do you use the Medicare Part B Update?
   - ❑ Daily
   - ❑ More than once weekly
   - ❑ Weekly
   - ❑ More than once monthly
   - ❑ Monthly

3. Please identify your role:
   - ❑ Billing office staff
   - ❑ Billing office manager
   - ❑ Clearinghouse staff
   - ❑ Clearinghouse manager
   - ❑ Administrative office staff
   - ❑ Administrative office manager
   - ❑ Practice manager
   - ❑ Compliance office staff
   - ❑ Compliance office manager
   - ❑ Facility administrator
   - ❑ Physician (MD/DO)
   - ❑ Physician Assistant, Nurse Practitioner (PA/NP)
   - ❑ Other health care professional
   - ❑ Health care consultant
   - ❑ Other ancillary staff

4. When locating information in the current publication, do you find the information you are seeking easily?
   - ❑ Yes ❑ No

5. What changes or additions do you recommend for the Medicare Part B Update!?

_____

_____

_____

6. How do you use the Medicare Part B Update! in your office?

_____

_____

_____

ORDER FORM — 2008 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 designated account number indicated below.

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

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
Medicare B Update! Subscription – The Medicare B Update! is available free of charge online at http://www.fcso.com (click on Medicare Providers). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2007 through September 2008.	700395	Hardcopy $60.00		
		CD-ROM $20.00		
2008 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2008 through December 31, 2008, is available free of charge online at http://www.fcso.com (click on Medicare Providers). Additional copies or a CD-ROM is available for purchase. The Fee Schedule contains calendar year 2008 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare Part B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	700400	Hardcopy: FL $12.00		
		Hardcopy: CT $12.00		
		CD-ROM: FL $6.00		
		CD-ROM CT $6.00		
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: _____

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 ***