MEDICARE B Update!

A NEWSLETTER FOR FLORIDA MEDICARE PART B PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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
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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 1-904-361-0723.

FROM THE CONTRACTOR

MEDICAL RECORD REVIEW REQUESTS

First Coast Service Options, Inc. (FCSO) has received questions from physicians regarding medical record review or, more specifically, requests from Medicare for medical records. A statement in both local and national coverage determinations (LCDs and NCDs) notes that medical record documentation maintained by the performing physician or allied provider must clearly indicate the medical necessity of the service being billed. In addition, documentation that the service was performed must be maintained in the patient's medical record. This information is normally found in the history and physical examination notes, office/progress notes, hospital notes, and/or procedure report.

Medical record reviews are conducted by different entities contracted by the Centers for Medicare & Medicaid Services (CMS) and other government offices, and each has distinct program goals. Under the Medicare Integrity Program enacted by Congress, entities such as FCSO, a carrier (pays Part B provider claims) and fiscal intermediary (pays Part A provider claims), are known as the affiliated contractor (AC), distinct from a program safeguards contractor (PSC). As a general rule, a PSC is accountable for reducing fraud and abuse in the Medicare program; an AC is responsible for reducing the Medicare fee-for-service claim payment error rate. Of course, there may be overlap in responsibilities and programs.

Other Medicare contractors that pay claims and may request records for medical review include the durable medical equipment regional carrier (DMERC) or DME MAC (DME Medicare administrative contractor) and the regional home health and hospice intermediary (RHHI). Though they do not pay claims directly, the quality improvement organizations (QIO) in each state have inpatient acute care hospital claim review responsibility, as well as other initiatives that may entail medical review. Two special PSC contractors administer the Comprehensive Error Rate Testing (CERT) program, and systematically request records for medical review. Also, the Office of the Inspector General (OIG), in the Department of Health & Human Services (which governs the Medicare program), conducts surveys or assessments that involve the claim payment process and necessitates medical review. Medical records for these reviews, and subsequent follow-up reviews, are requested by the entity contracted by the OIG for this purpose.

The following is a brief outline of medical record review: note that each program has a limited impact on the number of providers and/or number of claims reviewed.

Medical review of initial claims – the AC requests records in the prepayment development of a claim.

- Claims may have been submitted with procedure code(s) that require additional information for coverage and/or payment (e.g., an unlisted code).
- One of the services on the claim is under formal review based on utilization or other audits (these are usually outlined in a national or local policy or may be a PSC request).

Progressive correction action (PCA) process medical review – the AC process to lower the claims payment error rate. This is data-driven with a provider education and/or policy development focus.

- Post payment request for the documentation of claims.
- In some instances, may include prepayment development of a claim for certain codes submitted by a provider.

CERT program – The CERT documentation contractor requests records for review by the CERT review contractor. The CERT program randomly samples 200 claims per month per contractor nationally.

- Post payment request for the documentation of claims, usually from the prior year.

PSC and OIG – Programs to prevent fraud and abuse.

- Post payment request for the documentation of claims.
- Prepayment medical review related to a program safeguards initiative – requests come from the AC (such as FCSO) since these are new claims, although the documentation will be reviewed by the PSC.

FCSO paid over 90 million claims in fiscal year 2007 for Part A and B providers in Florida and Part B providers in Connecticut. Fortunately, only a small percentage of these claims require submission of medical records for review. If you receive a request for medical records on a Medicare beneficiary and are unsure of your responsibilities, please contact the Medicare Part B Customer Service Center at 1-866-454-9007 (FL) or 1-866-419-9455 (CT) for clarification, or call the number on the requesting letter for more details. Your prompt response to a legitimate request will benefit you, the beneficiary, and the Medicare program.

Source: FCSO Office of the Medical Director

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.

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

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 Medicare carrier. 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*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

CLAIMS

IMPORTANCE OF SUPPLYING CORRECT PROVIDER IDENTIFICATION INFORMATION

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the April 2008 Medicare B Update! pages 8-9.

Note: This article was revised on April 21, 2008, to remove all references to the 12-90 version of the CMS-1500. The CMS-1500 (12-90) version of the claim form is discontinued. Only the revised CMS-1500 (08-05) is to be used, effective on April 2, 2007.

Providers should read *MLN Matters* article MM5060 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5060.pdf*, which states the requirements for the newer form, CMS-1500 (08-05). Providers may also want to view *MLN Matters* MM5890 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5890.pdf*). MM5890 stated that effective with claims received on or after May 23, 2008, Medicare will not pay for referred or ordered services or items, unless the fields for the name and NPI of the ordering, referring and attending, operating, other, or service facility providers are completed on the claims.

MLN Matters Number: SE0529 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

AMBULANCE

AMBULANCE FEE SCHEDULE—CONVERSION FACTOR FILE FOR CY 2009 AMBULANCE INFLATION FACTOR

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

PROVIDER TYPES AFFECTED

Ambulance providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for ambulance services provided to Medicare beneficiaries.

WHAT PROVIDERS NEED TO KNOW

This article is based on change request (CR) 6000, which revises the ambulance fee schedule file layout for calendar year (CY) 2009. Specifically, only the conversion factor field is being modified to:

- Remove the sign in the numeric field.
- Expand the length of the conversion factor field.

For claims with dates of service on or after January 1, 2009, Medicare contractor(s) will recognize the new ambulance fee schedule file layout. For claims with dates of service prior to January 1, 2009, Medicare contractors will recognize the current layout.

ADDITIONAL INFORMATION

The official instruction, CR 6000, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1499CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

The ambulance fee schedule public use files are available at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp* on the CMS Web site.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found *at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* 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: MM6000
Related Change Request (CR) #: 6000
Related CR Release Date: May 2, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1499CP
Implementation Date: October 6, 2008

CONSOLIDATED BILLING

JULY QUARTERLY UPDATE TO 2008 ANNUAL UPDATE OF HCPCS CODES USED FOR SNF CONSOLIDATED BILLING ENFORCEMENT

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

PROVIDER TYPES AFFECTED

Providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries in skilled nursing facilities (SNFs).

PROVIDER ACTION NEEDED

This notification provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing (CB) provision of the SNF prospective payment system (PPS). Change request (CR) 6009 adds HCPCS code J9303 (Injection, panitumumab, 10mg) to the Major Category III.A. Chemotherapy services FI/A/B MAC Exclusion List retroactive to January 1, 2008.

BACKGROUND

The Social Security Act (Section 1888) codifies the SNF PPS and CB. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services are added by these routine updates; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are not subject to the consolidated billing provision of the SNF PPS. Services not appearing on this list submitted on claims to FIs/A/B MACS, A/B MACs, and carriers/A/B MACS, including DME MACs, will not be paid by Medicare to providers, other than an SNF, when included in SNF CB.

For non-therapy services, SNF CB applies only when the services are furnished to an SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to an SNF resident, regardless of whether Part A covers the stay. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in

July Update to 2008 Annual Update of HCPCS Codes Used for SNF CB, continued

a SNF stay. In order to assure proper payment in all settings, Medicare systems will edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

CR 6009 adds HCPCS code J9303 to the Major Category III.A. Chemotherapy services FI/A/B MAC Exclusion List retroactive to January 1, 2008.

Medicare contractors will reopen and reprocess claims affected by this instruction when providers bring such claims to their contractor's attention.

ADDITIONAL INFORMATION

The official instruction, CR 6009, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1501CP.pdf* on the CMS Web site.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* 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: MM6009
Related Change Request (CR) #: 6009
Related CR Release Date: May 9, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1501CP
Implementation Date: July 7, 2008

END-STAGE RENAL DISEASE

SERVICE INCLUDED IN THE MONTHLY CAPITATION PAYMENT

This information was previously published in the May 2008 Medicare B Update! (page 14) and has been revised to include replacement code 77080.

As a reminder, interpretations of the following tests are included in monthly capitation payment (MCP):

- Bone mineral density studies (*CPT* codes *76070, 76075, 77080, 78350*, and *78351)*
- Noninvasive vascular diagnostic studies of hemodialysis access (*CPT* codes *93925, 93926, 93930, 93931*, and *93990*)
- Nerve conduction studies (*CPT* codes *95900, 95903, 95904, 95925, 95926, 95927, 95934, 95935*, and *95936*)
- Electromyography studies (*CPT* codes *95860, 95861, 95863, 95864, 95867, 95869*, and *95872*).

Note: Separate payment may be made for medically necessary services that are included or bundled into the MCP (e.g., test interpretations) when furnished by physicians other than the monthly capitation payment physician.

Source: Publication 100-04, Chapter 8, Section 140A

EVALUATION AND MANAGEMENT SERVICES

PROLONGED SERVICES (CODES 99354 – 99359)

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

PROVIDER TYPES AFFECTED

Physicians and other qualified nonphysician practitioners (NPP) whose services are billed to Medicare carriers or Medicare administrative contractors (A/B MAC).

WHAT YOU NEED TO KNOW

Change request (CR) 5972, from which this article is taken, updates the sections of the *Medicare Claims Processing Manual* that address prolonged services codes, in order to be consistent with changes/deletions in codes and changes in typical/average time units in the *American Medical Association Current Terminology Procedural Terminology* (*CPT*) coding system.

Make sure that your billing staffs are aware of the prolonged services *CPT* code changes as described in *Background*, below.

BACKGROUND

Since *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Sections 30.6.15.1 Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes *99354 - 99357*) (ZZZ codes) and 30.6.15.2 (Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes *99358 - 99359*) were first written, several code changes, code deletions, and typical/average time units have changed in the *CPT* coding system.

Prolonged Services (Codes 99354 – 99359), continued

CR 5972, from which this article is taken, updates these sections that address prolonged services codes, in order to be consistent with the *CPT* coding changes.

These manual changes:

- Define prolonged services and explain the required evaluation and management (E&M) companion codes. (In keeping with current Medicare payment policy for physician presence and supporting documentation)
- Correct and update the tables for threshold times (reproduced below) to reflect code changes and current typical/average time units associated with the *CPT* levels of care in code families
- Explain in a new subsection (30.6.15.1 [H]), how to report physician visits for counseling and/or coordination of care when the visit is based on time and when the counseling and/or coordination service is prolonged.

A summary of these manual changes follow.

Prolonged Services Definitions

In the **office or other outpatient setting**, Medicare will pay for prolonged physician services (*CPT* code *99354*) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion E&M codes. The time for usual service refers to the typical/average time units associated with the companion E&M service as noted in the *CPT* code. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services with *CPT* code *99355*.

In the **inpatient setting**, Medicare will pay for prolonged physician services (code *99356*) (with direct face-to-face patient contact which require one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion E&M codes. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by *CPT* code *99357*.

Note: You should not separately report prolonged service of less than 30 minutes total duration on a given date, because the work involved is included in the total work of the E&M codes.

You may use code *99355* or *99357* to report each additional 30 minutes beyond the first hour of prolonged services, based on the place of service. These codes may be used to report the final 15 – 30 minutes of prolonged service on a given date, if not otherwise billed. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Required Companion Codes

Please remember that prolonged services codes *99354 – 99357* are not paid unless they are accompanied by the companion codes as described here.

The companion E&M codes for *99354* are:

- Office or other outpatient visit codes (*99201-99205*, *99212-99215*),
- Office or other outpatient consultation codes (*99241-99245*),
- Domiciliary, rest Home, or custodial care Services codes (*99324-99328*, *99334-99337*),
- Home services codes (*99341-99345, 99347-99350*);

The companion E&M codes for *99355* are *99354* and one of its required E&M codes.

The companion E&M codes for 99356 are the initial hospital care and subsequent hospital care codes (*99221-99223, 99231-99233*), the inpatient consultation codes (*99251-99255*); nursing facility services codes (*99304-99318*).

The companion codes for *99357* are *99356* and one of its required E&M codes.

Requirement for Physician Presence

You may count only the duration of direct face-to-face contact with the patient (whether the service was continuous or not) **beyond** the typical/average time of the visit code billed, to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable.

You cannot bill as prolonged services:

- In the **office setting**, time spent by office staff with the patient, or time the patient remains unaccompanied in the office; or
- In the **hospital setting**, time spent reviewing charts or discussing the patient with house medical staff and not with direct face-to-face contact with the patient or waiting for test results, for changes in the patient's condition, for end of a therapy, or for use of facilities.

Documentation

Unless you have been selected for medical review, you do not need to send the medical record documentation with the bill for prolonged services. Documentation, however, is required to be in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services that you bill.

You must appropriately and sufficiently document in the medical record that you personally furnished the direct face-to-face time with the patient specified in the *CPT* code definitions. Make sure that you document the start and end times of the visit, along with the date of service.

Use of the Codes

You can only bill the prolonged services codes if the total duration of all physician or qualified NPP direct face-to-face service (including the visit) equals or exceeds the threshold time for the E&M service the physician or qualified NPP provided (typical/average time associated with the *CPT* E&M code plus 30 minutes).

Threshold Times for Codes *99354* and *99355* (Office or Other Outpatient Setting)

If the total direct face-to-face time equals or exceeds the threshold time for code *99354*, but is less than the threshold time for code *99355*, you should bill the E&M visit code and code *99354*. No more than one unit of *99354* is acceptable.

If the total direct face-to-face time equals or exceeds the threshold time for code *99355* by no more than 29 minutes, you should bill the visit code *99354* and one unit of code *99355*. One additional unit of code *99355* is billed for each additional increment of 30 minutes extended duration.

Table 1 displays threshold times that your carriers and A/B MACs use to determine if the prolonged services codes *99354* and/or *99355* can be billed with the office or other outpatient settings, including outpatient consultation services and domiciliary, rest home, or custodial care services and home services codes. The *CPT* coding-derived changes are highlighted and noted in bolded italics.

Prolonged Services (Codes 99354 – 99359), continued

Table 1
Threshold Time for Prolonged Visit Codes *99354* and/or *99355* Billed with Office/Outpatient and Consultation Codes

Code	Typical Time for Code	Threshold Time to Bill Code *99354*	Threshold Time to Bill Codes *99354* and *99355*
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99241	15	45	90
99242	30	60	105
99243	40	70	115
99244	60	90	135
99245	***80***	***110***	***155***
99324	***20***	***50***	***95***
99325	***30***	***60***	***105***
99326	***45***	***75***	***120***
99327	***60***	***90***	***135***
99328	***75***	***105***	***150***
99334	***15***	***45***	***90***
99335	***25***	***55***	***100***
99336	***40***	***70***	***115***
99337	***60***	***90***	***135***
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

To get to the threshold time for billing code *99354* and two units of code *99355*, add 30 minutes to the threshold time for billing codes *99354* and *99355*. For example, when billing code *99205*, in order to bill code 99354 and two units of code *99355*, the threshold time is 150 minutes.

THRESHOLD TIMES FOR CODES *99356* AND *99357* (INPATIENT SETTING)

If the total direct face-to-face time equals or exceeds the threshold time for code *99356*, but is less than the threshold time for code *99357*, you should bill the visit and code *99356*.

Medicare contractors will not accept more than one unit of code *99356*. If the total direct face-to-face time equals or exceeds the threshold time for code *99356* by no more than 29 minutes, you should bill the visit code *99356* and one unit of code *99357*. One additional unit of code 99357 is billed for each additional increment of 30 minutes extended duration.

Table 2 displays the following threshold times that your Medicare contractors uses to determine if the prolonged services codes *99356* and/or *99357* can be billed with the inpatient setting codes. The *CPT* coding-derived changes are highlighted and noted in bolded italics.

Table 2
Threshold Time for Prolonged Visit Codes *99356* and/or *99357*
Billed with Inpatient Setting Codes

Code	Typical Time for Code	Threshold Time to Bill Code *99356*	Threshold Time to Bill Codes *99356* and *99357*
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110
99251	20	50	95
99252	40	70	115
99253	55	85	130

Prolonged Services (Codes 99354 – 99359), continued

Code	Typical Time for Code	Threshold Time to Bill Code *99356*	Threshold Time to Bill Codes *99356* and *99357*
99254	80	110	155
99255	110	140	185
99304	***25***	***55***	***100***
99305	***35***	***65***	***110***
99306	***45***	***75***	***120***
99307	***10***	***40***	***85***
99308	***15***	***45***	***90***
99309	***25***	***55***	***100***
99310	***35***	***65***	***110***
99318	***30***	***60***	***105***

Prolonged Services Associated With E&M Services Based Counseling and/or Coordination of Care (Time-Based)

When an E&M service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50 percent of the total time with the patient) in a face-to-face encounter between the physician or the qualified NPP and the patient in the office/clinic or the floor time in the scenario of an inpatient service, the E&M code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific *CPT* code billed (determined by the typical/average time associated with the E&M code) and should not be "rounded" to the next higher level. Further, in E&M services in which the code level is selected based on time, you may only report prolonged services with the highest code level in that family of codes as the companion code.

Billing Examples

Examples of billable and non-billable prolonged services follow.

- **Billable Prolonged Services**

Example 1

A physician performed a visit that met the definition of an office visit *CPT* code *99213* and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills *CPT* code *99213* and one unit of code *99354*.

Example 2

A physician performed a visit that met the definition of a domiciliary, rest home care visit *CPT* code *99327* and the total duration of the direct face-to-face contact (including the visit) was 140 minutes. The physician bills *CPT* codes *99327*, *99354*, and one unit of code *99355*.

Example 3

A physician performed an office visit to an established patient that was predominantly counseling, spending 75 minutes (direct face-to-face) with the patient. The physician bills *CPT* code *99215* and one unit of code *99354*.

- **Non-billable Prolonged Services**

Example 1

A physician performed a visit that met the definition of visit code *99212* and the total duration of the direct face-to-face contact (including the visit) was 35 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

Example 2

A physician performed a visit that met the definition of code *99213* and, while the patient was in the office receiving treatment for 4 hours, the total duration of the direct face-to-face service of the physician was 40 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

Example 3

A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code *99214*, which has a typical time of 25 minutes, and one unit of code *99354*. The physician must bill the highest-level code in the code family (*99215* which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.

Finally, you should remember that Medicare contractors will not pay (nor can you bill the patient) for prolonged services codes *99358* and *99359*, which do not require any direct patient face-to-face contact (e.g., telephone calls). These are Medicare covered services and payment is included in the payment for other billable services.

ADDITIONAL INFORMATION

You may find more information about billing with prolonged services codes *99354-99359* by going to CR 5972, located at *http://www.cms.hhs.gov/transmittals/downloads/R1490CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. You will find the updated *Medicare Claims Processing Manual* chapter 12 (Physicians/Nonphysician Practitioners), sections 30.6.15.1 Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes *99354-99357*) (ZZZ codes) and 30.6.15.2 (Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes *99358-99359*) as an attachment to that CR.

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: MM5972
Related Change Request (CR) #: 5972
Related CR Release Date: April 11, 2008
Effective Date: July 1, 2008
Related CR Transmittal #: R1490CP
Implementation Date: July 7, 2008

INTEGUMENTARY SERVICES

BLOOD-DERIVED PRODUCTS FOR CHRONIC NON-HEALING WOUNDS

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, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

STOP – Impact to You

This article is based on change request (CR) 6043 that provides the Centers for Medicare & Medicaid Services (CMS) updated policy regarding autologous blood-derived products for chronic non-healing wounds.

CAUTION – What You Need to Know

Effective March 19, 2008, CMS is maintaining its current noncoverage determination for autologous platelet rich plasma (PRP) for the treatment of chronic non-healing cutaneous wounds, and issuing a noncoverage determination for acute surgical wounds when the autologous PRP is applied directly to the closed incision and for dehiscent wounds.

GO – What You Need to Do

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

BACKGROUND

In 1992, the Centers for Medicare & Medicaid Services (CMS) issued a national noncoverage determination for autologous, platelet-derived wound healing formulas intended to treat patients with chronic non-healing wounds.

In December 2003, CMS issued a national noncoverage determination for use of autologous platelet rich plasma (PRP) for the treatment of chronic non-healing cutaneous wounds except for routine costs when used in accordance with the clinical trial policy defined in the *Medicare National Coverage Determinations (NCD) Manual* (section 310.1; see *http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4TXT.pdf* on the CMS Web site).

In April 2005, CMS issued an NCD to correct the erroneous potential for local coverage of becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous wounds, stating that, because it is usually self-administered, it would remain nationally noncovered under Part B based on the Social Security Act (Section 1861(s)(2)(A) and (B); see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* on the Internet).

On March 19, 2008, CMS issued a decision memorandum following a national coverage analysis to evaluate the use of autologous blood-derived products for the treatment of chronic non-healing cutaneous wounds, specifically the use of autologous PRP for the treatment of acute wounds where PRP is applied directly to the closed incision site, or for dehiscent wounds.

CMS determined that the evidence is inadequate to conclude that autologous PRP for the treatment of chronic non-healing cutaneous wounds, acute surgical wounds when the autologous PRP is applied directly to the closed incision, or dehiscent wounds, improves health outcomes in the Medicare population.

Therefore, effective March 19, 2008, CMS is maintaining its current noncoverage determination for autologous PRP for the treatment of chronic non-healing cutaneous wounds, and issuing a non-coverage determination for acute surgical wounds when the autologous PRP is applied directly to the closed incision and for dehiscent wounds. Effective for claims with dates of service on or after March 19, 2008, the use of autologous PRP for the treatment of acute surgical wounds where the PRP is applied directly to the closed incision, or dehiscent wounds, will be denied by Medicare contractors.

ADDITIONAL INFORMATION

The official instruction, CR 6043, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R83NCD.pdf* on the CMS Web site.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* 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: MM6043
Related Change Request (CR) #: 6043
Related CR Release Date: May 2, 2008
Effective Date: March 19, 2008
Related CR Transmittal #: R83NCD
Implementation Date: June 2, 2008

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Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare carrier. 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*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

THERAPY SERVICES

THERAPY PERSONNEL QUALIFICATIONS AND POLICIES EFFECTIVE JANUARY 1, 2008

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

PROVIDER TYPES AFFECTED

Physicians, nonphysician practitioners, and other providers who bill Medicare carriers, fiscal intermediaries (FI) or Medicare administrative contractors (A/B MAC) for outpatient therapy services provided to Medicare beneficiaries.

WHAT PROVIDERS NEED TO KNOW

Change request (CR) 5921, from which this article is taken, provides guidance for new regulations (See the *Federal Register* of November 27, 2007, for the discussion in the Medicare physician fee schedule (MPFS) final rule of 2008.) that address outpatient therapy services, including personnel qualifications and the timing of recertification of plans of care for Part B services. This article summarizes these regulations.

BACKGROUND

Professional standards have changed since the qualifications for individuals providing outpatient therapy services (physical therapy, occupational therapy and speech-language pathology services in 42CFR484.4 was last modified. In the calendar year 2008 MPFS final rule with comments, the Centers for Medicare & Medicaid Services (CMS) updated them to address more modern requirements. CR 5921, from which this article is taken, provides guidance for these new regulations.

Effective January 1, 2008, these personnel requirements are being applied to all settings except inpatient hospital, including critical access hospital services, and post-hospital skill nursing facility (SNF) care.

Effective July 1, 2008, these personnel qualifications are being applied consistently in all Medicare settings where therapy services are furnished.

Certain other policies concerning therapy services, and policies concerning recertification of plans of care for Part B services, some of which differ by setting are also effective January 1, 2008.

Note: The regulations in 42CFR409.17 concerning inpatient hospital services and inpatient critical access hospital services, and those in 42CFR409.23 concerning post hospital SNF care will become effective July 1, 2008. Only the personnel qualifications for those settings are addressed in this CR.

Qualifications for Individuals Providing Outpatient Therapy Services

Practice of Physical Therapy

For Medicare program coverage purposes, the new personnel qualifications for physical therapists were discussed in the 2008 MPFS. See the *Federal Register* of November 27, 2007 for the full text. See also the correction notice for this rule, published in the *Federal Register* on January 15, 2008. To view the official qualifications for physical therapists, see the revised chapter 15, section 230.1, of the *Medicare Benefit Policy Manual*, which is attached to CR 5921 at *http://www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf* on the CMS Web site.

Practice of Occupational Therapy

The new personnel qualifications for occupational therapists (OTs) were also discussed in the 2008 physician fee schedule. See the *Federal Register* of November 27, 2007, for the full text. See also the correction notice for this rule, published in the *Federal Register* on January 15, 2008. The official personnel qualifications of OTs are in the revised chapter 15, section 230.2 of the *Medicare Benefit Policy Manual* attached to CR 5921.

Practice of Speech-Language Pathology

A qualified speech-language pathologist for program coverage purposes meets one of the following requirements:

- The education and experience requirements for a certificate of clinical competence in (speech-language pathology) granted by the American Speech-Language Hearing Association
- Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

For outpatient speech-language pathology services that are provided incident to the services of physicians/nonphysician practitioners (NPPs), the requirement for speech-language pathology licensure does not apply; all other personnel qualifications do apply. Therefore, qualified personnel providing speech-language pathology services incident to the services of a physician/NPP must meet the above qualifications.

Timing of Recertification of Plans for Care for Part B services

CR 5921 also addresses the timing of recertification of plans for care for Part B services. The following summarizes the changes articulated in the *Medicare Benefit Policy Manual*, chapter 15 (Covered Medical and Other Health Services), section 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care).

First, please note that the physician's/NPP's certification of the plan (with or without an order) satisfies all of the certification requirements for the duration of the episode of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan.

The timing of plan recertification changed on January 1, 2008. Therefore, those certifications that were signed on, or prior to December 31, 2007, follow the rule in effect at that time; which required recertification every 30 calendar days. However, certifications that are signed on, or after January 1, 2008, follow the new rules in CR 5921 and are effective for an appropriate episode length based on individual patient condition up to 90 calendar days from the initial therapy treatment.

Specifically, a physician/NPP may certify or recertify a plan for whatever duration of treatment episode they determine is appropriate, up to a maximum of 90 calendar days. A certification interval will be the same length as an episode, if the episode is less than 90 calendar days. If the episode of care is anticipated to extend beyond the 90-

Therapy Personnel Qualifications and Policies Effective January 1, 2008, continued

calendar day limit for certification, it is appropriate (although not required) that the clinician who develops the plan estimate the duration of the entire episode for that setting.

Note: The progress report period has not changed. Progress reports are due at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less. The first day of the first reporting period is the same as the first day of the certification period and the first day of treatment (including evaluation). The first day of the second reporting period is the treatment day after the end of the first reporting period.

Other Issues in CR 5921
Other issues discussed in CR 5921 include:

- Medicare contractors will require that a new or significantly modified (changed) plan of care for outpatient therapy services be certified no more than 30 calendar days after the initial therapy treatment under that plan. Rules for delayed certification have not changed.
- Payment and coverage conditions require that the plan must be reviewed, as often as necessary but at least whenever it is certified or recertified. It is not required that the same physician/NPP who participated initially in recommending or planning the patient's care certifies and/or recertifies the plans.
- Medicare contractors will require recertification of outpatient therapy plans of care in intervals not to exceed 90 calendar days after the initial treatment day.
- Physicians/NPPs who feel that a visit for an examination is necessary prior to certifying the plan, or during the episode of treatment should indicate their requirement for visits, preferably on an order preceding the treatment, or on the plan of care that is certified. If the physician wishes to restrict the patient's treatment beyond a certain date when a visit is required, the physician should certify a plan only until the date of the visit. After that date, services will not be considered reasonable and necessary due to lack of a certified plan.
- Policies continue to allow delayed certification of plans of care. Certifications are acceptable, even when late, if the services appear to have been provided under the care of any physician (not only the one who certifies). Appearance of a physician's care may be in any form and includes orders, e.g., notes, phone conferences, team conferences and billing for physician services during which the medical record or the patient's history would, in good practice, be reviewed and would indicate therapy treatment is in progress.
- The guidance for delayed certification has not changed. A new plan of care is either an initial plan of care or a plan of care that has been significantly modified or changed, resulting in a change in long-term goals. It is expected that modifications to the plan concerning short-term goals or treatment techniques will be made frequently and these changes do not require certification or recertification.
- Medicare contractors will not require a certification "statement" at the time of certification.
- Medicare contractors will require a clinicians or facilities that appropriately furnish aquatic therapy in a community pool to rent or lease at least a portion of the community pool for the exclusive use of the therapist's patients.
- The same policies, e.g., concerning safety and medical necessity, continue to apply to services provided in part of a pool as were applied when the policy required use of the entire pool.

ADDITIONAL INFORMATION

You may find more information about the new therapy personnel qualification requirements and the timing of recertification of plans of care (effective January 1, 2008) by going to CR 5921, located at *http://www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf* on the CMS Web site. The updated Medicare *Benefit Policy Manual*, chapter 15 (Covered Medical and Other Health Services), sections 220 (Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance), 220.1.2 (Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services), 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care), 220.3 (Documentation Requirements for Therapy Services), 230.1 (Practice of Physical Therapy), 230.2 (Practice of Occupational Therapy), 230.3 (Practice of Speech-Language Pathology), 230.4 (Services Furnished by a Physical or Occupational Therapist in Private Practice) may be found as an attachment to that CR.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found *at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* 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: MM5921
Related Change Request (CR) #: 5921
Related CR Release Date: May 7, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R88BP
Implementation Date: June 9, 2008

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NATIONAL PROVIDER IDENTIFIER

PROVIDER AUTHENTICATION BY MEDICARE PROVIDER CONTACT CENTERS

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

PROVIDER TYPES AFFECTED

Physicians, other providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], regional home health intermediaries (RHHI), Medicare administrative contractors [A/B MAC], or durable medical equipment Medicare administrative contractors, [DME MAC]) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

SE0814 covers the implementation of the national provider identifier (NPI) and the provider transaction access number (PTAN), effective May 23, 2008, as the provider authentication elements used when providers make telephone or written inquiries to the Medicare fee-for-service contractor provider contact centers.

Note: For providers enrolled in Medicare before May 23, 2008, their PTAN initially will be their legacy provider number. New providers enrolling in Medicare on or after May 23, 2008, will be assigned a PTAN as part of the Medicare enrollment process.

BACKGROUND

In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare provider contact centers (PCC) must properly authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

Please refer to the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9), chapter 3, section 30 and chapter 6, section 80 for a complete discussion of this PCC authentication update. You may find these manual sections at *http://www.cms.hhs.gov/manuals/downloads/com109c03.pdf* and *http://www.cms.hhs.gov/manuals/downloads/com109c06.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Provider Authentication

The elements for provider authentication of telephone (either customer service representative [CSR] or interactive voice response [IVR]) and written inquiries are presented in the table below.

Provider Authentication Elements for Telephone & Written Inquiries

Effective Dates	Inquiry Type	Provider Elements To Be Authenticated*
On or after May 23, 2008	IVR	Provider NPI and PTAN
On or after May 23, 2008	CSR	Provider NPI and PTAN
On or after May 23, 2008	Written, including fax and email	Provider name, and either provider NPI or PTAN

*All elements must match unless otherwise specified

Written Inquiries – Exception to above authentication requirements

CMS allows an exception for written or faxed inquiries submitted on a provider's official letterhead, and e-mail inquiries (with an attachment on letterhead). If the provider's name and address are included in the letterhead and clearly establish the provider's identity, no NPI or PTAN is required for authentication.

ADDITIONAL INFORMATION

If you have any questions, please contact your carrier, FI, 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: SE0814
Related Change Request (CR) #: 5089, 5277
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

CHANGES TO INFORMATION REQUIRED WHEN CALLING MEDICARE

Important changes are beginning May 23, 2008, in conjunction with final implementation of the national provider identifier (NPI).

Remember to Have Your NPI and PTAN Available

Beginning May 23, 2008, Medicare guidelines require that contractors ask providers for both their provider transaction access number (PTAN) and NPI number, via both our interactive voice response (IVR) and customer service representative (CSR) lines. Therefore, it is vitally important you have this information available when calling any of our service lines.

Always use Your Most Current NPI When Asked to Provide This Information VIA our Customer Service and/or IVR Service Lines

First Coast Service Options, Inc. (FCSO) recognizes that some providers may have new NPI numbers as a result of a change you may have made. When calling our service lines, please be prepared to provide your most current NPI number. Having the most current NPI number can help us in validating this information at the start of each call.

Note: If you call the IVR after May 23, 2008, only to obtain status and/or check information, we recommend that you use the PTAN where the services were rendered. Providers will likely receive a faster response to status and check inquiries if this process is followed.

Providers With One NPI And Multiple PTANs

FCSO is aware that some providers have one NPI and multiple PTANs and multiple NPIs to one PTAN. When calling the IVR line beginning May 23, 2008, our system will be able to validate multiple NPI/PTAN combinations. However, it is possible you may experience a short delay while your information is being validated. We ask that you be patient and not hang up; the IVR will most likely be able to provide the information you need. Providers are encouraged not to call the CSR line for status, eligibility, and other information currently available via our IVR systems. CSRs are required to redirect providers back to the IVR to obtain any information available via the IVR systems.

The Medicare Call Centers are Ready for NPI Implementation Beginning May 23, 2008

FCSO recognizes the importance of the May 23, 2008, NPI implementation. While we will continue our goal to provide the best service possible and answer calls as quickly as we can, we do expect a higher than normal call volume. We ask for your patience with us during this time. If you begin to experience a higher than normal wait time, we recommend that you consider calling back at a different time. The best times to call are between 8:00 a.m. and 9:00 a.m.

Note: Providers are encouraged not to call the CSR line for status, eligibility, and other information currently available via our IVR systems. CSRs are required to redirect providers to the IVR to obtain any information available via the IVR systems.

NPI NEWS FOR MEDICARE FEE-FOR-SERVICE PROVIDERS

The NPI is Here. The NPI is Now. Are you Using it?

As of May 23, 2008, Medicare fee-for-service (FFS) were required to send NPI-Only in ALL provider identifier fields for all HIPAA and paper transactions where a provider identifier is required. If you send Medicare a transaction with a Medicare legacy identifier in any of the provider fields, your claim will be rejected. These transactions include all electronic and paper claims (837I, 837P, NCPDP, DDE and paper CMS-1500 and UB-04), the 276/277 claims status transaction, the 270/271 eligibility transaction, 835 remittance advice and SPR paper remittance.

If your billing software is set up to continue to send both the NPI and the legacy identifier, and your clearinghouse or billing service has not stripped the legacy identifier from your claim as of May 23, the responsibility falls to the provider to send in the Medicare claim with NPI-only, i.e., NO legacy identifiers.

NPIs FOR SECONDARY PROVIDERS

If the entity that is required to be identified in the secondary provider field (i.e., the ordering/referring/attending/operating/supervising/purchased service/other/service facility provider or prescriber) does not furnish an NPI, the billing provider must attempt to obtain that NPI in order to enter it on the claim. The billing provider may use the NPI Registry (*https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*) to obtain the secondary provider's NPI or it may need to directly contact the ordering/referring/attending/operating/supervising/purchased service/other/service facility or prescriber in order to obtain the NPI.

- If the billing provider has exhausted all possibilities of finding the NPI of the ordering/referring/attending/operating/supervising/purchased service/other or prescriber, Medicare FFS is permitting the billing provider (in the X12N 837 transactions) or the service provider (in the NCPDP 5.1 transaction) to use their own NPI as the identifier for those secondary providers. Medicare will reject claims if Medicare policy requires a secondary identifier and there is no NPI present.
- For service facility location loop, if the billing provider is still unable to obtain the NPI of the entity, no identifier should be reported in that loop.

TRANSCRIPT FOR APRIL 17 NPI ROUNDTABLE NOW AVAILABLE

View the transcript at *http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Transcript_for_April_17th_NPI_Roundtable.pdf* on the CMS Web site.

NEED MORE INFORMATION?

Still 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.

Source: CMS Provider Education Resource 200805-10 & 200805-20

GENERAL INFORMATION

CMS RECRUITING REGISTRIES AS A NEW WAY TO SUBMIT PQRI DATA

REGISTRY SELF-NOMINATIONS DUE TO CMS BY MAY 31, 2008

The Centers for Medicare & Medicaid Services (CMS) seeks self-nominations from clinical data registries interested in becoming a part of the submission process for the 2008 Physicians Quality Reporting Initiative (PQRI) Program.

In April 2008, CMS announced new options for participating in the PQRI program, including the option for eligible professionals to submit quality measures data to CMS through a qualified, established clinical data registry.

CMS is now accepting self-nominations from registries that wish to be considered a qualified, established clinical data registry to help eligible professionals qualify for PQRI incentive bonus payments.

Interested registries should visit the CMS PQRI Web site for information about:

- How a registry can nominate itself for consideration as a PQRI-participating registry
- The criteria CMS will use to determine whether a registry qualifies for inclusion in the list of qualified, established clinical data registries under the 2008 PQRI program.

CMS is accepting self-nominations from registries through May 31, 2008. To learn more about how registries can apply, read CMS' selection criteria and process online at *http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIRegistryRequirements.pdf* on the CMS Web site. (Refer to the document, "2008 PQRI Registry Requirements for Submission under New Options.")

For general information about the PQRI program, visit CMS' PQRI Web page at *http://www.cms.hhs.gov/PQRI* on the CMS Web site.

Source: Provider Education Resource 200805-03

ASSIGNMENT OF PROVIDERS TO MEDICARE ADMINISTRATIVE CONTRACTORS

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

PROVIDER TYPES AFFECTED

All physicians, providers and suppliers who submit claims to Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), carriers or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

IMPACT ON PROVIDERS

This "One Time Notice" change request (CR) describes the Centers for Medicare & Medicaid Services (CMS) approach for assigning providers to MACs and discusses the process of moving providers to MACs.

BACKGROUND

This article is based on CR 5979 and section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), public law 108–173, amended Title XVIII of the Social Security Act (the Act) to add section 1874A, Contracts with Medicare Administrative Contractors (MACs).

I. What are "MACs?"

Under section 911 of the MMA, Congress requires that CMS replace the current FI and carrier contracts with competitively procured contracts that conform to the Federal Acquisition Regulation (FAR). Under the new MAC contracting authority, CMS has six years - between 2005 and 2011 - to complete the transition of Medicare fee-for-service (FFS) claims processing activities from the FIs and carriers to the MACs.

For information on CMS' progress in awarding and implementing the MACs, please visit *http://www.cms.hhs.gov/MedicareContractingReform/* on the CMS Web site.

II. What is "Provider Nomination?"

"Provider Nomination" is a phrase that describes the former right of an individual provider or a chain of providers to select assignment to the FI of its choice. In section 911(b) of the MMA, Congress repealed the provider nomination provisions of the Social Security Act. Provider nomination has been replaced with the geographic assignment rule. Generally, a provider will be assigned to the MAC that covers the state where the provider is located. The CMS regulation at 42 CFR 421.404 reflects this policy shift. Other CMS regulations and policy manuals are in the process of being updated.

A moratorium was placed on the "change of intermediary" process for individual providers in October of 2005. transmittal 291 (CR # 5720), dated September 19, 2007, (see *http://www.cms.hhs.gov/Transmittals/downloads/R291OTN.pdf* on the CMS Web site) informed all FIs and A/B MACs that CMS would no longer accept a request to move from one FI/MAC to another FI/MAC from a provider moving in or out of a Medicare chain. There remains one exception for qualified chain providers (QCPs) as discussed in Section V below.

III. Where will providers eventually be assigned in the MAC environment?

A. Home Health & Hospice

All home health and hospice (HH&H) providers will be assigned to the MAC contracted by CMS to administer HH&H claims for the geographic locale in which the provider is physically located. See the following link for a description of the MAC-environment HH&H regions and the four MACs that will administer HH&H claims for those four regions. *http://www.cms.hhs.gov/MedicareContractingReform/06_SpecialtyMACJurisdictions.asp#TopOfPage*.

B. Durable Medical Equipment

Each supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) will submit claims to the durable medical equipment Medicare

Assignment of Providers to Medicare Administrative Contractors, continued

administrative contractors (DME MAC) contracted by CMS to administer DMEPOS claims for the geographic locale in which the beneficiary permanently resides. The link above under "A" also provides a description of the MAC-environment DMEPOS regions and the four MACs that will administer DMEPOS claims for those four regions.

C. Qualified Railroad Retirement Beneficiaries Entitled to Medicare

Physicians and other suppliers (except for DMEPOS suppliers) will continue to enroll with and bill the contractor designated by the Railroad Retirement Board (under section 1842(g) of The Act) for Part B services furnished to these beneficiaries. Suppliers of DMEPOS will bill the DME MACs.

D. Specialty Providers and Demonstrations

Specialty providers, and providers involved with certain demonstrations, will submit claims to a specific MAC designated by CMS. A list of those specialty services and their designated MACs is reflected in the following table:

MACs Designated to Process Specialty or Demonstration Claims

Specialty Service or Demonstration	MAC Jurisdiction
Centralized Billing for Mass Immunizers	4
Indian Health Services	4
Low Vision Demonstration	5,10, 11, 13, and 14
Rural Community Hospital Demonstration	1, 2, 4 and 5
Veterans Affairs Medicare Equivalent Remittance Advice Project	4
Chiropractic Services Demonstration	4 and 5
Home Health Third Party Liability Demonstration Project	14
Medicare Adult Day Care Demonstration	11, 14 and 15
Independent Organ Procurement Organizations	10
Religious Non-medical Health Care Institution (RNHCI)	10
Histocompatibility Lab	10

The following material describes the demonstrations and specialty providers listed above. Generally, a provider will already know whether or not it is participating in one of these categories.

Centralized Billing for Mass Immunizers – In order to encourage providers to supply flu and pneumococcal (PPV) vaccinations to Medicare beneficiaries, CMS currently authorizes a limited number of providers to centrally bill for flu and PPV immunization claims. Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type "Mass Immunizer," as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers processing claims. Centralized billers must send all claims for flu and PPV immunizations to a single carrier for payment, regardless of the carrier jurisdiction in which the vaccination was administered and the carrier must make payment based on the payment locality where the service was provided. IOM Pub. 100-04, chapter 18, sections 10.3 and 10.3.1 provide more specific information related to this activity.

Indian Health Services – The indian health service (IHS) is the primary health care provider to Medicare beneficiaries who are members of federally recognized tribes living on or near reservations. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries via a network of hospitals (including CAHs), freestanding clinics, FQHCs, RHCs and other entities.

While section 1814(c) and 1835(d) of the Social Security Act (the Act), as amended, generally prohibit payment to any federal agency, passage of the Indian Health Care Improvement Act (IHCIA) in 1976 provided for an exception, amending section 1880 of the Act, for facilities of the IHS whether operated by such Service or by an indian tribe or tribal organization (as defined in section 4 of the IHCIA). The exception under section 1880 limited payment to Medicare services provided in hospitals and skilled nursing facilities.

Effective July 1, 2001, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), section 432 extended payment on a fee-for-service (FFS) basis to services of physician and nonphysician practitioners furnished in IHS hospitals and freestanding clinics. This means that clinics associated with hospitals and freestanding clinics that are owned and/or operated by IHS are authorized to bill only the jurisdiction 4 MAC. Additionally, Tribal health facilities operated under Indian Self Determination Education and Assistance Act (ISDEAA) authorities are an extension of the IHS and considered facilities of the IHS. By virtue of this, they are authorized to bill the jurisdiction 4 MAC. ISDEAA authorities provide flexibilities to tribes in the administration of their programs that are not provided to general public providers.

Low Vision Demonstration – The Secretary of the Department of Health and Human Services is directed to carry out an outpatient vision rehabilitation demonstration project as part of the FY 2004 appropriations conference report to accompany public law HR 2673. This demonstration project will examine the impact of standardized Medicare coverage for vision rehabilitation services provided in the home, office, or clinic, under the general supervision of a physician. The services may be supplied by the following:

- Physicians
- Occupational therapists
- Certified low vision therapists
- Certified orientation and mobility specialists
- Certified vision rehabilitation therapists

This demonstration will last for five years through March 31, 2011, and is limited to services provided specifically in New Hampshire, New York City (all five boroughs), North Carolina, Atlanta, Kansas, and Washington State.

Assignment of Providers to Medicare Administrative Contractors, continued

Rural Community Hospital Association – The RCH Demonstration program was mandated by section 410A of the MMA. The Secretary is required to conduct the RCH Demonstration, lasting five years, to test the advisability and feasibility of establishing RCHs to provide Medicare covered inpatient hospital services in rural areas. This demonstration will allow selected rural hospitals to benefit from cost-based reimbursement for inpatient services. The Secretary is required to select not more than fifteen (15) hospitals to participate in the demonstration in states with low population densities. Currently, thirteen (13) hospitals participate in the program, serviced by seven different FIs.

Veteran Affairs (VA) Medicare Equivalent Remittance Advice Project – Current law permits the Department of VA to collect appropriate Medicare coinsurance and deductible amounts from supplemental insurers for claims for supplies and services ordinarily covered by Medicare but furnished:

- At VA facilities
- For veterans eligible to receive both VA health and Medicare benefits and also having Medicare supplemental insurance.

To facilitate this process, CMS entered into an interagency agreement with the VA whereby the CMS will help the VA work with a CMS contractor to adjudicate these claims to produce a remittance advice equivalent to that ordinarily produced for Medicare claims. The remittance advice, sent to the supplemental insurers, will help the insurers determine payment amounts they owe to the VA. The CMS will not pay these claims. Trailblazer was the contractor selected to perform the work.

Chiropractic Services Demonstration – Section 651 of the MMA requires CMS to conduct the Expansion of Coverage for Chiropractic Services Demonstration. The purpose of the demonstration is to evaluate the feasibility and advisability of expanding coverage of chiropractic services under Medicare. The demonstration is for two years and must be conducted in four geographic areas—two rural and two urban.

Home Health Third Party Liability Demonstration – The CMS and the states of Connecticut, Massachusetts, and New York have developed a demonstration program that will use a sampling approach to determine the Medicare share of the cost of home health services claims for dual eligible beneficiaries that were submitted to and paid by the Medicaid agencies. Sampling will be used in lieu of individually gathering Medicare claims from home health agencies (HHAs) for every dual eligible Medicaid claim each state may have paid in error. This process will eliminate the need for the HHAs to assemble, copy, and submit large numbers of medical records. The project currently covers the home health claims incurred in FY 2000 through 2007 for Massachusetts and New York and FY 2001 through 2005 for Connecticut.

Medicare Adult Day Care Demonstration – Section 703 of the MMA directs CMS to conduct a demonstration project that will test an alternative approach to the delivery of Medicare home health services. Under this demonstration, Medicare beneficiaries receiving home health may be eligible to receive medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home. The statute requires the demonstration to run for a period of three years at no more than five HHA sites in states that license certified medical adult day care facilities. Implementation of the demonstration began at five sites on August 1, 2006. Participation of Medicare beneficiaries is voluntary; up to 15,000 beneficiaries at any time will be eligible to enroll in the three-year demonstrations.

Medicare Home Health Agency Provider Enrollment Demonstration – This demonstration is designed to combat fraudulent home health activity in the Houston and Los Angeles areas. The principal provider enrollment task will be the revalidation of all HHAs in said areas.

Independent Organ Procurement Organizations – An organ procurement organization performs or coordinates the retrieval, preservation, and transportation of organs and maintains a system of locating prospective recipients for available organs.

Religious Non-Medical Health Care Institutions – A RNHCI provides care to beneficiaries in need of skilled nursing facility care or hospital care when the beneficiary's religious beliefs preclude admission to one of these institutional providers. This does not mean that the beneficiary will receive hospital or SNF care in the RNHCI, but that the beneficiary elected to pursue a religious approach to healing. Since the use of diagnoses or medical oversight is prohibited in a RNHCI, they are not candidates for any CMS existing PPS and continue to be paid using the TEFRA methodology.

Histocompatibility Lab – Histocompatibility Laboratories provide services related to tissue typing testing for possible organ recipients and donors to determine compatibility for an organ transplant. They operate on a cost reimbursement basis and bill transplant centers for their services.

E. The Geographic-Assignment Rule

Providers that are not within one of the categories described above (HH&H, DME, RRB, or specialty & demos) will be assigned to the MAC that covers the state where the provider is located. There are two exceptions.

First a qualified chain provider (QCP) may request that its member providers be serviced by a single A/B MAC – specifically, the A/B MAC that covers the state where the QCP's home office is located. The regulation at 42 CFR 421.404(b)(2) defines a qualified chain provider (QCP) as:

- Ten or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control, collectively totaling 500 or more certified Medicare beds
- Five or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control in three or more contiguous states, collectively totaling 300 or more certified Medicare beds.

CMS may assign non-QCP providers, as well as end-stage renal disease (ESRD) providers to an A/B MAC outside of the prevailing geographic assignment rule only to support the implementation of the MACs or to serve some other compelling interest of the Medicare program.

The second exception is for providers that meet the "provider-based" criteria of 42 CFR 413.65. Provider-based entities (other than HH+H providers) will be assigned to the MAC that covers the state where the main ("parent") provider is assigned.

IV. Where will providers be assigned in the interim?

All existing providers with a Medicare claims history will remain in their current FI assignments until their workload is transferred to an A/B MAC. The "change of intermediary"

Assignment of Providers to Medicare Administrative Contractors, continued

process ended for individual providers in 2005, and ended for chain providers in 2007. A change of ownership now serves only to update CMS provider data with information about the new owner.

The workload currently serviced by a legacy FI will be absorbed by the incoming MAC within the 12 months following the award of MAC contract. In some situations the workload transition may be delayed by an award protest.

New providers enrolling with Medicare will be assigned to the FI or MAC that covers the state where the provider is physically located, with a few exceptions:

- **The "Multi-Provider Complex/Sub-Unit" relationship (ref: 42 CFR 483.5[b])**. – An initial enrollment for a sub-unit will be assigned to the FI or MAC that currently serves the existing parent hospital – even if the parent hospital is not presently billing in accordance with the "geographic assignment rule."
- **An "initial enrollment" connected with a QCP**. – If a QCP acquires a new hospital, skilled nursing facility, or critical access hospital that is located outside home office A/B MAC jurisdiction, then CMS will endeavor to assign the provider to the MAC that covers the state where the QCP's home office is located. This special assignment is available only for "initial enrollments" – providers that are joining the Medicare program with neither an existing administrative contractor assignment nor a Medicare claims history.

The other exceptions track the MAC-world assignment rules discussed in sections III-A through III-D above.

V. How long will my interim assignment last?

An "out-of-jurisdiction provider" (OJP) is a provider that is not currently assigned to the A/B MAC or FI in accordance with sections III-A through III-D above (including the geographic assignment rule.) For example, an individual, freestanding provider located in Oregon, but currently assigned to the Florida FI, would be an OJP.

New MACs will initially service some OJPs until CMS undertakes the final reassignment of all OJPs to their destination MACs based on the geographic assignment rule.

CMS will start the overall transfer of OJPs to their final destination MACs after two events have taken place. The first event is when all 15 A/B MACs have been awarded and implemented. The second event is when all the systems and contractors that support the claims processing, provider enrollment, and cost report auditing functions at the departure and destination MACs are capable of supporting the move.

ADDITIONAL INFORMATION

For complete details regarding this CR, please see the official instruction (CR 5979) issued to your Medicare FI, A/B MAC, or RHHI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R333OTN.pdf* on the CMS Web site. To view any of the federal regulations cited in this article or in CR 5979, visit *http://www.gpoaccess.gov/cfr/index.html* on the Internet.

If you have questions, please contact your Medicare FI, A/B MAC, or RHHI at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5979
Related Change Request (CR) #: 5979
Related CR Release Date: April 18, 2008
Effective Date: May 19, 2008
Related CR Transmittal #: R333OTN
Implementation Date: May 19, 2008

CLINICAL LABORATORY FEE SCHEDULE FACT SHEET NOW AVAILABLE

The Clinical Laboratory Fee Schedule Fact Sheet, which provides general information about the clinical laboratory fee schedule, coverage of clinical laboratory services, and how payment rates are set, is now available in print format 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."

Source: CMS Provider Education Resource 200805-05

MEDICARE GUIDE TO RURAL HEALTH SERVICES INFORMATION

The April 2008 version of the Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians, which contains rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.pdf*.

Source: CMS Provider Education Resource 200805-14

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Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare carrier. 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*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

MAY IS NATIONAL OSTEOPOROSIS AWARENESS AND PREVENTION MONTH

In conjunction with the National Osteoporosis Awareness and Prevention Month, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of bone mass measurements for beneficiaries at clinical risk for osteoporosis.

Osteoporosis, or porous bone, is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased risk of fractures of the hip, spine, and wrist. Both men and women are affected by osteoporosis. One out of every two women and one in four men over 50 will have an osteoporosis-related fracture in their lifetime. The good news is that osteoporosis is a disease that can be prevented and treated. Medicare's bone mass measurement benefit can aid in the early detection of osteoporosis before fractures occur, provide a precursor to future fractures, and determine rate of bone loss.

As a health care professional, you play a crucial role in helping your patients maintain strong, healthy bones throughout their life. CMS needs your help to ensure that all eligible Medicare beneficiaries take full advantage of the bone mass measurement benefit. Please join with CMS in spreading the word about prevention and early detection of osteoporosis and the bone mass measurement benefit covered by Medicare.

HOW CAN I HELP?

National Osteoporosis Awareness and Prevention Month provides an excellent opportunity for health care professionals to help increase awareness, knowledge and understanding of prevention, early detection, and treatment of osteoporosis as well as strategies for managing the disease. You can help in a number of ways:

1) Stay abreast of the latest clinical guidelines for prevention, diagnosis, and treatment
2) Become familiar with Medicare's coverage of bone mass measurements
3) Talk with your patients about their risks factors for osteoporosis, prevention measures they can take to reduce their risk factors, and the importance of utilizing bone mass measurements
4) Encourage eligible Medicare patients to take full advantage of Medicare's bone mass measurement benefit.

Together we can help Medicare beneficiaries reduce bone fractures and maintain strong healthy bones.

FOR MORE INFORMATION

- For more information about Medicare's coverage of bone mass measurements, please visit the CMS Web site at *http://www.cms.hhs.gov/BoneMassMeasurement/*.
- The Medicare Learning Network (MLN) Bone Mass Measurements Brochure – this tri-fold brochure provides fee-for-services health care professionals and their staff with an overview of Medicare's coverage of bone mass measurements and it is available at *http://www.cms.hhs.gov/MLNProducts/downloads/Bone_Mass.pdf*.

To learn more about National Osteoporosis Awareness and Prevention Month, please visit The National Osteoporosis Foundation Web site at *http://www.nof.org/*.

"Osteoporosis – It's Beatable. It's Treatable."

Thank you for your support.

Source: CMS Provider Education Resource 200805-02

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

UPDATED MLN QUICK REFERENCE INFORMATION CHARTS

The following *Medicare Learning Network* (*MLN*) products have been updated and are now available to download from the CMS Web site or may be ordered, free of charge, from the MLN Product Ordering Page, at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

- **The Quick Reference Information: Medicare Preventive Services Chart** – This two-sided laminated reference chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings. (Feb. 2008) *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.
- **The Quick Reference Information: Medicare Part B Immunization Billing Chart** – This two-sided laminated reference chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines, and their administration. (Feb. 2008) *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.

Source: Provider Education Resource 200804-21

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DMEPOS COMPETITIVE BIDDING NEWS—ROUNDS 1 AND 2

CMS ANNOUNCES CONTRACT SUPPLIERS FOR ROUND 1 OF DMEPOS COMPETITIVE BIDDING

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for round 1 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Please visit the CMS Web site at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid* to view additional information. To view the Press Release, please click: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Revised Accreditation Deadlines for DMEPOS Competitive Bidding

In order to participate in the DMEPOS Competitive Bidding Program, suppliers must meet quality standards and be accredited by a CMS-approved Deemed Accreditation Organization. Suppliers that are interested in bidding in the second round of the program must be aware of changes to two key deadlines:

- Suppliers must be accredited or have applied for accreditation by July 21, 2008 (change from May 14, 2008), to submit a bid for the second round of competitive bidding. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation by July 21, 2008.
- To be awarded a contract, suppliers will need to be accredited. The accreditation deadline for the second round of competitive bidding is January 14, 2009 (change from October 31, 2008). Suppliers must be accredited before this date to be awarded a contract. Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

CMS has extended these deadlines because a significant number of suppliers in the 70 metropolitan statistical areas (MSAs) included in round 2 of the DMEPOS Competitive Bidding Program have not yet applied for accreditation. Suppliers in these MSAs that do not meet these accreditation deadlines cannot become DMEPOS competitive bidding contract suppliers, and will therefore be unable to furnish competitively bid items to any beneficiary residing in any part of the competitive bidding area during the contract period.

Suppliers can determine if they are serving beneficiaries in a round 2 MSA by visiting the following Web site: *http://www.census.gov/population/www/estimates/metrodef.html* and looking up their MSAs in the section called "counties with metropolitan and micropolitan statistical area codes." (In this file, MSAs are called CBSAs.) For example, the Los Angeles-Long Beach-Santa Ana, CA MSA is comprised of two counties: Los Angeles and Orange.

We urge all suppliers serving Medicare beneficiaries in the 70 round 2 MSAs to apply for accreditation now.

For a list of the CMS-approved Deemed Accreditation Organizations, visit *http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp*. For information about the Medicare DMEPOS Competitive Bidding program, visit *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/*.

Visit the Medicare Learning Network ~ It's Free!

Source: Provider Education Resource, Message 200805-15

POWER MOBILITY DEVICES FURNISHED IN COMPETITIVE BIDDING AREAS

CMS will be issuing instructions in the near future about a one-time DMEPOS competitive bidding transition policy for suppliers of purchased Group 3 single or multiple power option power mobility devices (PMDs) furnished to beneficiaries in competitive bidding areas (CBAs). In specific cases described below, suppliers who, prior to July 1, 2008, begin furnishing services related to providing these devices, but do not deliver the final PMD product until July 1, 2008, or later will be paid based on the 2008 fee schedule amounts for furnishing these PMDs to beneficiaries residing in Round One CBAs. This transition policy applies to both contract and noncontract suppliers.

The HCPCS codes subject to the transition policy include PMD codes K0856 thru K0864 and related accessories provided at the time the PMD is delivered to a beneficiary who resides in a Round One CBA. The specific claims subject to the transition policy are items that are delivered for use in the beneficiary's home on or after July 1, 2008, for which the supplier has:

- A signed order from the physician that is dated between April 1, 2008, and May 31, 2008
- Documentation that the face-to-face beneficiary examination by the physician that is necessary to determine medical necessity for the PMD occurred before July 1, 2008.

This documentation should be maintained by the supplier, but does not need to be submitted at the time the claim for the PMD is submitted. However, it should be made available upon request.

Suppliers should use the date of the physician order as the date of service on the claim (other than this limited, one-time exception, suppliers should be aware that the date of service that is recorded on a DMEPOS claim is the date that the item is delivered). In addition, suppliers should include on the claim for the PMD all accessories provided with the PMD and should use the same date of service used for the PMD for these items. Suppliers should report the date the PMD and related accessories were delivered for use in the beneficiary's home in the narrative section of the claim.

Source: Provider Education Resource, Message 200805-16

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* , select Medicare Providers, Connecticut or Florida, click on the "eNews" link located on the upper-right-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.

REVISION TO THE LCD

J0129: ABATACEPT—REVISION TO THE LCD

The local coverage determination (LCD) for abatacept was effective on June 30, 2007. Since that time, a revision was made to update the language for approved indications based on the Food and Drug Administration (FDA) drug label and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the requirement that adult patients have an inadequate response to one or more DMARDS such as methotrexate or TNF antagonists was deleted and the indication of juvenile idiopathic arthritis was added. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, ICD-9-CM 714.30 was added for the indication of juvenile idiopathic rheumatoid arthritis. Under the "Documentation Requirements" section of the LCD, required documentation for a history of failed treatment regimens with DMARDS and medical records required to support why other treatment regimens were omitted prior to treatment with abatacept have been deleted. Additionally, the "Sources of Information and Basis for Decision" section of the LCD was updated.

EFFECTIVE DATE

This revision to the LCD is effective for claims processed on or after May 20, 2008, for services rendered **on or after April 8, 2008**. The full text of this LCD is available through our provider education Web site at *http://www.fcso.com* on or after this effective date.

FLORIDA ONLY - ADDITIONAL INFORMATION

62310: EPIDURAL—REVISION TO THE CODING GUIDELINES

The "coding guidelines" attachment for the epidural local coverage determination (LCD) was last revised on February 29, 2008. Since that time, the "coding guidelines" attachment has been revised to include a statement regarding *CPT* code *72275* (Epidurography).

EFFECTIVE DATE

This revision to the "coding guidelines" attachment is effective for services rendered **on or after April 30, 2008**. The full text of this LCD is available through our provider education Web site at *http://www.fcso.com* on or after this effective date.

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CONNECTICUT EDUCATIONAL RESOURCES

UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS

JUNE 2008 – JULY 2008

EVALUATION & MANAGEMENT - "CONSULTATION SERVICES" WEBCAST

Topic: Consultation Services

When: June 17, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

HOT TOPICS TELECONFERENCE

Topic: Recent Medicare Changes, New/Revised Local Coverage Determinations (LCDs) and How to Avoid Top Claim Denials and Comprehensive Error Rate Testing (CERT) Errors

When: July 16, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

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 for which you wish to register. Class materials will be available under "My Courses" no later than one day before the event. If you need assistance, please contact our FCSO Medicare training help desk by calling 866-756-9160 or sending an e-mail to fcsohelp@geolearning.com.

- To locate this course on the provider training Web site:
  - Click "Course Catalog" from the top navigation bar, then click the "Catalog" link in the middle of the page
  - Type a keyword in the search box for the course you are interested in (such as "ASC" or "Hot Topics") and hit the "Search" button.
  - In the short list of courses that will appear, click the link for the course you're interested in and then click the "Preview Schedule" button at the bottom of the class description 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.
- **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 – If you would like to participate in any of these events and do not have access to the Internet, please leave a message on our Registration Hotline at (203) 634-5527 in order to have a paper registration form faxed to you.

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: _____

There's always something going on in Provider Outreach & Education! Keep checking our Web site at www.fcso.com and listening to information on our Registration Hotline at (203) 634-5527 for details about upcoming events.

Don't have time to attend an event? Check out our provider training Web site at www.fcsomedicaretraining.com for self-paced Web-based training classes.

FLORIDA EDUCATIONAL RESOURCES

UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS

JUNE 2008 – JULY 2008

EVALUATION & MANAGEMENT – "CONSULTATION SERVICES" WEBCAST

When: June 17, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

HOT TOPICS: MEDICARE UPDATES TELECONFERENCE

When: July 17, 2008
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

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.

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.

TIPS FOR USING THE FCSO PROVIDER TRAINING WEB SITE

The best way to search and register for Florida 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
- "FL – Part B or FL – Part A" 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.

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.) are being planned to help providers with hot issues. Keep checking our Web site, *www.fcso.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: 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.

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

Electronic Media Claims (EMC)/ The Electronic Data Interchange (EDI)
The EDI 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

Freedom of Information (FOIA)
Freedom of Information Act Requests
Post Office Box 2078
Jacksonville, Florida 32231

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
FAX : 1-904-361-0695
E-mail Address:
AskCTMedicare@fcso.com

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

BENEFICIARY

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

COMMUNICATION

Redetermination Requests
Medicare Part B Claims Review
P.O. Box 2360
Jacksonville, FL 32231-0018

Fair Hearing Requests
Medicare Hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of Information Act
Freedom of Information Act Requests
Post Office Box 2078
Jacksonville, Florida 32231

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
E-mail Address:
AskFloridaB@fcso.com
FAX: 1-904-361-0696

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

PROVIDER

Florida Medicare Contractor
www.floridamedicare.com

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

ORDER FORM— 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.	40300260	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 B Update! Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	40300270	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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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 ♦