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
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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

FIRST COAST SERVICE OPTIONS UNVEILS "NEWS & BULLETINS" PAGE

First Coast Service Options, Inc (FCSO) is pleased to announce the latest enhancement to our Web site: the "News & Bulletins" page. By bringing together Medicare articles and FCSO publications in one convenient location, this section is your one-stop for the latest Medicare news.

SAME LOCATION, NEW TITLE

With this launch, publications are now found by selecting the "News & Bulletins" link in the Quick Find menu on the Medicare Part A (Florida only) and Part B (Connecticut and Florida) main pages. To view or download publications, select the "Archives" link in the Topics Menu Bar at the top of the page.

All articles released during the month will be posted to this "News & Bulletins" page. Similar to an electronic magazine, this page builds chronologically with each new article released so that providers can stay up-to-date on the latest Medicare news.

At the end of the month, many of these articles will then be archived into our Medicare A Bulletin (Florida only) and/or Medicare B Update! publications (Connecticut and Florida). Those articles not included in our publications will remain on the appropriate Web site pages.

IMPROVED LAYOUT

Another change is the addition of a Topics Menu Bar, located at the top of the page, which organizes all articles by topic or specialty. Gone are the days of scrolling down a long list of articles! By clicking directly on your area of interest, this menu allows visitors to easily locate the articles most relevant to them.

These topic headings are modeled after the subject categories found in our Medicare A Bulletin (Florida only) and Medicare B Update! publications (Connecticut and Florida). If there are no articles yet released for a particular topic, you will see the message, "There are no updates in this section at this time."

As a reminder, you can still locate many of these articles on the topic and specialty pages throughout our Web site.

We need your feedback! Please let us know what you think about this latest enhancement by completing our Web Site Feedback. You can access this form in the "Contact" link located in the upper right corner of our Web site.

2008 FLORIDA MEDIFEST SYMPOSIUM—REGISTER TODAY

Registration is now open for FCSO's 2008 Medifest Symposium occurring on May 6 & 7 in Orlando, FL. This popular education seminar brings together Medicare experts, clinicians, billing staff, coders and suppliers throughout Florida to learn the latest on the Medicare program and to network with their peers. This year's Medifest is located at:

Marriott Orlando Downtown
400 West Livingston Street
Orlando, FL 32801
(407) 843-6664 or (800) 574-3160

FCSO is working hard to make this the most rewarding Medifest ever. Take a look at the changes coming this year…

- **Two 1-Day Sessions**. We will conduct Medifest as two 1-day sessions to accommodate providers' busy schedules. The cost to attend is $136 per person, per day.
- **Advanced Courses**. With our new training Web site, the LMS, FCSO now offers providers convenient and free access to its introductory-level Medicare courses. This allows us to devote this year's Medifest to more advanced courses targeted at experienced Medicare providers.
- **Mandatory Prerequisite Courses**. To ensure all participants benefit from the new advanced curriculum, some classes require completion of mandatory prerequisite Web-based Training (WBT) courses. All prerequisite courses are free and available through the LMS or CMS' Web site. Participants cannot register for classes with mandatory prerequisite WBTs until participants successfully complete them through the LMS.

In addition to the required prerequisites, we also suggest complementary WBT courses available through CMS' Web site. While these WBTs are not mandatory for registration, we encourage you to complete them.

To view the list of mandatory and recommended prerequisite WBT courses, as well as complete instructions on registering for this year's Medifest, visit our Web site at *www.fcso.com*. Click on "Florida Part A and B" under Medicare Providers, and select the "Provider Outreach & Education" tab.

This is the only Medifest event in Florida for 2008, and space is limited, so register early through the FCSO Medicare Training Web site, the Learning Management System (LMS), at *www.fcsomedicaretraining.com*. First-time users to LMS can set up an account using our user guide at *www.floridamedicare.com/Education/108651.asp*.

THE FCSO MEDICARE B UPDATE!

ABOUT THE CONNECTICUT AND FLORIDA *MEDICARE B UPDATE!*

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

The Provider Outreach & Education Publications team distributes the *Medicare B Update!* on a monthly basis.

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

WHO RECEIVES THE *UPDATE?*

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

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

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

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

CLEAR IDENTIFICATION OF STATE-SPECIFIC CONTENT

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

PUBLICATION FORMAT

The *Update!* is arranged into distinct sections.

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

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

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

QUARTERLY PROVIDER UPDATE

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

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

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

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

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

ADVANCE BENEFICIARY NOTICES

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

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

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

PATIENT LIABILITY NOTICE

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131form as part of the Beneficiary Notices Initiative (BNI) The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

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

ABN MODIFIERS

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

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

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

"GA" MODIFIER AND APPEALS

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

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

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

Connecticut
Medicare Part B Redeterminations Appeals
PO Box 45010
Jacksonville, FL 32232-5010

OR

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

SIGN UP TO OUR *eNEWS* ELECTRONIC MAILING LIST

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Medicare Providers, Connecticut or Florida, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

CLAIMS

EXTENSION OF THE DATES OF SERVICE ELIGIBLE FOR THE PHYSICIAN SCARCITY AREA BONUS PAYMENT

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

PROVIDER TYPES AFFECTED

Physicians, and other providers, who bill Medicare contractors (fiscal intermediaries [FI], carriers, or Medicare administrative contractors [A/B MAC]) for providing services to Medicare beneficiaries in designated physician scarcity areas (PSAs).

WHAT YOU NEED TO KNOW

CR 5937, from which this article is taken, announces the extension of the PSA bonus payment for dates of service through June 30, 2008. You should make sure that your billing staffs are aware of this PSA bonus payment extension.

BACKGROUND

Section 413(a) of the Medicare Modernization Act of 2003 (MMA) required the Centers for Medicare & Medicaid Services (CMS) to pay a 5 percent bonus to physicians in a designated PSA for dates of service from January 1, 2005 through December 31, 2007. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 amended Section 1833(u)(1) of the Social Security Act, extending the payment of the PSA bonus for dates of service through June 30, 2008. CR 5937, from which this article is taken, announces this extension and provides Medicare contractors with implementing instructions.

Medicare contractors will continue to pay PSA bonuses for dates of service from January 1, 2005 through June 30, 2008, regardless of whether the bonus is requested through submission of a modifier or made through an automated payment based on ZIP code. The primary care and specialty care scarcity areas in effect on December 31, 2007 will be used for 2008 services. FI and A/B MACs processing Part A claims will implement this CR on January 7, 2008, and carriers and A/B MACs processing Part B claims will implement it 30 days from issuance.

Carriers and A/B MACs processing Part B claims will Identify claims that contain modifier AR (physician providing services in a PSA) and are submitted with dates of service on or after January 1, 2008, and processed prior to this CR's implementation so that they may be included in the calculation in the first quarterly 2008 bonus payment. Additionally, when brought to their attention, carriers and A/B MACs processing Part B claims will re-open and re-process claims with these dates of service that are processed prior to the CR's implementation date in order to include modifier AR and make the appropriate bonus payment.

ADDITIONAL INFORMATION

You may find the official instruction, CR 5937, issued to your FI, carrier, or A/B MAC by visiting the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1434CP.pdf*.

The updated *Medicare Claims Processing* manual, chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), sections 250.2.1 (Billing and Payment in a Physician Scarcity Area (PSA)) and 250.2.2 (Zip Code Files); and *Medicare Claims Processing* manual, Chapter 12 (Physicians/Nonphysician Practitioners, Sections 90.5 (Billing and Payment in a Physician Scarcity Area (PSA)) and 90.5.2 (Identifying Physician Scarcity Area Locations) are attachments to that CR.

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: MM5937
Related Change Request (CR) Number: 5937
Related CR Release Date: February 5, 2008
Related CR Transmittal Number: R1434CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008 for contractors processing claims from institutions; no later than 30 days from issuance for carriers and A/B MACs processing professional claims.

AMBULANCE

REVISION TO CERTIFICATION FOR HOSPITAL SERVICES COVERED BY THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM AS IT PERTAINS TO AMBULANCE SERVICES

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

Note: Change request (CR) 5684 was rescinded and replaced by CR 5833. To view the *MLN Matters* article related to CR 5833, go to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5833.pdf* on the CMS Web site. This information was previously published in the February 2008 Medicare B Update! page 9.

MLN Matters Number: MM5684 *Revised*
Related Change Request (CR) #: 5684
Related CR Release Date: August 17, 2007
Effective Date: September 17, 2007
Related CR Transmittal #: R47GI
Implementation Date: September 17, 2007

AMBULATORY SURGICAL CENTER

ADDITIONAL PAYABLE HEALTHCARE COMMON PROCEDURE CODING SYSTEM "C" DRUG CODES IN AMBULATORY SURGICAL CENTERS

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

PROVIDER TYPES AFFECTED

Ambulatory surgical centers (ASC) submitting 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) 5885 which lists additional payable healthcare common procedure coding system (HCPCS) "C" drug codes for ASCs.

CAUTION – WHAT YOU NEED TO KNOW

CR 5885 instructs Medicare contractors to modify systems to accept four additional Healthcare Common Procedure Coding System (HCPCS) "C" codes (C9327, C9240, C9354, and C9355) and ensure that these HCPCS "C" codes are processed and paid using the same payment and claims processing policies issued by the Centers for Medicare & Medicaid Services (CMS) for the 2008 revision to the ASC payment system.

GO – WHAT YOU NEED TO DO

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

BACKGROUND

A final list of ASC payable HCPCS codes for January 1, 2008 was released in the recently issued ASC final rule (CMS-1392-FC) in the *Federal Register* (November 27, 2007).

However, there were four "C" codes recognized as payable in the ASC setting by the Centers for Medicare & Medicaid Services (CMS) that were approved too late in the process to be included in the *Federal Register's* final rule issuance. In addition, these "C" codes were not annotated as ASC payable codes in the 2008 HCPCS file release.

CR 5885 instructs that the following HCPCS "C" codes will be included on the final version ASC DRUG file released by CMS, as discussed in CR 5831.

HCPCS "C" Code	Descriptor	Effective Date
C9237	Inj, lanreotide acetate	January 1, 2008
C9240	Injection, ixabepilone	January 1, 2008
C9354	Veritas collagen matrix, cm2	January 1, 2008
C9355	Neuromatrix nerve cuff, cm	January 1, 2008

CR 5885 also instructs Medicare contractors that when these HCPCS "C" codes are submitted by ASCs for payment, they will be processed and paid using the same payment and claims processing policies issued by CMS for the 2008 revision to the ASC payment system.

Medicare contractors will make available to ASCs both:

- A list of all HCPCS that are payable in ASCs for 2008, including the additional HCPCS codes

ADDITIONAL PAYABLE HCPCS "C" DRUG CODES IN ASCS, CONTINUED

- The wage adjusted payment rates of these HCPCS codes, for those ASCs in their jurisdiction.

ADDITIONAL INFORMATION

The official instruction, CR 5885, issued to your Medicare carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1415CP.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: MM5885
Related Change Request (CR) #: 5885
Related CR Release Date: January 18, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1415CP
Implementation Date: January 30, 2008

2007 UPDATE OF HCPCS CODES AND PAYMENTS FOR AMBULATORY SURGICAL CENTERS

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

Note: This article was revised on January 24, 2008, to add a reference to SE0742. SE0742 announced that CMS was implementing significant revisions to the payment system for ASC services beginning with services rendered on or after January 1, 2008. SE0742 may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0742.pdf* on the CMS Web site. All other information remains the same. This information was previously published in the January 2007 *Medicare B Update!* page 7.

PROVIDER TYPES AFFECTED

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

IMPACT ON PROVIDERS

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

BACKGROUND

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

- The lesser of the Medicare Hospital Outpatient Prospective Payment System (OPPS) payment amount, or
- The ASC payment amount for services furnished on or after January 1, 2007.

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

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

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

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

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

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

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

2007 UPDATE OF HCPCS CODES AND PAYMENTS FOR ASCS, CONTINUED

ADDITIONAL INFORMATION

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

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

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

AMBULATORY SURGICAL CENTER CLAIMS PROCESSING MANUAL CLARIFICATION

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

Note: This article was revised on January 24, 2008, to add a reference to SE0742. SE0742 announced that CMS was implementing significant revisions to the payment system for ASC services beginning with services rendered on or after January 1, 2008. SE0742 may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0742.pdf on the CMS Web site. All other information remains the same.

PROVIDER TYPES AFFECTED

Providers and suppliers of ambulatory surgical center (ASC) services

PROVIDER ACTION NEEDED

This article is for informational purposes. CR 5026 revises the *Medicare Claims Processing Manual*, chapter 14 (Ambulatory Surgical Centers), sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services) and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) to clarify policy regarding the provision, coverage, and payment of services furnished in an ASC.

BACKGROUND

Medicare conventionally reimburses ASCs in the form of a single payment that includes all "facility services" that the ASC furnishes in connection with a covered procedure. However, an ASC (perhaps as part of a medical complex that may include other entities, such as an independent laboratory, supplier of durable medical equipment, or a physician's office) may also furnish a number of covered items and services that are not considered facility services.

Be aware that such entities, which are separate from the ASC, are covered separately under Part B. Further, in general, the items or services that these entities provide are not considered ASC services, and are therefore not included in the ASC payment, but are rather covered and paid for under the applicable Part B provisions.

Examples of such services include:

- Physicians' services
- Durable medical equipment (DME)
- Implantable DME
- Prosthetic devices
- Ambulance services
- Leg, arm, back and neck braces
- Artificial legs, arms and eyes
- Services of an independent laboratory.

More details about each of these services are shown in the following table.

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.

ASC CLAIMS PROCESSING MANUAL CLARIFICATION, CONTINUED

Table 1 - Examples of Services Not Included in the ASC Facility Rate

Items or Services	Who Receives Payment	Submit Bills To
Physicians' services Physicians who perform covered services in ASCs receive separate payment under Part B. Such services include: Anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patients' recovery from the anesthesia; Routine pre- or post- operative services, such as office visits, consultations, diagnostic tests, suture removal, dressing changes, and other services which are usually included in the physician fee for a given surgical procedure.	Physician	Carrier
Non-implantable durable medical equipment (DME) to ASC patients for in home use. ASCs who sell, lease, or rent items of DME to patients, are treated as DME suppliers. All of the ordinary DME-applicable rules and conditions apply to the ASC, including obtaining a supplier number and billing the DMERC as required.	Supplier An ASC can be a supplier of DME if it has a DME supplier number from the National Supplier Clearinghouse.	DMERC
Implantable DME and accessories ASCs who furnish implantable DME items to patients, bill the local carrier for the surgical procedure and the implantable device.	ASC	Carrier
Non-implantable prosthetic devices ASCs who furnish non-implantable prosthetic devices to patients, are treated as suppliers, and all the ordinary DME-applicable rules and conditions apply to the ASC, including obtaining a supplier number and billing the DMERC as required.	Supplier An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the National Supplier Clearinghouse.	DMERC
Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs [new technology intraocular lenses]), and accessories ASCs may bill and receive separate payment for prosthetic devices (other than intraocular lenses [IOLs]) that are implanted, inserted, or otherwise applied by surgical procedures on the ASC list of approved procedures. The ASC bills the local Carrier and receives payment according to the DMEPOS fee schedule. An intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC is included in the facility payment rate. ASCs may receive additional payment for approved NTIOLs that are furnished in an ASC during or subsequent to certain cataract procedures.	ASC	Carrier
Ambulance services ASCs who furnish ambulance services, may obtain approval as ambulance suppliers to bill covered ambulance services.	Certified ambulance supplier	Carrier

ASC CLAIMS PROCESSING MANUAL CLARIFICATION, CONTINUED

Items or Services	Who Receives Payment	Submit Bills To
Leg, arm, back, and neck braces These items of equipment are not included in the ASC facility payment amount, but are covered under Part B. ASCs who furnish these items to patients, are treated as suppliers, and all the rules and conditions ordinarily applicable to apply to the ASC, including obtaining a supplier number and billing the DMERC as required.	Supplier	DMERC
Artificial legs, arms, and eyes These items of equipment are not included in the ASC facility payment rate, but are covered under Part B. ASCs who furnish these items to patients, are treated as suppliers, and all the rules and conditions ordinarily applicable to suppliers apply to the ASC, including obtaining a supplier number and billing the DMERC as required.	Supplier	DMERC
Services furnished by an independent laboratory Only very limited numbers, and types, of diagnostic tests are considered ASC facility services and these are included in the ASC facility payment rate. Since coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics or hospitals is limited to facilities that meet the statutory definition of an independent laboratory, in most cases, diagnostic tests performed directly by an ASC are not considered ASC facility services (in fact are usually not covered under Medicare). ASC laboratories must be CLIA certified and will need to enroll with the carrier as a laboratory. Otherwise, the ASC makes arrangements with a covered laboratory or laboratories for laboratory services. If the ASC has a certified independent laboratory, the laboratory itself bills the carrier.	Certified lab. ASCs can receive lab certification and a CLIA number.	Carrier
Procedures NOT on the ASC list Physicians bill the carrier for the procedures and any implantable prosthetics/DME, using the ASC as the place of service.	Physician	Carrier

ADDITIONAL INFORMATION

You may find more information about services not included in the ASC facility rate (and the coverage of such services) by reviewing CR 5026, which is available at *http://www.cms.hhs.gov/Transmittals/downloads/R975CP.pdf* on the CMS Web site.

The revised *Medicare Claims Processing Manual,* Chapter 14 (Ambulatory Surgical Centers), Sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services) and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) are attached to CR 5026.

If you have any questions, please contact your carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf* 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: MM5026 *Revised*
Related Change Request (CR) #: 5026
Related CR Release Date: June 9, 2006
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Related CR Transmittal #: R975CP
Implementation Date: June 5, 2006

REVISED PAYMENT SYSTEM FOR AMBULATORY SURGICAL CENTERS IN CALENDAR YEAR 2008

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

Note: This article was revised on February 21, 2008, to add a reference to MLN Matters article MM5680 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5680.pdf*), which provides additional information on the background, policy, and instructions that your Medicare contractor will use to implement this revised payment system. The article was previously updated on January 31, 2008, to reflect that CMS issued a combined OPPS/ASC final rule on November 27, 2007. That rule includes updates to the ASC payment rates for calendar year (CY) 2008 and a link to that rule is in this article. This information was previously published in the November 2007 Medicare B Update! pages 10-15.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

STOP – Impact to You

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

CAUTION – What You Need to Know

On August 2, 2007, CMS issued a final rule (available at *http://www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp#TopOfPage* on the CMS Web site) that describes the revised ASC payment system. The revised ASC payment system provides a transition to the revised rates for currently covered ASC services from CY 2008 through CY 2010, during which time payments are based on a blend of the payment rates from the existing system and the revised payment rates calculated according to the methodology of the revised payment system. On November 27, 2007, CMS issued a combined outpatient prospective payment system (OPPS)/ASC final rule that includes updates to the ASC payment rates for CY 2008. The CY 2008 OPPS/ASC final rule is available at *http://www.cms.hhs.gov/ASCPayment/04f_CMS-1392-FC(ASC).asp#TopOfPage* on the CMS Web site.

GO – What You Need to Do

Be sure your billing personnel are aware of the new system and the coding requirements of the new system in order to assure prompt and accurate payment.

Overview

The August 2, 2007 ASC final rule (CMS-1517-F) outlines the policies for the revised ASC payment system. As recommended by the November 2006 Government Accountability Office report on ASC payment, CMS used the OPPS relative payment weights as a basis for payment under the revised ASC payment system. The payment policies for the revised ASC payment system expand the types of procedures that are eligible for Medicare payment when performed in the ASC setting, limit ASC payments for procedures that are performed predominantly in physicians' offices to the amount that would be paid for the non-facility practice expense (PE) under the Medicare physician fee schedule (MPFS), and allow for separate payment to ASCs for covered ancillary services that are provided integral to covered surgical procedures.

The November 27, 2007 OPPS/ASC final rule (CMS-1892-FC) provides updates to the CY 2008 ASC conversion factor and ASC payment rates.

There are currently about 4,800 ASCs enrolled in Medicare. Total Medicare expenditures for CY 2006 payments to ASCs are estimated at about $2.5 billion. Medicare ASC expenditures for CY 2008 are expected to be approximately $3 billion.

BACKGROUND

Since 1982, Medicare has paid for certain surgical procedures, including cataract removal, lens replacement, and colonoscopies, when performed in freestanding or hospital-based ASCs. Under the previous ASC payment system, Medicare paid for more than 2,500 surgical procedures on the ASC approved list, based on a simple fee schedule comprised of nine unadjusted prospectively determined payment rates. The rates of the nine payment groups, prior to the "limitation on payments" adjustment, ranged from $333 to $1339. Provider payments included a separate adjustment for geographic wage variation, and Medicare made a separate payment to physicians for professional services. ASC payment rates were last rebased in March 1990 using cost, charge, and utilization data from a 1986 survey of ASC costs.

With the passage of the MMA, Congress required CMS to revise the ASC payment system no later than January 1, 2008. In August of 2006, CMS issued a proposed rule encompassing proposed changes to OPPS policies and updates to the CY 2007 OPPS and ASC payment rates and the revised payment methodology for ASCs for CY 2008 implementation. The CY 2007 OPPS and ASC provisions were finalized in a final rule published November 24, 2006, and ASC policies related to the revised payment system to be implemented CY 2008 were finalized in the August 2, 2007 final rule.

Final ASC Revised Payment System Policies

Expanded List of ASC Procedures:

In the August 2, 2007 ASC final rule (CMS-1517-F), Medicare revised its criteria for identifying surgical procedures eligible for inclusion on the list of covered ASC procedures. The revised criteria resulted in expanded beneficiary access to procedures in the ASC setting by allowing approximately 790 additional surgical procedures on the list for CY 2008. Under the revised criteria, Medicare excludes only those surgical procedures determined to pose a significant safety risk to beneficiaries or that are expected to require an overnight stay following the procedure from the list of covered surgical procedures.

Medicare continued its policy to define surgical procedures as those listed by the American Medical Association (AMA) within the surgical range of *Current Procedural Terminology* (*CPT*) codes. It also included within the scope of surgical

REVISED PAYMENT SYSTEM FOR ASCS IN CALENDAR YEAR 2008, CONTINUED

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

In the CY 2008 OPPS/ASC final rule (CMS-1392-FC), CMS revised the lists of covered surgical procedures and covered ancillary services in response to public comments and in order to maintain consistency with revised OPPS policies. In addition, based on review of the most recent utilization data, a number of surgical procedures newly added for payment in CY 2008 in the ASC final rule were designated as office-based procedures and, therefore, are subject to the "office-based" payment methodology. A complete list of ASC covered surgical procedures, along with payment rates and payment indicators, is published in Addendum AA to this rule, and is available on the CMS Web site at http://ww.cms.hhs.gov/ASCPayment/ on the CMS Web site. Information related to ASC covered ancillary services is available in Addendum BB of the rule, also available on the CMS ASC payment Web site.

ASC Payment Rates Under the Revised System:

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

To establish the budget neutrality adjustment for the revised ASC payment system, CMS took into account the expected migration of surgical procedures among ASCs, physicians' offices, and hospital outpatient departments (HOPDs). The methodology assumed that approximately 25 percent of the HOPD volume of new ASC surgical procedures will migrate from hospitals to ASCs during the first two years of implementation of the revised ASC payment system and that 15 percent of the volume of new ASC surgical procedures currently provided in physicians' offices will migrate to ASCs during the first four years of the revised ASC payment system.

The illustrative budget neutrality adjustment factor of 67 percent for CY 2008 included in the August 2, 2007 final rule, (CMS-1517-F) was based on those assumptions and estimated CY 2008 OPPS and MPFS rates and full CY 2005 utilization data. The final ASC budget neutrality adjustment factor of 65 percent is presented in the OPPS/ASC final rule (CMS-1392-FC). The final budget neutrality adjustment factor is somewhat lower than the illustrative adjustment presented in the August 2, 2007 ASC final rule due to changes in OPPS payment rates as a result of APC recalibration, including the expansion of the size of the OPPS payment bundles, as well as use of CY 2006 claims and utilization data. Based on the final budget neutrality adjustment factor (65 percent), the ASC conversion factor for CY 2008 is calculated as 0.65 x $63.694 (CY 2008 OPPS conversion factor) = $41.401.

The standard ASC payment for covered surgical procedures is calculated as the product of the ASC conversion factor and the ASC relative payment weight (set based on the OPPS relative payment weight) for each separately payable procedure. Per Section 626 of the MMA, under the revised ASC payment system, contractors will pay ASCs 80 percent of the lesser of the actual charge for the services or the ASC payment rate. ASC payment rates for covered surgical procedures that are determined to be "office-based" and covered ancillary radiology procedures may not exceed the MPFS non-facility PE amounts for those services.

Payments to ASCs for covered surgical procedures and certain covered ancillary services are geographically adjusted using the pre-reclassification wage index that CMS uses to pay non-acute providers, with 50 percent as the labor-related factor.

Implementation and Updates:

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

In the annual updates to the ASC payment system, ASC relative payment weights will be set equal to the OPPS weights and will be scaled in order to maintain budget neutrality in the ASC payment system. Without scaling, changes in the OPPS relative payment weights for nonsurgical services could cause an increase or decrease in ASC expenditures due to differences between the mix of services provided by HOPDs and ASCs.

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

ASC Payment for Device-Intensive Procedures:

A modified payment methodology is used to establish the ASC payment rates for device-intensive procedures, defined as ASC covered surgical procedures that, under the OPPS, are assigned to APCs for which the device cost is greater than 50 percent of the APC's median cost. Payment for the high cost devices is packaged into the associated procedure payments under the revised ASC system, as it is under the OPPS. Medicare pays the same amount for the device-related portion of the procedure cost under the revised ASC payment system as under the OPPS. However, payment for the service portion of the ASC rate is calculated according to the standard rate setting methodology, using the ASC budget neutrality adjustment. Therefore, the service portion of the ASC payment for a device-intensive procedure is about 65 percent of the corresponding OPPS service payment, just like the payment for other surgical procedures under the revised ASC payment system. The sum of the ASC device and service portions constitutes the complete ASC procedure payment. ASCs should not report separate charges for devices.

The same policy related to full credit and no cost implantable device replacement that applies under the OPPS applies under the revised ASC payment system. That is, when a replacement device is supplied to the ASC at no cost or with full credit by the manufacturer, Medicare ASC payment for the procedure to implant the device is reduced by the device portion of

REVISED PAYMENT SYSTEM FOR ASCS IN CALENDAR YEAR 2008, CONTINUED

the ASC payment to account for the lower cost to the facility to furnish the procedure. Medicare provides the same amount of payment reduction based on the estimated device cost included in the ASC procedure payment that would apply under the OPPS for performance of those procedures under the same circumstances.

In the CY 2008 OPPS/ASC final rule (CMS-1392-FC), CMS implemented a policy to reduce the ASC payment by one half of the device offset amount for certain surgical procedures into which the device cost is packaged when an ASC receives a partial credit toward replacement of an implantable device. This partial payment reduction policy applies to certain covered surgical procedures in which the amount of the device credit is greater than or equal to 50 percent of the cost of the new replacement device being implanted. The ASC policy mirrors the policy under the OPPS for CY 2008. A special edition *MLN Matters* article, SE0732, provides details and billing guidance on the OPPS/ASC partial device credit policy and is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0732.pdf* on the CMS Web site.

Payment for ASC Covered Ancillary Services:

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

In the OPPS/ASC final rule with comment (CMS-1392-FC), CMS revised the definitions of "radiology and certain other imaging services" and "outpatient prescription drugs" to exclude those ASC covered ancillary radiology services and covered ancillary drugs and biologicals from designation as "designated health services," which are subject to physician self-referral prohibitions. Implanted brachytherapy sources qualify for inclusion in 42 C.F.R. section 411.355(f) and, as such, also are excepted from the physician self-referral prohibition.

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

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

Medicare makes separate payment at contractor-priced rates for devices that have pass-through status under the OPPS when the devices are an integral part of a covered surgical procedure. Medicare pays the same amount for brachytherapy sources under the revised ASC payment system as it pays hospitals under the OPPS if prospective rates are available. For the first six months of CY 2008, when OPPS payments for brachytherapy sources are cost-based, ASCs are paid for brachytherapy sources at contractor-priced rates.

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

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

Physician Payment for Noncovered ASC Procedures:

ASCs receive facility payments under the ASC payment system only for procedures included on the list of ASC covered procedures. They receive no facility payment for any other procedures. Prior to implementation of the revised ASC payment system on January 1, 2008, physicians were paid for their PE based on the facility PE relative value units (RVUs) for performing surgical procedures that were on the list of ASC covered surgical procedures. They were paid based on the nonfacility PE, or technical component RVUs, for performing services that were not included on the list.

To make the payments to physicians who furnish noncovered procedures in ASCs more consistent with the policy under the OPPS, and in recognition that under the revised ASC payment system only procedures that have been determined to pose a significant safety risk or are expected to require an overnight stay are excluded from the ASC list, beginning January 1, 2008, Medicare pays physicians at the facility PE payment amount, rather than the nonfacility PE amount, for furnishing noncovered procedures in ASCs.

New and Revised Billing Procedures

Reporting Separately Payable Ancillary Services:

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

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

Additionally, ASCs must bill separately for devices that have pass-through status under the OPPS when provided integral to covered surgical procedures in order to receive payment. ASCs should use the appropriate Level II HCPCS codes to report the devices. Only two devices currently have pass-through status under the OPPS: C1821 (Interspinous process distraction device [implantable]) and L8690 (Auditory osseointegrated device, includes all internal and external

REVISED PAYMENT SYSTEM FOR ASCS IN CALENDAR YEAR 2008, CONTINUED

components). For these two devices only, ASCs should report the code for the device and its charge. The Medicare contractor determines the payment amount for each of the pass-through devices.

ASCs also need to report the number of units for brachytherapy sources that are provided integral to covered surgical procedures. The ASC must report and charge Medicare and the beneficiary coinsurance for all brachytherapy sources that are ordered by the physician for a specific beneficiary, acquired by the ASC, and implanted in the beneficiary in the ASC in accordance with high quality clinical care standards.

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

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

Reporting Charges for Separately Payable Procedures and Services:

Under the revised payment system, ASCs must report charges for all separately payable procedures and services in order to receive correct payment. Medicare contractors make payment based on the lower of 80 percent of actual charges for separately payable procedures and services, or the ASC payment rate. ASCs should not report separate line item HCPCS codes or charges for procedures, services, drugs, devices, or supplies that are packaged into payment for covered surgical procedures.

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

For example, the charge reported for a procedure should include not only the charges associated with the service such as operating room time and recovery room use, but also the charges associated with implantable devices, supplies and any other services used in the procedure and packaged into the payment rate. Unlike the ASC payment system in effect prior to January 1, 2008, the revised payment system packages device payment into the payment for the associated procedure (i.e., the device is not paid separately). If the ASC bills a procedure code for a procedure (whether it is 'device-intensive' or not) and fails to include charges for the device in establishing the single line item charge for the covered surgical procedure, 80 percent of the procedure charge may be lower than the Medicare payment rate for that procedure code, which includes payment for devices and all packaged services and supplies. The contractor would make payment based on the provider's charges, possibly resulting in underpayment.

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

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

* All payment rates are hypothetical.

REVISED PAYMENT SYSTEM FOR ASCS IN CALENDAR YEAR 2008, CONTINUED

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

* All payment rates are hypothetical.

Billing Bilateral Procedures:

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

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

Correct Reporting								
Example	HCPCS	Description	PI	Units	ASC-Reported Charges	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider with Multiple Procedure Reduction	Unadjusted Beneficiary Payment to Provider with Multiple Procedure Reduction
Claim 1: Bilateral Procedure Reported on Two Lines	*15823*	Revision of Upper Eyelid	A2	1	$1,000	$800	$800 x .80 = $640	$800 x .20 = $160
	15823	Revision of Upper Eyelid	A2	1	$1,000	$800	($800 x .50) x .80 = $320	($800 x .50) x .20 = $80
Because the provider reports the bilateral procedure on two separate lines, and because the multiple procedure reduction applies to *15823*, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $1,200 for both procedures.								
Claim 2: Bilateral Procedure Reported on One Line with Two Units	*15823*	Revision of Upper Eyelid	A2	2	$2,000	$800 X 2	[$800 + ($800 x 0.50)] x .80 = $960	[$800 + ($800 x 0.50)] x .20 = $240
Because the provider reports the bilateral procedure using "2" in the units field, and because the multiple procedure reduction applies to *15823*, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $1,200 for both procedures.								

REVISED PAYMENT SYSTEM FOR ASCS IN CALENDAR YEAR 2008, CONTINUED

Incorrect Reporting								
Claim 3: Bilateral Procedure Reported on One Line with Bilateral Modifier	*15823* 50	Revision of Upper Eyelid	A2	1	$2,000	$800	$800 x .80 = $640	$800 x .20 = $160
Because the provider reports the bilateral procedure using the bilateral modifier, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $800 for only one of the procedures.								

* All payment rates are hypothetical.

ADDITIONAL INFORMATION

For more information regarding this and other ASC issues, including a list of frequently asked questions and answers, CMS encourages you to use the ASC Web page at *http://www.cms.hhs.gov/ASCPayment* on the CMS Web site.

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Implementation Date: January 7, 2008

COMPETITIVE ACQUISITION PROGRAM

MEDICARE PART B DRUG CAP: ADDITIONAL PHYSICIAN ELECTION PERIOD FOR 2008 IS UNDERWAY!

An additional election period for the 2008 Medicare Part B Drug Competitive Acquisition Program (CAP) began on January 15, 2008, and will conclude on February 15, 2008. The CAP is a voluntary program that offers physicians the option to acquire many drugs they use in their practice from an approved CAP vendor, thus reducing the time they spend buying and billing for drugs. For physicians who join during this additional election period, effective dates of participation will be April 1, 2008, to December 31, 2008.

Physicians are instructed to submit their CAP election forms to their local carrier or A/B MAC. Per change request (CR) 4064, local carriers are required to forward a list to the CAP designated carrier of all physicians and practitioners who have elected to participate in the CAP. This list is due on February 22, 2008. A joint signature memo (JSM) with instructions pertaining to posting information on the Ask the Contractor Teleconference (ATC), and processing additional election applications was sent out on January 9, 2008.

Participating CAP Physicians are required to use CAP-specific modifier codes and the dose specific prescription order number on their claims. The following CRs pertain to the Part B Drug CAP and may be found on the "Transmittals" page at *http://www.cms.hhs.gov/transmittals*.

2007: R1239CP, R1207CP, 1390CP
2006: R841CP, R839CP, R1034CP, R57MSP, R1088CP, R1076CP, R1055CP, R1313CP
2005: R777CP, R761CP, R715CP, R699CP

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

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

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

For questions on the CAP election process or general program inquiries, please call the CAP designated carrier, Noridian Administrative Services, at their CAP Vendor Contact Center at (888) 671-0536.

Source: Provider Education Resources Listserv, Message 200802-03

DRUGS AND BIOLOGICALS

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.

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.

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 2 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 8 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

ESAs IN CANCER AND RELATED NEOPLASTIC CONDITIONS, CONTINUED

- 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 non-covered 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

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

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

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 at *http://www.cms.hhs.gov/Transmittals/downloads/R80NCD.pdf* on the CMS Web site. The second transmittal revises the *Medicare Claims Processing Manual* and it is at *http://www.cms.hhs.gov/Transmittals/downloads/R1413CP.pdf* on the same site.

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

PROCESS FOR AMENDING THE LIST OF COMPENDIA FOR DETERMINATION OF MEDICALLY-ACCEPTED INDICATIONS FOR OFF-LABEL USES OF DRUGS AND BIOLOGICALS IN AN ANTI-CANCER CHEMOTHERAPEUTIC REGIMEN

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

PROVIDER TYPES AFFECTED

Providers who bill Medicare carriers and Medicare administrative contractors (A/B MAC) for drugs and biologicals used in anti-cancer chemotherapeutic regimens.

WHAT YOU NEED TO KNOW

CR 5870, from which this article is taken, announces that the 2008 Medicare physician fee schedule (MPFS) contains a new rule for revising the compendia list used to determine medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen."

BACKGROUND

A compendium (a comprehensive listing of either FDA-approved drugs and biologicals, or of a specific subset of drugs and biologicals — for example, a compendium of anti-cancer treatment):

- Is indexed by the drug or biological, rather than by disease.
- Includes a summary of the pharmacologic characteristics of each drug or biological's pharmacologic characteristics, and may include information on dosage, as well as recommended or endorsed uses in specific diseases.

Section 1861(t)(2)(B)(ii)(I) of the Social Security Act lists three drug compendia (American Hospital Formulary Service-Drug Information [AHFS–DI], American Medical Association Drug Evaluations [AMA–DE], and United States Pharmacopoeia-Drug Information [USP–DI]) that may be used to determine the medically accepted indications for drugs and biologicals used in an anti-cancer chemotherapeutic regimen. (The list is available on the Centers for Medicare & Medicaid [CMS] Web site at *http://www.cms.hhs.gov/CoverageGenInfo/02_compendia.asp#TopOfPage* on the CMS Web site.)

But changes in the pharmaceutical reference industry limit the availability of some of these statutorily named compendia for CMS reference.

Therefore, per section 1861(t)(2) of the Act that provides the Secretary of the Department of Health and Human Services the authority to revise the list of compendia for determining medically-accepted indications for drugs. CR 5870 announces that the 2008 MPFS contains a new rule for revising the compendia list used to determine medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen.

Process for Changing List of Compendia

Starting January 15, 2008, and each following January 15th, CMS will provide an annual 30-day open request period for the public to submit requests for additions or deletions to the compendia list that is on the CMS Web site.

By March 15th, CMS will post **complete** requests to its Web site for public notice and comment. Requests considered complete (and therefore accepted for review) must include the following information:

- The requestor's full name and contact information (including the mailing address, e-mail address, and telephone number).

Note: If the requestor is not an individual person, the information will identify the officer or other representative who is authorized to act for the requestor on all matters related to the request.

- Full identification of the requested compendium, including name, publisher, edition (if applicable) date of publication, and any other information needed for its accurate and precise identification.
- A complete copy (written, electronic, or available online at no cost to the Government) of the requested compendium.
- The specific action that the requestor wishes CMS to take, for example to add or delete a specific compendium.
- Detailed, specific documentation that the requested compendium does or does not comply with the conditions of this rule.

Note: Broad, nonspecific claims without supporting documentation cannot be efficiently reviewed; therefore, will not be accepted.

CMS will accept these public comments for a 30-day period beginning on the day the request is posted on the Web site.

Finally, in addition to this annual process, CMS may also generate a request for changes to the list at any time an urgent action is needed to protect the interests of the Medicare program and its beneficiaries.

Request Submission Instructions

You should note that a request might have only a single compendium as its subject (to provide greater clarity on the scope of the agency's review of a given request), though a requestor may submit multiple requests, each requesting a different action.

Requests must be in writing and submitted in either one (but not both) of the following two ways:

- In order to facilitate administrative efficiency, electronic requests are preferred. Each solicitation will include the electronic address for submissions.
- Hard copy requests can be sent to:

  Centers for Medicare & Medicaid Services
  Coverage and Analysis Group
  Mailstop C1–09–06
  7500 Security Boulevard
  Baltimore, MD, 21244.

Note: Make sure that you allow sufficient time for hard copies to be received prior to the close of the open request period.

Request Review

Compendia to determine medically-accepted indications of drugs and biologicals in anti-cancer therapy should have these desirable characteristics:

- Extensive breadth of listings
- Quick processing from application for inclusion to listing
- Detailed description of the evidence reviewed for every

PROCESS FOR AMENDING THE LIST OF COMPENDIA FOR DETERMINATION OF MEDICALLY-ACCEPTED INDICATIONS FOR OFF-LABEL USES OF DRUGS AND BIOLOGICALS IN AN ANTI-CANCER CHEMOTHERAPEUTIC REGIMEN , CONTINUED

individual listing.

- Use of pre-specified published criteria for weighing evidence.
- Use of prescribed published process for making recommendations.
- Publicly transparent process for evaluating therapies.
- Explicit "Not recommended" listing when validated evidence is appropriate.
- Explicit listing and recommendations regarding therapies, including sequential use or combination in relation to other therapies.
- Explicit "Equivocal" listing when validated evidence is equivocal.
- A process for public identification and notification of potential conflicts of interest of the compendia's parent and sibling organizations, reviewers, and committee members, with an established procedure to manage recognized conflicts.

When reviewing requests, CMS may consider:

- A compendium's attainment of these listed characteristics.
- Additional reasonable factors (For example, factors that are likely to impact the compendium's suitability for this use, such as a change in ownership or affiliation, the standards applicable to the evidence considered by the compendium, and any relevant conflicts of interest; and that broad accessibility by the general public to the information contained in the compendium may assist beneficiaries, their treating physicians or both in choosing among treatment options).
- The process by which the compendium grades the evidence used in making recommendations regarding off-label uses, as well as the grades themselves. Further, to facilitate administrative efficiency in the review of requests, CMS (at its discretion) may combine and consider multiple requests that refer to the same compendium, even if those requests are for different actions.

Publishing Review Results

CMS will publish decisions on the CMS Web site within 90 days after the close of the public comment period.

ADDITIONAL INFORMATION

You may find more information about the official instruction to your Medicare contractor about the new rule for revising the compendia list used to determine medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen by going to CR 5870, located at *http://www.cms.hhs.gov/Transmittals/downloads/R81BP.pdf* on the CMS Web site. The amended *Medicare Benefit Policy Manual,* chapter 15 *(*Covered Medical and Other Health Services, section 50.4.8 (Process for Amending the List of Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen) as an attachment to that CR.

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: MM5870
Related Change Request (CR) #: 5870
Related CR Release Date: February 7, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R81BP
Implementation Date: March 7, 2008

REPORTING OF HEMATOCRIT OR HEMOGLOBIN LEVELS FOR THE ADMINISTRATION OF ERYTHROPOIESIS STIMULATING AGENTS

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

Note: This article was revised on February 15, 2008, to add clarifying information to bullet points 1 and 3 under What You Need To Know. All other information remains the same. This information was previously published in the February 2008 Medicare B Update! pages 17-18.

PROVIDER TYPES AFFECTED

Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Competitive Acquisition Plan [CAP] designated carriers, and A/B Medicare administrative contractors [A/B MACs]) for providing ESAs and related anti-anemia administration services to Medicare beneficiaries.

IMPACT ON PROVIDERS

Effective for services on or after January 1, 2008, you must report the most recent hemoglobin or hematocrit levels on any claim for a Medicare patient receiving: (1) ESA administrations, or (2) Part B anti-anemia drugs other than ESAs used in the treatment of cancer that are not self-administered. In addition, non-ESRD claims for the administration of ESAs must also contain one of three new Healthcare Common Procedure Coding System (HCPCS) modifiers effective January 1, 2008. Failure to report this information will result in your claim being returned as unprocessed. (Note that renal dialysis facilities are already reporting this information on claim types 72x, so change request (CR) 5699 applies to providers billing with other types of bills.) See the rest of this article for reporting details.

REPORTING OF HCT OR HGB LEVELS FOR THE ADMINISTRATION OF ESAS, CONTINUED

BACKGROUND

Medicare Part B provides payment for certain drugs used to treat anemia caused by the cancer itself or by various anti-cancer treatments, including chemotherapy, radiation, and surgical therapy. The treatment of anemia in cancer patients commonly includes the use of drugs, specifically ESAs such as recombinant erythropoietin and darbepoetin. Emerging data and recent research has raised the possibility that ESAs administered for a number of clinical indications may be associated with significant adverse effects, including a higher risk of mortality in some populations.

Most recently, section 110 of Division B of the Tax Relief and Health Care Act (TRHCA) of 2006 directs the Secretary to amend Section 1842 of the Social Security Act by adding at the end the following new subsection: "Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual."

In light of the health and safety factors and the TRHCA legislation, effective January 1, 2008, the Centers for Medicare & Medicaid Services (CMS) is implementing an expanded reporting requirement for all claims billing for administrations of an ESA. Hematocrit and /or hemoglobin readings are already required for ESRD claims for administrations of an ESA. Effective with the implementation of CR 5699, all other claims for ESA administrations will also require the reporting of the most recent hematocrit or hemoglobin reading, along with one of three new HCPCS modifiers effective January 1, 2008.

In addition, CR 5699 requires the reporting of the most recent hematocrit or hemoglobin readings on all claims for the administration of Part B anti-anemia drugs OTHER THAN ESAs used in the treatment of cancer that are not self-administered.

WHAT YOU NEED TO KNOW

CR 5699, from which this article is taken, instructs all providers and suppliers that:

1. Effective January 1, 2008, all claims billing for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent hematocrit or hemoglobin reading available when the billed ESA dose was administered. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month. Claims submitted prior to the publication of CR 5699 that were not completed per the instructions in CR 5699 should be re-submitted.

- For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Such claims for ESAs not reporting a value code 48 or 49 will be returned to the provider.

- Effective for services on or after January 1, 2008, for professional paper claims, test results are reported in item 19 of the CMS-1500. For professional electronic claims (837P) billed to carriers or A/B MACs, providers report the hemoglobin or hematocrit readings in loop 2400 MEA segment. The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results. The test results should be entered as follows: TR= test results, R1=hemoglobin or R2=hematocrit (a 2-byte alpha-numeric element), and the most recent numeric test result (a 3-byte numeric element, decimal implied [xx.x]). Results exceeding 3-byte numeric elements (10.50) are reported as 10.5.

Examples: If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter: TR/R2/32.3.

- Effective for dates of service on and after January 1, 2008, contractors will return to provider paper and electronic professional claims, or return as unprocessable paper and electronic institutional claims for ESAs when the most recent hemoglobin or hematocrit test results are not reported.

- When Medicare returns a claim as unprocessable for ESAs with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 for failure to report the most recent hemoglobin or hematocrit test results, it will include claim adjustment reason code 16 (Claim/service lacks information which is needed for adjudication.) and remittance advice code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)

2. Effective January 1, 2008, all non-ESRD ESA claims billing HCPCS J0881 and J0885 must begin reporting one (and only one) of the following three modifiers on the same line as the ESA HCPCS:

    - EA: ESA, anemia, chemo-induced
    - EB: ESA, anemia, radio-induced
    - EC: ESA, anemia, non-chemo/radio.

- Non-ESRD ESA institutional claims that do not report one of the above three modifiers along with HCPCS J0881 or J0885 will be returned to the provider.

- Non-ESRD ESA professional claims that are billed without one of the three required modifiers as line items along with HCPCS J0881 or J0885 will be returned as unprocessable with reason code 4 and remark code MA130. If more than one modifier is reported, the claim will be returned with reason code 125 and remark code N63.

3. Effective January 1, 2008, all non-ESRD, non-ESA claims billing for the administration of Part B ani-anemia drugs used in the treatment of cancer that are not self-administered must report the most recent hematocrit or hemoglobin

REPORTING OF HCT OR HGB LEVELS FOR THE ADMINISTRATION OF ESAS, CONTINUED

reading. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month.

- Institutional claims that do not report the most recent hematocrit or hemoglobin reading will be returned to the provider.
- Professional claims that do not report the most recent hematocrit or hemoglobin reading will be returned as unprocessable using reason code 16, and remarks codes MA130 and N395.
- Your Medicare contractor will not search for claims with dates of service on or after January 1, 2008, processed prior to implementation of this CR, but will adjust such claims when you bring them to the attention of your contractor.

ADDITIONAL INFORMATION

For complete details regarding this CR please see the official instruction (CR 5699) issued to your Medicare carrier, FI, DME MAC, CAP Designated carrier, and A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1412CP.pdf* on the CMS Web site.

If you have questions, please contact your Medicare carrier, FI, DME MAC, CAP Designated 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: MM5699 *Revised*
Related Change Request (CR) #: 5699
Related CR Release Date: January 11, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1412CP
Implementation Date: April 7, 2008

INDEPENDENT DIAGNOSTIC TESTING FACILITY

REVISION TO INSTRUCTIONS RELATING TO COMPLIANCE STANDARDS FOR INDEPENDENT DIAGNOSTIC TESTING FACILITIES

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

PROVIDER TYPES AFFECTED

Independent diagnostic testing facilities (IDTFs) submitting claims to Medicare administrative contractors (A/B MACs) or carriers for services provided to Medicare beneficiaries.

IMPACT ON PROVIDERS

Change request (CR) 5856 incorporates into Pub.100-08, chapter 10 recent revisions to 42 CFR 410.33, pertaining to IDTFs and clarifies provisions in section 4.19 of chapter 10.

KEY POINTS

Listed below are the key points of CR 5856:

- IDTF changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the contractor via the CMS-855B within 30 calendar days of the change. All other changes to the IDTF's enrollment information must be reported within 90 calendar days.
- For purposes of 42 CFR 410.33(g)(3), hotel or motel is not considered an "appropriate site."
- IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.
- Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must:
  - Ensure that the insurance policy remains in force at all times and provides coverage of at least $300,000 per incident.
  - Notify the Centers for Medicare & Medicaid Services (CMS) designated contractor in writing of any policy changes or cancellations.

REVISION TO INSTRUCTIONS RELATING TO COMPLIANCE STANDARDS FOR IDTF, CONTINUED

- Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF (For mobile IDTFs, this documentation would be stored at their home office.). This includes, but is not limited to, the following:
  - The name, address, telephone number, and health insurance claim number of the beneficiary.
  - The date the complaint was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.
  - The name of the person making the decision and the reason for the decision, if an investigation was not conducted.
- Effective January 1, 2008, with the exception of hospital-based and mobile IDTFs, a fixed-base IDTF does not:
  - Share a practice location with another Medicare-enrolled individual or organization.
  - Lease or sublease its operations or its practice location to another Medicare-enrolled individual or organization.
  - Share diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization. (See 42 CFR section 410.33[g] [15]).
- Effective January 1, 2008, if the contractor determines that an IDTF is leasing or subleasing its operations to another organization or individual, the contractor will revoke the supplier's Medicare billing privileges.

Note: While the prohibition against the sharing of space at a practice location is effective on January 1, 2008 for newly-enrolling IDTFs (including those with applications that are still pending as of January 1, 2008), the space-sharing provision in 42 CFR section 410.33(g) (15) (i) for IDTFs that are currently occupying a practice location with another Medicare-enrolled individual or organization will not become effective until January 1, 2009.

- Effective January 1, 2008, the filing date of the Medicare enrollment application is the date that the Medicare contractor receives a signed provider enrollment application that it is able to process to approval. (See 42 CFR 410.33[l].)
- The effective date of billing privileges for a newly enrolled IDTF is the later of the following:
  - The filing date of the Medicare enrollment application that was subsequently approved by a Medicare fee-for-service contractor.
  - The date the IDTF first started furnishing services at its new practice location.
- A newly enrolled IDTF, therefore, may not receive reimbursement for services furnished before the effective date of billing privileges.
- The contractor will note that if it rejects an IDTF application on or after January 1, 2008, and a new application is later submitted, the date of filing is the date the contractor receives the new enrollment application.
- Under 42 CFR section 410.33(b)(1), each supervising physician must be limited to providing supervision to no more than three IDTF sites. This applies to both fixed sites and mobile units where three concurrent operations are capable of performing tests.

ADDITIONAL INFORMATION

For complete details regarding this CR, please see the official instruction (CR 5856) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R234PI.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: MM5856
Related Change Request (CR) #: 5856
Related CR Release Date: January 18, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R234PI
Implementation Date: April 22, 2008

LABORATORY/PATHOLOGY

CHANGES TO INDEPENDENT LABORATORY BILLING FOR THE TECHNICAL COMPONENT OF PHYSICIAN PATHOLOGY SERVICES

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

PROVIDER TYPES AFFECTED

Independent laboratories billing Medicare carriers or Medicare administrative contractors (A/B MACs) for services rendered to hospitalized Medicare beneficiaries.

WHAT PROVIDERS NEED TO KNOW

Qualifying independent laboratories may continue to bill Medicare directly for the technical component (TC) of certain physician pathology services provided to patients as part of a covered hospital inpatient stay or outpatient hospital service, through June 30, 2008.

BACKGROUND

November 2, 1999, the Centers for Medicare & Medicaid Services (CMS) stated it would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. Ordinarily, the provisions in the final physician fee schedule are implemented in the following year. However, new provisions established under Section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA), Section 732 of the Medicare Modernization Act (MMA), and Section 104 of the Tax Relief and Health Care Act of 2006 (TRHCA) have further delayed implementation of the proposed policy change. These provisions were scheduled to expire December 31, 2007.

The Section 104 of the Medicare, Medicaid and SCHIP Extension Act of 2007 created a new provision to extend Section 732 of the Medicare Modernization Act (MMA) provision an additional six months. This will allows qualifying independent laboratories to continue to bill Medicare for the technical component (TC) of certain physician pathology services provided to beneficiary in a covered hospital inpatient or outpatient event, regardless of the beneficiary's hospitalization status on the date the service was performed. Independent laboratories eligible to bill their carrier or Part A/B Medicare Administrative Contractor (Part A/B MAC) for these services may do so through June 30, 2008, regardless of the beneficiary's hospitalization status.

KEY POINTS

- Independent laboratories that qualify to bill for the TC of a physician pathology service furnished to an inpatient or outpatient of a covered hospital may continue to bill their carrier or Part A/B MAC for these services through June 30, 2008.
- Effective on or after July 1, 2008, only the hospital may bill for the TC of a physician pathology service provided to a hospital inpatient or outpatient.
- A covered hospital refers to a hospital that has an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which the laboratory furnished the TC of physician pathology services to fee-for service Medicare beneficiaries who were patients of the hospital.
- The hospital cannot bill under the outpatient prospective payment system (OPPS) for the TC of physician pathology services if the laboratory that services that hospital outpatient is receiving payment from its carrier or A/B MAC under the Medicare physician fee schedule.

ADDITIONAL INFORMATION

To see the official instruction (CR 5943) issued to your Medicare carrier or Part A/B MAC, refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1440CP.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: MM5943
Related Change Request (CR) #: 5943
Related CR Release Date: February 7, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1440CP
Implementation Date: March 7, 2008

CLINICAL LAB: NEW AUTOMATED TEST FOR THE AUTOMATED MULTI-CHANNEL CHEMISTRY CODE PANEL PAYMENT ALGORITHM

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

PROVIDER TYPES AFFECTED

All physicians and providers, who submit claims for the automated multi-channel chemistry (AMCC) to Medicare contractors (carriers, Medicare administrative contractors [A/B MACs], and fiscal intermediaries [FIs]) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5874 to alert providers that existing *current procedural terminology* (*CPT*) *82330*, *Calcium; ionized* is being paid as in individual test and was not included in the AMCC Panel Payment Algorithm. That changes effective July 1, 2008.

CAUTION – What You Need to Know

Effective July 1, 2008, *CPT 82330* will become an automated chemistry test within the AMCC Panel Payment Algorithm for payment purposes.

GO – What You Need to Do

Make certain your office staffs are aware of this change.

BACKGROUND

Effective January 1, 2008, the *CPT* Editorial Panel created a new code *80047 Basic metabolic panel (Calcium, ionized)* which is an AMCC code and is currently included in the AMCC Panel Payment Algorithm. The new code *80047* is comprised of eight component test codes (see below). Also, new CPT *80047* is not a replacement for code *80048 Basic metabolic panel*. Both codes *80048* and 80047 are included in the 2008 clinical laboratory fee schedule.

Key Points

- In order to determine payment for the new code *80047* using the AMCC Panel Payment Algorithm, existing code *82330*, *Calcium; ionized,* will be added as an AMCC panel code.
- Payment code ATP23 has also been included in the clinical laboratory fee schedule data file to correspond to the AMCC panel code addition.
- The *CPT* code *80047* Basic metabolic panel (calcium, ionized) is comprised of:
  - Calcium; ionized (*82330*)
  - Carbon dioxide (*82374*)
  - Chloride (*82435*)
  - Creatinine (*82565*)
  - Glucose (*82947*)
  - Potassium (*84132*)
  - Sodium (*84295*)
  - Urea Nitrogen (BUN) (*84520*)

For ESRD dialysis patients, *CPT 82330 calcium; ionized* will be included in the calculation for the 50/50 rule (Pub 100-04, chapter 16, section 40.6). When *CPT 82330* is billed as a substitute for *CPT 82310*, *Calcium; total*, it should be billed with modifier CD or CE. When *CPT 82330* is billed in addition to *CPT 82310*, it should be billed with CF modifier.

Note that, in accordance with the *Medicare Claims Processing Manual*, section 40.6.1, the new panel code *80047* cannot be billed for services ordered through an ESRD facility. All tests billed for services ordered through an ESRD facility must be billed individually, not in an organ disease panel. The *Medicare Claims Processing Manual* is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS Web site.

ADDITIONAL INFORMATION

To see the official instruction (CR 5874) issued to your Medicare carrier, FI, or A/B MAC, refer to *http://www.cms.hhs.gov/Transmittals/downloads/R83BP.pdf* on the 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: MM5874
Related Change Request (CR) #: 5874
Related CR Release Date: February 15, 2008
Effective Date: July 1, 2008
Related CR Transmittal #: R83BP
Implementation Date: July 7, 2008

IMPLEMENTATION OF THE MEDICARE CLINICAL LABORATORY SERVICES COMPETITIVE BIDDING DEMONSTRATION

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

PROVIDER TYPES AFFECTED

Providers or suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [A/B MAC]) and/or order laboratory services for Medicare fee-for-service (FFS) beneficiaries under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration project.

WHAT YOU NEED TO KNOW

Change request (CR) 5772, from which this article is taken, implements the Centers for Medicare & Medicaid Services (CMS) Medicare Clinical Laboratory Services Competitive Bidding Demonstration in the first Competitive Bidding Area (San Diego-Carlsbad-San Marcos, California metropolitan statistical area, or CBA1); and changes some of the demonstration's

requirements that were stated in CR 5205, issued August 1, 2006, (see the *MLN Matters* article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5205.pdf on the CMS Web site) and superceded by CR 5359, issued November 1, 2006, (see the *MLN Matters* article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5359.pdf on the CMS Web site).

Specifically, CR 5772 requires that:

- The demonstration covers tests provided to beneficiaries enrolled in the traditional fee-for-service (FFS) Medicare program who reside in the competitive bidding area (CBA1) during the 3-year demonstration period Required bidders that do not bid, or bid and do not win, may serve as a reference laboratory to laboratories participating in the demonstration. However, they would not be allowed to bill Medicare directly for demonstration tests performed for Medicare FFS beneficiaries residing in the CBA.
- *Laboratories not required to bid*: These laboratories will be paid under the competitively set demonstration fee schedule for the duration of the demonstration.
  - CMS will exempt laboratories that supply less than $100,000 annually in demonstration tests to Medicare FFS beneficiaries residing in the CBA from submitting bids.
  - CMS will exempt laboratories providing services exclusively to beneficiaries entitled to Medicare by reason of end-stage renal disease (ESRD) from submitting bids. (Tests that are paid as part of the ESRD payment bundle are excluded from the demonstration.)
  - CMS will exempt laboratories providing services exclusively to beneficiaries in nursing facilities or receiving home health services from submitting bids.

CR 5772 further announces that the demonstration in CBA1 is scheduled to begin on July 1, 2008; and provides Medicare contractors detailed record layouts for the quarterly report and for listing laboratories in the CBA.

CMS will issue a later CR that implements the demonstration in the second CBA (CBA2), which is tentatively scheduled to start on July 1, 2009.

BACKGROUND

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

In this project, each of two demonstration sites (competitive bidding areas – CBA1 and CBA2) will run for three years with a staggered start of one year. It will cover certain "demonstration tests" furnished under Medicare Part B to any beneficiary enrolled in FFS Medicare who lives in the CBAs.

Competitively bid fees will be set for all tests paid under the Medicare Part B clinical laboratory fee schedule in these demonstration sites, with the exception of Pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. In each CBA, the payment basis determined by the bidding will substitute for present payment under the existing clinical laboratory fee schedule.

CBAs will be defined geographically by ZIP codes, and will roughly correspond to a Metropolitan Statistical Area (MSA). Beneficiary residence status will be determined by information in the Medicare system as of the date the claim is processed, and review of a beneficiary's ZIP code of residence must reveal that it is included in the same listed CBA. CMS will provide Medicare contractors with a list of ZIP codes included in each MSA, which they will use to determine whether a beneficiary's residence is included in one of the CBAs.

Two previous Change Requests, (CR) 5205 and 5359 (issued August 1, 2006 and November 1, 2006, respectively), implemented the necessary system requirements to accomplish this project. CR 5772, from which this article is taken, establishes the project implementation dates; changes the requirements for referring and reference laboratory services, Skilled Nursing Facility (SNF) and Home Health services; and provides Medicare contractors a detailed record layout for the quarterly report, for listing laboratories in the CBA with their CB status.

The demonstration in CBA1 is scheduled to begin on July 1, 2008. CMS will issue a later CR that implements the demonstration in the second CBA (CBA2), which is tentatively scheduled to start on July 1, 2009. You should note that multiple winners are expected in each CBA.

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

LABORATORY CATEGORIES

Under the demonstration, laboratories will be classified as either: 1) "Required bidders" (laboratories that are required to bid in the demonstration because (regardless of where they are located) they provide FFS beneficiaries residing in the CBAs "demonstration tests" that yield $100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2006); or 2) "Non-required bidders" (laboratories whose payments for Medicare Part B (fee-for-service) payments for demonstration tests are below this $100,000 threshold.

"Non-required bidders" may choose to bid or not bid. Those that do not bid will be considered "passive" laboratories. Such passive laboratories, as well as "non-required bidders" who choose to bid (and win) and "required bidders" who win, (both labeled "winners") will be allowed to provide laboratory services to Medicare beneficiaries in the CBA and will be paid at the competitive bid rate for the demonstration tests paid under the Part B Clinical Laboratory Fee Schedule (CLFS), regardless of where the laboratory firm is located.

Conversely, "required bidders" and "non-required bidders" who bid and do not win (along with "required bidders" who do not bid) will be labeled "non-winners" under the demonstration. Medicare will not directly pay these "non-winner" laboratories (under either the Part B clinical laboratory fee schedule or the competitively bid price) for demonstration tests that they provide to beneficiaries residing in the CBAs for the duration of the demonstration (regardless of where the laboratory firm is located). Therefore, a passive laboratory that chooses to bid but does not "win" cannot participate in the demonstration in its "passive" status.

There are three types of passive laboratories: 1) "Passive-small business" (those with less than $100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBA); 2) "Passive-ESRD" – those that provide clinical laboratory services exclusively to beneficiaries with end

IMPLEMENTATION OF THE MEDICARE CLINICAL LABORATORY SERVICES COMPETITIVE BIDDING DEMONSTRATION, CONTINUED

stage renal disease (ESRD) residing in the CBAs); and 3) "Passive SNF/Home Health" – those that provide laboratory services exclusively to beneficiaries residing in nursing homes or are receiving home health services.

The "passive-small business" category of passive laboratories is subject to an annual payment ceiling of $100,000, however this payment ceiling threshold does not apply to the "passive ESRD" or "passive SNF/Home Health" laboratories. Further, you should note that the $100,000 threshold for "passive" laboratories does not include Medicare payment for tests excluded from the demonstration test list, services for beneficiaries residing in areas outside the CBA, or revenues from sources other than Medicare fee-for-service

You should also note that the $100,000 threshold does not apply to either the "passive ESRD" or passive SNF/Home Health laboratory categories.

In addition, in order to make it easier for nursing facilities to continue to provide continuity of care, CMS is exempting "passive SNF/Home Health" laboratories from being required bidders. Laboratories providing both Part A and Part B laboratory services to nursing facilities will be able to continue existing business relationships because they will not be at risk of losing Medicare Part A business as a result of the demonstration. They will be paid at the competitively set rate for demonstration tests otherwise paid under the Part B CLFS, and will also continue to receive payment for mileage, phlebotomy, and the existing payment under any schedule other than the Part B CLFS for those tests included in the demonstration.

You should also be aware that during the demonstration period, CMS will require that Medicare contractors monitor (and report to CMS quarterly):

- "Passive-small business" laboratories to ensure that their Medicare Part B annual payments for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the dollar threshold (so that they do not unfairly gain market share within the CBA). Passive laboratory firms exceeding their threshold limitations during the demonstration period will be converted to a "non-winner" status, and will be terminated from the demonstration project, and not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Note: All changes from a "passive" to a "non-winner" will be prospective to the next quarter.

- "Passive-ESRD" laboratories to ensure that payments under Medicare Part B for demonstration tests are provided only to beneficiaries with ESRD residing in the demonstration sites.

- "Passive SNF/Home Health" laboratories to ensure that payments under Medicare Part B for demonstration tests are provided only to beneficiaries residing in nursing homes or are receiving home health in the demonstration sites.

PROJECT IMPLEMENTATION

The project is being implemented in multiple phases. The first phase (analysis and design) was implemented in January 2007. The second phase (finalization of the requirements, coding development, testing and documentation) was implemented in April 2007.

CR 5772, from which this article is taken, announces that the demonstration in CBA1 is scheduled to begin on July 1, 2008, and that the tentative start date for the demonstration in the second CBA is July 1, 2009.

During the second quarter of calendar year (CY) 2008, CMS will provide Medicare contractors with:

- Information that specifies (along with a few other required fields) the laboratories' names and Medicare provider numbers, address and zip code, demonstration status (winning, passive (SB, SNF/Home Health, ESRD), or non-winner) and each laboratory's payment history for services provided to beneficiaries' living within the first CBA1 as of CY 2006. This information will identify the laboratories eligible to participate in the demonstration ("winning" laboratories), the passive laboratories that are exempt from bidding in the demonstration due to their relatively small size as measured by annual Medicare payments or due to their status as an ESRD or SNF/Home Health laboratory, and those not selected to participate in the demonstration after unsuccessfully bidding ("non-winner" laboratories). The list will specify the name of the laboratory, address, ZIP code, Medicare provider number, and the laboratory's demonstration status. Any changes to a laboratory's status in this report will be handled on an ad hoc basis.

- A test version of the laboratory competitive bidding demonstration fee schedule file containing the demonstration fee amounts for the preliminary list of services that the demonstration covers. (This test file will be populated only with the data pertaining to CBA1).

- Modifications to the existing 5-position national ZIP code pricing file for the laboratory competitive bidding demonstration. Also during the second quarter of CY 2008, CMS will provide the final version of the laboratory competitive bidding demonstration fee schedule file containing the *Current Procedural Terminology* (*CPT*) codes of the services covered by the demonstration and fees for CBA1.

To determine the correct laboratory competitive bidding fee schedule amount, contractors will use the July 2008 version of the 5-position national ZIP code pricing file to locate the ZIP code of the beneficiary's residence and map the beneficiary locality designation (i.e., CBA1 or CBA2) to the matching locality on the laboratory competitive bidding demonstration fee schedule file.

Notes:

1) This mapping is for demonstration pricing purposes only, and will not be used to report the laboratory state locality information.

2) For claims within a local carrier's jurisdiction, carriers will continue to report the state locality of the billing laboratory as they do now for clinical laboratory services.

CR 5772 also contains the following details about the demonstration:

- Physician office laboratory (POL) testing and hospital-based laboratories that function as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital are included in the demonstration. A POL enrolled as an independent laboratory or a hospital-based laboratory furnishing laboratory services to non-patients are subject to the demonstration rules. Services provided by a POL and/or a hospital-based laboratory for their own patients are not included in the demonstration and will continue to be paid under the existing CLFS.

IMPLEMENTATION OF THE MEDICARE CLINICAL LABORATORY SERVICES COMPETITIVE BIDDING DEMONSTRATION, CONTINUED

Note: For hospital-based laboratories, only 14X Type of Bills submitted for non-patient laboratory services are covered under this demonstration.

- Hospital inpatient testing is covered by Medicare Part A, it is, therefore, exempt from the demonstration.
- Pap smears and colorectal cancer screening tests are excluded from this demonstration by statute.
- Requirements under the Clinical Laboratory Improvement Amendments (CLIA) program as mandated in section 353 of the Public Health Service Act are applicable.
- Claims for phlebotomy, Healthcare Common Procedure Coding System (HCPCS) code 36415 (Collection of venous blood by venipuncture) must identify the place of service (POS), e.g., Skilled Nursing Facility (POS 31), Home (POS 12), ESRD treatment facility (POS 65), Physician's office (POS 11) or Independent laboratory (POS 81). If the specimen is collected at an independent laboratory draw station, you should use POS 81. For this demonstration, when the specimen is collected at a hospital laboratory or draw station that is acting as an independent laboratory, you should indicate the place of service for CPT code 36415 as POS 81.
- Referring and reference laboratories may be paid under the demonstration with some restrictions:
  - A winning or passive laboratory can refer out and bill for the reference laboratory service and be paid directly by Medicare.
  - A reference laboratory that was required to bid in the competitive bidding process but was not a winner under the demonstration can perform reference laboratory services but cannot bill Medicare directly or bill the beneficiary.
  - A reference laboratory that was not required to bid in the competitive bidding process can choose to bill for services that other laboratories refer to them. However, these laboratories are restricted to receiving payment less than $100,000 a year (for demonstration tests provided to FFS beneficiaries residing in the CBA), and if they exceed the $100,000 limit, they will be considered a non-winner and Medicare payment will not be allowed.
- **Non-winner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare denies payment for the test, nor may they charge the beneficiary for such a test.** However, non-winners may continue to furnish tests (that are outside the scope of the demonstration) to beneficiaries residing within the CBA, receive Medicare payment for such tests, and may appeal denial decisions for these services.
- Effective for claims with dates of services between July 1, 2008 and June 30, 2011, Medicare contractors will pay competitive bidding demonstration fee schedule amounts for claims that winning and/or passive laboratories submit for demonstration-covered services (including reference laboratory services) provided to beneficiaries residing in the CBA1. Moreover, CMS is aware that the allowed amount under the demonstration could be less than the regular fee schedule allowed amount. Therefore, contractors will add the following message for a demonstration remittance advice:

  M114 – This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, contact your local contractor.
- Laboratory tests which are exempt from the demonstration (e.g., pap smears, colorectal cancer screening tests), as well as new procedure codes that are added subsequent to the start of the demonstration will be paid in accordance with the existing CLFS. Laboratory tests provided to beneficiaries enrolled in the Medicare Program other than FFS or residing outside the CBA will be paid in accordance with the existing Part B CLFS.
- Effective for claims with dates of services on or after July 1, 2008 through June 30, 2011, carriers will deny, and intermediaries will reject, claims submitted by non-winner laboratories for demonstration-covered services provided to beneficiaries residing in the CBA1, using the following remittance advice reason code and remark codes:

  Reason code 96 – Non-covered charge(s).

  Remark Code M114 - This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.

  Remark Code M115 (For carriers) – No appeal rights. This item is denied when provided to this patient by a non-contract or non-demonstration supplier.

  Remark Code N83 (For intermediaries**)** - No appeal rights. Adjudicative decision based on the provisions of a demonstration project.
- Effective for claims with dates of services on or after July 1, 2008 through June 30, 2011, carriers will not reject claims with a modifier "90" (Reference (Outside) Laboratory) submitted by a winning or passive laboratory for demonstration-covered services provided to beneficiaries residing in the CBA1. However, they will reject claims from non-winning laboratories for demonstration covered services provided to such beneficiaries, even with modifier "90" present.
- Finally, all of the other business rules provided in CR 5205 and CR 5359 remain applicable, and are not changed by CR 5772.

ADDITIONAL INFORMATION

You may find the official instructions given to your carrier, FI, or A/B MAC in CR 5772 located at *http://www.cms.hhs.gov/Transmittals/downloads/R56DEMO.pdf* on the CMS Web site.

You might also want to look at MLN Matters article MM5359 (Laboratory Competitive Bidding Demonstration) which you may find at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5359.pdf* on the CMS Web site. (MM5359 superseded MM5205.)

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

IMPLEMENTATION OF THE MEDICARE CLINICAL LABORATORY SERVICES COMPETITIVE BIDDING DEMONSTRATION, 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: MM5772
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R56DEMO
Related Change Request (CR) #: 5772
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

LEGISLATIVE CHANGE AFFECTING THE 2008 MEDICARE PHYSICIAN FEE SCHEDULE AND EXTENSION OF THE 2008 PARTICIPATION OPEN ENROLLMENT PERIOD

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

PROVIDER TYPES AFFECTED

Physicians and other providers who bill Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], carriers, and Medicare administrative contractors [A/B MAC]) for professional services paid under the MPFS.

WHAT YOU NEED TO KNOW

Chang request (CR) 5944, from which this article is taken, provides Medicare contractors with information about (and instructions for implementing) legislative changes to the 2008 Medicare physician fee schedule (MPFS), and about the extension of the participation open enrollment period for 2008.

Effective for claims with dates of service January 1, 2008 through June 30, 2008, the update to the conversion factor will be 0.5 percent; and for claims with dates of service July 1, 2008 and after, will revert back to the previous payment methodology (the -10.1 percent update) that was outlined in the final rule, published in the *Federal Register* on November 27, 2007.

Additionally, the Centers for Medicare & Medicaid Services (CMS) has extended the 2008 participation open enrollment period from December 31, 2007, to February 15, 2008, therefore, it now runs from November 15, 2007 through February 15, 2008.

BACKGROUND

The Medicare, Medicaid, and SCHIP Extension Act of 2007 changes the rates of the 2008 MPFS. CR5944 informs Medicare contractors of this legislative change to the 2008 MPFS; the release of the new MPFS files for them to load; the need to be ready to process beginning January 7, all claims with dates of service on or after January 1, 2008, which contain MPFS services; and the extension of the participation open enrollment period for 2008.

MPFS RATE CHANGE

Effective for claims with dates of service January 1, 2008 through June 30, 2008, the update to the conversion factor will be 0.5 percent.

It is important that you understand, however, that this new legislation only impacts the MPFS rates during the first half of 2008 (claims with dates of service January 1, 2008, through June 30, 2008). Claims with dates of service July 1, 2008 and after will revert back to the previous payment methodology (the **-10.1%** update) that was outlined in the Final Rule, published in the Federal Register on November 27, 2007.

Note: The legislation also extends the 1.0 floor on the work geographic practice cost index for six months, i.e., through June 30, 2008.

This MPFS rate change also impacts several other fee schedule rates which are MFPS-derived, including the anesthesia conversion factors, purchased diagnostic file, and ambulatory surgical center (ASC) facility rates; but does not impact services that are not paid under the MPFS (e.g., DME, clinical lab, etc.).

Physicians do not need to take any additional action in order for their claims to be paid at the new 0.5 percent rate. Medicare contractors are able to process claims for services paid under the Medicare physician fee schedule that contain dates of service January 1 and after with the new 2008 rates. No adjustments should be necessary. Your Medicare contractors have been instructed to be ready to process all claims with 2008 dates of service with the new MPFS fees beginning January 7, 2008.

2008 Participation Open Enrollment Period Extension

Because this new legislation changes the 2008 MPFS rates, CMS has extended the 2008 participation open enrollment period from December 31, 2007 to February 15, 2008, therefore, it now runs from November 15, 2007 through February 15, 2008.

The effective date for any participation status change during the extension, however, remains January 1, 2008; and will be in force for the entire year. You should make your participation decision for 2008 based on the two new fee rates (i.e., the 0.5 percent update that is effective January through June, and the -10.1 percent update that is effective July through December).

Note: *CR 5944 revises CR 5732 (*Transmittal 1356 – Calendar Year (CY) 2008 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures, dated October 19, 2007*) to reflect the extension.*

LEGISLATIVE CHANGE AFFECTING THE 2008 MPFS AND EXTENSION OF THE 2008 PARTICIPATION OPEN ENROLLMENT PERIOD, CONTINUED

CR 5944 also contains additional Medicare contractor instructions:

- Any contractor unable to meet the January 7, 2008 for processing claims date, can hold affected claims for up to 14 calendar days after receipt; but all held claims must be released for payment no later than January 15, 2008.
- Contractors will not automatically make adjustments for providers who change their participation status after January 1, 2008 (you should begin billing claims according to the participation decision that you have made). However, they will adjust claims based on participation status changes that you bring to their attention.
- Your contractor will make the participation agreement available to you by placing it on their Web sites with participation enrollment (and termination) instructions. They will mail (at no charge) hard copies of the new 2008 MPFS, on request, to any physicians/practitioners who do not have Internet access and are unable to view the new fees on the contractor Web site. They will, however, charge a reasonable fee for mailing a hard copy of the 2008 MPFS to providers that do have Internet access, but who want a hard copy for convenience. Further, they will handle physicians/practitioners' requests for copies of the 2008 MPFS as customer services matters, and not as Freedom of Information Act (FOIA) requests; but will handle such requests from other members of the public as FOIA requests.
- Contractors will post the new fees on their Web sites as early as possible.
- Contractors will accept and process any participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before February 15, 2008.

ADDITIONAL INFORMATION

You may find the official instruction, CR 5944, issued to your carrier, FI, RHHI, or A/B MAC by visiting the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R312OTN.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: MM5944
Related Change Request (CR) Number: 5944
Related CR Release Date: February 1, 2008
Related CR Transmittal Number: R312OTN
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

EMERGENCY UPDATE TO THE 2008 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

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

PROVIDER TYPES AFFECTED

Physicians, other practitioners, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries and paid under the Medicare physician fee schedule database (MPFSDB).

PROVIDER ACTION NEEDED

The article is based on change request (CR) 5902 which amends payment files that were issued to Medicare contractors based upon the November 1, 2007, MPFS Final Rule.

BACKGROUND

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* on the Internet) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services. Previously, payment files were issued to Medicare contractors based upon the November 1, 2007, MPFS Final Rule. CR 5902 amends those payment files.

In summary, CR 5902 instructs your Medicare contractor to:

- Manually update their systems to reflect 5 base units for *Current Procedural Terminology* (*CPT*) code *01916*.
- Manually update their Healthcare Common Procedure Coding System (HCPCS) file to include the laboratory certification code (LC) 400 for *CPT* code *89060* on or after January 1, 2008.

Note: See Attachment 1 of CR 5902 for a list of detailed changes for certain *CPT*/HCPCS codes included in the Emergency Update to the 2008 Medicare Physician Fee Schedule Database (MPFSDB). The Web address for accessing CR 5902 is in the next section of this article.

ADDITIONAL INFORMATION

The official instruction, CR 5902, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1435CP.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: MM5902
Related Change Request (CR) #: 5902
Related CR Release Date: February 5, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1435CP
Implementation Date: January 7, 2008

VISION

USE OF HCPCS V2787 WHEN BILLING APPROVED ASTIGMATISM-CORRECTING INTRAOCULAR LENS IN ASCS, PHYSICIAN OFFICES, AND HOSPITAL OUTPATIENT DEPARTMENTS

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

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

STOP – Impact to You

This article is based on change request (CR) 5853 which provides instructions regarding the use of HCPCS code V2787 when billing for intraocular lens procedures and services involving recognized astigmatism-correcting intraocular lens (A-C IOLs) and taking place in ambulatory surgery centers (ASCs), physician offices, or hospital outpatient departments (HOPDs).

CAUTION – What You Need to Know

Effective for dates of service January 1, 2008 and later, when providing services to a Medicare beneficiary that involve the insertion of recognized A-C IOLs, and the service/procedure takes place in an ASC, HOPD, or physician office, then HCPCS Code V2787 should be billed to report the noncovered charges for the A-C IOL functionality of the inserted intraocular lens. **V2788 should not be used to report noncovered charges of the A-C IOLs on or after January 1, 2008**.

GO – What You Need to Do

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

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) previously announced in CR 5527 (transmittal 1228, April 27, 2007) a new administrator ruling regarding the insertion of A-C IOLs following cataract surgery. In that CR, CMS provided payment policies and billing instructions for services related to intraocular lens (IOL) procedures preformed with approved conventional IOLs or A-C IOLs in ASCs, HOPDs, or physician offices. In addition, that CR instructed providers to:

- Bill the noncovered charges of the A-C IOL functionality of the lens using HCPCS Code V2788 when inserting an A-C IOL, and
- Continue to bill HCPCS Code V2632, as appropriate, for the charges associated with the insertion of a conventional lens or the conventional functionality when an A-C IOL was inserted.

You may review CR 5527 at *http://www.cms.hhs.gov/transmittals/downloads/R1228CP.pdf* on the CMS Web site and its corresponding *MLN Matters* article, MM 5527, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5527.pdf* on the CMS Web site.

CR 5853 instructs that, effective for dates of service on or after January 1, 2008, services provided to Medicare beneficiaries involving the insertion of a recognized A-C IOL in an ASC, HOPD, or physician office, HCPCS Code V2787 should be billed to report the noncovered charges for the A-C IOL functionality of the inserted intraocular lens.

Note that (effective for dates of service on or after January 1, 2008) HCPCS Code V2788:

- **Is no longer valid** to report noncovered charges associated with the **A-C IOL**, **but**
- **Continues to be valid** to report noncovered charges associated with the **posterior Chamber IOL (P-C IOL)**.

Physician offices should continue to bill HCPCS Code V2632 for the payable conventional IOL functionality of the A-C IOL. The payment for the conventional lens portion of the A-C IOL lens continues to be bundled with the facility procedure payment for ASCs and HOPDs.

As of March 3, 2008, your Medicare contractor(s) will accept HCPCS Code V2787 for dates of service on or after January 1, 2008 to report non-covered charges incurred for services provided to a Medicare beneficiary involving the insertion an A-C IOL in a physician's office, an ASC facility, or a hospital outpatient setting. The annual HCPCS update will include the definition of HCPCS Code V2787 as follows:

Code	Descriptor
V2787	*Astigmatism correcting function of intraocular lens. Non-covered by Medicare statue.*

When Medicare denies A-C IOLs billed with V2787, they will return remittance reason code 96 (Noncovered charges) and remark code N425 (Statutorily excluded service[s]) or they may use reason code 204 (This service/equipment/drug is not covered under the patient's current benefit plan).

Note that your Medicare contractor will not search their files to reprocess claims for HCPCS Code V2787 that may have been denied prior to the implementation date for this change. However, they will adjust such claims if you bring them to the contractor's attention.

ADDITIONAL INFORMATION

The official instruction, CR 5853, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1430CP.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: MM5853
Related Change Request (CR) #: 5853
Related CR Release Date: February 1, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1430CP
Implementation Date: March 3, 2008

GENERAL COVERAGE

MODIFIER SUBMISSION REQUIREMENTS IN THE MULTI-CARRIER SYSTEM

In the Multi-Carrier System (MCS), certain procedure code modifiers must be submitted in the first modifier position to effectuate appropriate reimbursement. The modifiers listed below should be submitted immediately to the right of the procedure code in Item 24D of the CMS-1500 or the electronic equivalent.

AA Anesthesia services performed personally by anesthesiologist
AD Medical supervision by a physician: more than four concurrent anesthesia procedures
QB Physician providing service in a rural HPSA
QU Physician providing service in an urban HPSA
QW CLIA waived test
QX CRNA service: with medical direction by a physician
QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
QZ CRNA service: without medical direction by a physician
TC Technical component
26 Professional component
53 Discontinued procedure

In addition, ASC (ambulatory surgical center) facility charges must be submitted with modifier SG (Ambulatory Surgical Center facility service); however, the SG does not have to be entered in the first modifier position.

SMOKING AND TOBACCO USE CESSATION COUNSELING BILLING CODE UPDATE TO MEDICARE

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

PROVIDER TYPES AFFECTED

Physicians and providers who bill Medicare contractors (fiscal intermediaries [FI], carriers, or Medicare administrative contractors [A/B MAC]) for smoking and tobacco use cessation counseling.

PROVIDER ACTION NEEDED

STOP – IMPACT TO YOU

Effective for services on or after January 1, 2008, you must bill for smoking and tobacco use cessation counseling services with new *CPT* codes (*99406* or *99407*). If you bill using the former HCPCS codes (G0375 and G0376) for services provided after December 31, 2007, your claims will not be paid.

CAUTION – WHAT YOU NEED TO KNOW

CR 5878, from which this article is taken, announces that the 2008 Medicare physician fee database (MPFSDB) includes two new *CPT* codes for smoking and tobacco use cessation counseling services; replacing the temporary HCPCS G codes (G0375 and G0376) currently in use for billing these services. These new codes (effective on and after January 1, 2008) are:

99406 – Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407 – Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes.

GO – WHAT YOU NEED TO DO

Make sure that your billing staffs are aware of these newly required *CPT* codes for smoking and tobacco use cessation counseling services.

BACKGROUND

CR 5878, from which this article is taken, announces that the temporary HCPCS G codes G0375 and G0376, which are currently used to bill for Smoking and Tobacco Use Cessation Counseling services, are effective only through December 31, 2007.

They are being replaced by two new *CPT* codes (*99406 – Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*; and *99407 – Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes*). These new *CPT* codes, which are included in the 2008 MPFSDB, become effective for claims with dates of service January 1, 2008 and later.

FIs, carriers, and A/B MACs will pay for counseling services billed with HCPCS codes G0375 and G0376 for dates of service performed on and after March 22, 2005 through Dec. 31, 2007 and with *CPT* codes *99406* and *99407* for dates of service on or after January 1, 2008.

ADDITIONAL INFORMATION

You may find CR 5878 at *http://www.cms.hhs.gov/Transmittals/downloads/R1433CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. You will find the updated *Medicare Claims Processing Manual,* chapter 32 *(*Billing Requirements for Special Services), sections 12.1(HCPCS and Diagnosis Coding), 12.2 (Carrier Billing Requirements), and 12.3 (FI Billing Requirements) as an attachment to that CR.

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: MM5878
Related Change Request (CR) #: 5878
Related CR Release Date: February 1, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1433CP
Implementation Date: July 7, 2008

SUMMARY OF POLICIES IN THE 2008 MEDICARE PHYSICIAN FEE SCHEDULE AND THE TELEHEALTH ORIGINATING SITE FACILITY FEE PAYMENT AMOUNT

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

PROVIDER TYPES AFFECTED

Physicians, other practitioners, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries and paid under the Medicare physician fee schedule (MPFS).

PROVIDER ACTION NEEDED

This article is based on change request (CR) 5895 which contains summaries of the policy changes in the 2008 MPFS and the telehealth originating site facility fee for 2008. (Note: This CR does not include any changes that would be affected by recent legislation (i.e., 0.5 percent update to the conversion factor, changes to the geographic practice cost indices floor, etc. Information regarding these changes can be found in CR 5944, Legislative Change Affecting the 2008 Medicare Physician Fee Schedule (MPFS) and Extension of the 2008 Participation Open Enrollment Period.)

BACKGROUND

The Social Security Act (Section 1848(b)(1) at *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* on the Internet) requires the Centers for Medicare & Medicaid Services (CMS) to provide (by regulation before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year. CMS published a document that will affect payments to physicians effective January 1, 2008.

The Social Security Act (Section 1834(m) at *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm* on the Internet) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 21, 2002 at $20.

For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) as defined in the Social Security Act (Section 1842(i)(3) at *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm* on the internet). The MEI increase for 2008 is 1.8 percent.

For calendar year 2008, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is either 80 percent of the lesser of the actual charge or $23.35. Note: The beneficiary is responsible for any unmet deductible amount or coinsurance.

In summary, CR 5895 instructs your Medicare contractor to:

- Pay for the Medicare telehealth originating site facility fee as described by HCPCS code Q3014 at 80 percent of the lesser of the actual charge or $23.35
- Consider payment for the following HCPCS codes only when appropriate, reasonable and necessary (i.e., when the service is provided to evaluate patients with signs/symptoms of illness or injury) as per of the Social Security Act (Section 1862(a)(1)(A) at *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the Internet)
- See the attachment to CR 5895, available at *http://www.cms.hhs.gov/Transmittals/downloads/R1423CP.pdf* on the CMS Web site, for:
- A summary of significant issues discussed in CMS-1325-FC, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions.

ADDITIONAL INFORMATION

The official instruction, CR 5895, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1423CP.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).

Code	Descriptor
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and brief intervention, 15 to 30 minutes.
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (eg, AUDIT, DAST) and intervention greater than 30 minutes.

MLN Matters Number: MM5895
Related Change Request (CR) #: 5895
Related CR Release Date: February 1, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1423CP
Implementation Date: January 7, 2008

GENERAL INFORMATION

MEDICARE FEE FOR SERVICE LEGACY PROVIDER IDS PROHIBITED ON CMS-1500 CLAIMS AFTER THE REQUIRED DATE

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 CMS-1500 and CMS-1450 (UB-04) claims to Medicare carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME MACs), and/or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

STOP – Impact to You

Effective May 23, 2008, if you report a provider legacy identifier on Medicare CMS-1500 or CMS-1450 (UB-04) claims, your contractors will return them as unprocessable.

CAUTION – What You Need to Know

CR 5858, from which this article is taken, announces that provider legacy identifiers are not to be reported on Medicare CMS-1500 or CMS-1450 claims received on or after May 23, 2008 (the date at which the national provider identifier [NPI] is required to be reported on claims). After that date, claims containing legacy identifiers will be returned as unprocessable.

GO – What You Need to Do

Make sure that your billing staffs are aware that effective May 23, 2008, only NPIs are to be reported on Medicare CMS-1500 and CMS-1450 claims.

BACKGROUND

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique NPI to each physician, supplier, and other health care provider who conducts HIPAA standard electronic transactions. In accordance with this act, CMS began issuing NPIs on May 23, 2005.

Further, on April 2, 2007, the Department of Health and Human Services (DHHS) provided covered entities guidance regarding contingency planning for NPI implementation. In this guidance, as long as a health plan was compliant, meaning they could accept and send NPIs on electronic transactions; they could establish contingency plans to facilitate the compliance of their trading partners.

As a compliant health plan, on April 20, 2007, Medicare fee for service (FFS) established a contingency plan that followed this guidance. Since then, the Centers for Medicare & Medicaid Services (CMS) has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only
- Medicare legacy only (PINs, UPINs, or national supplier clearinghouse number)
- NPI and legacy combination.

CR 5858, from which this article is taken, announces that. beginning on May 23, 2008, CMS requires the NPI to be submitted on CMS-1500 and CMS-1450 paper claims; and legacy numbers will NOT be permitted on claims received on or after that date. Effective that date, CMS-1500 and CMS-1450 claims containing legacy identifiers will be returned as unprocessable, without appeal rights.

When returning these claims, your contractors will use an appropriate message and remittance advice remark code, such as:

> **N257** Missing/incomplete/invalid billing provider primary identifier.

Note that contractors will not return claims in certain situations where an NPI is not required (e.g., foreign claims, deceased provider claims, and other situations as allowed by CMS in the future). Such claims will be processed with established procedures for such claims.

ADDITIONAL INFORMATION

You may find more information about the prohibition of Medicare fee for service legacy provider IDs on CMS-1500 and CMS-1450 claims after the NPI required date by going to CR 5858, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1432CP.pdf* on the CMS Web site. You will find updated *Medicare Claims Processing Manual* (100-04), chapter 26 (Completing and Processing Form CMS-1500 Data Set), section 10.4 (Items 14-33 - Provider of Service or Supplier Information) as an attachment to that CR.

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

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

MLN Matters Number: MM5858
Related Change Request (CR) #: 5858
Related CR Release Date: February 1, 2008
Effective Date: Claims received on or after May 23, 2008
Related CR Transmittal #: R1432CP
Implementation Date: April 7, 2008

UPCOMING CRITICAL DATES FOR MEDICARE'S FEE-FOR-SERVICE IMPLEMENTATION OF THE NATIONAL PROVIDER IDENTIFIER

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

PROVIDER TYPES AFFECTED

This article is primarily for physicians and providers who submit Medicare claims using the Medicare fee-for-service (FFS) 837P and the CMS-1500.

PROVIDER ACTION NEEDED

This special edition article, SE0802, is being provided by the Centers for Medicare & Medicaid Services (CMS) in order to clear up some confusion that providers are experiencing regarding the March 1, 2008 implementation of the national provider identifier (NPI) on professional claims, and the May 23, 2008 requirement for ONLY the NPI on all Health Insurance Portability & Accountability Act (HIPAA) electronic transactions and their paper versions.
The following charts illustrate expected claim results for different identifiers, or combinations of identifiers, submitted in the primary provider fields on the Medicare FFS 837P and CMS-1500. Note that when the chart indicates that claims will be paid, this would only be if no other errors (non-NPI) exist.

Prior to March 1, 2008 – 837P and 1500 Claims, Primary Provider Fields

Legacy Medicare Identifier	NPI	Result
X	Claim will be paid	
X	X	Claim will be paid as long as there is an NPI/legacy match on the NPI crosswalk*
X	Claim will be paid as long as there is an NPI/legacy match on the NPI crosswalk*	

As of March 1, 2008 – 837P and 1500 Claims, Primary Provider Fields

Legacy Medicare Identifier	NPI	Result
X	Claim will be rejected	
X	X	Claim will be paid as long as there is an NPI/legacy match on the NPI crosswalk*
X	Claim will be paid as long as there is an NPI/legacy match on the NPI crosswalk*	

May 23, 2008 and Beyond – All Providers, All Transactions, Both Primary and Secondary Provider Fields**

Legacy Medicare Identifier	NPI	Result
X	Claim/transaction will reject	
X	X	Claim/transaction will reject

* Claims will reject when there is not a match on the Medicare NPI crosswalk. You must correct any data, which may be preventing an NPI/legacy match on the NPI crosswalk. The correction might require that you file a CMS-855 Medicare Provider Enrollment form with your Medicare carrier, A/B MAC, or DME MAC a process which can take a number of months to accomplish.

**HIPAA electronic transactions (837I, 837P, 837COB, NCPDP, 276/277, 270/271, and 835), paper claims and SPR remittance advice.

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 (i.e., no Medicare legacy number) by submitting one or two claims today for each NPI you've been assigned. 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, validate that the National Plan and Provider Enumeration System (NPPES) has the correct Medicare Legacy number. If your NPPES information is correct, contact your Medicare carrier or A/B MAC enrollment staff for advice right away.

UPCOMING CRITICAL DATES FOR MEDICARE'S FFS IMPLEMENTATION OF THE NPI, CONTINUED

ADDITIONAL INFORMATION

As of January 1, 2008, FFS Medicare required an NPI in the primary provider fields on the 837I and UB-04 claim types. Providers billing with these claim forms must continue to include an NPI in the primary provider field until May 23rd at which time an NPI-only is required in all fields

For more information on correcting NPPES errors and how to use the NPI on Medicare claims, visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf* on the CMS Web site.

If you do not have an NPI, you need to obtain one as soon as possible. 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.

A table of Medicare's key dates relative to the NPI is available at the CMS NPI page *http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp* on the CMS Web site. More information and education on the NPI can be found through the CMS NPI page *http://www.cms.hhs.gov/NationalProvIdentStand* on the CMS Web site.

MLN Matters Number: SE0802
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

REMINDER—MANDATORY REPORTING OF THE NATIONAL PROVIDER IDENTIFIER ON ALL PART B CLAIMS

Effective March 1, 2008, your Medicare fee-for-service claims must include a national provider identifier (NPI) in the primary provider fields on the claim (i.e., the billing, pay-to provider, and rendering provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., referring, ordering and supervising) may continue to include only your legacy number, if you choose.

Failure to submit an NPI in the primary provider fields will result in your claim being rejected, beginning March 1, 2008.

In addition, if you already bill using the NPI/legacy pair in the primary provider fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI in the primary provider fields. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims.

CONTACT INFORMATION FOR ELECTRONIC CLAIMS

For additional information regarding electronic claims, please contact Medicare EDI at:

Connecticut - 1-203-639-3160 option 6.
Florida - 1-904-354-5977 option 4.

Source: CMS Joint Signature Memorandum 08048, November 14, 2007

IMPORTANT NPPES INFORMATION FOR ORGANIZATION PROVIDERS

THE NPI IS HERE. THE NPI IS NOW. ARE YOU USING IT?

When organization health care providers apply for NPIs, it is important that they enter their correct legal business name and employer identification number (EIN).

National Plan and Provider Enumeration System (NPPES) will be establishing a verification process with the Internal Revenue Service (IRS) to verify the legal business name and the associated EIN submitted on the NPPES applications and updates.

Providers will be notified as the Centers for Medicare & Medicaid Services (CMS) develops and implements this process. In the meantime, CMS encourages providers to be proactive and verify that this information is correct in order to avoid any potential issues in the future.

IMPORTANT INFORMATION FOR MEDICARE PROVIDERS

Importance of "Complete" Medicare Provider/Supplier Enrollment Applications Correcting your 855 enrollment form can be critical to assuring your claims are processed. We are urging providers to avoid delays in 855 processing that are caused by missing or incomplete information.

CMS has instructed its Medicare fee-for-service (FFS) contractors to process complete Medicare provider/supplier enrollment applications that contain all supporting documentation, including the electronic funds transfer authorization agreement (CMS-588) and licensing information, within prescribed processing timeframes. Incomplete or incorrect application information will result in an extension of these processing times for as long as it takes to obtain the correct information from the provider. This wastes precious time, especially for those seeking to rectify NPI/legacy conflicts and poses unnecessary work for both the contractor and the provider.

For an enrollment application to be considered complete:

1. All applicable sections of the CMS-855 and fields, including check boxes, within a section must be filled-out at the time of filing,

IMPORTANT NPPES INFORMATION FOR ORGANIZATION PROVIDERS, CONTINUED

2. The application must contain an original signature (blue ink is preferred) and date of signature (blue ink is preferred), and
3. The application must be accompanied by all supporting documentation listed in section 17 of the enrollment application.

MAKE SURE YOU UNDERSTAND THE KEY DATES: NEW *MLN MATTERS* ARTICLE NOW AVAILABLE

The latest NPI-related *MLN Matters* article is now available and illustrates information, in chart form, regarding the difference between the March 1st and May 23rd FFS Medicare NPI implementation dates. Visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0802.pdf* to view this article.

REMINDER FOR FFS MEDICARE PHYSICIANS, NON-PHYSICIAN PRACTITIONERS & OTHER SUPPLIERS

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 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.

Source: Provider Education Resources Listserv, Message 200802-08

2008 MEDICARE PART B PARTICIPATING PHYSICIAN AND SUPPLIER DIRECTORY

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD will be available on the Connecticut and Florida Medicare Part B Web sites no later than March 17, 2008, at:

Connecticut: *http://www.connecticutmedicare.com/Reference/MEDPARD/index.asp*
Florida: *http://www.floridamedicare.com/Reference/MEDPARD/index.asp*

Source: Pub 100-20, Transmittal 312, Change Request 5944

CLARIFICATION—PROVIDER BILLING PROCEDURES RELATED TO THE TRANSITION TO THE COORDINATION OF BENEFITS CONTRACTOR

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

Note: This article was revised on January 31, 2008, to add a reference to MM5837 (Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-based Crossover Process) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5837.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. MM5837 provides formal confirmation of CMS' decision to not require Medicare Part B contractors to update their internal insurer tables or files with each Medigap insurer's newly assigned COBA Medigap claim-based ID. All other information remains unchanged. This information was previously published in the July 2007 *Medicare B Update!* pages 29-30.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

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

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

CLARIFICATION—PROVIDER BILLING PROCEDURES RELATED TO THE TRANSITION TO THE COBC, CONTINUED

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

Effective October 1, 2007, if a provider or its billing vendor files a Medicare claim with a COBA ID other than the COBA Medigap IDs on the above-referenced Medigap Billing ID list, Medicare will generate an MA-19 message on the provider's 835 electronic remittance advice (ERA) or other remittance advice in use. This message indicates: "Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer."

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

Providers should not contact those insurers or payers listed as participating in the automatic crossover process for purposes of determining whether CMS has assigned them a COBA Medigap claim-based ID. As aforementioned, providers or their billing vendors should also not utilize COBA ID information from this listing on their incoming Medicare claims for the purpose of triggering Medigap claim-based crossovers.

Important: Not every Medigap insurer is utilizing the automatic crossover process for the purpose of identifying all of its covered members or policyholders for crossover purposes and for receiving crossover claims for those Medicare beneficiaries. An example of this scenario is as follows: If the COBC was approached by a new Medigap insurer that specified that it needed to apply for a Medigap claim-based ID (range 55000 to 59999) for various segments of its covered membership, but will utilize the automatic complementary crossover process for the remainder of its Medigap membership, the COBC would, following execution of the COBA crossover agreement with the insurer, assign it two COBA IDs—one for automatic crossover (range 30000 to 54999 for automatic Medigap eligibility file-based crossover) and the other for Medigap claim-based crossover (55000 to 59999). Thus, this Medigap insurer would appear on both the listing of automatic crossover insurers as well as the Medigap Billing ID listing at the respective URL links on the COB Web site, referenced above.

BACKGROUND

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

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

The three (3) options available to each Medigap insurer for addressing its receipt of Medicare crossovers remain as follows:

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

To be clear, if a Medigap insurer is currently participating fully in the automatic (or COBA eligibility file-based) crossover process, it merely needs to inform the COBC of this decision. Upon doing so, that Medigap insurer will experience no disruption in its receipt of crossover claims. Based upon its most recent review of trending, CMS has noted that the vast majority of the larger, more commonly known Medigap insurers, which were already participating fully in the Medicare automatic crossover process, have informed CMS and the COBC that they plan to continue to participate fully in the automatic crossover process for purposes of fulfilling their mandatory Medigap crossover payment responsibilities on behalf of their Medigap policyholders. In other words, the majority of the larger, more commonly known Medigap insurers have exercised option #1, above.

ADDITIONAL INFORMATION

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

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

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

MLN Matters Number: SE0743 *Revised*
Related Change Request (CR) #: CR5601 and CR5662
Related CR Release Date: N/A
Effective Date: October 1, 2007
Related CR Transmittal #: N/A
Implementation Date: N/A

GUIDED PATHWAYS TO MEDICARE RESOURCES FOR MEDICARE FEE-FOR-SERVICE HEALTH CARE

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of the latest Medicare Learning Network provider education product entitled, "Guided Pathways to Medicare Resources for Medicare Fee-for-Service Health Care Professionals."

Guided Pathways has been developed as an educational tool for fee-for-service (FFS) health care staff who are relatively unfamiliar with the Medicare program, as well as for those professionals looking for easy access to the many resources on the CMS Web site. Using a "road trip" motif, the pathways lead users through nine broad sections of information covering the Medicare program, with links to further pertinent information. The pathways also provide links to other government resources pertaining to Medicare FFS items. Guided Pathways may be accessed at *http://www.cms.hhs.gov/apps/training/guidedpathways/index.html* on the CMS Web site.

Located in the Provider Communications Group within CMS, the Medicare Learning Network (MLN) is the brand name for official CMS educational products designed to promote national consistency of information developed for Medicare FFS initiatives. Most importantly, it is available to help you! Each quarter the MLN will send updates on the latest products available - so be on the lookout!

For more information on the Medicare Learning Network, please visit *www.cms.hhs.gov/MLNGenInfo* on the CMS Web site. Questions and requests for additional information may be sent to the MLN Mailbox at *MLN@cms.hhs.gov*.

Source: Provider Education Resources Listserv, Message 200801-24

NEW MEDICARE LEARNING NETWORK PRODUCTS NOW AVAILABLE ON THE TOPIC OF IACS-PC

As we have previously mentioned, the Centers for Medicare & Medicaid Services (CMS) will soon be offering the Provider Enrollment, Chain and Ownership System (PECOS) and Provider Statistical and Reimbursement Report (PS&R) online.

These new online enterprise applications will allow Medicare fee-for-service (FFS) providers to access, update, and submit enrollment and cost report information over the Internet. Providers and/or appropriate staff must register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider Community (IACS-PC). CMS urges FFS providers to read the series of *MLN Matters* articles on this subject and act now. They may be accessed at the following URLs:

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf

Source: CMS Provider Education Resource 200802-05

REVISED MEDICARE LEARNING NETWORK PRODUCTS

The following products are now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

- The revised Medicare Physician Fee Schedule Fact Sheet (January 2008), which provides general information about the Medicare physician fee schedule, may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*.
- The revised Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart (January 2008), which provides Medicare claim processing information related to SNF spells of illness, may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/SNFSpellIllnesschrt.pdf*.

Source: Provider Education Resources Listserv, Message 200802-10

FEBRUARY IS AMERICAN HEART MONTH

Since 1999, the rate of deaths from coronary heart disease and stroke in American has declined. While much progress has been achieved in reducing the death rate, heart disease and stroke still remain the number 1 and number 3 causes of death in the U.S., and a major cause of disability and reduced quality of life. Found more often among people aged 65 or older, heart disease is largely preventable. The Centers for Medicare & Medicaid Services (CMS) is taking this opportunity to remind health care professionals that Medicare beneficiaries are covered for certain cardiovascular screening blood tests. This screening can help beneficiaries learn if they have an increased risk of heart disease and stroke.

Medicare provides coverage of the following cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke:
Total cholesterol test
Cholesterol test for high-density lipoproteins
Triglycerides test

Coverage of cardiovascular screening blood tests is provided as a Medicare Part B benefit. The beneficiary will pay nothing for the blood tests (there is no coinsurance or co-payment and no deductible for this benefit).

Important note: The cardiovascular screening benefit covered by Medicare is a stand alone billable service separate from the initial preventive physical examination (IPPE) or Welcome to Medicare visit, and does not have to be obtained within the first six months of a beneficiary's Medicare Part B coverage.

FEBRUARY WAS AMERICAN HEART MONTH, CONTINUED

SPREAD THE WORD

CMS needs your help getting the word out about the cardiovascular screening benefit covered by Medicare. Talk with your patients about their risk factors for cardiovascular disease and how they can help lessen their risk through lifestyle modifications such as diet, physical activity, better control of cholesterol, and smoking cessation or if necessary with medication. Encourage your Medicare patients not previously diagnosed with cardiovascular disease to take full advantage of the cardiovascular screening blood tests covered by Medicare**. It could save their lives!**

FOR MORE INFORMATION

CMS has developed a variety of educational products and resources to help health care professionals and their staff learn more about coverage, coding, billing, and reimbursement for preventive and screening services covered by Medicare.

The MLN Preventive Services Educational Products Web Page - provides descriptions and ordering information for MLN preventive services educational products and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

Expanded Benefits Brochure - This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of the IPPE, ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests. *http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf* To order copies of the brochure, go to the Medicare Learning Network 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 cardiovascular screening benefit at *http://www.cms.hhs.gov/CardiovasDiseaseScreening/*.

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

For information about American Heart Month, please visit the American Heart Association's Web site at *http://www.americanheart.org/presenter.jhtml?identifier=1200000* and the Centers for Disease Control and Prevention's Web site at *http://www.cdc.gov/DHDSP/announcements/american_heart_month.htm* on the Web.

Source: Provider Education Resources Listserv, Messages 200802-04 & 200801-26

FEBRUARY FLU SHOT REMINDER

It's Not Too Late to Give and Get the Flu Shot!

In the U.S., the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one-time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. Don't Get the Flu. Don't Give the Flu. Get Vaccinated!

Remember – Influenza and pneumococcal vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are not Part D covered drugs. You and your staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing the special edition *MLN Matters* article SE0748 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf* on the CMS Web site.

Source: Provider Education Resources Listserv, Message 200801-26

CONNECTICUT PROVIDER CONTACT CENTER TRAINING CLOSURES

The Connecticut Part B Provider Contact Center will be temporarily closed for business on the following date:

Friday, March 28, 2008
2:00 P.M. - 4:00 P.M.

Our customer service representatives will be undergoing training during the above referenced time. Although our customer service representatives will not be available, the interactive voice response (IVR) unit will be available as usual at 1-866-419-9455 (toll-free).

For specific claim information, the IVR hours are:
6:00 a.m. – 6:00 p.m. Monday through Friday

For recorded information on current Medicare issues, the IVR hours are:
24 hours a day, 7 days a week

We apologize for any inconvenience this may cause. First Coast Service Options, Inc. (FCSO) is committed to continually providing the best service to our customers.

HOLIDAY CLOSURES

FCSO holiday closures are available at *http://www.connecticutmedicare.com/header/Contact/108369.asp*.

NEW FLORIDA SERVICE LINE OPTION FOR TELEPHONE ADJUSTMENTS AND MSP

First Coast Service Options, Inc. strives to provide our customers quick access to information and service to help you better manage your work. In keeping with our continuous service improvements, we are proud to announce the latest feature available on our toll free line.

Effective March 3, 2008, the Florida call center menu will offer customers with provider telephone adjustment requests and questions on MSP the option to speak directly to a customer service representative (CSR) specialized in these areas.

HOW IT WORKS

- Call Florida Part B customer service toll-free line at 1-866-454-9007.
- For questions pertaining to MSP and/or if you need a telephone adjustment performed, you will be prompted to press option 4.

As noted above, specific CSRs have been designated to answer questions related to MSP and telephone adjustments. If a non-designated CSR receives a call related to telephone adjustments and/or MSP, the caller will be asked to hang up, redial the toll free line, and select the appropriate option.

WEBCAST RECORDINGS OFFERED THROUGH FCSO MEDICARE TRAINING WEB SITE

We know that your busy schedule may not always permit you to participate in a Webcast. With your needs in mind, FCSO's Provider Outreach and Education team now offers recordings of past Webcasts in the Library section of FCSO's Learning Management System (LMS). The LMS can be accessed at *www.fcsomedicaretraining.com*.

1. From the welcome page, click the Library tab.
2. From the Library page, click the Online Resources sub-tab.
3. You will be able to select recordings and presentations for Ask the Contractor, Hot Topics, Ambulatory Surgical Centers (ASC), Provider Enrollment, Evaluation and Management, and The Final Rule Webcasts.

Recordings are available 24 hours a day, seven days a week. Upon clicking on the title of a recording, a player is launched without the need for time consuming downloading. Recordings play both the audio and visual of the Webcast right on your computer screen, providing you the ability to move to specific sections of the Webcast. For your convenience, we also provide you with the presentation materials used during the Webcast.

FIRST-TIME USER?

Please set up an account using the instructions located at the "eLearning (LMS)" link in the Provider Outreach & Education section of our provider Web sites.

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.

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

ADVANCE BENEFICIARY NOTICE

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

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

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

REVISION TO THE LCD

J0881: ERYTHROPOIESIS STIMULATING AGENTS—REVISION TO THE LCD

The local coverage determination (LCD) for epoetin alfa was last revised on January 18, 2008. Since that time, the LCD has been revised. First Coast Service Options, Inc. (FCSO) published a draft LCD for erythropoiesis stimulating agents (ESAs) for notice and comment during the October 2007 LCD cycle. FCSO elected to delay the finalization and implementation of this draft LCD pending the release of final contractor instructions for implementing the national coverage decision (NCD) on ESA use in cancer and related neoplastic diseases (change request [CR] 5818, transmittals 80 and 1413). These final instructions were received on January 14, 2008, and FCSO has made the necessary revisions to the draft LCD. With finalization of this draft LCD, FCSO has done a major revision to the epoetin alfa LCD by incorporating the content of the darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) LCD into this new ESA LCD. With the implementation of the ESA LCD, the Aranesp® LCD will be retired.

Revisions include updating the "Indications and Limitations of Coverage and/or Medical Necessity", "Utilization Guidelines" and "Documentation Requirements" sections of the LCD according to the revised product labels and including language related to the information published regarding the black box warnings on ESA use. Language related to the coverage and non-coverage restrictions imposed by the NCD have also been outlined in the LCD. ICD-9-CM coding has been revised to outline covered ICD-9-CM codes for each HCPCS code. The coding guideline attachment has been revised to include language regarding the new expanded reporting requirements for hemoglobin and hematocrit and also the requirements for including one of the new non-ESRD ESA modifiers on each claim for ESAs. A complete discussion for these new requirements may be found in CR 5699, transmittal 1412, dated January 11, 2008. The nationally noncovered ICD-9-CM codes listed in the NCD are included in the coding guideline attachment of the LCD. ICD-9-CM codes for the indications covered by the NCD are listed in the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

As noted below the effective date of this LCD revision is April 7, 2008. Please note however, that the requirements outlined in the LCD related to the NCD were effective on the day the Centers for Medicare & Medicaid Services (CMS) released the NCD as effective, July 30, 2007. Providers have been required to follow the NCD provisions as of July 30, 2007. Revisions made in the coding guideline attachment of the LCD related to CR 5699 are effective April 7, 2008, for services rendered on or after January 01, 2008.

EFFECTIVE DATE

This revision is effective for services rendered **on or after April 7, 2008**. The full text of this LCD is available through our provider education Web site at *http://www.fcso.com* on or after this effective date.

The retirement of the Darbepoetin alfa (Aranesp) (novel erythropoiesis stimulating protein [NESP]) LCD is effective for services rendered **on or after April 7, 2008**.

ADDITIONAL INFORMATION

BILLING LABORATORY TESTS FOR DIALYSIS PATIENTS

According to the Internet-Only Manual (IOM), *Medicare Benefit Policy Manual,* Pub. 100-02, chapter 11, section 30.2-30.2.1, certain end stage renal disease (ESRD) laboratory tests that are provided to ESRD beneficiaries are included in the composite rate calculations. Therefore, the tests may not be billed separately to the Medicare program.
The following list identifies certain separately billable laboratory tests that are covered routinely. These tests have specific frequency and diagnosis guidelines that apply.

Tests performed that exceed the listed frequencies are only covered if medically necessary, which must be documented in the patient's records, except for serum aluminum and serum ferritin, which may be covered routinely based on the knowledge that the patient is ESRD. Claims submitted for the laboratory tests listed below require a dual diagnosis. Claims must include the ESRD (ICD-9-CM diagnosis code 585.6) diagnosis requiring dialysis, in addition to the diagnosis representing the nature of the illness or injury requiring the additional test(s). Claims submitted without both diagnoses will be denied.

Per Treatment – All hematocrit, hemoglobin, and clotting time tests furnished incident to dialysis treatments

Weekly – (1) Prothrombin time for patients on anticoagulant therapy, and (2) Serum Creatinine

Weekly or Thirteen Per Quarter – BUN
Monthly – Serum Calcium, Serum Potassium, Serum Chloride, CBC, Serum Bicarbonate, Serum Phosphorous, Total Protein, Serum Albumin, Alkaline Phosphatase, aspartate amino transferase (AST) (SGOT) and LDH

Automated Battery of Tests – If an automated battery of tests, such as the SMA- 12, is performed and contains most of the tests listed in one of the weekly or monthly categories, it is not necessary to **separately** identify any tests in the battery that are not listed

BILLING LABORATORY TESTS FOR DIALYSIS PATIENTS, CONTINUED

Serum Aluminum – one every three months

Serum Ferritin – one every three months

Composite Rate Test for Hemodialysis, IPD, CCPD, Hemofiltration				
Chemistry	***CPT* Code**	**Monthly**	**Weekly**	**13 per Quarter**
Albumin	*82040*	X		
Alkaline Phosphatase	*84075*	X		
AST (SGOT)	*84450*	X		
Calcium	*82310*	X		
Chloride	*82435*	X		
CO2 (bicarbonate)	*82374*	X		
Creatinine	*82565*		X	
LDH	*83615*	X		
Phosphorus	*84100*	X		
Potassium	*84132*	X		
Protein, total	*84155*	X		
Urea nitrogen (BUN)	*84520*			X

Composite Rate Test for CAPD				
Chemistry	***CPT* Code**	**Monthly**	**Weekly**	**13 per Quarter**
Albumin	*82040*	X		
Alkaline Phosphatase	*84075*	X		
AST (SGOT)	*84450*	X		
Calcium	*82310*	X		
CO2 (bicarbonate)	*82374*	X		
Creatinine	*82565*	X		
LDH	*83615*	X		
Phosphorus	*84100*	X		
Potassium	*84132*	X		
Protein, total	*84155*	X		
Sodium	*84295*	X		
Urea nitrogen (BUN)	*84520*	X		

PROVIDERS BILLING FOR *CPT* CODE *99211*

First Coast Service Options, Inc. data analysis demonstrates that providers in Connecticut and Florida continue to incorrectly bill for *CPT* code *99211* (*Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services*.), despite various articles and publications regarding this error. One of the main contributors to this error is the billing of regularly scheduled prothrombin time (PT) lab tests (*CPT* code *85610*), along with *CPT* code *99211*, when there is no documentation of a separately identifiable evaluation and management (E/M) service having been rendered. If the PT level is the reason for a patient encounter, and no other service is being performed, it is not appropriate to bill for an E/M service in addition to the PT level. If services are provided and documented that support billing an E/M service in addition to the PT, it is appropriate to bill both services. Supporting documentation for *CPT* code *99211* must meet all the requirements for E/M billing, and must be separate and identifiable if billed on the same date of service as another payable service.

In cases where *CPT* code *99211* is billed in conjunction with *CPT* code *85610*, it is not sufficient to simply document activities related to drawing a blood sample, recording the results, and, in some cases, changing the medication dosage. When billing a *99211* E/M code, the presenting problem(s) is usually minimal, and, typically, five minutes is spent providing the service. Please note that there must be a presenting problem documented, and the documentation must demonstrate the reason for an E/M service on that particular date of service. The documentation must contain evidence of a face-to-face encounter for the purpose of evaluating the patient. In the absence of such documentation, both the Part B carrier and the comprehensive error rate-testing (CERT) contractor will deny services billed with *CPT* code *99211*.

The *CPT* description of *99211* includes the words, "…that may not require the presence of a physician." This has led some providers to mistakenly conclude that they can bill Medicare for a *99211* E/M visit for services performed by their staff when the physician is not present in office. This is incorrect. When *CPT* code *99211* is billed for services performed by the physician's office staff, these services are billed "incident to" the physician's professional services. In order to bill Medicare for "incident to" services, all of the "incident to" requirements must be met. This includes the presence of the physician in the office at the time the service is rendered.

Another area of concern is the level of documentation required when billing for *CPT* code *99211*. At a minimum, the medical record should document the reason and actions taken to address the patient's presenting problem, All of the other requirements for medical record documentation, such as the patient's name, date, facility identity, provider identity, signature and legibility must be documented.

90660-FLUMIST®-INFLUENZA VIRUS VACCINE LIVE, INTRANASAL

The initial approval by the U. S. Food and Drug Administration (FDA) for FluMist®-influenza virus vaccine live, intranasal, which contains a weakened form of the live virus and is sprayed in the nose, was previously limited to healthy children 5 years of age and older to adults up to age 49.

On September 19, 2007, the label was updated to include the FDA-approved revised indications for the FluMist®-iInfluenza virus vaccine live, intranasal, for the active immunization of individuals 2 to 49 years of age against influenza disease caused by influenza virus subtypes A and type B contained in the vaccine.

EFFECTIVE DATE

Effective for services rendered on or after September 19, 2007, Medicare will consider intranasally administered influenza vaccine (FluMist®) a medically necessary alternative to injectable influenza vaccine for immunocompetent healthy persons 2 to 49 years of age per FDA recommendations.

CONNECTICUT EDUCATIONAL RESOURCES

UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS – *MARCH 2008 – APRIL 2008*

EVALUATION & MANAGEMENT - "OBSERVATION CARE" WEBCAST

Topic: Hospital Observation Services
When: March 18, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

PROVIDER OUTREACH & EDUCATION ADVISORY GROUP (POE AG) MEETING

When: March 19, 2008
Time: 8:30 a.m. – 10:00 a.m.

For membership information, visit the POE AG page in the Provider Outreach & Education section.

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

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.

BACK TO BASICS MEDICARE SEMINAR

Are you a new provider, small provider, paper claim submitter, a provider without Internet access or have new personnel in your office who need basic Medicare training? If you answered "yes," then this FREE seminar is for you! Based on provider feedback from previous in-person seminars, we have designed this event in order to maximize the learning experience for office staff while reducing the time you are away from the office.

Participants can choose to attend all of the four classes offered, can attend just one class, or can attend any combination of classes that accommodate your training needs and schedule. Providers are encouraged to register via *www.fcsomedicaretraining.com*. Providers who do not have Internet access or are unfamiliar with the Web site can use the fax registration form on the following page. Don't miss out on this one-time only interactive training seminar – register today!

BACK TO BASICS MEDICARE SEMINAR, CONTINUED

SEMIMAR LOCATION INFORMATION

When: Thursday, April 17, 2008
Where: Hartford Marriott Rocky Hill
100 Capital Blvd, Rocky Hill, CT

CLASS DESCRIPTIONS

CMS-1500/National Provider Identifier

This course will provide a comprehensive overview of the Medicare-required items on the CMS-1500 claim form (or its electronic equivalent) including the proper use of national provider identifiers (NPIs). Discussion includes claims submission timeframes and how to avoid common billing errors. Each item on the CMS-1500 will be reviewed in detail and attendees will participate in interactive exercises to enhance their learning experience.

Modifiers

This course focuses on the most commonly used modifiers, including KX, GA/GZ/GY, 24, 25, 58, 78 and 79 just to name a few. Participants will learn how to identify situations when modifiers are needed, as well as when and where modifiers should be placed on the CMS-1500 (or its electronic equivalent). Attendees will participate in interactive exercises to enhance their learning experience.

Medicare Secondary Payer

This interactive course will provide a comprehensive overview of the Medicare Secondary Payer (MSP) program, including an overview of the roles and responsibilities of the different entities involved for MSP issues. Participants will learn how to avoid payment roadblocks through an increased understanding of MSP provisions as they relate to working aged, disability, liability, auto insurance and end-stage renal disease (ESRD). In addition, participants will apply guidelines to case scenarios to determine when Medicare is secondary and understand the required items on the CMS-1500 (or its electronic equivalent) when billing MSP claims.

Self-Service Tools

This interactive course will help Medicare providers and office staffs use all of Medicare's self-service options. Attendees will learn about the recent enhancements to the interactive voice response unit (IVR), how to navigate the First Coast Service Options, Inc. (FCSO) Connecticut provider Web site (*www.fcso.com*), and the Centers for Medicare & Medicaid Services (CMS) Web site (*www.cms.hhs.gov*) in order to locate Medicare regulations, fee schedules and pricing files, commonly used forms, and local coverage determinations (LCDs). In addition, participants will learn how to efficiently use the FCSO provider training Web site (*www.fcsomedicaretraining.com*) in order to sign up for FCSO seminars and to take Web-based training courses. A demonstration of our newest learning method, the webcast, will also be provided.

CLASS SCHEDULE

Class Times	Class Option #1	Class Option #2
Session 1 (8:30 AM – 10:00 AM)	Modifiers	Self-Service Tools
Session 2 (10:15 AM – 11:45 AM)	CMS-1500/NPI	MSP
Session 3 (1:00 PM – 2:30 PM)	CMS-1500/NPI	MSP
Session 4 (2:45 PM – 4:15 PM)	Modifiers	Self-Service Tools

FAX REGISTRATION

Please submit a separate form for each person attending. Circle the class(es) above you are registering for and fax to (203) 639-3069 by April 11, 2008. For questions regarding this event or registration, please leave a detailed voicemail message on the Registration Hotline at (203) 634-5527.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Please Note:

Pre-registration is required for all classes.

There is a maximum of 50 participants per class.

There are no Continuing Education Credits (CEUs) for any of the classes.

Sign-in will begin 10 minutes prior to the start of each class.

Coffee, tea, soda and water will be offered throughout the day, but lunch is on your own.

Free parking is available at the hotel. For driving directions, please call the Hartford Marriott Rocky Hill at (860) 257-6000.

FLORIDA EDUCATIONAL RESOURCES

UPCOMING PROVIDER OUTREACH AND EDUCATION EVENTS

MARCH 2008 – APRIL 2008

HOT TOPICS: MEDICARE UPDATES WEBCAST

When: March 13, 2008
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Webcast

EVALUATION & MANAGEMENT - "OBSERVATION CARE" WEBCAST
Topic: Hospital Observation Services
When: March 18, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

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

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

Important Addresses, Phone Numbers, and Web Sites

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: _____

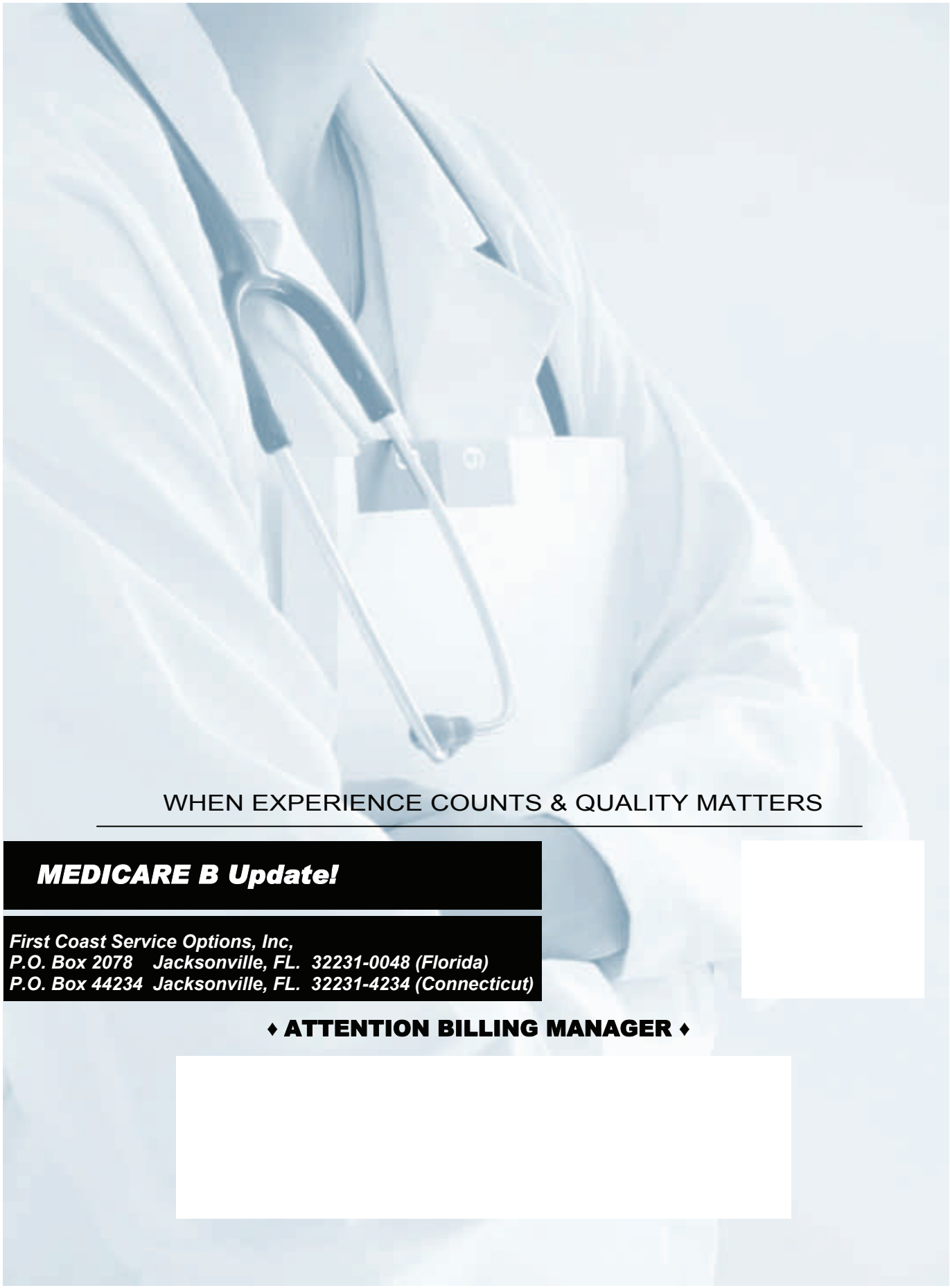
Provider/Office Name: _____

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 ♦