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
- ☐ Office manager
- ☐ Billing/Vendor
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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

2008 MEDIFEST SYMPOSIUM—REGISTRATION ENDING SOON

Registration is still open for the 2008 Medifest Symposium occurring on **May 6 & 7** in Orlando, but spaces are going quickly so reserve your spot today.

FCSO's (First Coast Service Options, Inc.) popular educational seminar brings together Medicare experts, clinicians, billing staff and coders throughout Florida to learn the latest on the Medicare program and to network with peers. Based on your feedback, we designed this year's Medifest with exciting enhancements that you won't want to miss:

- **Two 1-Day Sessions**. We are offering Medifest as two 1-day sessions to accommodate providers' busy schedules and to encourage a variety of participation. The cost is $136 per person, per day.
- **Smaller Class Size and More Interactive Activities**: To ensure an optimal learning experience, we are limiting each class to 40 participants. Classes will also be more interactive this year, with problem-solving activities and real-world scenarios to reinforce your understanding of the curriculum.
- **Advanced Courses and Specialty Topics**. You told us and we listened! This year's Medifest is devoted to more advanced courses and specialty topics targeting experienced Medicare providers. Examples of our new cutting-edge classes include:
  - Better Business through Better Billing
  - E/M Coding
  - Medicare Review/Data Analysis
  - Specialty classes on Therapy and Rehabilitation, Skilled Nursing Facility, and Independent Diagnostic Testing Facility

To ensure all participants benefit from this advanced curriculum, some courses require completion of prerequisite Web-based Training (WBT) courses. All prerequisites are free, brief and conveniently available through our Learning Management System (LMS) or CMS' Web site. Participants cannot register for courses with mandatory prerequisites until they successfully complete them.

For complete instructions on registering for the 2008 Medifest, or to view event location, class offerings and course descriptions, see our Web site at *www.fcso.com*. Under "Medicare Providers," click "Florida Part A or B," then select the "Provider Outreach and Education" tab.

THIS IS THE ONLY MEDIFEST THIS YEAR, AND SPACE IS LIMITED, SO DON'T FORGET TO REGISTER TODAY!

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.

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

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CLAIMS

QUARTERLY UPDATE TO CORRECT CODING INITIATIVE EDITS, VERSION 14.1, EFFECTIVE APRIL 1, 2008

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

PROVIDER TYPES AFFECTED

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

BACKGROUND

This article is based on change request (CR) 5936, which provides a reminder for physicians to take note of the quarterly updates to correct coding initiative (CCI) edits.

The National Correct Coding Initiative developed by the Centers for Medicare & Medicaid (CMS) helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in:

- The American Medical Association's (AMA's) *Current Procedural Terminology* (*CPT*) manual
- National and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice
- Review of current coding practice.

KEY POINTS

The latest package of CCI edits, version 14.1, will be effective April 1, 2008. Version 14.1 of the CCI edits will include all previous versions and updates from January 1, 1996 to the present and will be organized into two tables:

- Column 1/Column 2 Correct Coding Edits
- Mutually Exclusive Code (MEC) Edits

Additional information about CCI, including the current CCI and MEC edits, is available at *http://www.cms.hhs.gov/NationalCorrectCodInitEd* on the CMS Web site.

ADDITIONAL INFORMATION

The CCI and MED file formats are defined in the *Medicare Claims Processing Manual*, chapter 23, section 20.9, which may be found at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS Web site.

The official instruction, CR 5936, issued to carriers and A/B MACs regarding this update may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1464CP.pdf* on the CMS Web site. If you have any questions, please contact your Medicare carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

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

MLN Matters Number: MM5936
Related Change Request (CR) #: 5936
Related CR Release Date: February 22, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R1464CP
Implementation Date: April 7, 2008

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IMPORTANCE OF SUPPLYING CORRECT PROVIDER IDENTIFICATION INFORMATION

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

Note: This article was revised on March 11, 2008, to clarify that all references to the form should state CMS-1500 (12-90). Providers may also want to refer to *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). The previous revision to the article added a reference to *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. This information was previously published in the Third Quarter 2005 *Medicare B Update!* pages 11-12.

PROVIDER TYPES AFFECTED

Physicians, providers, and suppliers who bill Medicare carriers, including durable medical equipment Medicare administrative contractors (DME MACs).

PROVIDER ACTION NEEDED

The Centers for Medicare & Medicaid Services (CMS) would like to remind providers and their billing staffs of the importance of reporting the correct provider identification information in items 17, 17a, 24K, and 33 of the CMS-1500 (12-90), or the electronic equivalent. This information is critical for accurate and timely processing and payment of your claims.

ADDITIONAL INFORMATION

Please be aware of the following instructions:

Items 17 and 17a

On the CMS-1500 (12-90), or electronic equivalent, the provider must submit the appropriate referring or ordering physician name in item 17, and the unique physician identification number (UPIN) of that referring/ordering physician in item 17a. These are required fields when a service was ordered or referred by a physician. When a claim involves multiple referring and/or ordering physicians, you must prepare a separate claim submission for each ordering/referring physician.

Item 17

Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Item 17a

Enter the UPIN of the referring/ordering physician listed in item 17.

- **Referring physician** – is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Ordering physician** – is a physician or, when appropriate, a nonphysician practitioner (NPP) who orders nonphysician services for the patient. See Pub. 100-02, *Medicare Benefit Policy Manual*, chapter 15 for NPP rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or NPP's service.

The ordering/referring requirement became effective January 1, 1992, and is required by section 1833(q) of the Act. All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name and UPIN. This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- Diagnostic laboratory services
- Diagnostic radiology services
- Portable X-ray services
- Consultative services
- Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list shall also show the ordering/referring physician's name and UPIN. For example, a surgeon shall complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned UPIN appear in items 17 and 17a.

When a service is incident to the service of a physician or NPP, the name and assigned UPIN of the physician or NPP who performs the initial service and orders the nonphysician service must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services must obtain a UPIN even though they may never bill Medicare directly. A physician who has not been assigned a UPIN must contact the local Medicare carrier to obtain the UPIN. A list of toll free numbers of the Medicare carriers is available at: *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN of the physician supervising the limited licensed practitioner must appear in items 17 and 17a.

When a patient is referred to a physician who also orders **and** performs a diagnostic service, a separate claim form is required for the diagnostic service. Enter the original ordering/referring physician's name and UPIN in items 17 and 17a of the first claim form. Enter the ordering (performing) physician's name and UPIN in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service).

Importance of Supplying Correct Provider Identification Information, continued

***Item 24K* (See note above to reference MM5060, which changes the requirement for Item 24K.)**

Enter the **provider identification number (PIN)** of the performing provider of service/supplier in item 24K if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same CMS-1500 (12-90), or electronic equivalent, show the individual PIN of each performing provider in the corresponding line item. In the case of a service provided incident to the service of a physician or nonphysician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in item 24K. UPINs are not appropriate identifiers for item 24K.

Item 33

Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. **This is a required field.**

For a provider who is **not** a member of a group practice (e.g., private practice), enter the PIN at the bottom of item 33 for paper claims. The PIN should be entered on the **left** side, next to the PIN field.

If a group practice is billing, then the **group PIN** is to be placed in item 33 for paper claims. Enter the group PIN at the bottom of item 33 on the **right** side, next to the GRP field. Enter the PIN for the performing provider of service/supplier who is a member of that group practice in item 24K.

Suppliers billing a DME MAC will use the national supplier clearinghouse (NSC) number in this item.

Note: When implemented, the national provider identification (NPI) number will replace the PIN and UPIN. At that time, you will use the NPI number in items 17a, 24K, and 33.

The above instructions are included in chapter 26 of the *Medicare Claims Processing Manual*. That manual is available at *http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912* on the CMS Web site.

The *Medicare Benefit Policy Manual* may be found at *http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS012673* on the CMS Web site.

If you have questions, please contact your carrier/DME MAC at their toll free number, available 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: SE0529
Related Change Request (CR) #: N/A *Revised*
Related CR Release Date: N/A

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AMBULATORY SURGICAL CENTER

SURGICAL DIAGNOSTIC PROCEDURES REQUIRING MODIFIER TC WHEN BILLED BY AN AMBULATORY SURGICAL CENTER

The following procedure codes have a PC/TC tag of 1 (global procedure), which means these codes have both a professional (PC) and technical component (TC). Effective January 1, 2008, the Centers for Medicare & Medicaid Services has instructed Medicare contractors to only reimburse the ambulatory surgical center (ASC) for the TC of these procedures. If an ASC submits any of these codes as a global procedure (without the technical component modifier), the claim will be returned as unprocessable.

G0130	*0067T*	*0144T*	*0145T*	*0146T*
0147T	*0148T*	*0149T*	*0150T*	*0151T*
51725	*51726*	*51736*	*51741*	*51772*
51784	*51785*	*51792*	*51795*	*51797*
54240	*54250*	*59020*	*59025*	*62252*

Additionally, ASC approved codes (radiology and non-radiology) that require modifier TC are listed in the 2008 ASC disclosures with the "TC".

HELPFUL LINKS

Additional information is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5680.pdf* and *http://www.cms.hhs.gov/manuals/downloads/clm104c14.pdf*.

Source: Publication 100-04, Chapter 14, Section 50

AUDIOLOGY

UPDATE TO AUDIOLOGY POLICIES

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

PROVIDER TYPES AFFECTED

Physicians, nonphysician practitioners, audiologists, and speech-language pathologists submitting claims to Medicare administrative contractors (A/B MACs), carriers and fiscal intermediaries (FIs) for services provided to hearing impaired Medicare beneficiaries.

IMPACT ON PROVIDERS

This article is based on change request (CR) 5717, which alerts affected providers that there are updates to language in the *Medicare Benefit Policy Manual (MBPM)* chapter 15, sections 80.3 and 230.3 and the *Medicare Claims Processing Manual (MCPM)* chapter 12, section 30.3. These manual changes highlight coding issues, including auditory implants as auditory prosthetic devices, differentiate the functions of speech-language pathologists and audiologists in aural rehabilitation, and discuss policy related to automated hearing testing.

CR 5717 states that:

Medicare pays for:

- Audiological diagnostic tests under the benefit for "other diagnostic tests".
- Audiological evaluations, which include tests of tinnitus, auditory processing and osseointegrated devices.
- Medicare does cover treatment for beneficiaries with disorders of the auditory systems as speech-language pathology services.
- Audiological tests may be ordered for any beneficiary when there is suspicion of impairment of the auditory systems, including tinnitus, auditory processing or balance.
- Audiological tests should not be ordered for the purpose of fitting or modifying a hearing aid.
- Audiological **tests are covered** and payable when performed by qualified audiologists.
- Medicare **does not cover audiological treatment**, including hearing aids.

BACKGROUND

The sections of the *MBPM* concerning audiological services had not been updated since the manual was last published in 2003. Since that time, there have been requests for clarification of some of the language. You may review the details of these changes by looking at the revised manual sections, which are attached to CR 5717. The *MBPM* chapter 15 section 80.3 and section 230.3 and the *MCPM* chapter 12 section 30.3 are also attached to CR 5717.

KEY POINTS

The revised *MBPM* chapter 15 sections 80.3 and 230.3 and the revised *MCPM* chapter 12 section 30.3 point out that audiologists and speech-language pathologists each furnish separate services to hearing impaired beneficiaries. Osseointegrated auditory implants are prosthetic devices. **Services using automated devices that do not require the skills of an audiologist are not covered services**. The following are the key points for specific requirements listed in the *MBPM* and the *MCPM*.

Under conditions already noted above, Medicare will pay as follows:

- Medicare will pay for appropriately provided audiological diagnostic tests depending on the reason for the test.

Update to Audiology Policies, continued

- Medicare will pay audiologists for the global service when audiologists perform both the technical and professional components of services that have both components. The most recent Medicare physician fee schedule for pricing and supervision levels for audiology services may be reviewed at *http://www.cms.hhs.gov/PFSlookup/01_Overview.asp#TopOfPage* on the CMS Web site.
- Medicare will not include diagnostic analysis of implants, (such as cochlear, osseointegrated or brainstem implants, including programming or reprogramming following implantation) in the global fee for the surgery.
- Medicare will pay audiologists for the technical component of audiological tests when they perform only the technical component and a physician or qualified nonphysician practitioner provides the professional component of services that have both components.
- Medicare will pay for osseointegrated prosthetic devices under provisions of the applicable payment system. Payment may differ depending upon whether the device is furnished on an inpatient or outpatient basis, by a hospital subject to the outpatient prospective payment system (OPPS), by a critical access hospital (CAH), by a physician's clinic, or by a federally qualified health center (FQHC).
- Medicare will pay for timed codes *92620* and *92621* when billed for appropriately provided evaluation of auditory processing disorders.
- The timed code *92506* is one of the "always therapy" codes listed in the *MCPM* that must be furnished by a speech-language pathologist under the standards and conditions for speech-language pathology services (See also the *MBPM* chapter 15, sections 220& 230). Audiologists may not be paid for these codes.
- Medicare will pay for appropriately provided auditory rehabilitation evaluation as a speech-language pathology benefit when furnished by a speech-language pathologist.
- Medicare will pay for appropriately provided auditory rehabilitation evaluation as a diagnostic test benefit when furnished by an audiologist.
- Medicare will pay for appropriately provided speech-language pathology services after implantation of auditory devices.
- Medicare will pay for appropriately provided services of an audiologist for diagnostic evaluation of cochlear implants. At the time of issuance of CR 5717, the codes for diagnostic analysis of cochlear implants are *92601, 92602, 92603* and *92604*.

Medicare will NOT pay for:

- Medicare will not pay for diagnostic evaluation of cochlear implants by speech-language pathologists, or others who are not audiologists, with the exception of physicians and nonphysician practitioners who may personally provide the services that are within their scope of practice.
- Medicare will not pay for services documented as audiological services when they have been furnished through the use of computers that do not require the skills of an audiologist.
- Medicare will not pay audiologists for treatment services.
- Medicare will not pay for diagnostic audiological tests provided by technicians unless the order specifies each test individually. Note that technicians must meet qualifications determined by the Medicare contractor being billed, which will include, at a minimum, qualification requirements of state and/or local law and successful conclusion of a curriculum including both classroom training and supervised clinical experience administering the audiological service. (However, when an audiologist does the tests and the orders do not name specific tests, the audiologist may select the appropriate battery of tests.)
- Medicare will not pay for services that require the skills of an audiologist when furnished by an AuD 4th year student who is not qualified according to section 1861(ll)(3) of the Act.
- Medicare will not pay for audiological services incident to the service of a physician or nonphysician practitioner.
- Medicare will not pay for the technical component of audiological diagnostic tests performed by a qualified technician unless the medical record contains the name and professional identity of the technician who actually performed the service and the physician or nonphysician supervisor who provides the direct supervision has documented the clinical decision-making and active participation in delivery of the service.
- Medicare will not pay for computer-controlled hearing tests that are screening tests, which do not require the skilled services of an audiologist and are not covered or payable using codes for diagnostic audiological testing. Examples include, but are not limited to, otograms and pure tone or immitance screening devices that do not require the skills of an audiologist.

ADDITIONAL INFORMATION

There are actually two transmittals issued to your Medicare contractor for CR 5717. The first contains changes to the *MCPM* and is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1470CP.pdf* on the CMS Web site.

The second has the changes to the *MBPM* and is available at *http://www.cms.hhs.gov/Transmittals/downloads/R84BP.pdf* on the same site.

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

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

MLN Matters Number: MM5717
Related Change Request (CR) #: 5717
Related CR Release Date: February 29, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R84BP and R1470CP
Implementation Date: April 7, 2008

DRUGS AND BIOLOGICALS

ADDITIONAL CLARIFICATION REGARDING PROCESSING OF DRUG CLAIMS WITH MODIFIER JW

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

PROVIDER TYPES AFFECTED

Physicians, providers and suppliers billing Medicare contractors (Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs], carriers and/or durable medical equipment Medicare administrative contractors [DME MACs]) for drugs or biologicals provided to Medicare beneficiaries.

IMPACT ON PROVIDERS

When processing all drugs **except those provided under the Competitive Acquisition Program (CAP)** for Part B drugs and biologicals, Medicare contractors may require the use of the modifier JW to identify unused drug or biologicals from single use vials or single use packages that are appropriately discarded. This **modifier will provide payment for the discarded drug or biological.**

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) issued this CR 5923 to notify providers of the *Medicare Claims Processing Manual* update that clarifies the use of modifier JW when processing all drugs except CAP drugs.

ADDITIONAL INFORMATION

To see the official instruction (CR 5923) issued to your Medicare carrier, DME/MAC, FI and/or A/B MAC, visit on the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1478CP.pdf*.

If you have questions, please contact your Medicare carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5923
Related Change Request (CR) Number: 5923
Related CR Release Date: March 14, 2008
Related CR Transmittal Number: R1478CP
Effective Date: January 1, 2008
Implementation Date: April 14, 2008

ERYTHROPOIESIS STIMULATING AGENTS IN CANCER AND RELATED NEOPLASTIC CONDITIONS

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

Note: CMS has revised this *MLN Matters* article on March 18, 2008, to correct the bullet regarding the "Maintenance of ESA therapy" (see bullet paragraph in **bold** for easy identification). It should have stated that the "starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30 percent) four weeks after initiation of therapy and the rise in hemoglobin is **>** 1g/dL (hematocrit > 3 percent)." All other information remains the same. The *MLN Matters* article MM5818 was published in the March 2008 *Medicare B Update!* (pages 19-20).

PROVIDER TYPES AFFECTED

Providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC] and durable medical equipment Medicare administrative contractors [DME MAC]) for administering or supplying erythropoiesis stimulating agents (ESAs) for cancer and related neoplastic conditions to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Following a national coverage analysis (NCA) to evaluate the uses ESAs in non-renal disease applications, the Centers for Medicare & Medicaid Services (CMS), on July 30, 2007, issued a decision memorandum (DM) that addressed ESA use in non-renal disease applications (specifically in cancer and other neoplastic conditions).

Change request (CR) 5818 communicates the NCA findings and the coverage policy in the national coverage determination (NCD). Specifically, CMS determines that ESA treatment is reasonable and necessary for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions; and not reasonable and necessary for beneficiaries with certain other clinical conditions, as listed below.

The HCPCS codes specific to non-end-stage renal disease (ESRD) ESA use are J0881 and J0885. Claims processed with dates of service July 30, 2007, through December 31, 2007,do not have to include the ESA modifiers as the modifiers are not effective until January 1, 2008. However, providers are to begin using the modifiers as of January 1, 2008, even though full implementation of related system edits are not effective until April 7, 2008.

Make sure that your billing staffs are aware of this guidance regarding ESA use.

BACKGROUND

Emerging safety concerns (thrombosis, cardiovascular events, tumor progression, and reduced survival) derived from clinical trials in several cancer and non-cancer populations prompted CMS to review its coverage of ESAs. In so doing, on March 14, 2007, CMS opened an NCA to evaluate the uses of ESAs in non-renal disease applications, and on July 30, 2007, issued a DM specifically narrowed to the use of ESAs in cancer and other neoplastic conditions.

ESA in Cancer and Related Neoplastic Conditions, continued

Reasonable and Necessary ESA Use

CMS has determined that ESA treatment for the anemia secondary to a regimen of myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is reasonable and necessary only under the following specified conditions:

- The hemoglobin level immediately prior to the first administration is < 10 g/dL (or the hematocrit is < 30 percent) and the hemoglobin level prior to any maintenance administration is < 10g/dL (or the hematocrit is < 30 percent).
- The starting dose for ESA treatment is up to either of the recommended Food and Drug Administration (FDA) approved label starting doses for cancer patients receiving chemotherapy, which includes the 150 U/kg/3 times weekly or the 40,000 U weekly doses for epoetin alfa and the 2.25 mcg/kg/weekly or the 500 mcg once every three week dose for darbepoetin alpha.
- **Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30 percent) 4 weeks after initiation of therapy and the rise in hemoglobin is > 1g/dL (hematocrit > 3 percent).**
- For patients whose hemoglobin rises < 1 g/dl (hematocrit rise < 3 percent) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains < 10 g/dL after 4 weeks of treatment (or the hematocrit is < 30 percent), the recommended FDA label starting dose may be increased once by 25 percent. Continued use of the drug is not reasonable and necessary if the hemoglobin rises < 1 g/dl (hematocrit rise < 3 percent) compared to pretreatment baseline by 8 weeks of treatment.
- Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3 percent) over any two-week period of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30 percent). Continuation and reinstitution of ESA therapy must include a dose reduction of 25 percent from the previously administered dose.
- ESA treatment duration for each course of chemotherapy includes the eight weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen.

Not Reasonable and Necessary ESA Use

Either because of a deleterious effect of ESAs on the underlying disease, or because the underlying disease increases the risk of adverse effects related to ESA use, CMS has also determined that ESA treatment is not reasonable and necessary for beneficiaries with the following clinical conditions:

- Any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), or bone marrow fibrosis.
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Anemia of cancer not related to cancer treatment.
- Any anemia associated only with radiotherapy.
- Prophylactic use to prevent chemotherapy-induced anemia.
- Prophylactic use to reduce tumor hypoxia.
- Erythropoietin-type resistance due to neutralizing antibodies.
- Anemia due to cancer treatment if patients have uncontrolled hypertension.

Claims Processing

Effective for claims with dates of service on or after January 1, 2008, Medicare will deny non-ESRD ESA services for J0881 or J0885 when:

- Billed with modifier EC (ESA, anemia, non-chemo/radio) when a diagnosis on the claim is present for any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Billed with modifier EC for any anemia in cancer or cancer treatment patients due to bone marrow fibrosis, anemia of cancer not related to cancer treatment, prophylactic use to prevent cancer-induced anemia, prophylactic use to reduce tumor hypoxia, erythropoietin-type resistance due to neutralizing antibodies, and anemia due to cancer treatment if patients have uncontrolled hypertension.
- Billed with modifier EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0 percent or greater is reported.
- Billed with modifier EB (ESA, anemia, radio-induced).

Note: Denial of claims for non-ESRD ESAs for cancer and related neoplastic indications as outlined in NCD 110.21 are based on reasonable and necessary determinations. A provider may have the beneficiary sign an advance beneficiary notice (ABN), making the beneficiary liable for services not covered by Medicare. When denying ESA claims, contractors will use Medicare summary notice 15.20, *The following policies [NCD 110.21] were used when we made this decision*, and remittance reason code 50, *These are noncovered services because this is not deemed a 'medical necessity' by the payer*. However, standard systems shall assign liability for the denied charges to the provider unless documentation of the ABN is present on the claim. Denials are subject to appeal and standard systems shall allow for medical review override of denials. Contractors may reverse the denial if the review results in a determination of clinical necessity.

Medicare contractors have discretion to establish local coverage policies for those indications not included in NCD 110.21.

ESA in Cancer and Related Neoplastic Conditions, continued

Medicare contractors will not search files to retract payment for claims paid prior to April 7, 2008. However, contractors shall adjust claims brought to their attention.

Additional Information

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

This addition/revision of section 110.21 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060[a][4] [2005]). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869[f][1][A][I] of the Social Security Act.)

The official instruction, CR 5818, was issued to your contractor in two transmittals. The first is the NCD transmittal and that is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R80NCD.pdf*.

The second transmittal revises the *Medicare Claims Processing Manual* and it is on the same site at *http://www.cms.hhs.gov/Transmittals/downloads/R1413CP.pdf*.

MLN Matters Number: MM5818 *Revised*
Related Change Request (CR) #: 5818
Related CR Release Date: January 14, 2008
Related CR Transmittal Number: R80NCD and R1413CP
Effective Date: July 30, 2007
Implementation Date: April 7, 2008

Influenza Virus Vaccine Payment Update and Instruction for Pneumococcal Vaccine

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

Provider Types Affected

Physicians, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries [FI], carriers, or A/B MACs) for providing influenza and pneumococcal vaccines to Medicare beneficiaries.

What You Need to Know

Change request (CR) 5910, from which this article is taken, clarifies CR 5744 (Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price [AWP]), released October 26, 2007. It provides Medicare contractors additional instructions regarding the pediatric pneumococcal vaccine *CPT* code *90669*, and the updated payment allowance for the nasal influenza virus vaccine *CPT* code *90660*.

The Medicare Part B payment allowance for *CPT 90660* is $22.031, effective September 19, 2007. Make sure that your billing staffs are aware of these *CPT* code updates.

Background

CR 5744 (Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price [AWP]), released October 26, 2007; provided the payment allowances for pneumococcal vaccine *Current Procedural Terminology* (*CPT*) codes *90732* and *90669*, and influenza virus vaccines *CPT* codes *90655*, 90656, 90657, *90658*, and *90660*).

CR 5910, from which this article is taken, augments CR 5744 by providing additional instructions regarding pediatric pneumococcal vaccine *CPT* code *90669*, and the updated payment allowance for the nasal influenza virus vaccine *CPT* code *90660*. These changes are:

- ***CPT* Code *90669* – Effective January 1, 2008,** FIs, carriers, and A/B MACs will accept claims containing 90669 for pneumococcal vaccine. In order to facilitate appropriate payment for *CPT* code *90669* (*Pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use*), carriers and A/B MACs will use a payment indicator of "1" and the deductible indicator of "1". Providers should bill HCPCS code G0009 when billing for services on or after January 1, 2008, for the administration of *CPT* code *90669*.
- ***CPT* Code *90660* –** On September 19, 2007, the Food and Drug Administration (FDA) approved FluMist for the 2007-2008 influenza season. Thus, your FI, carrier, or A/B MAC may cover *CPT 90660* (*FluMist®, a nasal influenza vaccine*) if it determines that its use is medically reasonable and necessary for the beneficiary. The Medicare Part B payment allowance for *CPT 90660* is $22.031, effective September 19, 2007, except where the vaccine is furnished in the hospital outpatient department. This supersedes the allowance figure provided in CR 5744.

Note: All other instructions in CR 5744 remain in effect.

Please note that, except when the vaccine is furnished in the hospital outpatient department, the Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP, as reflected in the published compendia payment for the vaccine is based on reasonable cost.

Also note that annual Part B deductible and coinsurance amounts do not apply; and that all physicians, non-physician practitioners, and suppliers who administer the influenza virus and pneumococcal vaccinations must take assignment on the claim for the vaccine.

Finally, your Medicare contractor will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims that you bring to their attention.

Additional Information

You may find more information about the additional information regarding *CPT* codes *90669* and *90660* by going to CR 5910, located at *http://www.cms.hhs.gov/*

Influenza Virus Vaccine Payment Update and Instruction for Pneumococcal Vaccine, continued

Transmittals/downloads/R1461CP.pdf on the CMS Web site. You might also want to review the *MLN Matters* article related to CR 5744. You may find that article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5744.pdf* on the CMS Web site.

If you have any questions, please contact your FI, carrier, or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5910
Related Change Request (CR) #: 5910
Related CR Release Date: February 22, 2008
Effective Date: January 1, 2008, except as noted in article.
Related CR Transmittal #: R1461CP
Implementation Date: No later than March 24, 2008

PART B DRUG COMPETITIVE ACQUISITION PROGRAM QUARTERLY DRUG LIST UPDATE

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

PROVIDER TYPES AFFECTED

Physicians billing Medicare administrative contractors (A/B MACs) and carriers for Medicare Part B drugs, and approved CAP vendors billing the designated Medicare A/B MAC or carrier.

WHAT PROVIDERS NEED TO KNOW

This article is based on change request (CR) 5948, which provides notice that there will be a Part B Competitive Acquisition Program (CAP) quarterly drug list update effective April 1, 2008. CR 5948 notifies carriers and A/B MACs of the processes necessary for implementing the Part B CAP quarterly drug list update effective April 1, 2008.

BACKGROUND

Section 303 (d) of the Medicare Modernization Act requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. The CAP is an alternative to the average sales price (ASP) (buy and bill) methodology for acquiring certain Part B drugs, which are, administered incident to a physician's services. Beginning with drugs administered on or after July 1, 2006, physicians have a choice between buying and billing these drugs under the ASP system, or obtaining these drugs from the vendor selected in the competitive bidding process.

KEY POINTS

- A quarterly update of the CAP drug list will become effective on April 1, 2008.
- Payment amounts for drugs added to the CAP drug list as a result of the update will be implemented for claims with dates of service beginning April 1, 2008 per the new file.

ADDITIONAL INFORMATION

To see the official instruction (CR 5948) issued to your Medicare carrier or A/B MAC, visit *http://www.cms.hhs.gov/Transmittals/downloads/R1455CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

For more information about the CAP for Part B Drugs & Biologicals, refer to *http://www.cms.hhs.gov/CompetitiveAcquisforBios/* on the CMS Web site.

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

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: MM5948
Related Change Request (CR) #: 5948
Related CR Release Date: February 22, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R1455CP
Implementation Date: April 7, 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.

SYSTEMS CHANGES FOR PRESCRIPTION ORDER NUMBERS FOR THE COMPETITIVE ACQUISITION PROGRAM FOR PART B DRUGS AND BIOLOGICALS

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

PROVIDER TYPES AFFECTED

Physicians submitting Competitive Acquisition Program (CAP) claims to Medicare contractors (carriers, 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) 5855, which implements system changes for prescription order numbers for the CAP for Part B drugs and biologicals.

CAUTION – What You Need to Know

Necessary edits will be implemented to the Medicare Part B claims processing system to treat CAP claims received with inappropriate spaces in prescription order numbers as well as claims with prescription order numbers with less than 10 characters as unprocessable. A new Medicare system edit will also treat duplicate prescription order numbers as unprocessable. These edits are necessary for CAP claims to process and pay correctly. Physicians submitting claims under the CAP may not submit new claims with prescription order numbers that have been submitted on previously adjudicated claims, even if the prior claims have been denied.

GO – What You Need to Do

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

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) has learned that some providers are submitting CAP claims with prescription order numbers that have inappropriate spaces inserted thus disrupting the matching process with the vendor claims.

CR 5855 implements Medicare Part B claims processing systems edits that will treat claims processed on or after July 7, 2008, as unprocessable when submitted with inappropriate spaces in the prescription order number. Claims also submitted with prescription order numbers less than 10 characters will be treated as unprocessable.

Note that CR 5855 further instructs that CAP physicians/providers should not submit new claims with prescription order numbers that have been submitted on previously adjudicated claims, even if the prior claims have been denied. These physicians/providers must request an adjustment to the original claim. Claims previously returned as unprocessable may be resubmitted with the original prescription number after being corrected.

Medicare contractors will treat the entire claim as unprocessable when a claim is received with CAP services, but the prescription number is a duplicate of a number on a prior claim. This also applies if the prescription order number has inappropriate spaces or is less than 10 characters. This also applies to claims submitted with the modifier J1, but lacking a prescription order number.

When claims are returned as unprocessable because the prescription number is missing, is less than 10 characters or has inappropriate spaces, contractors will also return claim adjustment reason code (CARC) 16 (Claim/service lacks information which is needed for adjudication.) and remittance advice remark code (RARC) MA130 (Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.) and RARC N388 (Missing/incomplete/invalid prescription number).

When claims are returned as unprocessable due to duplicate prescription numbers, contractors will indicate on the returned remittance advice for such claims, a CARC 18 (Duplicate claim/service) and RARC MA130 (Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.), RARC N389 (Duplicate prescription number submitted), RARC M16 (Please see our Web site, mailings, or bulletins for more details covering this policy/procedure/decision), and RARC N185 – (Alert: Do not resubmit this claim/service).

ADDITIONAL INFORMATION

The official instruction, CR 5855, issued to your Medicare carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1453CP.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM5855
Related Change Request (CR) #: 5855
Related CR Release Date: February 22, 2008
Effective Date: Claims processed on or after July 7, 2008
Related CR Transmittal #: R1453CP
Implementation Date: July 7, 2008

END-STAGE RENAL DISEASE

TEACHING PHYSICIAN REQUIREMENTS FOR END STAGE RENAL DISEASE MONTHLY CAPITATION PAYMENT

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

PROVIDER TYPES AFFECTED

Physicians who bill Medicare carriers or Medicare administrative contractors (A/B MAC) for end-stage renal disease (ESRD)-related visits in teaching settings under the monthly capitation payment (MCP).

WHAT YOU NEED TO KNOW

Change request 5932, from which this article is taken, announces that the *Medicare Claims Processing Manual*, chapter 12 (Physicians/Non-physician Practitioners), section 100.1.6 (Miscellaneous) has been updated to indicate that the physician presence policy applies to end-stage renal disease (ESRD)-related visits furnished under the MCP. This means that patient visits furnished by residents may be counted toward the MCP visits if the teaching MCP physician is physically present during the visits.

The teaching physician may utilize the resident's notes, however, the physician must document his or her physical presence during the visit(s) furnished by the resident and that he or she reviewed the resident's notes.

Note: You can document these criteria as part of an extensive once a month MCP note.

Make sure that your billing staffs are aware of these manual changes; and that in teaching settings, you document such ESRD-related MCP physician visits appropriately.

BACKGROUND

The Medicare physicians fee schedule (MPFS) payment rules for teaching physicians' services (set forth in CFR 415.172 and the *Medicare Claims Processing Manual* chapter 12 [Physicians/Non-physician Practitioners], section 100.1 [Payment for Physician Services in Teaching Settings Under the MPFS]), specify that if a resident participates in a service furnished in a teaching setting, the MPFS payment is made only if a teaching physician is physically present during the key portion of any service or procedure for which payment is sought.

With regard to the monthly management of dialysis patients; the ESRD-related visits are considered to be the key portion of the MCP service that determines the applicable payment amount.

Previously, chapter 12, section 100.1.6 of the *Medicare Claims Processing Manual* stated that the teaching physician presence policy does not apply to the renal dialysis services of a physician paid under the MCP. However, this manual instruction did not reflect policy changes made to the way physicians and practitioners are paid for managing patients on outpatient dialysis. As discussed in the CY 2004 MPFS rule, the MCP physician or practitioner must furnish at least one patient visit per month to receive payment for the MCP service (center-based patients). Therefore in CR 5932, from which this article is taken, the Centers for Medicare & Medicaid Services (CMS) modifies chapter 12, section 100.1.6 to indicate that physician presence policy applies for ESRD related visits furnished under the MCP.

This means, as the teaching physician, you may count the patient visits that residents furnish toward the MCP visits if you are physically present during the visit. You may utilize the resident's notes, however you must document your physical presence during the visit(s) furnished by the resident and also document that you reviewed the resident's notes.

Note: The outpatient ESRD MCP services G codes are reported once per month, and you could document your physical presence during the visit(s) and your review of the resident's notes as part of an extensive once a month MCP note.

ADDITIONAL INFORMATION

You may find more information about teaching physician requirements for ESRD MCP by going to CR 5932, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1458CP.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM5932
Related Change Request (CR) #: 5932
Related CR Release Date: February 22, 2008
Effective Date: March 24, 2008
Related CR Transmittal #: R1458CP
Implementation Date: March 24, 2008

MANUALIZATION OF PAYMENT FOR OUTPATIENT END-STAGE RENAL DISEASE RELATED SERVICES

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

PROVIDER TYPES AFFECTED

Physicians and other practitioners who bill Medicare contractors (carriers or Medicare administrative contractors [A/B MAC]) for providing outpatient end-stage renal disease (ESRD) services to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change request 5931, from which this article is taken, updates the *Medicare Claims Processing Manual*, chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), section 140 (Monthly Capitation Payment Method for Physicians' Services Furnished to Patients on Maintenance Dialysis) to reflect changes in the payment methodology for ESRD services (as discussed in the CY 2004 and CY 2005 Medicare physician fee schedule final rules).

ESRD-related services (per full month), as described by *Current Procedural Terminology* (*CPT*) codes *90918-90921*, and those (less-than-full-month), as described by *CPT* codes *90922-90925*, are no longer valid for Medicare. They have been replaced by healthcare common procedure coding system (HCPCS) codes G0308 through G0327 (HCPCS codes G0308-G0319 are used for center based patients on dialysis, HCPCS codes G0320 – G0323 are used for home dialysis patients and HCPCS codes G0324 through G0327 are used for less-than-full-month services).

These policies have been discussed in prior communications to providers and CMS is now incorporating these changes into their manuals. Thus, while this article is informational in nature, be sure that your billing staffs are aware of these coding policies for ESRD services.

BACKGROUND

In the *Federal Register* published November 7, 2003, (68 FR 63216), the Centers for Medicare & Medicaid Services (CMS) established new G codes for managing dialysis patients; with varying monthly capitation payments (MCP) based on 1) the number of visits provided within each month, and 2) the beneficiary's age.

Under this payment methodology, physicians bill separate codes for providing one ESRD-related visit per month, two to three visits per month, or four or more visits per month; and in turn, receive the lowest payment amount when providing one visit per month, a higher payment when providing two to three visits per month, and the highest payment amount when providing at least four visits per month.

On September 17, 2004, CR 3414, "Payment for Outpatient ESRD-Related Services," provided interim-billing instructions for specific less-than-full-month ESRD-related scenarios (e.g. transient patients) and for visits furnished to patients in hospital observation status. In these two instances, physicians and practitioners were instructed to use the unlisted dialysis procedure code (*CPT* code *90999*). To view the related MLN Matters article on "Payment for Outpatient ESRD-Related Services", please visit *http://www.cms.hhs.gov/MLNMattersArticles/Downloads/MM3414.pdf* on the CMS Web site.

Subsequently, in the *Federal Register* published November 15, 2004, (69 FR 66357), CMS: 1) changed the descriptor of the G codes for ESRD-related home dialysis services, less-than-full-month (G0324 through G0327) to allow other partial month scenarios (in addition to patients dialyzing at home); and 2) established policy that permits visits furnished to beneficiaries in hospital observation status to be counted for purposes of billing the MCP service. These policy changes superseded the interim billing instructions contained in CR 3414.

Finally, CR 3595, "Emergency Update to the CY 2005 Physician Fee Schedule Data Base", which is discussed in *MLN Matters* article MM3595 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3595.pdf* on the CMS Web site, published December 23, 2004, included descriptors of G0324-G0327 to allow these codes to be used for other scenarios in addition to home dialysis less than full month, (e.g. transient patients, partial month due to hospitalization, transplant or when the patient expired, and when a permanent change in MCP physician occurs during the month).

Now, CR 5931, from which this article is taken, updates the *Medicare Claims Processing Manual*, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), section 140 (Monthly Capitation Payment Method for Physicians' Services Furnished to Patients on Maintenance Dialysis) to reflect these requirement changes.

Additionally, it notifies you that this section has been reorganized. Some of the information previously contained in sections 140.1 and 140.2 has been moved to section 140; and the title of section 140.1 has been changed to "Payment for ESRD-Related Services Under the Monthly Capitation Payment (Center Based Patients)" and the title of section 140.2 has been changed to "Payment for ESRD-Related Services (Per Diem)". Further, Sections 140.5, (Determining MCP Amount for Physician's Service to Maintenance Dialysis Patients) and 140.51 (Temporary Absence Under MCP) were deleted from chapter 8 as these sections are superseded by the new instructions.

Note: ESRD-related services as described by HCPCS codes G0308 – G0327 are already included as part of the HCPCS payment file, and Medicare contractors are currently making payment for these service.

ADDITIONAL INFORMATION

You may see these policies for the payment for outpatient ESRD-related services by going to CR 5931, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1456CP.pdf* on the CMS Web site. You will find the updated *Medicare Claims Processing Manual,* chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), sections 140 (Monthly Capitation Payment Method for Physicians' Services Furnished to Patients on Maintenance Dialysis), 140.1 (Payment for ESRD-Related Services Under the Monthly Capitation Payment [Center Based Patients]), 140.1.1 (Payment for Managing Patients on Home Dialysis), 140.1.2 (Patients That Switch Modalities [Center to Home and Vice Versa]), 140.2 (Payment for ESRD-Related Services [Per Diem]), 140.2.1 (Guidelines for Physician or Practitioner Billing [Per Diem]), 140.3 (Data Elements Required on Claim for Monthly Capitation Payment), and 140.4 (Controlling Claims Paid Under the Monthly Capitation Payment Method) as an attachment to that CR.

Manualization of Payment for Outpatient ESRD Related Services, continued

You might also want to look at *MLN Matters* articles Payment for Outpatient ESRD-Related Services (September 17, 2004) and Emergency Update to the 2005 Medicare Physician Fee Schedule Database (MPFSDB) (December 23, 2004) which you may find at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3414.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3595.pdf* on the CMS Web site,

If you have any questions, please contact your carrier or /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).

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Related Change Request (CR) #: 5931
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Related CR Transmittal #: R1456CP
Implementation Date: March 24, 2008

EVALUATION AND MANAGEMENT SERVICES

PAYMENT FOR HOSPITAL OBSERVATION SERVICES AND OBSERVATION OR INPATIENT CARE SERVICES

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

PROVIDER TYPES AFFECTED

Physicians and qualified nonphysician practitioners (NPPs), submitting claims to Medicare administrative contractors (A/B MACs) and carriers for hospital observation services provided to Medicare beneficiaries during a hospital visit.

IMPACT ON PROVIDERS

Change request (CR) 5791 alerts providers to updates regarding:

- Payment for hospital observation services (*Current Procedural Terminology* (*CPT*) codes *99217-99220*)
- Observation or inpatient care services (including admission and discharge services – CPT codes *99234-99236*).

See the *Key Points* section of this article for a complete list of the updates.

BACKGROUND

This CR 5791 updates chapter 12, section 30.6.8 of the *Medicare Claims Processing Manual* as finalized in the Medicare physician fee schedule final rule, dated November 1, 2000, Vol.65, No. 212, pp. 65408 and 65409. The updated section of this manual is attached to CR 5791 and the address/link to the CR is listed in the *Additional Information* section of this article.

KEY POINTS

The payment policy requirements according to CR 5791 are as follows:

- Physicians and qualified NPPs **should report** Initial observation care using a code from *CPT* code range *99218-99220* when the observation care is less than eight hours on the same calendar date.
- Physicians and qualified NPPs **should not report** an observation care discharge service (*CPT* code *99217*) when the observation care is less than eight hours on the same calendar date.
- Physicians and qualified NPPs should report initial observation care using a code from *CPT* code range *99218-99220* and an observation care discharge service (*CPT* code *99217*) when the patient is admitted for observation care and discharged on a different calendar date.
- Physicians and qualified NPPs should report observation or inpatient care service (including admission and discharge service) using a code from *CPT* code range *99234-99236* when the patient is admitted for observation care for a minimum of eight hours but less than 24 hours and discharged on the same calendar date.
- Physicians and qualified NPPs **should not** report observation care discharge service (*CPT* code *99217*) when the observation care is a minimum of eight hours and less than 24 hours and the patient is discharged on the same calendar date.
- Physicians and qualified NPPs should report office or other outpatient visit using a code from *CPT* code range *99211-99215* for a visit before the discharge date in those rare instances when a patient is held in observation care status for more than two calendar dates.
- Physicians and qualified NPPs should document the medical record to satisfy the evaluation and management guidelines for admission to and discharge from observation care or inpatient hospital care.

Payment for Hospital Observation Services and Observation or Inpatient Care Services, continued

- Physicians and qualified NPPs should note that the documentation requirements for history, examination and medical decision-making should be met.
- Physicians and qualified NPPs should document his/her physical presence.
- Physicians and qualified NPPs should document his/her personal provision of observation care.
- Physicians and qualified NPPs should document the number of hours the patient remained in the observation care status.
- The physicians and qualified NPPs should personally document the admission and discharge notes.

Additional Information

You may see the official instruction (CR 5791) issued to your Medicare A/B MAC or carrier, or FI by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1466CP.pdf* on the CMS Web site.

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

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Related Change Request (CR) #: 5791
Related CR Release Date: February 22, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R1466CP
Implementation Date: April 7, 2008

Payment for Inpatient Hospital Visits—General

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

Provider Types Affected

Physicians and nonphysician practitioners (NPPs), submitting claims to Medicare administrative contractors (A/B MACs) and/or carriers for services provided to Medicare beneficiaries during a hospital visit.

Provider Action Needed

Providers should note the payment policy for billing inpatient hospital visits provided on the same day as critical care services. See the *Key Points* section of this article for a complete list of the updates.

Background

CR 5792 updates chapter 12, section 30.6.9 of the *Medicare Claims Processing Manual*. The updated section of this manual is attached to CR 5792 and the address/link to that CR is listed in the *Additional Information* section of this article.

Key Points

Physicians and qualified NPPs should note the payment policy requirements according to CR 5792 are as follows:

- When a hospital inpatient (or emergency department or office/outpatient) evaluation and management (E/M) service is furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care, both the critical care services (*Current Procedural Terminology* (*CPT*) codes *99291* and *99292*) and the previous E/M service may be paid for the same date of service.
- During critical care management of a patient those services that do not meet the level of critical care should be reported using an inpatient hospital care service with *CPT* subsequent hospital care using a *CPT* code in the *99231-99233* range.
- Physicians and qualified NPPs may report both critical care services and an inpatient hospital care service for the same patient on the same calendar date when during critical care management of a patient the services do not meet the level of critical care services.
- Physicians and qualified NPPs are reminded that both initial hospital care codes (*CPT* codes *99221-99223*) and subsequent hospital care codes are “per diem” services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.
- Physicians and qualified NPPs are advised to retain documentation for discretionary Medicare carrier or A/B MAC review in case claims are questioned. The retained documentation must support why the same physician or physicians of the same specialty in a group practice submitted claims for both critical care services and other E/M services for the patient on the same date of service.

Additional Information

You may see the official instruction (CR 5792) issued to your Medicare A/B MAC or carrier by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1473CP.pdf* on the CMS Web site.

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

Payment for Inpatient Hospital Visits—General, continued

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

MLN Matters Number: MM5792
Related Change Request (CR) #: 5792
Related CR Release Date: March 7, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R1473CP
Implementation Date: April 7, 2008

PAYMENT FOR INITIAL HOSPITAL CARE SERVICES AND OBSERVATION OR INPATIENT CARE SERVICES

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

PROVIDER TYPES AFFECTED

Physicians and qualified nonphysician practitioners (NPP) who bill Medicare carriers and Medicare administrative contractors (A/B/MACs) for inpatient services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Change request 5793, from which this article is taken, updates initial hospital care policy found in the *Medicare Claims Processing Manual* that includes admission and discharge services on the same calendar date of service. It advises physicians and NPPs of which *Current Procedural Terminology* (*CPT*) codes to use when inpatient hospital care is less than 8 hours on the same calendar date, when a patient is admitted and discharged on a different calendar date, and when admitted for eight hours but less than 24 hours on the same calendar date. It also identifies medical record documentation requirements.

BACKGROUND

CR 5793, from which this article is taken, updates initial hospital care policy found in the *Medicare Claims Processing Manual*, chapter 12 (Physicians/Nonphysician Practitioners), section 30.6.9.1 (Payment for Initial Hospital Care Services (Codes *99221-99223* and Observation or Inpatient Care Services (Including Admission and Discharge Services) (Codes *99234-99236*). It advises physicians and NPPs of the correct *CPT* codes to use when inpatient hospital care is less than 8 hours on the same calendar date, when a patient is admitted and discharged on a different calendar date, and when admitted for 8 hours but less than 24 hours on the same calendar date; and identifies medical record documentation requirements.

This physician payment policy was finalized in the Medicare physician fee schedule final rule, dated November 1, 2000, Vol. 65, No. 212, pp. 65408-65409 with the implementation of the *American Medical Association Current Procedural Terminology* (*CPT*) codes for *CPT* 2001.

Specifically, CR 5793 reminds physicians and qualified NPPs that:

- When a patient is admitted to inpatient hospital care for less than eight hours on the same calendar date, you shall report the initial hospital care using a code from *CPT* code range *99221 – 99223*. In this scenario, do not use the hospital discharge day management service, *CPT* code *99238* or *99239*.
- When a patient is admitted for inpatient hospital care and discharged on a different calendar date, you shall report the initial hospital care using a code from *CPT* code range *99221-99223* and *CPT* code *99238* or *99239* for a hospital discharge day management service.
- When a patient is admitted to inpatient hospital care for a minimum of eight hours but less than 24 hours and discharged on the same calendar date, you shall report the observation or inpatient hospital care services (including admission and discharge services same day) using a code from *CPT* code range *99234-99236*, and no additional discharge service.

Remember that your medical record documentation must meet the evaluation and management (E/M) documentation requirements for history, examination and medical decision-making. For reporting *CPT* codes *99234-99236* the medical record shall include:

- Documentation stating the stay for hospital treatment or observation care status involves eight hours but less than 24 hours.
- Documentation identifying the billing physician was present and personally performed the services.
- Documentation identifying the admission and discharge notes were written by the billing physician.

ADDITIONAL INFORMATION

You may find more information about the correct *CPT* codes to use for initial hospital care services and observation or inpatient care services (including admission and discharge services) by going to CR 5793 located at *http://www.cms.hhs.gov/Transmittals/downloads/R1465CP.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), section 30.6.9.1 (Payment for Initial Hospital Care Services [codes *99221-99223]* and Observation or Inpatient Care Services [including admission and discharge services) [codes *99234 – 99236]*) 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).

Payment for Initial Hospital Care Services and Observation or Inpatient Care Services, continued

MLN Matters Number: MM5793
Related Change Request (CR) #: 5793
Related CR Release Date: February 22, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R1465CP
Implementation Date: April 7, 2008

SUBSEQUENT HOSPITAL VISITS AND HOSPITAL DISCHARGE DAY MANAGEMENT SERVICES

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

PROVIDER TYPES AFFECTED

Physicians and qualified nonphysician practitioners (NPPs), submitting claims to Medicare administrative contractors (A/B MACs) and carriers for services provided to Medicare beneficiaries during a hospital visit.

IMPACT ON PROVIDERS

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5794 to alert providers to updates regarding:

- Physician payment policy for subsequent hospital care visits during a global surgery period
- The appropriate use of hospital discharge day management services for a final hospital visit by the attending physician and also for a death pronouncement.

See the *Key Points* section of this article for a complete list of the updates.

BACKGROUND

This CR 5794 updates chapter 12, section 30.6.9.2 of the *Medicare Claims Processing Manual*. The updated section of this manual is attached to CR 5794, which is available at the Web address listed in the *Additional Information* section of this article. The Medicare physician fee schedule payment amount for surgical procedures includes all services (e.g., evaluation and management services) that are part of the global surgery payment. Therefore, physicians and qualified NPPs should note that Medicare will not pay more than that amount when a bill is fragmented for staged procedures.

KEY POINTS

The updated manual provisions according to CR 5794 are as follows:

- Physicians and qualified NPPs shall remember that subsequent hospital care visits (*Common Procedural Terminology* [*CPT]* codes *99231 – 99233*) are not separately payable during the global surgery period even when a bill is fragmented for a staged procedure.
- A hospital discharge day management service (*CPT* code *99238* or *99239*) is a face-to-face evaluation and management (E/M) service between the attending physician and the patient.
- Only the attending physician of record (or physician acting on behalf of the attending physician) shall report the hospital discharge day management service (*CPT* code *99238* or *99239*).
- Physicians and qualified NPPs who manage concurrent health care problems not primarily managed by the attending physician shall use the subsequent hospital care code from *CPT* code range *99231 – 99233* for a final visit.
- The physician or qualified NPP shall report the hospital discharge day management service for the date of actual visit even if the patient is discharged on a different calendar date.
- CMS reminds physicians and qualified NPPs that only one hospital discharge day management service is payable per patient per hospital stay.
- Paperwork involved in patient discharge day management services is paid through the pre- and post-service work of an E/M service.
- Physicians and qualified NPPs shall not bill both a subsequent hospital care visit and a hospital discharge day management service on the calendar date of discharge.
- Physicians and qualified NPPs should note that a hospital admission and discharge on the same day should be reported using the observation or inpatient care services (including admission and discharge services) from *CPT* code range *99234 – 99236* when specific Medicare criteria identified in chapter 12, section 30.6.9.1 of the *Medicare Claims Processing Manual* are met.
- Only the physician who personally performs the pronouncement of death shall bill for the face-to-face hospital discharge day management service (*CPT* codes *99238* or *99239*).
- The date of the death pronouncement shall reflect the date of service on the calendar date it was performed even if the paperwork is delayed to a subsequent date.

ADDITIONAL INFORMATION

You may see the official instruction (CR 5794) issued to your Medicare A/B MAC or carrier by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1460CP.pdf* on the CMS Web site.

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

Subsequent Hospital Visits and Hospital Discharge Day Management Services, continued

MLN Matters Number: MM5794
Related Change Request (CR) #: 5794
Related CR Release Date: February 22, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R1460CP
Implementation Date: April 7, 2008

LABORATORY/PATHOLOGY

HEALTHCARE COMMON PROCEDURE CODING SYSTEM CODES SUBJECT TO AND EXCLUDED FROM CLINICAL LABORATORY IMPROVEMENT AMENDMENTS EDITS

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

PROVIDER TYPES AFFECTED

Clinical diagnostic laboratories billing Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for laboratory tests.

PROVIDER ACTION NEEDED

STOP – Impact to You

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare carrier or A/B MAC for a *CPT* code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

CAUTION – What You Need to Know

The CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *CPT* codes that CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 5926, from which this article is taken, informs carriers and A/B MACS about the new *CPT* codes for 2008 that are subject to CLIA edits and also about those that are now excluded from CLIA edits.

GO – What You Need to Do

Make sure that your billing staffs are aware of these CLIA-related HCPCS changes for 2008 and that you remain current with certification requirements.

BACKGROUND

The CLIA require a laboratory facility to be appropriately certified for each test it performs.

To ensure that Medicare and Medicaid only pay for laboratory tests that are performed by certified facilities, carriers and A/B MACs will edit each Medicare claim submitted for a HCPCS code considered to be a CLIA laboratory test. These *CPT* codes change each year, and CR 5926, from which this article is taken, informs carriers and A/B MACs about the new *CPT* codes for 2008 that are both subject to, and excluded from, CLIA edits.

The *CPT* codes listed in the chart that follows are new for 2008 and are subject to CLIA edits. The list does not include new *CPT* codes for waived tests or provider-performed procedures. The *CPT* codes listed below require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) will not be paid for these tests and the claims will be denied. Failure to submit your CLIA number on claims containing one of these *CPT* codes will result in the Medicare carrier or A/B MAC returning your claim as unprocessable.

CPT	*Description*
80047	*Basic metabolic panel (Calcium, ionized)*
82610	*Cystatin C*
83993	*Calprotectin, fecal*
84704	*Gonadotropin, chorionic (hCG); free beta chain*
86356	*Mononuclear cell antigen, quantitative (eg, flow cytometry), not otherwise specified, each antigen*
87500	*Infectious agent detection by nucleic acid (DNA or RNA); vancomycin resistance (eg, enterococcus species van A, van B), amplified probe technique*

HCPCS Subject to and Excluded from CLIA Edits, continued

CPT	*Description*
87809	*Infectious agent antigen detection by immunoassay with direct optical observation; adenovirus*
88381	*Microdissection (ie, sample preparation of microscopically identified target); manual*
89322	*Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)*
89331	*Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)*
87809	*Infectious agent antigen detection by immunoassay with direct optical observation; adenovirus*
88381	*Microdissection (ie, sample preparation of microscopically identified target); manual*
89322	*Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)*
89331	*Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)*

Other Key Points

- The *CPT* code *86586* [*Unlisted antigen, each*] was discontinued on December 31, 2007.
- For 2008, the new *CPT* code *86486* [*Skin test; unlisted antigen, each*] is excluded from CLIA edits and does not require a facility to have any CLIA certificate.

Additional Information

To see the official instruction (CR 5926) issued to your Medicare carrier or A/B MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R1471CP.pdf* on the CMS Web site.

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

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

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Related Change Request (CR) #: 5926
Related CR Release Date: February 29, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1471CP
Implementation Date: April 7, 2008

New Waived Tests

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

Provider Types Affected

Physicians, providers and suppliers who bill Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for clinical diagnostic laboratory services.

What You Need to Know

The list of tests approved by the Food and Drug Administration (FDA) as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) has been updated.

Background

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

The chart below identifies the newly added waived tests and their effective dates. The *Current Procedural Terminology* (*CPT*) codes for these tests must have the modifier QW to be recognized as a waived test.

***CPT* Code**	**Effective Date**	**Description**
87880QW	June 25, 2007	PSS World Medical Select Diagnostics Strep A Dipstick
86308QW	July 12, 2007	Signify Mono Cassette {Whole Blood}
86308QW	July 12, 2007	Poly Stat Mono Test {Whole Blood}
86308QW	July 12, 2007	Clearview MONO Whole Blood, K042272/A016
86318QW	July 25, 2007	Polymedco Poly Stat H. Pylori Test (Whole Blood)
86318QW	July 25, 2007	Henry Schein One Step+ H. Pylori Rapid Test Device (Whole Blood)
87880QW	August 14, 2007	Moore Medical The Supply Experts Strep A Rapid Test – Dipstick
87880QW	August 21, 2007	Jant Pharmacal Accustrip Strep A Value+ Test Strip
87880QW	August 21, 2007	Abbott Laboratories Signify Strep A Dipstick

New Waived Tests, continued

CPT Code	Effective Date	Description
86318QW	September 11, 2007	Abbott Laboratories Signify H. Pylori Cassette {Whole Blood}
82465QW, *83718QW*, *82947QW*, *82950QW*, *82951QW*, *82952QW*	September 21, 2007	Polymer Technology Systems CardioChek PA Analyzer (PTS Panels CHOL+HDL+GLUC Panel Test Strips)
82465QW, 83718QW, 82947QW, 82950QW, 82951QW, 82952QW	September 21, 2007	Polymer Technology Systems CardioChek Brand Analyzer (PTS Panels CHOL+HDL+GLUC Panel Test Strips)
85014QW	September 21, 2007	Abbott i-STAT Chem8+ Cartridge {Whole Blood}
82465QW, 83718QW	October 15, 2007	Polymer Technology Systems CardioChek PA Analyzer (PTS Panels CHOL+HDL Panel Test Strips)
82465QW, 83718QW	October 15, 2007	Polymer Technology Systems CardioChek Brand Analyzer (PTS Panels CHOL+HDL Panel Test Strips)
82565QW, 84520QW	October 18, 2007	Abaxis Piccolo xpress Chemistry Analyzer (Kidney Check Panel){Whole Blood}
86703QW	October 22, 2007	Clearview Complete HIV 1/2 {Fingerstick Venipuncture, whole blood}
80051QW	October 30, 2007	Abaxis Piccolo Blood Chemistry Analyzer (Electrolyte Metabolic Reagent Disc){Whole Blood}
80051QW	October 30, 2007	Abaxis Piccolo xpress Chemistry Analyzer (Electrolyte Metabolic Reagent Disc){Whole Blood}
87804QW	November 1, 2007	BinaxNOW Influenza A & B Test {Nasopharyngeal (Np) Swab and Nasal Wash/Aspirate Specimens and Nasal Swabs (NS)}
80101QW	December 13, 2007	Quest Diagnostics Incorporated, Express Results Integrated Multi-Drug Screen Cup {professional use}
80047QW	January 1, 2008	Abbott i-STAT Chem8+ Cartridge {Whole Blood}
80048QW	January 16, 2008	Abaxis Piccolo Blood Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood}
80048QW	January 16, 2008	Abaxis Piccolo xpress Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood}
80053QW	January 16, 2008	Abaxis Piccolo Blood Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood}
80053QW	January 16, 2008	Abaxis Piccolo xpress Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood}

The new waived *CPT*/HCPCS code, *80047QW*, has been assigned for the ionized calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen tests performed using the Abbott i-STAT Chem8+ Cartridge {Whole Blood}. This *CPT* code may be used for claims submitted by facilities with a valid, current CLIA certificate of waiver with dates of service on or after January 1, 2008.

The new waived *CPT*/HCPCS code, *80048QW*, has been assigned for the calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen tests performed using the the Abaxis Piccolo Blood Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood}. This *CPT* code may be used for claims with dates of service on or after January 16, 2008, submitted by facilities with a valid, current CLIA certificate of waiver.

The new waived *CPT*/HCPCS code, *80051QW*, has been assigned for the carbon dioxide, chloride, potassium, and sodium tests performed using the Abaxis Piccolo Blood Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood}, the Abaxis Piccolo Blood Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood} and the Abaxis Piccolo Blood Chemistry Analyzer (Electrolyte Metabolic Reagent Disc){Whole Blood}. This *CPT* code may be used for claims submitted by facilities with a valid, current CLIA certificate of waiver with dates of service on or after October 30, 2007.

The new waived *CPT*/HCPCS code, *80053QW*, has been assigned for the alanine amino transferase, aspartate amino transferase, albumin, total bilirubin, total calcium, carbon dioxide, chloride, creatinine, glucose, alkaline phosphatase, potassium, total protein, sodium, and urea nitrogen tests performed using the Abaxis Piccolo Blood Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood}. This *CPT* code may be used for claims with dates of service on or after January 16, 2008, submitted by facilities with a valid, current CLIA certificate of waiver.

New Waived Tests, continued

The following *CPT* codes do not require the modifier QW in order to be recognized as waived tests:

***CPT* Code**	**Description**
81002	Dipstick or tablet reagent urinalysis – non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen
81025	Urine pregnancy tests by visual color comparison
82270, 82272, G0394 (Contact your Medicare carrier or A/B MAC for claims instructions.)	Fecal occult blood
82962	Blood glucose by glucose monitoring devices cleared by the FDA for home use
83026	Hemoglobin by copper sulfate – non-automated
84830	Ovulation tests by visual color comparison for human luteinizing hormone
85013	Blood count; spun microhematocrit
85651	Erythrocyte sedimentation rate – non-automated

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

Additional Information

To see the official instruction (CR 5913) issued to your Medicare carrier or A/B MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R1477CP.pdf* on the CMS Web site. A complete list of tests granted waived status under CLIA is attached to CR 5913. For more information about CLIA, refer to *http://www.cms.hhs.gov/CLIA/01_Overview.asp#TopOfPage* on the CMS Web site.

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

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: MM5913
Related Change Request (CR) #: 5913
Related CR Release Date: March 14, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R1477CP
Implementation Date: April 7, 2008

PSYCHIATRIC SERVICES

Psychological and Neuropsychological Tests

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

Note: This article was revised on March 3, 3008, to reflect a revision made to CR 5204. The article was changed to correct a reference in the first paragraph of the *Background* section to section 1861 (s)(2)(c) of the Social Security Act . The correct section number is 1861 (s)(3). Also, the CR release date, transmittal number, and Web address for accessing CR 5204 were changed. All other information remains the same. This information was previously published in the November 2006 Medicare B Update! pages 13-15.

Provider Types Affected

Providers who bill Medicare carriers or fiscal intermediaries (FIs) for the provision of diagnostic psychological and neuropsychological tests

Provider Action Needed

STOP – Impact to You

Effective January 1, 2006, carriers and FIs will pay (under the Medicare physician fee schedule (MPFS) database) for diagnostic psychological and neuropsychological tests that are within the *CPT* code range of *96101* through *96120*.

Psychological and Neuropsychological Tests, continued

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) announces the revision of the *CPT* codes for psychological and neuropsychological tests (codes *96101* through *96120*) to include tests performed by technicians and computers (*CPT* codes *96102*, *96103*, *96119* and *96120*) in addition to those performed by physicians, clinical psychologists, independently practicing psychologists and other qualified nonphysician practitioners (as described in Background, below).

GO – What You Need to Do

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

BACKGROUND

Medicare Part B coverage of psychological tests and neuropsychological tests is authorized under section 1861(s)(3) of the Social Security Act, and payment for these tests is authorized under section 1842(b)(2)(A) of the Social Security Act.

The CPT codes for these tests are included in the range of codes from *96101* to *96120*. The appropriate codes when billing for psychological tests are: *96101, 96102, 96103, 96105, 96110*, and *96111*; and when billing for neuropsychological tests are: *96116, 96118, 96119* and *96120*. All of the tests under this *CPT* code range *96101-96120* are covered and indicated as active codes under the MPFS database.

More specifically, CR 5204, from which this article is taken, provides that (effective January 1, 2006) the *CPT* codes for psychological and neuropsychological tests include tests performed by technicians and computers (*CPT* codes *96102, 96103, 96119* and *96120*) in addition to tests performed by physicians, clinical psychologists, independently practicing psychologists and other qualified nonphysician practitioners.

These changes, made in accordance with the final physician fee schedule regulation, were published in the *Federal Register* on November 21, 2005, at 70 FR 70279 and 70280 under Table 29 (AMA, Relative Value Update Committee (RUC) and Health Care Professional Advisory Committee (HCPAC) Recommendations and CMS Decisions for New and Revised 2006 CPT Codes).

You should be aware of some supervision requirements for diagnostic psychological and neuropsychological tests. First, under the diagnostic tests provision, all diagnostic tests are assigned a certain level of supervision. Generally, regulations governing the diagnostic tests provision allow only physicians to provide the assigned level of supervision for such tests; however, for diagnostic psychological and neuropsychological tests, there is a regulatory exception that allows either a clinical psychologist (CP) or a physician to perform the assigned general supervision.

Moreover, nonphysician practitioners such as nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs), who personally perform diagnostic psychological and neuropsychological tests are excluded from having to perform these tests under the supervision requirements of the diagnostic psychological and neuropsychological tests benefit, that is, under the general supervision of a physician or a CP.

In fact, rather than providing them under the requirements for diagnostic psychological and neuropsychological tests, NPs and CNSs must perform such tests under the requirements of their respective benefit. Therefore, NPs and CNSs must perform them in collaboration (as defined under Medicare law at section 1861(aa)(6) of the Act) with a physician. Likewise, PAs must perform these tests under the general supervision of a physician as required for services furnished under the PA benefit.

To continue, physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs) are authorized to bill three test codes (*96105*, *96110*, and *96111*) as "sometimes therapy" codes. However, when PTs, OTs and SLPs perform these three tests, they must do so under the general supervision of a physician or a CP.

You should also note that expenses for diagnostic psychological and neuropsychological tests are not subject to the outpatient mental health treatment limitation, which is the payment limitation on treatment services for mental, psychoneurotic and personality disorders as authorized under Section 1833(c) of the Social Security Act. Further, the payment amounts that are billed for tests performed by a technician or a computer reflect a site of service payment differential for the facility and non-facility settings.

Remember that CPs, NPs, CNSs and PAs are required by law to accept assigned payment for psychological and neuropsychological tests. And although independently practicing psychologists (IPPs) are not required to accept assigned payment for these tests, they must report the name and address of the physician who ordered the test on the claim form when billing for tests. (An IPP is any psychologist who is licensed (or certified) to practice psychology in the state or jurisdiction where furnishing services or, if the jurisdiction does not issue licenses, if provided by any practicing psychologist. Examples of psychologists (other than CPs) whose psychological and neuropsychological tests are covered under the diagnostic tests provision include, but are not limited to, educational psychologists and counseling psychologists.) Additionally, there is no authorization under Medicare law for payment for diagnostic tests when performed on an "incident to" basis.

Following is a summary of who may bill for diagnostic psychological and neuropsychological tests, and references for the review of qualifications, when appropriate.

Providers that May Bill for Diagnostic Psychological and Neuropsychological Tests

CPs	See qualifications under chapter 15, section 160 of the *Medicare Benefits Policy Manual*.
NPs –to the extent authorized under State scope of practice.	See qualifications under chapter 15, section 200 of the *Medicare Benefits Policy Manual.*
CNSs –to the extent authorized under State scope of practice.	See qualifications under chapter 15, section 210 of the *Medicare Benefits Policy Manual.*
PAs – to the extent authorized under State scope of practice.	See qualifications under chapter 15, section 190 of the *Medicare Benefits Policy Manual*.
Independently practicing psychologists (IPPs)	
PTs, OTs and SLPs	See qualifications under chapter 15, sections 220-230.6 of the *Medicare Benefits Policy Manual*.

Psychological and Neuropsychological Tests, continued

The *Medicare Benefits Policy Manual* is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS Web site.

Here are some other important things that you should know.

- The technician and computer *CPT* codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Therefore, *CPT* psychological test code *96101* will not be paid if you include it in the bill for the same tests or services performed under psychological test codes *96102* or *96103*.
  Similarly, *CPT* neuropsychological test code *96118* will not be paid when included in the bill for the same tests or services performed under neuropsychological test codes *96119* or *96120*. Note, however, *CPT* codes *96101* and *96118* can sometimes be paid separately, when billed on the same date of service for different and separate tests from *96102*, *96103*, *96119* and *96120*.
- Under the MPFS, there is no payment for services performed by students or trainees. Accordingly, Medicare does not pay for services represented by *CPT* codes *96102* and *96119*, when performed by a student or a trainee. However, the presence of a student or a trainee while the test is being administered does not prevent a physician, CP, IPP, NP, CNS or PA from performing and being paid for the psychological test under *96102* or the neuropsychological test under *96119*.
- Fiscal intermediaries will continue to pay claims from providers of outpatient Part B therapy services (including physical therapy, occupational therapy, and speech-language pathology) for *CPT* codes *96105*, *96110* and *96111* with revenue codes and corresponding therapy modifiers (42x with GP, 43x with GO, and 44x with GN, respectively).
- Finally, your carriers and fiscal intermediaries do not have to search their files to either retract payment for claims already paid, or to retroactively pay claims to January 1, 2006; they will adjust claims that you bring to their attention.

Additional Information

You may find more information about psychological and neuropsychological tests by reading CR 5204, located at *http://www.cms.hhs.gov/Transmittals/downloads/R85BP.pdf* on the CMS Web site. As an attachment to this CR, you will find updated relevant portions of Publication 100.02 (*Medicare Benefit Policy Manual*), chapter 15 (Covered Medical and Other Health Services), section 80.2 (Psychological Tests and Neuropsychological Tests)
If you have any questions, please contact your carrier or FI at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

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

MLN Matters Number: MM5204 *Revised*
Related Change Request (CR) #: 5204
Related CR Release Date: February 29, 2008
Effective Date: January 1, 2006
Related CR Transmittal #: R85BP
Implementation Date: December 28, 2006

RADIOLOGY

Clarification of Bone Mass Measurement Billing Requirements Issued in CR 5521

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 bone mass measurement (BMM) services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5847, which clarifies the claims processing instructions contained in CR 5521. Only those business requirements changing from CR 5521 are listed in CR 5847, and the BMM benefit policy is not changing. The basic clarification is that Medicare allows codes other than *CPT* code *77080* (i.e., *76977, 77078, 77079, 77081, 77083*, and G0130) to be paid even though claims for such services report both a screening diagnosis code and an osteoporosis code.

Background

The Social Security Act (sections 1861[s][15] and [rr][1]) (as added by the Balanced Budget Act of 1997 [BBA; section 4106]) standardize Medicare coverage of medically necessary BMMs by providing for uniform coverage under Medicare Part B. Effective for dates of service on and after January 1, 2007, the calendar year (CY) 2007 physician fee schedule (PFS) final rule expanded the number of beneficiaries qualifying for BMM by reducing the dosage requirement for glucocorticoid (steroid) therapy from 7.5 mg of prednisone per day to 5.0 mg. It also changed the definition of BMM by removing coverage for a single-photon absorptiometry as it is not considered reasonable and necessary under the Social Security Act section 1862 [a][1][A]). Finally, it required in the case of monitoring and confirmatory baseline BMMs, that they be performed with a dual-energy x-ray absorptiometry (axial) test.

Clarification of BMM Billing Requirements Issued in CR 5521, continued

The Centers for Medicare & Medicaid Services (CMS) issued CR 5521 (Transmittal 70; May 11, 2007) to provide benefit policy and claims processing instructions for BMM tests. CMS has learned that the updated policy described in CR 5521 is not being implemented uniformly and some covered services are being denied in error.

You may review the *MLN Matters* article related to CR 5521 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5521.pdf* on the CMS Web site. CR 5847 clarifies the claims processing instructions contained in CR 5521 and lists only those business requirements changing from CR 5521. The key clarifications are as follows, effective for dates of services on and after January 1, 2007, the following apply to BMM:

- Certain BMM tests are covered when used to screen patients for osteoporosis subject to the frequency standards described in section 80.5.5 of the *Medicare Benefit Policy Manual*, which may be found at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS Web site.
- Medicare contractors will pay claims for screening tests when coded as follows:
  - Contains *Current Procedural Terminology* (*CPT*) procedure code *77078, 77079, 77080, 77081*, *77083, 76977* or G0130.
  - Contains a valid ICD-9-CM diagnosis code indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy. Contractors are to maintain local lists of valid codes for the benefit's screening categories.
- Contractors will deny claims for screening tests when coded as follows:
  - Contains *CPT* procedure code *77078, 77079, 77081, 77083, 76977* or *G0130*
  - Does not contain a valid ICD-9-CM diagnosis code indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.
  - Dual-energy x-ray absorptiometry (axial) tests are covered when used to monitor FDA-approved osteoporosis drug therapy subject to the 2-year frequency standards described in section 80.5.5 of the *Medicare Benefit Policy Manual*.
- Contractors will pay claims for monitoring tests when coded as follows:
  - Contains *CPT* procedure code *77080*
  - Contains 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as the ICD-9-CM diagnosis code.
- Contractors will deny claims for monitoring tests when coded as follows:
  - Contains *CPT* procedure code *77078, 77079, 77081, 77083, 76977* or G0130.
  - Contains 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as the ICD-9-CM diagnosis code, but does not contain a valid ICD-9-CM diagnosis code from the local lists of valid ICD-9-CM diagnosis codes maintained by the Medicare contractor for the benefit's screening categories indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.
  - Single photon absorptiometry ***tests are not covered.*** *Contractors will d*eny *CPT* procedure code *78350*.

Note: As mentioned, these are clarifications and the BMM benefit policy is not changing. Also, note that while Medicare contractors will not search their files to reprocess claims already processed, they will adjust claims that you bring to their attention.

ADDITIONAL INFORMATION

The official instruction, CR 5847, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1416CP.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM5847
Related Change Request (CR) #: 5847
Related CR Release Date: January 18, 2008
Effective Date: January 1, 2007
Related CR Transmittal #: R1416CP
Implementation Date: February 20, 2008

ELECTRONIC DATA INTERCHANGE

CLAIM STATUS CATEGORY CODE AND CLAIM STATUS CODE UPDATE

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

PROVIDER TYPES AFFECTED

Physicians, providers, and suppliers who submit health care claim status transactions to Medicare contractors (carriers, Medicare administrative contractors [A/B MACs], durable medical equipment Medicare administrative contractors [DME MACs]), fiscal intermediaries [FIs], and regional home health intermediaries [RHHIs]).

PROVIDER ACTION NEEDED

STOP – Impact to You

This article is based on change request (CR) 5947, which indicates there have been updates to the claim status category codes and claim status codes.

CAUTION – What You Need to Know

All code changes approved during the October 2007 meeting of the national Code Maintenance Committee have been posted at *http://www.wpc-edi.com/content/view/180/223/* and will become effective April 1, 2008.

GO – What You Need to Do

See the *Background* section of this article for further details.

BACKGROUND

The Health Insurance Portability and Accountability Act (HIPPA) requires all health care benefit payers, including Medicare, to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee. These codes are used in the X12 276/277 health care claim status request and response format to explain the status of submitted claim(s).

The decisions about additions, modifications, and retirement of existing claim status category and claim status codes made at the October 2007 meeting of the National Code Maintenance Committee were posted at *http://www.wpc-edi.com/content/view/180/223/* on November 5, 2007. These updates are effective April 1, 2008, and are to be used in editing of all X12 276 transactions processed by Medicare contractors on or after April 7, 2008.

ADDITIONAL INFORMATION

To see the official instruction (CR 5947) issued to your Medicare FI, carrier, DME MAC, or A/B MAC, refer to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1468CP.pdf*.

If you have questions, please contact your Medicare carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5947
Related Change Request (CR) Number: 5947
Related CR Release Date: February 29, 2008
Related CR Transmittal Number: R1468CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

HEALTHCARE PROVIDER TAXONOMY CODE UPDATE EFFECTIVE APRIL 1, 2008

Effective April 1 2008, the Healthcare Provider Taxonomy Codes (HPTC) were updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of the HPTC is available from the *Washington Publishing Company Web site* at *http://www.wpc-edi.com/codes/taxonomy*.

If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level rejection may occur.

To ensure you do not receive a claim or file level rejection, it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system please contact your software support vendor.

Source: Publication 100-04, Transmittal 1462, Change Request 5951

REMITTANCE ADVICE REMARK CODE AND CLAIM ADJUSTMENT REASON CODE UPDATE

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR 5942, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs), effective April 1, 2008. Be sure billing staff are aware of these changes.

BACKGROUND

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at *http://www.wpc-edi.com/Codes* on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5942.

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

ADDITIONAL INFORMATION

To see the official instruction (CR 5942) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1475CP.pdf* on the CMS Web site.

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

If you have questions, please contact your Medicare carrier, RHHI, DME/MAC, FI and/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).

REMITTANCE ADVICE REMARK CODE CHANGES

New Codes

Code	Current Narrative	Medicare Initiated
N430	Procedure code is inconsistent with the units billed. Start: 11/5/2007 *Note: (New Code 11/5/07)*	Yes
N431	Service is not covered with this procedure. Start: 11/5/2007 *Note: (New Code 11/5/07)*	Yes
N432	Adjustment based on a Recovery Audit. Start: 11/5/2007 *Note: (New Code 11/5/07)*	Yes

Modified Codes

Code	Current Modified Narrative	Last Modification Date
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	11/5/2007
M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	11/5/2007

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

Code	Current Modified Narrative	Last Modification Date
M75	Multiple automated multichannel tests performed on the same day combined for payment.	11/5/2007
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.	11/5/2007
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.	11/5/2007
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.	11/5/2007
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	11/5/2007
N70	Consolidated billing and payment applies.	11/5/2007
N367	**Alert:** The claim information has been forwarded to a Consumer Account Fund processor for review.	11/5/2007
N377	Payment based on a processed replacement claim.	11/5/2007
N385	Notification of admission was not timely according to published plan procedures.	11/5/2007

Deactivated Codes

Code	Current Narrative	Modification Date
MA119	Provider level adjustment for late claim filing applies to this claim. Start: 1/1/1997 | Stop: 5/1/2008 | Last Modified: 11/5/2007 *Note: (Deactivated eff. 5/1/08 [Consider using Reason Code B4])*	Deactivated eff. 5/1/08

CLAIM ADJUSTMENT REASON CODES

New Codes

Code	Current Narrative	Implementation Date
212	Administrative surcharges are not covered Start: 11/05/2007	11/05/2007

Modified Codes

Code	Modified Narrative	Implementation Date
121	Indemnification adjustment - compensation for outstanding member responsibility. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment. Start: 10/31/2005 | Last Modified: 09/30/2007	4/1/2008
206	National Provider Identifier - missing. Start: 07/09/2007 | Last Modified: 09/30/2007	4/1/2008
207	National Provider identifier - Invalid format Start: 07/09/2007 | Stop: 05/23/2008 | Last Modified: 09/30/2007	4/1/2008
208	National Provider Identifier - Not matched. Start: 07/09/2007 | Last Modified: 09/30/2007	4/1/2008
15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008

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

Code	Modified Narrative	Implementation Date
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
20	This injury/illness is covered by the liability carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
21	This injury/illness is the liability of the no-fault carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
22	This care may be covered by another payer per coordination of benefits. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
23	The impact of prior payer(s) adjudication including payments and/or adjustments. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
31	Patient cannot be identified as our insured. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
33	Insured has no dependent coverage. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
34	Insured has no coverage for newborns. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
55	Procedure/treatment is deemed experimental/investigational by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
56	Procedure/treatment has not been deemed `proven to be effective' by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
61	Penalty for failure to obtain second surgical opinion. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
95	Plan procedures not followed. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
107	The related or qualifying claim/service was not identified on this claim. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
108	Rent/purchase guidelines were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
112	Service not furnished directly to the patient and/or not documented. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
115	Procedure postponed, canceled, or delayed. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
116	The advance indemnification notice signed by the patient did not comply with requirements. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
117	Transportation is only covered to the closest facility that can provide the necessary care. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
118	ESRD network support adjustment. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
129	Prior processing information appears incorrect. Start: 02/28/1997 | Last Modified: 09/30/2007	4/1/2008
135	Interim bills cannot be processed. Start: 10/31/1998 | Last Modified: 09/30/2007	4/1/2008

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

Code	Modified Narrative	Implementation Date
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). Start: 10/31/1998 | Last Modified: 09/30/2007	4/1/2008
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. Start: 02/28/1999 | Last Modified: 09/30/2007	4/1/2008
138	Appeal procedures not followed or time limits not met. Start: 06/30/1999 | Last Modified: 09/30/2007	4/1/2008
141	Claim spans eligible and ineligible periods of coverage. Start: 06/30/1999 | Last Modified: 09/30/2007	4/1/2008
142	Monthly Medicaid patient liability amount. Start: 06/30/2000 | Last Modified: 09/30/2007	4/1/2008
146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	4/1/2008
148	Information from another provider was not provided or was insufficient/incomplete. Start: 06/30/2002 | Last Modified: 09/30/2007	4/1/2008
150	Payer deems the information submitted does not support this level of service. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
151	Payer deems the information submitted does not support this many services. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
152	Payer deems the information submitted does not support this length of service. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
153	Payer deems the information submitted does not support this dosage. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
154	Payer deems the information submitted does not support this day's supply. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
155	Patient refused the service/procedure. Start: 06/30/2003 | Last Modified: 09/30/2007	4/1/2008
157	Service/procedure was provided as a result of an act of war. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
158	Service/procedure was provided outside of the United States. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
159	Service/procedure was provided as a result of terrorism. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
160	Injury/illness was the result of an activity that is a benefit exclusion. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
163	Attachment referenced on the claim was not received. Start: 06/30/2004 | Last Modified: 09/30/2007	4/1/2008
164	Attachment referenced on the claim was not received in a timely fashion. Start: 06/30/2004 | Last Modified: 09/30/2007	4/1/2008
165	Referral absent or exceeded. Start: 10/31/2004 | Last Modified: 09/30/2007	4/1/2008
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
169	Alternate benefit has been provided. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
173	Service was not prescribed by a physician. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
174	Service was not prescribed prior to delivery. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
175	Prescription is incomplete. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
176	Prescription is not current. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
177	Patient has not met the required eligibility requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
178	Patient has not met the required spend down requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
179	Patient has not met the required waiting requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008

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

Code	Modified Narrative	Implementation Date
180	Patient has not met the required residency requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
181	Procedure code was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
182	Procedure modifier was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
186	Level of care change adjustment. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Start: 10/31/2005 | Last Modified: 09/30/2007	4/1/2008
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. Start: 02/28/2006 | Last Modified: 09/30/2007	4/1/2008
195	Refund issued to an erroneous priority payer for this claim/service. Start: 02/28/2006 | Last Modified: 09/30/2007	4/1/2008
197	Precertification/authorization/notification absent. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
202	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
203	Discontinued or reduced service. Start: 02/28/2007 | Last Modified: 09/30/2007	4/1/2008
A8	Ungroupable DRG. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B8	Alternative services were available, and should have been utilized. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B9	Patient is enrolled in a Hospice. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B14	Only one visit or consultation per physician per day is covered. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B16	`New Patient' qualifications were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B18	This procedure code and modifier were invalid on the date of service. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B20	Procedure/service was partially or fully furnished by another provider. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008

Deactivated Codes

Code	Current Narrative	Implementation Date
25	Payment denied. Your Stop loss deductible has not been met. Start: 01/01/1995 | Stop: 04/01/2008	4/1/2008
126	Deductible -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 1.	4/1/2008
127	Coinsurance -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 2.	4/1/2008
145	Premium payment withholding Start: 06/30/2002 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code CO and code 45.	4/1/2008
A4	Medicare Claim PPS Capital Day Outlier Amount. Start: 01/01/1995 | Stop: 04/01/2008 | Last Modified: 09/30/2007	4/1/2008

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

MLN Matters Number: MM5942
Related Change Request (CR) #: 5942
Related CR Release Date: March7, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R1475CP
Implementation Date: April 7, 2008

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.

National Provider Identifier

NPI Required for all HIPAA Standard Transactions on May 23, 2008

NPI Is Here. NPI Is Now. Are You Using It? As of May 23, 2008, the national provider identifier (NPI) will be required for all HIPAA standard transactions. This means:

For all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, DDE, 276/277, 270/271 and 835), paper claims (UB-04 and CMS-1500) and SPR remittance advice.

The reporting of Medicare legacy identifiers in any primary or secondary provider fields will result in the rejection of the transaction.

Reminder: May 23rd Is Only Two Months Away, Be Prepared! Test NPI-Only Now

Now that the NPI is required on all Medicare claims in the primary provider fields, if your claims are being successfully processed with NPI/legacy pairs (and most are) now is the time to begin testing claims using the NPI alone.

If the Medicare NPI crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims reject, go into your NPPES record and validate that the information you are sending on the claim is consistent with the information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims three-four days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call the customer service representative at your Medicare carrier, FI, or A/B MAC enrollment staff or your DME MAC to discuss your situation and, if necessary, have it investigated. Have a copy of your NPPES record or your NPI registry record available. The contractor telephone numbers are likely to be quite busy, so don't wait.

Doing this testing now will allow time for any needed corrections prior to May 23, 2008, the date when only the NPI will be accepted in all provider fields.

Need More Information?

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

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

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

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the CMS Web page *http://www.cms.hhs.gov/NationalProvIdentStand*.

Visit The Medicare Learning Network – It's Free!

Source: CMS Provider Education Resource 200803-12

Collapsing Medicare Provider Transaction Access Numbers to Ensure a One-to-One National Provider Identifier Match

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

Provider Types Affected

Providers and suppliers billing Medicare contractors (Medicare administrative contractors [A/B MACs], and carriers) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5906 because it believes that providers and suppliers may want to collapse their assigned Medicare provider transaction access numbers (PTANs) to insure a one-to-one national provider identifier (NPI) match. Providers may collapse PTANs that are assigned to additional locations **only if the additional locations are all assigned the same tax identification number (TIN) and are within the same pricing locality.**

Background

Changes in the Medicare provider and supplier enrollment process over the years have resulted in differences in the assignment of Medicare PTAN. Those differences, combined with Medicare's requirement to capture the NPI as part of the enrollment process, affect the type of information that is collected and maintained in Provider Enrollment, Chain Ownership System (PECOS), and then transferred to Medicare Claims System (MCS) and Medicare's NPI crosswalk.

Presently, some Medicare carriers issue separate PTANs to physicians, nonphysician practitioners, and other suppliers with multiple practice locations. To ensure that carriers are assigning PTANs in a more consistent manner and to aid in the implementation of the NPI, carriers and A/B MACs will assign the minimum number of PTANs necessary to ensure that proper payments are made.

Key Points

- Providers and suppliers can request their carrier or A/B MAC collapse their PTANs by submitting a letter on their letterhead to the Medicare contractor. The letter must contain:
- The TIN of the provider/entity and/or the social security number of the individual(s)
- The effective date for the collapsed PTANs

Collapsing Medicare PTANs to Ensure a One-to-One NPI Match, continued

- A signature of the authorized official making the request.
- In addition, Organizations must complete the following sections of the CMS-855B application:
  - Section 1.A. – You are changing your information
  - Section 1.B. – Practice Location Information
  - Section 2.B.3. – Correspondence Address
  - Section 3. – Adverse Legal Actions/Convictions
  - Section 4 – should be replaced with a spreadsheet containing all the PTANs for the group and its individuals with associated NPIs, all practice location addresses for the group and any special payment address, and identify on the spreadsheet of which group/individual PTANS are to remain active and which are to be end dated
  - Section 13. – Contact person
  - Section 15 – Certification Statement
- Sole Proprietors, in addition to the letter, must submit the following sections of the CMS-855I application:
  - Section 1.A. – You are changing your information
  - Section 1.B. – Practice Location Information
  - Section 2.A. – Identifying information
  - Section 2.B. – Correspondence Address
  - Section 3. – Adverse Legal Actions/Convictions
  - Section 4 – should be replaced with a spreadsheet containing all the PTANs for the sole proprietor with associated NPIs, all practice location addresses and any special payment address, and identify on the spreadsheet of which PTANS are to remain active and which are to be end dated
  - Section 13. – Contact information
  - Section 15 – Certification Statement.
- If it is determined, the provider or supplier is not in PECOS, the Medicare contractor will request a complete 855B or 855I application to be submitted.
- Internet-based PECOS, which is to be implemented later this year, will not support collapsing of assigned Medicare PTANs by a provider or supplier. Therefore, if a provider or supplier requests to collapse their Medicare PTANs, **this process will have to be done by the CMS-855 paper application process.**

Additional Information

To see the official instruction (CR 5906) issued to your Medicare carrier or A/B MAC, refer to *http://wwww.cms.hhs.gov/Transmittals/downloads/R244PI.pdf* on the CMS Web site.

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

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: MM5906
Related Change Request (CR) #: 5906
Related CR Release Date: February 29, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R244PI
Implementation Date: April 7, 2008

NPI: What to do if Your 837P or CMS-1500 Medicare Claim Rejects & More

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

Verifying NPPES Data

CMS has found a significant number of instances where either the legal business name (LBN) and/or employer identification number (EIN) of an organization health care provider who has been assigned a national provider identifier (NPI) do not match Internal Revenue Service (IRS) records. In some cases, this is caused by health care providers who are individuals who erroneously applied for NPIs as organizations and who reported their social security numbers (SSN) in the EIN field. As a first step to improving the quality of information in the National Plan and Provider Enumeration System (NPPES), we are requesting that organization health care providers verify their LBN and EIN within NPPES. This is especially important if the organization health care provider is experiencing any Medicare claims processing issues.

Important Information for Medicare FFS Providers

Effective March 1, 2008, all 837P and CMS-1500 claims received must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject.

What to do if Your 837P or CMS–1500 Claim Rejects

- Check your record in the National Plan and Provider Enumeration System (NPPES)

Validate that the legacy identifier sent on the claim is reported in your NPPES record. If the legacy identifier is not there, it needs to be added.

Validate that the LBN for a provider/supplier who is an organization or the legal name for a provider/supplier who is an individual or a sole proprietorship is correct.

Validate that the correct entity type was selected at the time of NPI application. Individuals obtain an NPI as Entity Type 1. Organizations obtain an NPI as Entity Type 2 NPI.

(Note: If you enumerated through the EFI alternative or submitted a paper NPI application, you should use the NPI Registry to check the content of your NPPES record. Make sure to have the customer service representative (CSR) at your Medicare contractor verify your EIN because the NPI Registry does not display EINs.)

- If the above validation is successful and your claims continue to reject, call the CSR at your Medicare contractor.

Have a copy of your NPPES record or your NPI Registry record in hand. A copy of your NPPES record can be printed from NPPES by going online at *https://nppes.cms.hhs.gov* and using the user ID and password selected when you applied

NPI: What to do if Your 837P or CMS-1500 Medicare Claim Rejects & More, continued

for your NPI. If you obtained your NPI through the EFI alternative or submitted a paper NPI application, you should print your record from the NPI Registry at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do* . EINs and SSNs are not displayed in the NPI Registry.

Have the claim reject number and message.

Be prepared to give the following information:

1. LBN of the organization or legal name of the individual
2. Contractor tracking number (if known)
3. Approximate date (month/year) when the CMS-855 enrollment application was submitted or last updated
4. Provider/Supplier Tax Identification Number (EIN or SSN)
5. NPI
6. Medicare legacy identifier
7. Practice location on claim (i.e., where is the practice located (e.g., 100 Main St., New Orleans, LA)
8. Contact Information where you can be reached if further discussion is needed

Some Clearinghouses Continue to Strip Information From Medicare Claims

It has come to CMS' attention that some clearinghouses continue to strip NPIs, as well as other information, from Medicare claims. If your clearinghouse continues to strip your NPI from your claims for any reason, notify your Medicare contractor immediately so that CMS can work with your clearinghouse to resolve the issue.

In some cases, clearinghouses are stripping the SY qualifier and the SSN from claims that contain an NPI. Based on business requirement 4320.17 (outlined in Transmittal number 204, dated February 1, 2006), the qualifier SY is an acceptable qualifier for use on Medicare claims. See below block for specific details. You should share this information with your clearinghouse if you suspect they are stripping the SY qualifier and the SSN from your claims.

4320.17 Shared systems shall reject as non-compliant with the implementation guide any 837 version 4010A1 claim that contains XX in NM108, the NPI in NM109, and 1C or 1G as applicable in REF01of the same loop, but which lacks another REF01 in the billing or pay-to-provider loop with the EI (EIN) qualifier and number or the SY (SSN, applies to carriers & DMERCs only) qualifier and number to convey the taxpayer identifier.

Test NPI–Only Now

If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims reject, go into your NPPES record and validate that the information you are sending on the claim is consistent with the information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or your DME MAC. Have a copy of your NPPES record or your NPI Registry record available. The contractor telephone numbers are likely to be quite busy, so don't wait.

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.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the *www.cms.hhs.gov/NationalProvIdentStand* CMS Web page.

Source: CMS Provider Education Resource 200803-02

National Provider Identifier—March 1st Milestone

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

Important Information for Medicare Fee-For-Service Providers - March 1 Milestone

Effective March 1, 2008, all 837P and CMS-1500 claims must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include a national provider identifier (NPI) will cause the claim to reject!

Background

One of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish unique national identifiers for providers. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. On March 1, 2008, Medicare claims submitted by physicians and other practitioners, laboratories, ambulance company suppliers, DMEPOS suppliers and others that bill Medicare are required to include the new NPI.

Providers must use this information when they submit their claims to Medicare carriers, A/B Medicare administrative carriers (MACs), and DME MACs when they use certain electronic and paper Medicare claims (specifically the X12N 837P electronic claim and the CMS-1500 paper claims).

Hospitals, skilled nursing facilities, home health care agencies and other such institutional providers were required to begin using their NPI beginning on January 1, 2008

The deadlines for submitting Medicare claims using the NPI are necessary to help the Centers for Medicare & Medicaid Services (CMS), the Medicare contractors and health care providers prepare for the final May 23, 2008 deadline for full NPI compliance. While the final NPI Rule required compliance on May 23, 2007, CMS stated in the NPI National Contingency Guidance that it will not take enforcement action against covered entities that deploy contingency plans through May 23, 2008, provided that conditions in the Guidance were met.

CMS is anticipating that some providers will experience some problems with claims submitted after March 1 – problems could arise in the following situations:

NPI—March 1st Milestone, continued

- The provider does not have an NPI
- The provider does not submit their NPI on their claim
- The provider has already received an NPI, but the NPI is not consistent with the provider's enrollment information received by the contractor.

Providers whose claims are rejected and returned to them should immediately contact their contractor before resubmitting that claim or submitting new claims for services provided to Medicare beneficiaries. Contact information for the Medicare contractors may be found at *www.cms.hhs.gov/MLNGenInfo/* under "Downloads." The file is named, "Provider Call Center Toll-Free Numbers Directory."

Current Status

Physicians, nonphysician practitioners, labs, ambulance company suppliers, DME suppliers, and others who traditionally bill carriers and DME MACs (2/22/08):

- About 91.3 percent of Medicare carrier claims and 88.5 percent of DME MAC claims are being submitted with an NPI or NPI/legacy pair in the primary provider identifier fields (these numbers are consistent with institutional provider NPI use before the January 1 change).
- For claims submitted with an NPI, the current reject rate for carrier and DME MAC claims ranges from 1-12 percent, depending on the carrier. CMS has received very few complaints from providers.

Institutional Providers (January 1, 2008, deadline)

- In mid-January, the NPI submission rate jumped to 99 percent - compared to 90 percent in December.
- Currently, the submission rate is over 99.9 percent. Less than 0.1 percent of claims are being rejected for not having an NPI in the appropriate fields.

The March 1, 2008, Deadline

Expectations for March 1:

- A small portion of claims will continue to be submitted without an NPI. These claims will be rejected. Providers have had over two years to acquire and test their NPI.
- Some rejections may occur because a contractor has not completed processing a provider's enrollment application, submitted by the provider to fix inconsistencies between a provider's NPI and Medicare's provider enrollment files.

Medicare Risk Mitigation

CMS and the Medicare contractors are taking aggressive steps to ensure that providers will be paid for treating Medicare beneficiaries after March 1.

Medicare contractors are enhancing their toll-free phone lines by expanding the number of people available to answer calls. Throughout the month of February, CMS has intensified its planning efforts to assist contractors to prepare for the March 1 implementation date. In February 2008, CMS held a training session with contractor call centers and CMS regional office staff to ensure they are able to address provider inquiries on NPI issues.

Daily calls with the carriers, A/B MACs, and DME MACS are scheduled to monitor the status of successful and rejected claims, inquiries, enrollment backlog status, and other relevant information.

Each contractor has created a NPI Coordination Team to quickly identify and resolve claims processing issues related to the submission of the NPI or NPI-legacy combination, expedite the processing of enrollment applications, and address other issues that may arise.

CMS has implemented temporary measures to allow the Medicare contractors time to address some of the backlog issues, but at some contractors, more work is needed.

Current Claims Process as of March 1

Currently, most Medicare providers (and their claims clearinghouse vendors) are submitting claims that include their new NPI. For those providers who don't have an NPI, they are submitting claims using their legacy provider numbers. When the claim is submitted, Medicare's computer systems will check to confirm that the claim includes an NPI. If there is no NPI, the claim will be rejected and the provider will receive an error message pointing to the lack of an NPI. If the provider has an NPI, the provider should make sure that the number is on the claim and resubmit the claim. If at that point the claim is again rejected, the provider should immediately contact the Medicare contractor to ensure that all provider records are correct before resubmitting the claim.

Contact information for the Medicare contractors may be found at *www.cms.hhs.gov/MLNGenInfo/* under "Downloads." The file is named, "Provider Call Center Toll-Free Numbers Directory."

Medicare contractors expect to be able to handle all incoming calls, but some callers may experience extended hold times. CMS is urging providers to be patient – their issues will be addressed.

The Future – May 23, 2008

With May 23, 2008 less than three months away, CMS and the Medicare health care providers must make sure they are ready for full NPI implementation. Providers must be certain their NPI information and Medicare enrollment information is accurate and up-to-date before that date. Further, if providers' claims are being successfully processed with NPI/legacy pairs (and most are) now is the time for them to begin testing claims using only the NPI. Providers should start with small volumes of these NPI-only claims and gradually increase their submissions. Doing this testing now will allow time for any needed corrections prior to the May 23, 2008, deadline when claims must include the NPI only.

What to do if your 837P and CMS-1500 Claims are Rejected

Check your record in the National Plan and Provider Enumeration System (NPPES)

- Validate that the legacy identifier sent on the claim is reported in the provider/supplier's NPI Registry record. If the legacy identifier is not there, instruct the provider/supplier to add it.
- Validate that the Legal Business Name (if the provider/supplier is an organization) or the Legal Name (if the provider/supplier is an individual or a sole proprietorship) is correct.
- Validate that the correct Entity type was selected by the provider/supplier when applying for the NPI. Individuals obtain an NPI as Entity Type 1. Organizations obtain an NPI as Entity Type 2 NPI.

Note: If you enumerated through the EFI alternative, you should use the NPI Registry to check the content of the NPPES file. Make sure to have the customer

NPI—March 1st Milestone, continued

service representative at your Medicare contractor verify your supplier tax identification number [TIN]/ employer identification number [EIN] as the NPI Registry does not list this information.

If these claims are still rejecting, call your Medicare contractor.

- Have a copy of the NPPES record in hand. A copy of the NPPES record may be obtained online at *https://nppes.cms.hhs.gov*. The EIN or social security number (SSN) will not be shown on this print out.
- Have the claim reject number and message
- Be prepared to give the following information:

1. Legal business name of the organization
2. Contractor tracking number (if known)
3. Approximate date (month/year) when the 855-enrollment application was submitted
4. Provider/supplier TIN or SSN
5. NPI
6. Medicare legacy identifier
7. Practice location on claim (i.e. where is the practice located (e.g. 100 Main St. New Orleans, LA)
8. Contact information where provider/supplier can be reached if further discussion is needed

TEST NPI-ONLY NOW

If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims rejects, go into your NPPES record and validate that the information you are sending on the claim is the same information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or the national supplier clearinghouse for advice right away. Have a copy of your NPPES record available. The enrollment telephone numbers are likely to be quite busy, so don't wait.

TRANSCRIPT FROM FEBRUARY 6, 2008 ROUNDTABLE NOW AVAILABLE

The transcript from the February 6, 2008, NPI Roundtable on the FFS Medicare Implementation is now available at *http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp* on the CMS NPI Web page.

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 can be found through the CMS NPI page *www.cms.hhs.gov/NationalProvIdentStand* on the CMS Web site. Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the *www.cms.hhs.gov/NationalProvIdentStand* CMS Web page.

Source: Provider Education Resources Listserv, Message 200802-20

IMPORTANT NPI REMINDERS FOR FEE-FOR-SERVICE MEDICARE PROVIDERS

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

ATTENTION: FEE-FOR-SERVICE (FFS) MEDICARE PHYSICIANS, NONPHYSICIAN PRACTITIONERS & OTHER SUPPLIERS

Reminder – Effective March 1, 2008, when required for Medicare claim submission, all 837P and CMS-1500 claims must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject. Visit the CMS NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp* for more details.

TEST NPI-ONLY NOW

If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims rejects, go into your NPPES record and validate that the information you are sending on the claim is the same information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or the national supplier clearinghouse for advice right away. Have a copy of your NPPES record available. The enrollment telephone numbers are likely to be quite busy, so don't wait.

NEED MORE INFORMATION?

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: Provider Education Resources Listserv, Message 200802-13

ADDITIONAL INFORMATION ON REPORTING A NATIONAL PROVIDER IDENTIFIER FOR ORDERING/REFERRING AND ATTENDING/OPERATING/OTHER/SERVICE FACILITY FOR MEDICARE CLAIMS

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

Note: CMS has revised this *MLN Matters* article on March 5, 2008, to remove the parenthetical phrase of "MD and DO" from the "Note" paragraph. All other information remains the same. The *MLN Matters* article MM5890 was published in the February 2008 *Medicare B Update!* (pages 49-50).

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

STOP – Impact to You

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.

CAUTION – What You Need to Know

Change request (CR) 5890, from which this article is taken, provides that it is the claim/bill submitter's responsibility to obtain the national provider identifiers (NPIs) from the ordering, referring and attending, operating, other, service facility providers, or purchased service providers. Further, it requires that the provider or supplier who is furnishing the services or items, after unsuccessfully attempting to obtain the NPI from these providers; report their own name and NPI in the ordering/referring/attending/operating/other/service facility provider/purchased service provider fields of the claims.

GO – What You Need to Do

Make sure that your billing staffs are aware of this requirement to place the "furnishing" provider or supplier's name and NPI in the appropriate fields and to use your name and NPI if those of the ordering/referring and attending/operating/other/service facility provider/purchased service providers are not obtainable.

BACKGROUND

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The NPI final rule (45 CFR Part 162, CMS-045-F), published on January 23, 2004, established the NPI as this standard; and mandates that all entities covered under HIPAA (including health care providers) comply with the requirements of this NPI final rule.

Medicare previously required a unique physician identification number (UPIN) be reported on claims for any ordering, referring/attending, operating, other, and service facility providers (i.e., or for any provider that is not a billing, pay-to, or rendering provider). Further, in accordance with the NPI final rule; effective May 23, 2008, when reported on a claim, the identifier for such a provider must be an NPI, regardless of whether the provider is a covered entity, or participates in the Medicare program. **Therefore, Medicare will not pay for referred or ordered services, or items, unless the name and NPI number of the ordering, referring and attending, operating, other, or service facility provider are on the claim.**

Note: Physicians and the following nonphysician practitioners: 1) nurse practitioners (NP); 2) clinical nurse specialist (CNS); 3) physician assistants (PA); 4) and certified nurse midwives (CNM) are the only types of providers eligible to refer/order services or items for beneficiaries.

You should be aware that it is the claim/bill submitter's responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers' NPIs on the claim. If these providers do not directly furnish their NPIs to the billing provider at the time of the order, the billing provider must contact them to obtain their NPIs prior to delivery of the services or items.

If, after several unsuccessful attempts to obtain the NPI from the ordering, referring, attending, operating, other, service facility provider, or purchased service provider; CR 5890, from which this article is taken, requires that (effective May 23, 2008) the provider or supplier who is furnishing the services or items report their own name and NPI in the claim's ordering/referring/attending/operating/other/service facility provider/purchased service provider fields.

ADDITIONAL INFORMATION

You may find more information about reporting an NPI for ordering, referring and attending, operating, other, service facility providers for Medicare claims by going to CR 5890, located on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R235PI.pdf*.

If you have questions, please contact your Medicare carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5890 *Revised*
Related Change Request (CR) Number: 5890
Related CR Release Date: January 18, 2008
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

GENERAL INFORMATION

AMBULANCE FEE SCHEDULE FACT SHEET

The Ambulance Fee Schedule Fact Sheet, which provides general information about the Ambulance fee schedule, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AmbulanceFeeSched_508.pdf*.

Source: Provider Education Resources Listserv, Message 200802-15

AMBULATORY SURGICAL CENTER FEE SCHEDULE FACT SHEET NOW AVAILABLE

The Ambulatory Surgical Center Fee Schedule Fact Sheet, which provides general information about the ambulatory surgical center (ASC) fee schedule, ASC payments, and how ASC payment amounts are determined, 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 200803-06

CHANGE IN THE AMOUNT IN CONTROVERSY REQUIREMENT FOR ADMINISTRATIVE LAW JUDGE HEARINGS AND FEDERAL DISTRICT COURT APPEALS

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

PROVIDER TYPES AFFECTED

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

IMPACT ON PROVIDERS

This article is based on change request (CR) 5897, which notifies Medicare contractors of an increase in the amount in controversy (AIC) required to sustain administrative law judge (ALJ) and federal district court appeal rights beginning January 1, 2008. ***The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2008, is $110. The amount remaining in controversy requirement for requests made on or after January 1, 2008, is $120. For Federal District Court review, the amount remaining in controversy goes from $1,130 for requests prior to January 1, 2008, to $1,180 for requests on or after that date.***

BACKGROUND

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amended the Medicare claim appeal process. In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for annual reevaluation (beginning in 2005) of the dollar amount in controversy required for an administrative law judge (ALJ) hearing and federal district court review.

CR 5897 revises the *Medicare Claims Processing Manual* (Publication 100-4, chapter 29, section 330.1 and section 345.1) to update the AIC required for an ALJ hearing or federal district court review. As of January 1, 2008, the amount remaining in controversy must be at least $120 for an ALJ hearing or at least $1,180 for a federal district court review requested on or after January 1, 2008.

ADDITIONAL INFORMATION

The official instruction, CR 5897, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1437CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

If you have questions, please contact your Medicare carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS 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: MM5897
Related Change Request (CR) Number: 5897
Related CR Release Date: February 5, 2008
Related CR Transmittal #: R1437CP
Effective Date: January 1, 2008
Implementation Date: May 5, 2008

CHANGES TO THE PART B INTERACTIVE VOICE RESPONSE SYSTEM AVAILABILITY

The time frame in which providers can access specific claim and/or eligibility information via the interactive voice response (IVR) system has been revised. It is now available (except for regularly scheduled maintenance and holidays) as follows:

Monday - Friday 6:30 a.m. – 6:30 p.m. EST
Saturday 6:00 am – 4:00 pm p.m. EST

All other information is still available 24 hours a day, 7 days a week (except for maintenance and holidays as noted above) at 1-877-847-4992.

INFORMATIONAL DVD AVAILABLE FOR INDIAN HEALTH PROVIDERS

The Centers for Medicare & Medicaid Services (CMS) is making the following DVD available for Indian Health providers: Our Health, Our Community: Medicare, Medicaid and SCHIP outreach to American Indians/Alaskan Natives is a brief informational DVD on the benefits of enrolling in Medicare, Medicaid and SCHIP for the American Indian/Alaskan Native audience. This DVD may be used in hospital, clinic, and physician office waiting rooms, local TV stations, exhibits, training events, or any place American Indians and Alaskan Natives are gathered. (ICN# 6940) (Dec 2007) Run time is 7 mins, 51 seconds. This product is only for those providers that serve the American Indian and Alaskan Native populations. To order a free copy, go to the Medicare Learning Network MLN Product Ordering Page *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* and select the DVD title from the product list.

Source: CMS Provider Education Resource 200803-05

MARCH IS NATIONAL COLORECTAL CANCER AWARENESS MONTH

The goal of this national health observance is to increase awareness that colorectal cancer is largely preventable, treatable and beatable. In conjunction with National Colorectal Cancer Awareness Month, the Centers for Medicare & Medicaid Services (CMS) remind health care professionals that Medicare provides coverage for certain colorectal cancer screenings. Colorectal cancer affects both men and women of all racial and ethnic groups, and is most often found in people aged 50 years or older. And the risk for developing colorectal cancer increases with age.

MEDICARE COVERED COLORECTAL CANCER SCREENINGS

Medicare provides coverage of colorectal cancer screenings for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema rendered in place of the screening colonoscopy. An individual is considered to be at high risk for colorectal cancer if he or she has:

- had colorectal cancer before
- a history of polyps
- a family member who has had colorectal cancer or a history of polyps
- a personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colititis.

Medicare provides coverage for the following colorectal cancer screenings subject to certain coverage, frequency, and payment limitations:

- Fecal occult blood test (FOBT)
- Colonoscopy
- Sigmoidoscopy
- Barium enema (as an alternative to a covered screening flexible sigmoidoscopy or screening colonoscopy)

PREVENTION IS KEY

Colorectal cancer is the second leading cancer killer in the United States; however it doesn't have to be. Colorectal cancer is largely preventable through screening which can find precancerous polyps-abnormal growths in the colon or rectum-so that they can be removed before turning into cancer. Screening also helps find colorectal cancer at an early stage, when treatment can often lead to a cure. CMS needs your help to ensure that eligible Medicare patients get screened for colorectal cancer. Talk with your Medicare patients and their caregivers about the importance of being screened and those patients who were screened before entering Medicare should be encouraged to continue with screening at clinically appropriate intervals.

For More Information

- CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.
- The *MLN* Preventive Services Educational Products Web Page – provides descriptions and ordering information for *Medicare Learning Network* (*MLN*) preventive services educational products and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- Cancer Screenings Brochure – This tri-fold brochure provides health care professionals with an overview of cancer screenings covered by Medicare, including colorectal cancer screening services. *http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf*. To order copies of the brochure, go to the *MLN* Product Ordering Page located at: *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.
- For information to share with your Medicare patients, visit *http://www.medicare.gov*.

March is National Colorectal Cancer Awareness Month, continued

- For more information about National Colorectal Cancer Awareness Month, please visit *http://www.preventcancer.org/colorectal3c.aspx?id=1036*.

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

Source: Provider Education Resources Listserv, Message 200803-08

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.*

MARCH IS NATIONAL NUTRITION MONTH

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of nutrition, healthful eating and the medical nutrition therapy (MNT) benefit covered by Medicare. Approximately 8.6 million Americans1 at least 60 years or older are diagnosed with diabetes or acute renal failure. MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

MEDICARE COVERAGE

Medicare provides coverage of medical nutrition therapy (MNT) for beneficiaries diagnosed with diabetes and/or renal disease (except for those receiving dialysis) when provided by a registered dietitian or nutrition professional who meets the provider qualification requirements. The beneficiary's treating physician must provide a referral and indicate a diagnosis of diabetes or renal disease. Medicare provides coverage for three hours of MNT in the first year and two hours in subsequent years. Additional hours may be covered in certain situations. Note: For the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant for up to 36 months post transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [Glomerular Filtration Rate (GFR) 13-50 ml/min/1.73m2].

HELP US SPREAD THE WORD

As a trusted source of health care information, your patients rely on their physician's or other health care professional's recommendations. CMS needs your help to ensure that all eligible people with Medicare are aware of the medical nutrition therapy benefit. Talk with your eligible Medicare patients about the benefits of managing diabetes and renal disease through MNT and encourage them to make an appointment with a registered dietitian or nutrition professional qualified to provide MNT services covered by Medicare.

FOR MORE INFORMATION

CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- **The *MLN* Preventive Services Educational Products Web Page** – provides descriptions and ordering information for *Medicare Learning Network* (*MLN*) preventive services educational products and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- **Diabetes-Related Services Brochure** – This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf* To order copies of the brochure, go to the *MLN* Product Ordering System located at: *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* .

The CMS Web site provides additional information about the MNT benefit at *http://www.cms.hhs.gov/MedicalNutritionTherapy/.*

For information to share with your Medicare patients, visit *http://www.medicare.gov*.

For more information about National Nutrition Month®, please visit *http://www.eatright.org*.

Thank you for your support in helping CMS spread the word about the benefits of good nutrition, healthful eating and the medical nutrition therapy benefit covered by Medicare that may help people with Medicare learn to control and manage their medical conditions.

[1] The United States Renal Data System and National Diabetes Information Clearinghouse; *http://diabetes.niddk.nih.gov/dm/pubs/statistics*.

Source: CMS Provider Education Resource 200803-05

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SIGN UP TO OUR *eNEWS* ELECTRONIC MAILING LIST

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your 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.

The Medicare Appeals Process: Five Levels to Protect Providers

The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers brochure has been updated and is now available to order print copies or as a downloadable PDF file. To view the PDF file, go to *http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf* or to order hard copies, please visit the MLN Product Ordering Page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS Web site.

Source: CMS Provider Education Resource 200803-01

Opportunity to Participate in Third Annual Medicare Contractor Provider Satisfaction Survey Ends in April

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

Provider Types Affected

All Medicare physicians, providers, and suppliers billing the Medicare fee-for-service (FFS) program who were selected to participate in the Medicare Contractor Provider Satisfaction Survey (MCPSS) for 2008.

Provider Action Needed

Those Medicare providers who were selected by the Centers for Medicare & Medicaid Services (CMS) to participate in the MCPSS are asked to please take the time to complete the survey or respond to the survey contractor, Westat, follow-up calls. The survey is designed so that it can be completed in 15 minutes and responses may be submitted via a secure Web site, mail, fax, or over the telephone. Currently the average response rate is 32 percent; CMS' goal is to reach a 65 percent response rate. Data collection ends in April.

Background

The MCPSS offers providers the opportunity to contribute directly to CMS' understanding of contractor performance as well as aid future process improvement efforts of Medicare contractors (carriers, fiscal intermediaries, Medicare administrative contractors [A/B MACs], and durable medical equipment Medicare administrative contractors [DME MACs]). Specifically, the survey is used by CMS as an additional measure to evaluate contractor performance. In fact, all MACs will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

The MCPSS is designed to gather quantifiable data on provider satisfaction levels with the key services that comprise the provider-contractor relationship. The survey focuses on seven major parts of the relationship: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement.

Respondents are asked to rate their experience working with contractors using a scale of 1 to 6 with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The results of the second MCPSS showed that 85 percent of respondents rated their contractors between 4 and 6.

The 2007 MCPSS results indicate that the provider inquiry function has the greatest influence on whether providers are satisfied with their contractors. This indicated a shift from 2006, when the claims processing function was the strongest predictor of a provider's overall satisfaction.

"CMS and the Medicare contractor community are committed to high quality relationships with the provider community," CMS Acting Administrator Kerry Weems said in a recent CMS press release. "The MCPSS provides contractors with greater insight into their provider communities, and allows them to make process improvements based on provider feedback."

"The shift from claims processing to provider inquiries as the top predictor of satisfaction is a perfect example of the type of trend data the MCPSS will reveal," Weems said. "Contractors are able to factor this insight into how they prioritize their provider-focused efforts."

Additional Information

To review the complete report of the second MCPSS refer to: *http://www.cms.hhs.gov/mcpss/downloads/mcpss_report.pdf* on the CMS Web site. To review a summary of the 2007 MCPSS refer to *http://www.cms.hhs.gov/mlnmattersarticles/downloads/se0733.pdf* on the CMS Web site. CMS plans to make the survey results publicly available in July 2008. Further information about the MCPSS is available at *http://www.cms.hhs.gov/MCPSS* on the CMS Web site.

MLN Matters Number: SE0804
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Florida Provider Contact Center Training Closures

The Florida Part B Provider Contact Center will be closed from 8:00 – 10:00 a.m. on the following dates:

Friday, April 11, 2008

Friday, April 18, 2008

Friday, April 25, 2008

Our customer service representatives will be undergoing training during the above referenced times.

Although our customer service representatives will not be available, the Medicare Part B Interactive Voice Response (IVR) unit will be available as usual at 1- 877-847-4992 (toll-free).

2008 PHYSICIAN QUALITY REPORTING INITIATIVE UPDATE

PHYSICIAN QUALITY REPORTING INITIATIVE: OPPORTUNITY TO SUGGEST MEASURES FOR CONSIDERATION FOR INCLUSION IN 2009

The Centers for Medicare & Medicaid Services (CMS) is now accepting quality measure suggestions for consideration for possible inclusion in the proposed set of quality measures to be published in the 2009 Medicare physician fee schedule (MPFS) proposed rule for the Physician Quality Reporting Initiative (PQRI).

For more information on this opportunity to suggest measures for consideration for inclusion in 2009, please go to *http://www.cms.hhs.gov/PQRI*, and select the Measures/Codes tab on the left side of the page. Next, scroll down to the Downloads section and select "Notice of 2009 Measure Suggestions."

UPDATES TO THE 2008 PQRI TOOL KIT

The PQRI Tool Kit has been updated to include a downloadable file containing Data Collection Worksheets for all 119 2008 PQRI quality measures. To access this file, please go to *http://www.cms.hhs.gov/PQRI*, and select the PQRI Tool Kit tab on the left side of the page. Then, scroll down to the Downloads section and select "2008 PQRI Data Collection Worksheets."

NEW FREQUENTLY ASKED QUESTIONS (FAQS)

CMS updates the FAQs for PQRI on an ongoing basis, as inquiry volumes and new program developments indicate the need for new or updated FAQs. The following new FAQs may be of particular interest at this time, as they focus on the process for validating whether a professional participating in the 2008 PQRI is reporting on a sufficient number of measures.

#8973 - Question: Is there a measure applicability validation (MAV) process for 2008 Physician Quality Reporting Initiative (PQRI)?

#8973 - Answer: Yes. The PQRI 2008 Measure Applicability Validation Process for Claims-Based Participation is described in a document available for download from the Analysis and Payment page of the PQRI section of the CMS Web site (*http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage*).

#8974 - Question: How does the two-step validation process work for the Physician Quality Reporting Initiative (PQRI)?
#8974 - Answer: Professionals who report successfully on each of fewer than three measures are subject to the 2008 PQRI Measure Applicability Validation (MAV) process for claims-based participation. Professionals who report on three or more measures are not subject to MAV. (The 2008 PQRI Measure Finder Tool is available to assist you in finding measures that may apply to your practice, and is available for download from the PQRI Toolkit page of the CMS Web site at: *http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIMeasureFinderTool.zip*).

Step 1 of MAV relates measures to one another by placing them in closely related clusters. This test is based on the concept that if one measure in a cluster of measures related to a particular clinical topic or professional service is applicable to a professional's practice, then other closely related measures (measures in that same cluster) may also be applicable. The 2008 PQRI MAV clusters and the measures included in each are described in the document titled "2008 Measure-Applicability Validation Process for Claims-Based Participation," which is available for download from the Analysis and Payment page of the PQRI section of the CMS Web site. CMS has not included in any clusters certain measures that are not suited for MAV clustering in the 2008 PQRI, for reasons described in the MAV process document.

Step 2 of MAV looks to see if an eligible professional treated more than a minimum number (threshold) of eligible cases that met the requirements of other measures within the cluster. For 2008 claims-based participation in PQRI, measure-specific thresholds may be determined based on analysis of data that will become available during the reporting period. In no case, however, will any measure's 2008 PQRI applicability threshold be less than 30 reportable instances. The cases to which a measure applies are identified by the line-item diagnosis and service codes billed for each rendering NPI. Any complicating diagnoses on the Part B base claim are not considered in 2008 PQRI analyses for claims-based participation. Cases that count toward the applicability threshold for any individual NPI will also not include those for which the qualifying diagnosis and procedure codes are identified by another rendering professional's individual NPI. Eligible professionals who pass Step 2 of 2008 PQRI MAV will be eligible for the PQRI incentive payment.

Source: Provider Education Resources Listserv, Message 200802-18

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.

UPIN AND/OR NPI REQUIRED FOR IMMUNOSUPPRESSIVE DRUGS

This article was previously published in the December 2006 *Medicare B Update!* (page 31). This article serves as a reminder that effective for claims processed on or after October 26, 2006, immunosuppressive drugs are being denied as unprocessable if submitted without a valid unique physician identification number (UPIN). Currently, these claims may be submitted with a national provider identifier (NPI)/UPIN pair or NPI only. However, effective for claims received on or after May 23, 2008, immunosuppressive drugs will be denied as unprocessable if submitted without a valid NPI. Providers will need to resubmit a new claim with a valid NPI. The following is a list of the immunosuppressive drug codes to which these rules apply.

IMPACTED PROCEDURE CODES

J0480	J0702	J0704	J0800	J1020	J1030	J1040	J1094
J1100	J1700	J1710	J1720	J2650	J2920	J2930	J3301
J3302	J3303	J7500	J7501	J7502	J7504	J7505	J7506
J7507	J7509	J7510	J7511	J7513	J7515	J7516	J7517
J7518	J7520	J7525	J7599	J7624	J7637	J7638	J7683
J7684	J8530	J8540	J8610				

Source: CMS IOM, Publication 100-04, Chapter 26, Section 10.4

ROUND ONE OF THE MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

The Centers for Medicare & Medicaid Services (CMS) has announced the single payment amounts for round one of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

Please visit the CMS Web site at *www.cms.hhs.gov/CompetitiveAcqforDMEPOS/* to view additional information. To view the press release, please click: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: Provider Education Resources Listserv, Message 200803-10

SIGN UP TO OUR *eNEWS* ELECTRONIC MAILING LIST

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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-righ-hand corner of the page and follow the prompts.

MORE INFORMATION

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

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

LOCAL COVERAGE DETERMINATIONS - TABLE OF CONTENTS

REVISION TO THE LCDS

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 LCDS

J9170: DOCETAXEL (TAXOTERE®)—REVISION TO THE LCD

The local coverage determination (LCD) for docetaxel (Taxotere®) was last updated on April 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, for docetaxel – J9170.

A revision was made updating FDA-approved verbiage for locally advanced squamous cell carcinoma of the head and neck by removing the word "inoperable" from this indication under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. This indication now reads as follows:

> Docetaxel in combination with cisplatin and fluorouracil is indicated for the induction treatment of patients with locally advanced squamous cell carcinoma of the head and neck.
>
> In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

EFFECTIVE DATE

This revision to the LCD is effective for services rendered on or after September 28, 2007. The full text of this LCD is available through our provider education Web site *http://www.fcso.com*.

J9355: TRASTUZUMAB (HERCEPTIN®)—REVISION TO THE LCD

The local coverage determination (LCD) for trastuzumab (Herceptin®) was last updated on April 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, for trastuzumab – J9355.

Revisions for FDA-approved indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD and included a new indication for adjuvant breast cancer following multi-modality anthracycline based therapy. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated, and "Dosage and Administration" information was added under the "Utilization Guidelines" section of the LCD.

EFFECTIVE DATE

This revision to the LCD is effective for services rendered on or after January 18, 2008. The full text of this LCD is available through our provider education Web site *http://www.fcso.com*.

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.

CONNECTICUT EDUCATIONAL RESOURCES

UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS

APRIL 2008 – MAY 2008

EVALUATION & MANAGEMENT - "CRITICAL CARE" WEBCAST

Topic: Critical Care Services
When: April 15, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

BACK TO BASICS MEDICARE SEMINAR

Topic: Modifiers, CMS-1500/NPI, MSP & Self-Service Tools
When: April 17, 2008
Time: 8:30 a.m. – 4:15 p.m.
Type of Event: In person Seminar

EVALUATION & MANAGEMENT - INPATIENT HOSPITAL SERVICES WEBCAST

Topic: Inpatient Hospital Services
When: May 20, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

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 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.

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

Fax – If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to (904) 361-0407. Keep listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events!

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to event advertisement.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

There's always something going on in Provider Outreach & Education! Keep checking the Connecticut area of *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 the eLearning section in the Connecticut area of *www.fcso.com* to take self-paced Web-based training classes.

FLORIDA EDUCATIONAL RESOURCES

UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS

APRIL 2008 – MAY 2008

EVALUATION & MANAGEMENT - "CRITICAL CARE" WEBCAST
Topic: Critical Care Services
When: April 15, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

HOT TOPICS: MEDICARE UPDATES WEBCAST
When: May 15, 2008
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Webcast

2008 MEDIFEST SYMPOSIUM
When: May 6 & 7, 2008
Where: Marriott Orlando Downtown
400 West Livingston Street
Orlando, FL 32801
(407) 843-6664
Type of Event: In person seminar/symposium

EVALUATION & MANAGEMENT – "SUBSEQUENT HOSPITAL CARE" WEBCAST
When: May 20, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

TWO EASY WAYS TO REGISTER

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

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

Fax – If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to (904) 361-0407. Keep listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events!

PLEASE NOTE:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to event advertisement.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

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

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

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

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

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

Attention: Financial Services
Use this attention line to return duplicate payments or overpayment refunds.

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

Attention: 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

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

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

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 ♦