Medicare B Update!

A Newsletter for Connecticut and Florida Medicare Part B Providers

Highlights In This Issue…

Features

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

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

Routing Suggestions:

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

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TABLE OF CONTENTS

Medicare B Update!

Vol. 6, No. 1
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Publications Staff
Terri Drury
Millie C. Pérez
Mary Barnes
Betty Alix

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

Questions concerning this publication or its contents may be faxed to (904) 361-0723.

FROM THE CONTRACTOR

2008 Medifest Symposium—Mark Your Calendars

May 6 – 7, 2008 in Orlando

First Coast Service Options, Inc. (FCSO) invites Florida providers to save the date for our annual **Medifest Symposium** on **May 6 – May 7, 2008** in Orlando.

Our popular educational seminar brings together Medicare experts, providers, billing staff, coders and suppliers throughout Florida to learn the latest on the Medicare program and to network with your peers. And this year, we have implemented exciting new changes to Medifest that you won't want to miss!

What's New This Year

This year's Medifest will be more rewarding and convenient than ever. New changes include:

Two One-Day Sessions

To better accommodate your schedule, we will conduct Medifest as two one-day sessions, offering general classes in the morning and specialty courses in the afternoon. Come for one day or stay for two, there will be a diversity of classes for you to chose from.

Panel Discussion Sessions

Participants will have the opportunity to dialogue with a panel of representatives from FCSO's staff and leadership levels, and to network with their peers.

More Advanced Classes

Based on your recommendations, we will conduct all courses at a more advanced level this year. To ensure everyone benefits from this new curriculum, participants must complete one Web-based training (WBT) course prior to registering for each class. These pre-requisite WBTs will be available through our learning management dystem in February 2008.

Interested?

More information on registration and how to complete pre-requisite WBT courses will be coming soon in future communications. Stay tuned to our Web site at *www.fcso.com*, or through our event registration hotline at 904-791-8103.

This will be the only Medifest event for Florida providers in 2008, so don't forget to mark your calendars!

Marriott Orlando Downtown
400 West Livingston Street
Orlando, FL 32801
May 6 – May 7, 2008

Sign up to our *eNews* electronic mailing list

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

THE FCSO MEDICARE B UPDATE!

About the Connecticut and Florida *Medicare B Update!*

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

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

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

Who Receives the *Update?*

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

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

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

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

Clear Identification of State-Specific Content

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

Publication Format

The *Update!* is arranged into distinct sections.

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

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

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

Quarterly Provider Update

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

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

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

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

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

Have You Visited the FCSO Web Site Lately?

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

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

This information and much more are just a few clicks away! You can access the Florida or Connecticut Medicare provider Web sites anytime by going to *www.fcso.com*. Once there, under "Medicare Providers", click either Florida or Connecticut.

Advance Beneficiary Notices

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

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

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

Patient Liability Notice

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

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

ABN Modifiers

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

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

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

"GA" Modifier and Appeals

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

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

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

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

OR

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

CLAIMS

Quarterly Update to Correct Coding Initiative Edits, Version 14.0, Effective January 1, 2008

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

Provider Types Affected

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

Background

This article is based on change request (CR) 5824, which provides a reminder for physicians to take note of the quarterly updates to correct coding initiative (CCI) edits. The National Correct Coding Initiative developed by the Centers for Medicare & Medicaid (CMS) helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in:

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

Key Points

The latest package of CCI edits, version 14.0, is effective January 1, 2008. version 14.0 of the CCI edits will include all previous versions and updates from January 1, 1996 to the present and will be organized into two tables:

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

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

Additional Information

The CCI and MED file formats are defined in the *Medicare Claims Processing Manual*, Publication 100-4, chapter 23, section 20.9, which may be found at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS website.

The official instruction, CR 5824, issued to carriers and A/B MACs regarding this update may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1386CP.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: MM5824
Related Change Request (CR) #: 5824
Related CR Release Date: November 30, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1386CP
Implementation Date: January 7, 2008

AMBULANCE

Medicare Payments for Ambulance Transports

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the December 2007 Medicare B Update! pages 11-12.

Note: This article was revised on December 12, 2007, to provide additional clarification. Some language regarding emergency and nonemergency transports and the physician certification statement was removed and readers are referred instead to the actual regulations. In addition, some language was added as reflected in print that is bold & italicized.

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MAC) for ambulance services or who initiate ambulance transports for their Medicare patients.

Provider Action Needed

STOP – Impact to You

According to a recent study conducted by the Office of the Inspector General (OIG), "Medicare Payments for Ambulance Transports," during the calendar year 2002, twenty-five percent of ambulance transports did not meet Medicare's program requirements. This resulted in an estimated $402 million of improper payments. In two out of three cases, third-party providers(most likely not the patient) who requested transports may not have been aware of Medicare's requirements for ambulance transports.

CAUTION – What You Need to Know

Liability for overpayment resulting from a denied ambulance transport claim depends on the type of denial. A denial due to coverage reasons (such as when other forms of transportation are not contraindicated) may result in a liability to the Medicare beneficiary. Claims denied due to level of service requirements are often down-coded to a lower level of ambulance service. In this case, the ambulance supplier is generally liable in the event of an overpayment. ***Please keep in mind that any discussion in this article does not supersede CMS' rules, regulations, manual instructions, or the Social Security Laws.***

GO – What You Need to Do

Please refer to the *Background* and *Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified. It is important to know whether Medicare would cover the use of an ambulance transport for your patient, and if so, what level of service would be covered. Please refer to the *Background* section of this special edition article for information about payment and level of service requirements for ambulance transports.

Background

Some key provisions of the OIG Report are as follows:

Medicare Coverage of Ambulance Transports

When evaluating coverage of ambulance transport services, two separate questions are considered:

1. Would the patient's health at the time of the service be jeopardized if an ambulance service was not used? If so, Medicare will cover the ambulance service whether it is emergency or non-emergency use of the transport. If not, the Centers for Medicare & Medicaid Services (CMS) will deny the transport claim. Additionally, Medicare does not cover non-ambulance transports.
2. Once coverage requirements are met, Medicare asks the following question: What level of service (determined by medical necessity) is appropriate with regard to the diagnosis and treatment of the patient's illness or injury? If the incorrect level of service is billed and subsequently denied, Medicare will usually reimburse at a lower rate reflecting the lower level of services judged appropriate.

Levels of ambulance service are differentiated by the equipment and supplies carried in the transport and by the qualifications and training of the crew. They include:

a) Basic ***L***ife ***S***upport ***(BLS)***
b) Advanced ***L***ife ***S***upport ***(ALS) – Level 1 (ALS1) and Level 2 (ALS2)***
c) Specialty ***C***are ***T***ransport ***(SCT)***
d) Air transport – fixed wing and rotary wing

In addition, both the BLS and ALS1 levels of ambulance service can be categorized as either emergency or non-emergency. As defined in 42 CFR 414.605, an emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance entity begins as quickly as possible to take the steps necessary to respond to the call.

Documentation Requirements

Ambulance suppliers are not required to submit documentation in addition to the uniform CMS-1500 submitted by independent ambulance suppliers to Medicare carriers or A/B MACs or the UB-04 (CMS-1450) billed to FIs or A/B MACs by ambulance suppliers that are owned by or affiliated with a Medicare Part A provider such as a hospital.

However, ambulance suppliers are required to retain documentation that contains information about the personnel involved in the transport and the patient's condition and to ***make that documentation available to*** Medicare FIs, carriers, and A/B MACs upon request. Ambulance suppliers are also required to obtain a physician certification statement (PCS) for non-emergency transports ***in some circumstances. These circumstances are defined in 42 CFR 410.40(d)(2) and 42 CFR 410.40(d)(3)*** (see 42 CFR 410.40 link in the *Additional Information* section).

How to Avoid Improper Billing

- Be sure that coverage criteria and level of service criteria for ambulance transport are met and that it is backed up with the appropriate documentation. For guidance, you may wish to refer to change request (CR) 5442 "Ambulance Fee Schedule – Medical Conditions List – Manualization," which contains an educational guideline that was developed to assist ambulance

Medicare Payments for Ambulance Transports, continued

providers and suppliers ***in*** communicat***ing*** the patient's condition to Medicare FIs, carriers, and A/B MACs as reported by the dispatch center and as observed by the ambulance crew. The link to this CR is provided below.

- Maintain documentation that will help to determine whether ambulance transports meet program requirements when Medicare FIs, carriers, and A/B MACs conduct medical reviews. Be sure to send complete documentation when requested by your FI, carrier, or A/B MAC. Generally, coverage errors for emergency transports were due to documentation discrepancies between the ambulance supplier and the third-party provider (e.g., emergency room records).
- Note whether your FI, carrier, or A/B MAC has implemented origin or destination modifiers such as for a dialysis facility and for non-emergency transports to and from a hospital, nursing home, or physician's office. Be sure to include these modifiers (if available) when billing for ambulance services. They will help your FI, carrier, or A/B MAC to determine, through a prepayment edit process, whether the coverage and/or level of service for ambulance use is correct.

Additional Information

SE0724 is based on the January 2006 U.S. Department of Health and Human Services (HHS) OIG report, *Medicare Payments for Ambulance Transports*, which is located at *http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf* on the OIG HHS Web site.

CR 5442, dated February 23, 2007, "Ambulance Fee Schedule – Medical Conditions List – Manualization Revisions," is located at *http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf* on the CMS Web site.

The regulations at 42 CFR 410.40(d)(2) and (3) state the circumstances when a PCS is required and may be found at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410_40.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: SE0724 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
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Implementation Date: N/A

AMBULATORY SURGICAL CENTER

Adjustment to Payment Under Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System for Partial Device Credit

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

Provider Types Affected

Providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries, which are paid under the OPPS or the ASC payment system.

Provider Action Needed
STOP – Impact to You

This article informs affected providers of how partial credits for medical devices are to be reported and paid under the OPPS and ASC payment systems.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is implementing a partial device credit policy for hospitals paid under the OPPS and for ASCs paid under the revised ASC payment system (for services furnished on or after January 1, 2008). The partial credit policy applies to the same devices, ambulatory payment classifications (APCs), and ASC procedures to which the no cost or full credit policy applies. Medicare payment will be reduced by 50 percent of the estimated cost of the device (i.e., the device offset percentage) in cases in which the hospital or ASC reports that it received a partial credit of 50 percent or more of the cost of the new device that is being implanted. See the table of applicable APCs at *http://www.cms.hhs.gov/HospitalOutpatientPPS/* for the percentage reduction to the payment when the hospital reports a partial credit of 50 percent or more for a specified replacement device (also listed in those tables).

A table of covered ASC surgical procedures to which the partial device credit policy applies is available at *http://cms.hhs.gov/ASCPayment/*. Table 58 provides the device offset percentages for the selected OPPS APCs to which the partial device credit policy applies under the revised ASC payment system. ASCs will receive the same amount of payment reduction (in dollars) as a hospital when reporting a partial credit for a new replacement device.

Adjustment to Payment Under Hospital OPPS and ASC Payment System for Partial Device Credit, continued

GO – What You Need to Do

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

Background

In general, CMS includes the full payment for devices with the payment for the service in which the device is used by using only outpatient hospital claims that contain the full cost of medical devices in setting the Medicare payment rates.

In some cases, the cost of the device is a very large proportion of the cost of the procedure on which the APC payment for the procedure is based. Thus, when the provider receives partial credit for the device and therefore, does not incur the full cost of the procedure, it is necessary to adjust the payment so that the payment reflects the reduced cost of the device. This is necessary to:

- Provide an appropriate payment for the service.
- Ensure that the Medicare beneficiary's co-payment liability is reduced when appropriate.

CMS determined that partial credits occur more commonly than do full credits or no cost devices. In addition, CMS has learned that typical industry practice for some types of devices is to:

- Provide a 50 percent credit in cases of device failure (including battery depletion) under warranty if a device failed before three years of use.
- Prorate the credit over time between three and five years after the initial device implantation, as the useful life of the device declines.

In these cases, neither the hospital nor ASC is incurring the full cost of the device, although the Medicare payment is calculated based on the full cost of the device.

Effective for services furnished on or after January 1, 2007, CMS implemented a policy to adjust the OPPS payment for procedures assigned to selected APCs when any of the specified devices was implanted in a beneficiary (and remained in the patient at least temporarily) and was furnished either without cost or with full credit for the cost of the device being replaced. See CR 5263 (Transmittal 1103, November 3, 2006, *http://www.cms.hhs.gov/transmittals/downloads/R1103CP.pdf*) or related *MLN Matters* article MM5263 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5263.pdf*) and the *Medicare Claims Processing Manua*l (Pub.100-4, chapter 4, section 61.3 *http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf*) on the CMS Web site.

Hospitals report the occurrence of a no cost or full credit device to CMS by reporting modifier **FB** on the line with the procedure code in which the no cost or full credit device is used when the device is on the list of specified devices to which this policy applies. The lists of affected devices and APCs are located on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 626) requires implementation of a revised ASC payment system no later than January 1, 2008. The revised payment system to be implemented January 1, 2008, is based on the relative payment weights established under the OPPS and many of the payment policies of the OPPS, including the full device credit policy. A special edition *MLN Matters* article outlining the new ASC payment system is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf*.

Effective January 1, 2008, CMS is also implementing a partial device credit policy under both the OPPS and the ASC payment system.

Hospitals and ASCs report the occurrence of a partial credit device to CMS by reporting modifier **FC** on the line with the procedure code in which the partial credit device is used when the device is on the list of specified devices to which this policy applies. The devices, APCs, and covered ASC surgical procedures to which the partial device credit policy applies are the same as the devices, APCs, and covered ASC surgical procedures to which the full device credit policy applies (modifier **FB**).

For services furnished on or after January 1, 2008, hospitals and ASCs are required to report modifier **FC** with the procedure code for all cases in which:

- The device being implanted is on the list of creditable devices.
- The procedure code in which the device is used is assigned to an APC that is on the list of APCs to which the policy applies in the case of hospitals, or on the list of procedures to which the policy applies in the case of ASCs.
- The hospital or ASC received a credit of 50 percent or more of the estimated cost of the new replacement device.

The list of devices, APCs, and ASC procedures to which this policy applies is available on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

The reduction to the APC payment amount when the hospital reports a partial credit for the new replacement device is available on that web site as well. An ASC will receive the same amount of payment reduction (in dollars) as a hospital when it reports receiving a partial device credit for a particular procedure.

Remember that both hospitals and ASCs are required to report modifier the **FC** with the code for the device implantation procedure, not with the code for the device. Failure to include the proper modifiers on claims as appropriate may result in payment to which the provider is not entitled. If hospitals report the modifier with the device code instead of the procedure code, the claim will be returned.

Because hospitals may not know the amount of credit the manufacturer will provide for the replacement device when the replacement procedure takes place, hospitals will have the option of either: (1) submitting the claim for the device replacement procedure to their Medicare contractor immediately without modifier **FC** and then submitting a claim adjustment with modifier **FC** at a later date once a credit determination is made; or (2) holding the claim for the device replacement procedure until a determination is made by the manufacturer on the partial credit amount, and submitting the claim with modifier **FC** appended to the implantation procedure code if the partial credit is 50 percent or more of the cost of the replacement device.

ASCs have the same two billing options as outlined above for hospitals, but if an ASC chooses Option 1 and

Adjustment to Payment Under Hospital OPPS and ASC Payment System for Partial Device Credit, continued

bills for a replacement device procedure prior to receiving a manufacturer's credit determination, it must subsequently contact the Medicare contractor regarding a claims adjustment if a credit of 50 percent or more is received.

When hospitals or ASCs use Option 1, they should be mindful that the initial Medicare payment for the procedure involving the replacement device is conditional and subject to adjustment.

Following are some hypothetical examples that illustrate the revised policy:

OPPS Examples (all payment amounts are hypothetical)

Example	HCPCS/ *CPT*	Description	SI	Units	APC	Unadjusted Payment	Offset Value	New Unadj. Payment
Claim 1: Full Credit or No Cost Replacement Device	*33240* **FB**	Implant ICD	T	1	0107	$18,000	$17,000	$1,000
	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	$24	---	$24
Because claim 1 is being billed as a full credit or no cost replacement device, it receives the full offset of $17,000.								
Claim 2: Partial Credit Replacement Device	*33240* **FC**	Implant ICD	T	1	0107	$18,000	$8,500 ($17,000 x 0.5)	$9,500 ($8,500 + $1,000)
	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	$24	---	$24
Because claim 2 is being billed with a partial credit replacement device, the offset is half of the full offset value.								
Claim 3: Multiple Procedure Discount and Partial Credit Replacement Device	*33240* **FC**	Implant ICD	T	1	0107	$18,000	$8,500 ($17,000 x 0.5)	$9,500 ($8,500 + $1,000)
	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	$24	---	$24
	35180	Fistula Repair	T	1	0093	$1,500	---	$750 ($1,500 x 0.5)
Because claim 3 is being billed with a partial credit replacement device, the offset is half of the full offset value. Also, APC 0093 is discounted according to the multiple procedure discount rule. If the payment for APC 0093 were greater than the payment for APC 0107 after discount for the partial device credit, the multiple procedure discount would have been applied to further discount payment for APC 0107. The post-offset payment rate is used in discount determination, rather than the pre-offset payment rate.								
Claim 4: Terminated Procedure and Partial Credit Replacement Device	*33240* FC and 73	Implant ICD	T	1	0107	$18,000	$8,500 ($17,000 x 0.5)	$4,750 (($8,500 + $1,000) x 0.5)
	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	$24	---	$24
Because claim 4 is being billed with a partial credit replacement device, the offset is half of the full offset value. Also, APC 0107 is discounted due to the presence of modifier 73, which identifies the service as being terminated prior to the administration of anesthesia or initiation of the procedure.								
Claim 5: FC Modifier on Partial Credit Replacement Device Line	*33240*	Implant ICD	T	1	0107	**I/OCE Edit #75:** Incorrect billing of modifier **FB** or **FC**		
	C1721 **FC**	ICD	N	1	==			
	93005	EKG	S	1	0099			
Because modifier FC is located on the line for the device, instead of the procedure used to implant the device, the claim is returned to the provider due to I/OCE edit #75.								

Adjustment to Payment Under Hospital OPPS and ASC Payment System for Partial Device Credit, continued

ASC Examples (All payment amounts are hypothetical)

Note: Payment for devices, with the exception of pass through devices, are packaged into payment for the device implantation procedure. In the below examples, the device is not shown as a separate line item on the ASC claim because, in order to ensure appropriate payment, ASCs should not report packaged devices as separate line items on the claim.

Example	HCPCS/ *CPT*	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
Claim 1: Full Credit or No Cost Replacement Device ASC implants ICD replacement device (procedure 33240, device C1721) and receives full credit or incurs no cost for the replacement device.	*33240* **FB**	Implant ICD	J8	1	$17,500	$17,000	$500
Claim 2: Partial Credit Replacement Device ASC implants ICD replacemer device (procedure 33240, device C1721) and receives partial credit for the replacement device.	*33240* **FC**	Implant ICD	J8	1	$17,500	$8,500 ($17,00 0 x 0.5)	$9,000 ($8,500 + $500)
Claim 3: Multiple Procedure Discount and Partial Credit Replacement Device ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device. ASC also performs an additional procedure (33218), to which the multiple procedure discount applies.	*33240* **FC**	Implant ICD	J8	1	$17,500	$8,500 ($17,00 0 x 0.5)	$9,000 ($8,500 + $500)
	33218	Electrode Repair	G2	1	$1000	--	$500 ($1000 x 0.5)
Claim 4: Terminated Procedure and Partial Credit Replacement Device ASC brings patient into operating room to implant ICD (procedure 33240, device C1721) and receives partial credit for the replacement device. ASC terminates the procedure prior to the administration of anesthesia or initiation of the procedure.	*33240* **FC and 73**	Implant ICD	J8	1	$17,500	$8,500 ($17,00 0 x .5)	$4,500 (($8,500 + $500) x 0.5)

Adjustment to Payment Under Hospital OPPS and ASC Payment System for Partial Device Credit, continued

Example	HCPCS/ *CPT*	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
Claim 5: FC modifier on Partial Credit Replacement Device Line ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device.	*33240*	Implant ICD	J8	1	**Incorrect billing** because ASCs may not report device HCPCS codes or device charges on a separate line on the claim. Device payment is packaged into payment for the device implantation procedure, and charges for the device should be included in the line-item charge for the device implantation procedure. This bill will not result in accurate payment because there is no ASC payment rate for the device, and the payment for the implantation procedure will be made at the lesser of the ASC charges or the ASC rate.		
	C1721 **FC**	ICD	N1	1			
Claim 6: Partial Credit Replacement Device But FC Modifier Not Reported on Procedure Code ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device, but fails to append the FC modifier to the procedure code.	*33240*	Implant ICD	J8	1	**Incorrect billing** if partial credit is known at the time of billing. FC modifier should have been appended to the procedure code. If partial credit is unknown at the time of billing and the partial credit is received by the ASC at a later time, the ASC should contact the contractor to request an adjustment.		

Disclaimer: The above claim examples are hypothetical only and aim to reflect the pricing concepts, effective January 1, 2008. The rates above do not represent actual payment rates.

Additional Information

To view the official instruction (CR 5668) on which this article is based, providers may visit the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R1383CP.pdf*.

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

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

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Implementation Date: N/A

CHIROPRACTIC SERVICES

Addressing Misinformation Regarding Chiropractic Services and Medicare

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

Provider Types Affected

Providers submitting claims to Medicare contractors (carriers, and/or Part A/Part B Medicare administrative contractors [A/B MACs]) for chiropractic services provided to Medicare beneficiaries

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to correct misinformation in the chiropractic community relating to Medicare and its regulations as they relate to chiropractic services. This article is informational only and represents no changes to existing Medicare policy.

Background

In order to correct misinformation about Medicare and its regulations, which exist in the chiropractic community, the American Chiropractic Association (ACA) works to check the validity of all claims and provide accurate information based on the Medicare manual system, maintained by CMS, as well as information in regulatory and statutory language. CMS is providing this special edition article, which it hopes, will clarify certain issues, around which there may be some confusion. The specific issues being addressed are:

Misinformation #1

There is a 12-visit cap or limit for chiropractic services.

Correction: There are no caps/limits in Medicare for covered chiropractic care rendered by chiropractors who meet Medicare's licensure and other requirements as specified in the *Medicare Benefit Policy Manual*, chapter 15, section 30.5. (This manual is available at *http://www.cms.hhs.gov/manuals/IOM/list.asp* on the CMS Web site.)

There may be review screens (numbers of visits at which the Medicare carrier or A/B MAC may require a review of documentation), but caps/limits are not allowed.

The Social Security Act (section 1862 (a)(1); see *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the Internet) provides that Medicare will only pay for items or services it determines to be "reasonable and necessary," and if those items or services can be shown to be "reasonable and necessary," then those items or services are covered and will be paid by Medicare.

Misinformation #2

If you are a nonparticipating (nonpar) provider, you do not have to worry about billing Medicare.

Correction: Being nonpar does not mean you don't have to bill Medicare. All Medicare covered services must be billed to Medicare, or the provider could face penalties.

A nonpar provider is actually a provider involved in the Medicare program who has enrolled to be a Medicare provider but chooses to receive payment in a different method and amount than Medicare providers classified as participating. The nonpar provider may receive reimbursement for rendered services directly from their Medicare patients. They submit a bill to Medicare so the beneficiary may be reimbursed for the portion of the charges for which Medicare is responsible.

It is important to note that nonpar providers may choose to accept assignment, therefore, the amount paid by the beneficiary must be reported in Item 29 of the CMS 1500. This ensures that the beneficiary is reimbursed (if applicable) prior to Medicare sending payment to the provider.

Whether or not a nonpar provider chooses to accept assignment on all claims or on a claim-by-claim basis, their Medicare reimbursement is five percent less than a participating provider, as reflected in the annual Medicare physician fee schedule.

You may find a copy of the Medicare Participating Provider Agreement at *http://www.cms.hhs.gov/cmsforms/downloads/cms460.pdf* on the CMS Web site. The form contains important information regarding the participation process and the annual opportunity you have to make or change your participation decision.

Additional information is available in the *Medicare Benefit Policy Manual* (chapter 15; Covered Medical and Other Health Services) at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site and the *Medicare Claims Processing Manual* (chapter 12; Physician/Nonphysician Practitioners) at *http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf* on the CMS Web site.

Misinformation #3

If you are a nonparticipating (nonpar) provider, you will never be audited nor have claims reviewed, etc.

Correction: Any Medicare claim submitted may be audited/reviewed; the nonparticipating (nonpar) or participating (par) status of the physician does not affect the possibility of this occurring. CMS audits/reviews are intended to protect Medicare trust funds and also to identify billing errors so providers and their billing staff can be alerted of errors and educated on how to avoid future errors. Correct coverage, reimbursement, and billing requirements are readily available to assist you in understanding Medicare requirements. This information is in Medicare manuals that are at *http://www.cms.hhs.gov/Manuals/* on the CMS Web site. In addition, an excellent way to stay informed about changes to Medicare billing and coverage requirements is to monitor *MLN Matters* articles, such as this one, which are available at *http://www.cms.hhs.gov/MLNMattersArticles/* on the same site.

Addressing Misinformation Regarding Chiropractic Services and Medicare, continued

Misinformation #4

You can opt out of Medicare.

Correction: Opting out of Medicare is not an option for Doctors of Chiropractic. Note that opting out and being nonparticipating are not the same things. Chiropractors may decide to be participating or nonparticipating with regard to Medicare, but they may not opt out.

For further discussions of the Medicare "opt out" provision, see the *Medicare Benefits Policy Manual* (chapter 15, section 40; Definition of Physician/Practitioner) at *http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf* on the CMS Web site.

Misinformation #5

You should get an advance beneficiary notification (ABN) signed once for each patient, and it will apply to all services, all visits.

Correction: The decision to deliver an ABN must be based on a genuine reason to expect that Medicare will not pay for a particular service on a specific occasion for that beneficiary due to lack of medical necessity for that service. The ABN then allows the beneficiary to make an informed decision about receiving and paying for the service. Should the beneficiary decide to receive the service, you must then submit a claim to Medicare even though you expect the beneficiary to pay and you expect that Medicare will deny the claim.

For further information, see the *Medicare Claims Processing Manual* (chapter 30) at *http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf* and the *Medicare Benefits Policy Manual* (chapter 15) at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site. Also see "What Doctors Need to Know about the Advance Beneficiary Notice (ABN)" at *http://www.cms.hhs.gov/MLNProducts/downloads/ABN_READERS.pdf* on the CMS Web site.

Misinformation #6

Maintenance care is not a covered service under Medicare.

Correction: Spinal manipulation is a covered service under Medicare, no matter which phase of care you may be in; however, maintenance care is not **medically reasonable and necessary and therefore not reimburseable by Medicare**. Acute, chronic, and maintenance adjustments are all "covered" services, but only acute and chronic services are considered active care and may, therefore, be reimbursable. Maintenance therapy is defined (per chapter 15, section 30.5.B. of the *Medicare Benefits Policy Manual*) as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

See MM3449 (Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3449.pdf* on the CMS Web site. This article contains important information on completing claims and how to identify acute and chronic adjustments as opposed to maintenance adjustments. **The article also recommends you consider issuing an ABN to the Medicare beneficiary when you provide maintenance services**. Additional details are available in the *Medicare Benefits Policy Manual*, chapter 15, section 30.5 (Chiropractor's Services) at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site.

Misinformation #7

Nonpar providers do not have the same documentation requirements as par providers.

Correction: Chiropractic care has documentation requirements to show medical necessity. The participating status of the provider is irrelevant to the documentation requirements.

Specific details regarding documentation are in the *Medicare Benefit Policy Manual* (chapter 15, sections 30.5 and 240) at *http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf* on the CMS Web site. Also, see the *Medicare Claims Processing Manual* (chapter 12, section 220) at *http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf* on the CMS Web site.

Additional Information

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

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

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COMPETITIVE AQUISITION PROGRAM

Quarterly Competitive Acquisition Program Drug and Annual CAP Drug Price Updates

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

Provider Types Affected

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

What Providers Need to Know Action Needed

This article is based on change request (CR) 5839, which provides additional information and instructions for the implementation of the CAP pertaining to CAP drug categories and fee schedule as outlined in CR 5079 (transmittal 1055, dated September 11, 2006, *http://www.cms.hhs.gov/Transmittals/downloads/R1055CP.pdf)* and CR 4064 (transmittal 777, dated December 9, 2006, *http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf)* on the CMS Web site.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, (MMA, section 303 (d); *http://www.cms.hhs.gov/MMAUpdate*) requires the implementation of a CAP for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians have a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process.

CR 4064 describes requirements for carriers to develop provider files that list physicians who have enrolled with an approved CAP vendor and the category (or categories) of drugs that the CAP vendor will furnish under the CAP as outlined in: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf* on the CMS Web site.

CR 5079 automated the process of updating the list of drugs paid under the CAP. CR 5079 provides additional information and instructions for the implementation of the CAP pertaining to the CAP drug categories and fee schedule as outlined in *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf* on the CMS Web site.

Key Points of CR 5839

The list of drugs supplied under the CAP is subject to quarterly drug updates and an annual price update. The Centers for Medicare & Medicaid Services (CMS) makes a CAP drug file available to the designated carrier once each quarter unless there are no updates to the CAP drug list, in which case the previous quarter's file continues to be used. Local carriers and A/B MACs receive the list of CAP drugs by HCPCS code from the CAP designated carrier.

- The CAP designated carrier shall download the January 2008 CAP drug-pricing file through the Centers for Disease Control and Prevention on or after December 18, 2007. The CAP designated carrier will then make the updated CAP drug list available to other contractors who process related claims.
- Medicare contractors will receive CAP HCPCS updates from the designated carrier on or about December 21, 2007.
- Contractors will use the updated CAP drug list to establish the identity of drugs paid under the Medicare Part B Drug CAP.

Additional Information

To see the official instruction (CR 5839) issued to your Medicare A/B MAC or carrier, go to *http://www.cms.hhs.gov/Transmittals/downloads/R1390CP.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM5839
Related Change Request (CR) #: 5839
Related CR Release Date: December 13, 2007
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Related CR Transmittal #: R1390CP
Implementation Date: January 7, 2008

CONSOLIDATED BILLING

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

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

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (fiscal intermediaries [FIs], carriers, regional home health intermediaries [RHHIs], and DME Medicare administrative contractors [DME MACs] and Part A/B Medicare administrative contractors [A/B MACs]) for medical supply or therapy services.

What Providers Need to Know

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing (CB) provision of the home health prospective payment system (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2008. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the *Additional Information* section of this article.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA.) As a result, billing for all such items and services is to be done by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes. Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physician
- Supplies incidental to physician services
- Supplies used in institutional settings.

Medicare has issued a recurring update notification, which provides the annual HH consolidated billing updates for non-routine supplies and therapies effective January 1, 2008. These lists are updated annually, effective each January 1, to reflect the annual changes to the HCPCS code set. The lists may also be updated as frequently as quarterly if required by the creation of temporary HCPCS codes during the year.

Change request (CR) 5829 provides the annual HH CB update effective January 1, 2008. The following tables describe the HCPCS codes and the specific changes to each that this notification is implementing for claims with dates of service on or after January 1, 2008.

Table 1: Non Routine Supplies

Code	Description	Action
A5083	Continent device, stoma absorptive cover for continent stoma	Add
A5105	Urinary suspensory with leg bag with or without tube, each	Redefine
A6200	Composite dressing, pad size 16 sq. In. Or less, without adhesive border, each dressing	Delete
A6201	Composite dressing, pad size more than 16 sq. In. But less than or equal to 48 sq. In., without adhesive border, each dressing	Delete
A6202	Composite dressing, pad size more than 48 sq. In., without adhesive border, each dressing	Delete
A6413	Adhesive bandage, first-aid type, any size, each	Add

Annual Update of HCPCS Codes Used for HHCB Enforcement, continued

Table 2: Therapies

Code	Description	Action	Replacement Code or Code being Replaced
96125	Standardized cognitive performance testing per hour	Add	*96125*

Additional Information

For details regarding this CR, please see the official instruction issued to your Medicare FI, carrier, A/B MAC, RHHI, or DME MAC. This may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1391CP.pdf* on the CMS Web site.

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

A complete historical listing of codes subject to HH CB may be found at *http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp* on the CMS Web site.

To review the Medicare manual instructions discussed in this article see the *Medicare Claims Processing Manual*, chapter 10, section 20.1 at *http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf* on the CMS Web site.

MLN Matters Number: MM5829 Related Change Request (CR) #: 5829
Related CR Release Date: December 14, 2007 Effective Date: January 1, 2008
Related CR Transmittal #: R1391CP Implementation Date: January 7, 2008

DIABETIC SERVICES

An Overview of Medicare Covered Diabetes Supplies and Services

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

Provider Types Affected

Physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for Medicare-covered diabetes benefits.

Provider Action Needed

This article is informational only and represents no Medicare policy changes.

Background

Diabetes is the sixth leading cause of death in the United States, and approximately 20 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. Millions of people have diabetes and do not know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, and death related to pneumonia and flu. Scientific evidence now shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay much of the illness and complications associated with diabetes.

This special edition article presents an overview of the diabetes services and supplies covered by Medicare (Part B and Part D) to assist physicians, providers, suppliers, and other health care professionals who provide diabetic supplies and services to Medicare beneficiaries.

Medicare Part B Covered Diabetic Supplies

Medicare covers certain supplies if a beneficiary has Medicare Part B and has diabetes. These supplies include:

- Blood glucose self-testing equipment and supplies
- Therapeutic shoes and inserts
- Insulin pumps and the insulin used in the pumps

Blood Glucose Self-testing Equipment and Supplies

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. This includes those who use insulin and those who do not use insulin. These supplies include:

- Blood glucose monitors
- Blood glucose test strips
- Lancet devices and lancets

An Overview of Medicare Covered Diabetes Supplies and Services, continued

- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies.

If the beneficiary

- **Uses insulin**, they may be able to get up to 100 test strips and lancets every month, and one lancet device every six months.
- **Does not use insulin**, they may be able to get 100 test strips and lancets every three months, and one lancet device every six months.

If a beneficiary's doctor says it is medically necessary, Medicare will cover additional test strips and lancets for the beneficiary.

Medicare will only cover a beneficiary's blood glucose self-testing equipment and supplies if they get a prescription from their doctor.

Their prescription should include the following information:

- That they have diabetes
- What kind of blood glucose monitor they need and why they need it (i.e., if they need a special monitor because of vision problems, their doctor must explain that.)
- Whether they use insulin
- How often they should test their blood glucose

A beneficiary needing blood glucose testing equipment and/or supplies:

- Can order and pick up their supplies at their pharmacy.
- Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order. Their doctor cannot order it for them.
- Must ask for refills for their supplies.

Note: Medicare will not pay for any supplies not asked for, or for any supplies that were sent to a beneficiary automatically from suppliers. This includes blood glucose monitors, test strips, and lancets. Also, if a beneficiary goes to a pharmacy or supplier that is not enrolled in Medicare, Medicare will not pay. The beneficiary will have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor test strips. A beneficiary cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly. Beneficiaries should only pay their coinsurance amount when they get their supply from their pharmacy or supplier for assigned claims. If a beneficiary's pharmacy or supplier **does not** accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

Before a beneficiary gets a supply, it is important for them to ask the supplier or pharmacy the following questions:

- Are you enrolled in Medicare?
- Do you accept assignment?

If the answer to either of these two questions is "no," they should call another supplier or pharmacy in their area who answers "yes" to be sure their purchase is covered by Medicare, and to save them money.

If a beneficiary cannot find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.

Therapeutic Shoes and Inserts

If a beneficiary has Medicare Part B, has diabetes, and meets certain conditions (see below), Medicare will cover therapeutic shoes if they need them. The types of shoes that are covered each year include one of the following:

- One pair of depth-inlay shoes **and** three pairs of inserts; or
- One pair of custom-molded shoes (including inserts) if the beneficiary cannot wear depth-inlay shoes because of a foot deformity **and** two additional pairs of inserts.

Note: In certain cases, Medicare may also cover separate inserts or shoe modifications instead of inserts.

In order for Medicare to pay for the beneficiary's therapeutic shoes, the doctor treating their diabetes must certify that they meet **all** of the following three conditions:

- They have diabetes.
- They have at least one of the following conditions in one or both feet:

An Overview of Medicare Covered Diabetes Supplies and Services, continued

- Partial or complete foot amputation
- Past foot ulcers
- Calluses that could lead to foot ulcers
- Nerve damage because of diabetes with signs of problems with calluses
- Poor circulation; or
- Deformed foot

- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

- A podiatrist or other qualified doctor must prescribe the shoes, and
- A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes to the beneficiary.

Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year, and the fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

Insulin Pumps and the Insulin Used in the Pumps

Insulin pumps worn outside the body (external), including the insulin used with the pump, may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. If a beneficiary needs to use an insulin pump, their doctor will need to prescribe it. In the original Medicare plan, the beneficiary pays 20 percent of the Medicare-approved amount after the yearly Part B deductible. Medicare will pay 80 percent of the cost of the insulin pump. Medicare will also pay for the insulin that is used with the insulin pump.

Medicare Part B covers the cost of insulin pumps and the insulin used in the pumps. However, if the beneficiary injects their insulin with a needle (syringe), Medicare Part B does not cover the cost of the insulin, but the Medicare prescription drug benefit (Part D) covers the insulin and the supplies necessary to inject it. This includes syringes, needles, alcohol swabs and gauze. The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as the beneficiary is on the Medicare Part D plan's formulary.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies after the yearly Medicare part B deductible has been met. In the original Medicare plan, Medicare covers 80 percent of the Medicare-approved amount (after the beneficiary meets their annual Medicare Part B deductible of $131 in 2007), and the beneficiary pays 20 percent of the total payment amount (after the annual Part B deductible of $131 in 2007). This amount can be higher if the beneficiary's doctor does not accept assignment, and the beneficiary may have to pay the entire amount at the time of service. Medicare will then send the beneficiary its share of the charge.

Medicare Part D Covered Diabetic Supplies and Medications

This section provides information about Medicare prescription drug coverage (Part D) for beneficiaries with Medicare who have or are at risk for diabetes. If a beneficiary wants Medicare prescription drug coverage, they must join a Medicare drug plan. The following diabetic medications and supplies are covered under Medicare drug plans:

- Diabetes supplies
- Insulin
- Anti-diabetic drugs.

Diabetes Supplies

Diabetes supplies associated with the administration of insulin may be covered for all people with Medicare Part D who have diabetes. These medical supplies include the following:

- Syringes
- Needles
- Alcohol swabs
- Gauze
- Inhaled insulin devices.

Insulin

Injectable insulin **not** associated with the use of an insulin infusion pump is covered under Medicare Part D drug plans.

Anti-diabetic Drugs

Anti-diabetic drugs may maintain blood glucose that is not controlled by insulin, and Medicare drug plans can cover anti-diabetics drugs such as:

- Sulfonylureas (i.e. glipizide, glyburide)
- Biguanides (i.e. metformin)
- Thiazolidinediones (i.e. Starlix® and Prandin®)
- Alpha glucosidase inhibitors (i.e. Precose®).

Medicare Part B Covered Diabetic Services

Medicare Part B covers all of the diabetes services listed in this section unless otherwise noted. For people with diabetes, Medicare covers certain services. A doctor must write an order or referral for the beneficiary to get these services. These services include the following:

- Diabetes screenings
- Diabetes self-management training
- Medical nutrition therapy services
- Hemoglobin A1c tests
- Special eye exams.

Diabetes Screenings

Medicare pays for a beneficiary to get diabetes-screening tests if they are at risk for diabetes. These tests are used to detect diabetes early, and some, but not all, of the conditions that may qualify a beneficiary as being at risk for diabetes include:

- High blood pressure

An Overview of Medicare Covered Diabetes Supplies and Services, continued

- Dyslipidemia (history of abnormal cholesterol and triglyceride levels)
- Obesity (with certain conditions)
- Impaired blood glucose tolerance
- High fasting blood glucose.

Diabetes screening tests are also covered if a beneficiary answers "yes" to two or more of the following questions:

- Are you age 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, siblings)?
- Do you have a history of gestational diabetes (diabetes during pregnancy)
- Did you deliver a baby weighing more than nine pounds?

Based on the results of these tests, a beneficiary may be eligible for up to two diabetes screenings every year at no cost (no coinsurance, or copayment or Part B deductible). Medicare will pay for a beneficiary to get two diabetes screening tests in a 12-month period, but not less than six months apart. After the initial diabetes-screening test, the beneficiary's doctor will determine when to do the second test. Diabetes screening tests that are covered include the following:

- Fasting blood glucose tests
- Other tests approved by Medicare as appropriate.

Diabetes Self-management Training (DSMT)

Diabetes self-management training helps a beneficiary learn how to successfully manage their diabetes. Their doctor or qualified nonphysician practitioner must prescribe this training for them for Medicare to cover it. A beneficiary can get diabetes self-management training if they met one of the following conditions during the last 12 months:

- They were diagnosed with diabetes.
- They changed from taking no diabetes medication to taking diabetes medication, or from oral diabetes medication to insulin.
- They have diabetes and have recently become eligible for Medicare.
- They are at risk for complications from diabetes. A doctor may consider the beneficiary at increased risk if they have any of the following:
  - They had problems controlling their blood glucose, have been treated in an emergency room or have stayed overnight in a hospital because of their diabetes.
  - They have been diagnosed with eye disease related to diabetes.
  - They had a lack of feeling in their feet or some other foot problems like ulcers, deformities, or have had an amputation.
  - Been diagnosed with kidney disease related to diabetes.

A beneficiary must get this training from an accredited diabetes self-management education program as part of a plan of care prepared by their doctor or qualified non-physician practitioner. The American Diabetes Association or the Indian Health Service accredits these programs. Health care providers who have special training in diabetes education teach classes.

A beneficiary is covered by Medicare to get a total of 10 hours of initial training within a continuous 12-month period. One of the hours can be given on a one-on-one basis. The other nine hours must be training in a group class. The initial training must be completed no more than 12 months from the time the beneficiary starts the training.

A doctor or qualified nonphysician practitioner may prescribe 10 hours of individual training if the beneficiary is blind or deaf, has language limitations, or no group classes have been available within two months of the doctor's order. To be eligible for two more hours of follow-up training each year after the year the beneficiary received initial training, they must get another written order from their doctor. The two hours of follow-up training can be with a group or they may have one-on-one sessions. A doctor or qualified non-physician practitioner must prescribe the follow-up training each year for Medicare to cover it.

Beneficiaries learn how to successfully manage their diabetes in DSMT classes, and the training includes information on self-care and making lifestyle changes. The first session consists of an individual assessment to help the instructors better understand the beneficiary's needs. Classroom training includes topics such as the following:

- General information about diabetes, and the benefits and risks of blood glucose control.
- Nutrition and how to manage ones diet.
- Options to manage and improve blood glucose control.
- Exercise and why it is important to ones health.
- How to take ones medications properly.
- Blood glucose testing and how to use the information to improve ones diabetes control.
- How to prevent, recognize, and treat acute and chronic complications from ones diabetes.
- Foot, skin, and dental care.
- How diet, exercise, and medication affect blood glucose.
- How to adjust emotionally to having diabetes.
- Family involvement and support.
- The use of the health care system and community resources.

Note: If a patient lives in a rural area, they may be able to get DSMT in a federally qualified health center (FQHC). For more information about FQHCs, visit the CMS Web site at *http://www.cms.hhs.gov/center/fqhc.asp*.

FQHCs are special health centers, usually located in urban or rural areas, and they can give routine health care at a lower cost. Some FQHCs are community health centers, tribal FQHC Clinics, certified rural health clinics, migrant health centers, and health care for the homeless programs.

An Overview of Medicare Covered Diabetes Supplies and Services, continued

Medical Nutrition Therapy (MNT) Services

In addition to DSMT, medical nutrition therapy services are also covered for people with diabetes or renal disease. To be eligible for this service, a beneficiary's fasting blood glucose has to meet certain criteria. Also, their doctor must prescribe these services for them. A registered dietitian or certain nutrition professionals can give these services, and the services include the following:

- An initial nutrition and lifestyle assessment
- Nutrition counseling (what foods to eat and how to follow an individualized diabetic meal plan)
- How to manage lifestyle factors that affect diabetics
- Follow-up visits to check on progress in managing diet.

Medicare covers three hours of one-on-one medical nutrition therapy services the first year the service is provided, and two hours each year after that. Additional MNT hours of service may be obtained if the beneficiary's doctor determines there is a change in their diagnosis, medical condition, or treatment regimen related to diabetes or renal disease and orders additional MNT hours during that episode of care.

Foot Exams and Treatment

If a beneficiary has diabetes-related nerve damage in either of their feet, Medicare will cover one foot exam every six months by a podiatrist or other foot care specialist, unless they have seen a foot care specialist for some other foot problem during the past six months. Medicare may cover more frequent visits to a foot care specialist if a beneficiary has had a non-traumatic (not because of an injury) amputation of all or part of their foot or their feet have changed in appearance which may indicate they have serious foot disease.

Hemoglobin A1c Tests

A hemoglobin A1c test is a lab test ordered by the beneficiary's doctor. It measures how well a beneficiary's blood glucose has been controlled over the past three months. Anyone with diabetes is covered for this test if his or her doctor orders it. Medicare may cover this test when a beneficiary's doctor orders it.

Glaucoma Tests

Medicare will pay for a beneficiary to have their eyes checked for glaucoma once every 12 months. This test must be done or supervised by an eye doctor who is legally allowed to give this service in their state.

Special Eye Exam

People with Medicare who have diabetes can get special eye exams to check for eye disease (called a dilated eye exam). These exams must be done by an eye doctor who is legally allowed to provide this service in their state. The dilated eye exam is recommended once a year and must be performed by an eye doctor who is legally allowed to provide this service in the beneficiary's state.

Diabetes Supplies and Services Not Covered by Medicare

The original Medicare plan and Medicare drug plans (Part D) do not cover everything. Diabetes supplies and services **not** covered by Medicare include:

- Eye exams for glasses (eye refraction)
- Orthopedic shoes (shoes for people whose feet are impaired, but intact)
- Routine or yearly physical exams (Medicare will cover a one-time initial preventive physical exam (the "Welcome to Medicare" physical exam) within the first six months of the beneficiary enrolling in Part B—coinsurance and Part B deductible applies.)
- Weight loss programs.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.

***Medicare Learning Network* –** The *Medicare Learning Network (MLN)* is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the *Medicare Learning Network* Web page on the CMS Web site at *http://www.cms.hhs.gov/MLNGenInfo*.

Patient Resources – For literature to share with Medicare patients, please visit on the Internet *http://www.medicare.gov*.

The National Diabetes Education Program – NDEP (*http://ndep.nih.gov/*) provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.

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

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

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Effective Date: N/A
Implementation Date: N/A

DRUGS AND BIOLOGICALS

2008 Allowances for Administration of Pneumococcal Pneumonia, Hepatitis B, and Influenza Virus Vaccines

The following are the 2008 allowances for the administration of pneumococcal pneumonia, hepatitis B, and influenza virus vaccines.

Connecticut Fees

Code	Fees
G0008	23.35
G0009	23.35
G0010	23.35
G0377	23.35

Florida Fees

Code	Loc 1/2	Loc 03	Loc 04
G0008	19.84	20.99	22.07
G0009	19.84	20.99	22.07
G0010	19.84	20.99	22.07
G0377	19.84	20.99	22.07

DURABLE MEDICAL EQUIPMENT

Fee Schedule Update for 2008 for Durable Medical Equipment, Prosthetics, Orthotics and Supplies

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

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 5803, which provides the annual update to the 2008 DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure your billing staff are aware of these changes.

Background

This recurring update notification, CR 5803, provides specific instructions regarding the 2008 annual update for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by section 1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained at 42 CFR 414.102.

The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), chapter 23, section 60; *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*) on the Centers for Medicare & Medicaid Services (CMS) Web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at *http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp* on the CMS Web site.

Key Points

- The following codes are being **deleted** from the HCPCS effective January 1, 2008, and are therefore being removed from the DMEPOS and PEN fee schedule files:

B4086	L1870	L3830	L3910	L3930	L3946
E2618	L1880	L3835	L3916	L3932	L3948
K0553	L3800	L3840	L3918	L3934	L3950
K0554	L3805	L3845	L3820	L3936	L3952
K0555	L3810	L3850	L3922	L3938	L3954
L0960	L3815	L3855	L3924	L3940	L3985
L1855	L3820	L3860	L3926	L3942	L3986
L1858	L3825	L3907	L3928	L3944	

2008 DMEPOS Fee Schedule Update, continued

- The payment category for code K0730 is revised to move the controlled dose inhalation drug delivery system from the DME payment category for capped rental items to the DME payment category for inexpensive and routinely purchased items, effective January 1, 2008. The total payment for inexpensive and/or routinely purchased items may not exceed the fee schedule amount for purchase of the equipment. In the case of controlled dose inhalation drug delivery systems furnished on a purchase basis on or after January 1, 2008, the allowed payment amount will be reduced by the total rental payments previously made for the item.
- The fee schedule amounts established for HCPCS codes K0553, K0554 and K0555 will directly crosswalk to new HCPCS codes A7027, A7028 and A7029, respectively.
- As of the July 2007 HCPCS quarterly update, the following composite dressing HCPCS codes are noncovered by Medicare, effective July 1, 2007: A6200, A6201 and A6202. To reflect this change, the fee schedule amounts for codes A6200, A6201 and A6202 will be removed from the fee schedule file as part of this update. Medicare contractors will deny claims for A6200, A6201 and A6202 with dates of service July 1, 2007, through December 31, 2007.
- CMS will establish fee schedule amounts for the following HCPCS codes : B4087, B4088, E2312, E2312KC, E2373, E2313, L1846, L3808, L3923, L3764, L3763, L3925, L3929, and L3931. These fee schedule amounts will be added to the fee schedule file on January 1, 2008, and are effective for claims with dates of service on or after January 1, 2008. The existing fee schedule amounts for HCPCS code E2373 will become the full replacement E2373 KC fees, effective January 1, 2008.
- Suppliers are to submit the modifier KC when billing for the full replacement of HCPCS power wheelchair interface codes E2373 and E2312.
- Note that HCPCS codes E0328 and E0329 are rarely appropriate for Medicare billings, payment for pediatric beds represented by these codes will be based on individual Medicare contractor consideration.
- As part of this update, CMS is implementing the 2008 national monthly payment rates for stationary oxygen equipment, (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2008. CMS is revising the fee schedule file to include the new 2008 monthly payment rate of $199.28 for stationary oxygen equipment. As required by statute, these payment rates are adjusted annually to assure budget neutrality on the addition of the new oxygen generating portable equipment class. Accordingly, a reduction to the national monthly payment amount for stationary oxygen equipment for 2008 that is necessary to offset payments under the new class will be slightly lower ($0.56) (from $199.84 to $199.28) than previously announced.
- As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.
- The following are the new HCPCS codes, effective January 1, 2008:

A4252	A9277	E2227	L3931
A5083	A9278	E2228	L7611
A6413	A9283	E2312	L7612
A7027	B4087	E2313	L7613
A7028	B4088	E2397	L7614
A7029	E0328	L3925	L7621
A9274	E0329	L3927	L7622
A9276	E0856	L3929	V2787

Additional Information

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

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

You may see the official instruction (CR 5803) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1388CP.pdf* on the CMS Web site.

MLN Matters Number: MM5803
Related Change Request (CR) #: 5803
Related CR Release Date: December 7, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1388CP
Implementation Date: January 7, 2008

2008 DMEPOS Fee Schedule Update, continued

2008 Connecticut Fees

Proc	Fee	Proc	Fee	Proc	Fee	Proc	Fee
A4561	$19.95	L8614	$16,447.22	L8681	$926.72	Q0486	$246.75
A4562	$49.68	L8615	$380.34	L8682	$5,027.57	Q0487	$287.87
A7040	$39.48	L8616	$88.59	L8683	$4,425.41	Q0489	$13,707.92
A7041	$74.19	L8617	$77.37	L8684	$584.96	Q0490	$592.93
A7042	$177.41	L8618	$22.11	L8685	$11,027.88	Q0491	$932.17
A7043	$28.11	L8619	$7,060.69	L8686	$7,036.64	Q0492	$75.09
E0749	$284.37	L8621	$0.52	L8687	$14,351.67	Q0493	$213.84
E0782	$3,649.40	L8622	$0.28	L8688	$9,157.52	Q0494	$180.95
E0783	$8,186.91	L8623	$54.55	L8689	$1,454.68	Q0495	$3,522.58
E0785	$401.63	L8624	$136.00	L8690	$4,011.80	Q0496	$1,264.31
E0786	$7,985.84	L8630	$385.88	L8691	$2,248.74	Q0497	$394.79
L8600	$541.09	L8631	$1,881.80	L8695	$14.04	Q0498	$433.17
L8603	$376.16	L8641	$400.93	Q0480	$75,952.87	Q0499	$140.74
L8606	$184.87	L8642	$243.90	Q0481	$12,254.10	Q0500	$25.75
L8609	$5,494.58	L8658	$349.58	Q0482	$3,838.22	Q0501	$430.68
L8610	$502.81	L8659	$1,627.34	Q0483	$15,811.73	Q0502	$548.31
L8612	$616.35	L8670	$478.18	Q0484	$3,070.59	Q0503	$1,096.63
L8613	$268.38	L8680	$387.36	Q0485	$296.46	Q0504	$578.67

2008 Florida Fees

Proc	Fee	Proc	Fee	Proc	Fee	Proc	Fee
A4561	$20.59	L8614	$16,446.04	L8681	$981.19	Q0486	$254.17
A4562	$51.18	L8615	$391.80	L8682	$5,178.96	Q0487	$296.54
A7040	$40.68	L8616	$91.26	L8683	$4,558.65	Q0489	$14,120.67
A7041	$76.43	L8617	$79.71	L8684	$598.65	Q0490	$610.79
A7042	$181.58	L8618	$22.76	L8685	$11,359.92	Q0491	$960.21
A7043	$28.92	L8619	$7,054.74	L8686	$7,248.56	Q0492	$77.38
E0749	$241.71	L8621	$0.53	L8687	$14,783.80	Q0493	$220.26
E0782	$4,293.41	L8622	$0.29	L8688	$9,433.27	Q0494	$186.39
E0783	$8,186.91	L8623	$56.20	L8689	$1,498.46	Q0495	$3,628.69
E0785	$472.50	L8624	$140.06	L8690	$4,132.59	Q0496	$1,302.40
E0786	$7,985.84	L8630	$289.41	L8691	$2,316.45	Q0497	$406.68
L8600	$536.42	L8631	$1,942.28	L8695	$14.48	Q0498	$446.22
L8603	$376.73	L8641	$314.11	Q0480	$78,239.88	Q0499	$144.97
L8606	$197.76	L8642	$257.84	Q0481	$12,623.10	Q0500	$26.52
L8609	$5,660.03	L8658	$269.47	Q0482	$3,953.79	Q0501	$443.65
L8610	$550.24	L8659	$1,676.32	Q0483	$16,287.84	Q0502	$564.81
L8612	$580.34	L8670	$478.18	Q0484	$3,163.05	Q0503	$1,129.65
L8613	$259.83	L8680	$399.03	Q0485	$305.39	Q0504	$596.08

EVALUATION AND MANAGEMENT

Addition to Medicare Telehealth Services

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on change request (CR) 5628, which adds the neurobehavioral status exam (as represented by *CPT* code *96116*) to the list of Medicare telehealth services.

CAUTION – What You Need to Know

Effective January 1, 2008, the telehealth modifiers "GT" (via interactive audio and video telecommunications system) and modifier "GQ" (via asynchronous telecommunications system) are valid when billed with *CPT* code *96116*.

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) announced in CR 5628 that the neurobehavioral status exam (*CPT* code *96116*) has been added to the list of Medicare telehealth services (see the final rule for the calendar year [CY] 2008 physician fee schedule [CMS-1385-FC]). Previously, CMS determined that, if the eligibility criteria, and conditions of payment are satisfied, the use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end stage renal disease related services, and individual medical nutrition therapy. CR 5628 added neurobehavioral status exam to the list of telehealth services (bolded). Medicare telehealth services are listed below.

- Consultations (*CPT* codes *99241 - 99275*) – Effective October 1, 2001 – December 31, 2005.
- Consultations (*CPT* codes *99241 - 99255*) – Effective January 1, 2006.
- Office or other outpatient visits (*CPT* codes *99201 – 99215*).
- Individual psychotherapy (*CPT* codes *90804 – 90809*).
- Pharmacologic management (*CPT* code *90862*).
- Psychiatric diagnostic interview examination (*CPT* code *90801*) – Effective March 1, 2003.
- End stage renal disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) – Effective January 1, 2005.
- Individual medical nutrition therapy (HCPCS/*CPT* codes G0270, *97802*, and *97803*) – (Effective January 1, 2006).
- **Neurobehavioral status exam (*CPT* code *96116*) (Effective January 1, 2008).**

In addition, effective January 1, 2008, the following modifiers are valid when billed with *CPT* code *96116*:

GT Via interactive audio and video telecommunications system
GQ Via asynchronous telecommunications system

The expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, or payment or billing methodology applicable to Medicare telehealth services as set forth in the *Medicare Benefit Policy Manual* (Publication 100-02, chapter 15, section 270) and the *Medicare Claims Processing Manual* (Publication 100-04, chapter 12, section 190).

For example, originating sites must be located in either a non-metropolitan statistical area (non-MSA) county or rural health professional shortage area (HPSA) and must be one of the following:

- Physician's or practitioner's office
- Hospital
- Critical access hospital (CAH)
- Rural health clinic
- Federally qualified health center.

Also, an interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary, and as a condition of payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used.

Addition to Medicare Telehealth Services, continued

Effective January 1, 2008, CR 5628 instructs that:

- Your local Part B carrier and or A/B MAC will pay for *CPT* code *96116* according to the appropriate physician or practitioner fee schedule amount when submitted with a modifier GT or GQ.
- Your local FIs and or A/B MACs will pay for *CPT* code *96116* when submitted with a modifier GT or GQ, by CAHs that have elected method II payment on type of bill (TOB) 85x.

Additional Information

To view the official instructions issued to your carrier, FI, or A/B MAC, see the two transmittals for CR 5628 at *http://www.cms.hhs.gov/Transmittals/downloads/R1277CP.pdf* and *http://www.cms.hhs.gov/transmittals/downloads/R74BP.pdf* on the CMS Web site.

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

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

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Related Change Request (CR) #: 5628
Related CR Release Date: June 29, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1277CP and R74BP
Implementation Date: January 7, 2008

LABORATORY/PATHOLOGY

2008 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

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

Provider Types Affected

Clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

What Providers Need to Know

This article and related CR 5813 contain important information regarding:

- The 2008 annual updates to the clinical laboratory fee schedule;
- Mapping for new codes for clinical laboratory tests; and
- Laboratory costs related to services subject to reasonable charge payments.

Key Points

Updates to Fees

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2008 is 0 percent. Payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). For a cervical or vaginal smear test (Pap smear), section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount.

Remember that the Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

The 2008 national minimum payment amount is $14.76 ($14.76 plus 0 percent update for 2008). The affected codes for the national minimum payment amount include the following:

88142	*88143*	*88147*	*88148*	*88150*	*88152*	*88153*
88154	*88164*	*88165*	*88166*	*88167*	*88174*	*88175*
G0123	G0143	G0144	G0145	G0147	G0148	P3000

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with §1833(h)(4)(B)(viii) of the Act.

Access to 2008 Clinical Laboratory Fee Schedule

Internet access to the 2008 clinical laboratory fee schedule data file should be available after November 16, 2007, at *http://www.cms.hhs.gov/ClinicalLabFeeSched* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Medicaid state agencies, the Indian Health Service, the United Mine Workers, Railroad Retirement Board, and other interested parties should use the Internet to retrieve the 2008 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public Comments

On July 16, 2007, CMS hosted a public meeting to solicit input on the payment relationship between 2007 codes and

Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment, continued

new 2008 *Current Procedural Terminology* codes. Notice of the meeting was published in the *Federal Register* on May 25, 2007 and on the CMS Web site on June 18, 2007.

Change request recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at *http://www.cms.hhs.gov/ClinicalLabFeeSched* on the CMS Web site. Additional written comments from the public were accepted until October 5, 2007.

Comments after the release of the 2008 laboratory fee schedule may be submitted to the following address so that CMS may consider them for the development of the 2009 laboratory fee schedule. A comment should be in written format and include clinical, coding, and costing information. To make it possible for CMS and its contractors to meet a January 3, 2009 implementation date, comments must be submitted before August 1, 2008.

Centers for Medicare & Medicaid Services (CMS)
Center for Medicare Management
Division of Ambulatory Services
Mailstop: C4-02-14
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Additional Pricing Information

The 2008 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes *36415*, P9612, and P9615).

For dates of service January 1, 2008 through December 31, 2008, the fee for clinical laboratory travel code P9603 is $0.935 per mile and for code P9604 is $9.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for calendar year 2008, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2008 laboratory fee schedule also includes codes that have a modifier QW to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2008 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

The *CPT* Editorial Panel has created code *80047* (Basic metabolic panel [Calcium, ionized]), which is an automated multi-channel chemistry (AMCC) code.

New code *80047* is not a replacement for code 80048 (Basic metabolic panel). Code *80047* is comprised of eight component test codes, i.e.:

- Calcium, ionized (*82330*)
- Carbon dioxide (*82374*)
- Chloride (*82435*)
- Creatinine (*82565*)
- Glucose (*82947*)
- Potassium (*84132*)
- Sodium (*84295*)
- Urea nitrogen (BUN) (*84520*)

Note: *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.

Mapping Information

CMS advises the following:

- New code *80047* is priced at the same rate as *80048* with final payment determined by the AMCC Panel Payment Algorithm
- New code *82310QW* is priced at the same rate as *82310*
- New code *82565QW* is priced at the same rate as *82565*
- New code *82610* is priced at the same rate as *83883*
- New code *83655QW* is priced at the same rate as 83655
- New code *83993* is priced at the same rate as *83631*
- New code *84704* is priced at the same rate as *84702*
- New code *86356* is priced at the same rate as *86361*
- New code *87500* is priced at the same rate as *87641*
- New code *87809* is priced at the same rate as *87802*
- New code *89321QW* is priced at the same rate as *89321*
- New code *89322* is priced at the sum of the rates of *89320* and *85007*
- New code *89331* is priced at the sum of the rates of *89320* and *87015*
- New AMCC code ATP23 is priced at the same rate as ATP22

Laboratory Costs Subject to Reasonable Charge Payment in 2008

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as prescribed by section 1842(b)(3) of the Act and 42 CFR 405.509(b)(1). The inflation-indexed update for year 2008 is 2.7 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, chapter 23, section 80-80.8. If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. The *Medicare Claims Processing Manual* is located at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS Web site.

When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual*, chapter 8, section 60.3 instructs that the reasonable charge basis applies. However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment, continued

Blood Products

P9010	P9011	P9012	P9016	P9017	P9019	P9020
P9021	P9022	P9023	P9031	P9032	P9033	P9034
P9035	P9036	P9037	P9038	P9039	P9040	P9043
P9044	P9048	P9050	P9051	P9052	P9053	P9054
P9055	P9056	P9057	P9058	P9059	P9060	

Also, the following codes should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, chapter 3, section 20.5-20.54 (located at *http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS Web site):

P9010	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on section 1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048 should be obtained from the Medicare Part B Drug Pricing Files.

Transfusion Medicine

86850	*86860*	*86870*	*86880*	*86885*	*86886*
86890	*86891*	*86900*	*86901*	*86903*	*86904*
86905	*86906*	*86920*	*86921*	*86922*	*86923*
86927	*86930*	*86931*	*86932*	*86945*	*86950*
86960	*86965*	*86970*	*86971*	*86972*	*86975*
86976	*86977*	*86978*	*86985*	*G0267*	

Reproductive Medicine Procedures

89250	*89251*	*89253*	*89254*	*89255*	*89257*	*89258*
89259	*89260*	*89261*	*89264*	*89268*	*89272*	*89280*
89281	*89290*	*89291*	*89335*	*89342*	*89343*	*89344*
89346	*89352*	*89353*	*89354*	*89356*		

Additional Information

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

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

To see the official instruction, CR 5813, issued to your Medicare FI, Carrier or A/B MAC, go to *http://www.cms.hhs.gov/Transmittals/downloads/R1400CP.pdf* on the CMS Web site.

Instruction for calculating reasonable charges are located in the *Medicare Claims Processing Manual*, chapter 23, section 80-80.8 at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS Web site.

MLN Matters Number: MM5813
Related Change Request (CR) #: 5813
Related CR Release Date: December 20, 2007
Effective Date: January 1, 2008
Related CR Transmittal #: R1400CP
Implementation Date: January 7, 2008

2008 CONNECTICUT FEES

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
ATP02	7.28	ATP23	16.95	P9615	3.00	*80076*	11.42	*80172*	22.76
ATP03	9.29	G0027	9.09	Q0111	5.96	*80100*	14.65	*80173*	20.34
ATP04	9.80	G0103	25.70	Q0112	5.96	*80101*	19.24	*80174*	24.05
ATP05	10.93	G0123	28.31	Q0113	7.56	*80101* QW	19.24	*80176*	20.52
ATP06	10.96	G0143	28.31	Q0114	9.99	*80102*	18.51	*80178*	9.24
ATP07	11.42	G0144	29.85	Q0115	13.83	*80150*	21.06	*80178* QW	9.24
ATP08	11.83	G0145	37.01	*36415*	3.00	*80152*	25.01	*80182*	18.93
ATP09	12.13	G0147	15.90	*78267*	10.98	*80154*	25.84	*80184*	16.01
ATP10	12.13	G0148	21.23	*78268*	94.11	*80156*	20.34	*80185*	18.52
ATP11	12.34	G0306	10.86	*80047*	27.68	*80157*	18.52	*80186*	19.23
ATP12	12.62	G0307	9.04	*80048*	11.83	*80158*	25.23	*80188*	23.18
ATP16	14.77	G0328	20.28	*80051*	9.80	*80160*	24.05	*80190*	23.41
ATP18	14.87	G0328 QW	20.28	*80053*	14.77	*80162*	18.55	*80192*	23.41
ATP19	15.45	G0394	4.54	*80061*	18.72	*80164*	18.93	*80194*	20.39
ATP20	15.95	P2038	7.02	*80061* QW	18.72	*80166*	21.66	*80195*	19.17
ATP21	16.45	P3000	14.76	*80069*	12.13	*80168*	22.83	*80196*	9.92
ATP22	16.95	P9612	3.00	*80074*	66.54	*80170*	22.90	*80197*	19.17

Update for Connecticut Clinical Laboratory Fee Schedule, continued

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
80198	19.77	*82042*	7.23	*82274* QW	20.28	*82533*	22.78	*82728*	19.03
80200	22.52	*82043*	8.09	*82286*	9.62	*82540*	6.48	*82731*	89.99
80201	16.66	*82044*	6.39	*82300*	32.33	*82541*	25.23	*82735*	25.91
80202	18.93	*82044* QW	6.39	*82306*	41.36	*82542*	25.23	*82742*	27.66
80299	19.13	*82045*	47.43	*82307*	45.02	*82543*	25.23	*82746*	20.54
80400	45.56	*82055*	15.10	*82308*	37.41	*82544*	25.23	*82747*	24.20
80402	121.46	*82055* QW	15.10	*82310*	7.20	*82550*	9.10	*82757*	24.24
80406	109.34	*82075*	16.84	*82310* QW	7.20	*82552*	18.71	*82759*	30.01
80408	175.34	*82085*	13.56	*82330*	16.26	*82553*	16.13	*82760*	15.64
80410	112.23	*82088*	56.94	*82331*	7.23	*82554*	16.58	*82775*	29.43
80412	460.50	*82101*	32.50	*82340*	8.43	*82565*	7.16	*82776*	11.31
80414	72.16	*82103*	18.77	*82355*	16.17	*82565* QW	7.16	*82784*	12.99
80415	78.08	*82104*	12.72	*82360*	17.99	*82570*	7.23	*82785*	23.01
80416	184.38	*82105*	23.44	*82365*	18.01	*82570* QW	7.23	*82787*	11.20
80417	61.46	*82106*	23.44	*82370*	17.51	*82575*	13.20	*82800*	11.83
80418	809.76	*82107*	89.99	*82373*	25.23	*82585*	11.98	*82803*	27.04
80420	100.64	*82108*	35.60	*82374*	6.83	*82595*	9.04	*82805*	39.65
80422	64.38	*82120*	5.25	*82375*	17.22	*82600*	27.11	*82810*	12.20
80424	70.56	*82120* QW	5.25	*82376*	8.37	*82607*	21.06	*82820*	13.96
80426	207.40	*82127*	19.37	*82378*	26.51	*82608*	20.01	*82926*	7.61
80428	93.16	*82128*	19.37	*82379*	23.57	*82610*	19.00	*82928*	9.15
80430	109.60	*82131*	23.57	*82380*	12.89	*82615*	11.41	*82938*	24.72
80432	188.73	*82135*	16.89	*82382*	24.02	*82626*	35.31	*82941*	24.64
80434	141.30	*82136*	23.57	*82383*	35.01	*82627*	31.07	*82943*	19.97
80435	143.85	*82139*	23.57	*82384*	35.28	*82633*	43.28	*82945*	5.48
80436	127.36	*82140*	20.36	*82387*	29.07	*82634*	40.90	*82946*	21.06
80438	70.41	*82143*	9.61	*82390*	15.01	*82638*	17.11	*82947*	5.48
80439	93.88	*82145*	13.40	*82397*	19.74	*82646*	28.85	*82947* QW	5.48
80440	81.24	*82150*	9.06	*82415*	17.70	*82649*	35.91	*82948*	4.43
81000	4.43	*82154*	40.29	*82435*	6.42	*82651*	36.07	*82950*	6.64
81001	4.43	*82157*	40.90	*82436*	7.02	*82652*	53.78	*82950* QW	6.64
81002	3.57	*82160*	34.94	*82438*	6.63	*82654*	19.34	*82951*	17.99
81003	3.14	*82163*	28.68	*82441*	8.12	*82656*	16.12	*82951* QW	17.99
81003 QW	3.14	*82164*	20.39	*82465*	6.08	*82657*	25.23	*82952*	5.48
81005	3.03	*82172*	21.65	*82465* QW	6.08	*82658*	25.23	*82952* QW	5.48
81007	3.59	*82175*	26.51	*82480*	11.01	*82664*	48.00	*82953*	21.16
81007 QW	3.59	*82180*	13.81	*82482*	10.74	*82666*	30.01	*82955*	13.55
81015	4.24	*82190*	20.83	*82485*	28.85	*82668*	26.26	*82960*	8.47
81020	5.15	*82205*	16.01	*82486*	25.23	*82670*	39.04	*82962*	3.27
81025	8.84	*82232*	22.61	*82487*	22.30	*82671*	45.13	*82963*	30.01
81050	4.19	*82239*	23.94	*82488*	29.85	*82672*	30.30	*82965*	10.80
82000	17.31	*82240*	24.31	*82489*	25.84	*82677*	33.79	*82975*	22.13
82003	28.28	*82247*	7.02	*82491*	25.23	*82679*	34.88	*82977*	9.77
82009	6.31	*82248*	7.02	*82492*	25.23	*82679* QW	34.88	*82978*	19.91
82010	11.42	*82252*	2.84	*82495*	28.34	*82690*	24.15	*82979*	9.62
82010 QW	11.42	*82261*	23.57	*82507*	38.85	*82693*	20.82	*82980*	25.60
82013	15.61	*82270*	4.54	*82520*	21.17	*82696*	32.95	*82985*	21.06
82016	19.37	*82271*	4.54	*82523*	26.11	*82705*	7.11	*82985* QW	21.06
82017	23.57	*82271* QW	4.54	*82523* QW	26.11	*82710*	23.47	*83001*	25.97
82024	53.97	*82272*	4.54	*82525*	17.34	*82715*	24.05	*83001* QW	25.97
82030	36.05	*82272* QW	4.54	*82528*	31.45	*82725*	18.60	*83002*	25.88
82040	6.37	*82274*	20.28	*82530*	23.35	*82726*	25.23	*83002* QW	25.88

Update for Connecticut Clinical Laboratory Fee Schedule, continued

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
83003	23.29	*83605*	14.92	*83893*	5.60	*84126*	35.59	*84378*	16.10
83008	23.45	*83605* QW	14.92	*83894*	5.60	*84127*	16.28	*84379*	16.10
83009	94.11	*83615*	8.44	*83896*	5.60	*84132*	6.42	*84392*	6.64
83010	17.58	*83625*	17.88	*83897*	5.60	*84133*	6.01	*84402*	35.57
83012	24.02	*83630*	27.42	*83898*	23.42	*84134*	20.38	*84403*	36.08
83013	94.11	*83631*	27.42	*83900*	46.84	*84135*	26.73	*84425*	29.67
83014	10.98	*83632*	28.24	*83901*	23.42	*84138*	26.46	*84430*	16.26
83015	26.31	*83633*	7.69	*83902*	19.83	*84140*	28.89	*84432*	22.44
83018	30.68	*83634*	16.10	*83903*	23.42	*84143*	31.89	*84436*	9.61
83020	17.99	*83655*	16.91	*83904*	23.42	*84144*	29.15	*84437*	9.04
83021	25.23	*83655* QW	16.91	*83905*	23.42	*84146*	27.08	*84439*	12.60
83026	3.30	*83661*	30.71	*83906*	23.42	*84150*	34.88	*84442*	20.66
83030	11.56	*83662*	26.43	*83907*	18.66	*84152*	25.70	*84443*	23.47
83033	8.33	*83663*	26.43	*83908*	23.42	*84153*	25.70	*84443* QW	23.47
83036	13.56	*83664*	26.43	*83909*	23.42	*84154*	25.70	*84445*	71.05
83036 QW	13.56	*83670*	12.80	*83912*	5.60	*84155*	5.12	*84446*	19.81
83037	21.06	*83690*	9.62	*83913*	18.66	*84156*	5.12	*84449*	25.15
83037 QW	21.06	*83695*	18.09	*83914*	23.42	*84157*	5.12	*84450*	7.22
83045	6.93	*83698*	47.43	*83915*	15.58	*84160*	7.23	*84450* QW	7.22
83050	7.73	*83700*	15.73	*83916*	28.09	*84163*	16.29	*84460*	7.40
83051	10.21	*83701*	34.68	*83918*	23.00	*84165*	15.01	*84460* QW	7.40
83055	6.87	*83704*	44.08	*83919*	23.00	*84166*	24.92	*84466*	17.84
83060	11.56	*83718*	11.44	*83921*	23.00	*84181*	23.80	*84478*	8.04
83065	9.62	*83718* QW	11.44	*83925*	27.19	*84182*	25.15	*84478* QW	8.04
83068	11.83	*83719*	16.26	*83930*	9.24	*84202*	20.05	*84479*	9.04
83069	5.51	*83721*	13.33	*83935*	9.52	*84203*	12.03	*84480*	19.81
83070	6.64	*83721* QW	13.33	*83937*	41.71	*84206*	23.53	*84481*	23.67
83071	8.70	*83727*	24.02	*83945*	17.99	*84207*	34.32	*84482*	22.02
83080	23.57	*83735*	9.36	*83950*	89.99	*84210*	15.17	*84484*	13.75
83088	41.26	*83775*	10.30	*83970*	57.67	*84220*	13.18	*84485*	10.49
83090	23.57	*83785*	34.36	*83986*	5.00	*84228*	12.22	*84488*	5.47
83150	27.04	*83788*	25.23	*83986* QW	5.00	*84233*	89.99	*84490*	10.63
83491	24.47	*83789*	25.23	*83992*	20.54	*84234*	90.64	*84510*	14.53
83497	15.09	*83805*	24.63	*83993*	27.42	*84235*	73.12	*84512*	10.76
83498	37.95	*83825*	22.72	*84022*	21.76	*84238*	51.09	*84520*	5.51
83499	35.22	*83835*	23.67	*84030*	7.69	*84244*	30.73	*84525*	5.25
83500	31.65	*83840*	22.81	*84035*	5.11	*84252*	16.26	*84540*	6.64
83505	33.96	*83857*	15.01	*84060*	10.32	*84255*	35.67	*84545*	7.94
83516	16.12	*83858*	20.71	*84061*	11.06	*84260*	24.31	*84550*	6.31
83518	11.85	*83864*	27.82	*84066*	13.50	*84270*	30.36	*84560*	6.64
83518 QW	11.85	*83866*	13.76	*84075*	7.23	*84275*	18.77	*84577*	4.88
83519	16.46	*83872*	8.19	*84078*	10.20	*84285*	32.90	*84578*	4.54
83520	18.09	*83873*	24.04	*84080*	20.66	*84295*	6.72	*84580*	9.92
83525	15.98	*83874*	18.04	*84081*	23.09	*84300*	6.79	*84583*	7.02
83527	18.09	*83880*	47.43	*84085*	9.42	*84302*	6.79	*84585*	21.66
83528	22.22	*83880* QW	47.43	*84087*	14.42	*84305*	29.70	*84586*	49.37
83540	9.05	*83883*	19.00	*84100*	6.63	*84307*	25.54	*84588*	47.43
83550	12.21	*83885*	34.23	*84105*	7.23	*84311*	9.77	*84590*	15.03
83570	12.36	*83887*	33.09	*84106*	5.99	*84315*	3.50	*84591*	15.03
83582	19.80	*83890*	5.60	*84110*	11.80	*84375*	27.39	*84597*	13.00
83586	17.89	*83891*	5.60	*84119*	9.61	*84376*	7.69	*84600*	22.45
83593	36.75	*83892*	5.60	*84120*	20.55	*84377*	7.69	*84620*	16.55

Update for Connecticut Clinical Laboratory Fee Schedule, continued

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
84630	15.91	*85307*	21.41	*85810*	16.32	*86331*	16.75	*86651*	18.43
84681	29.07	*85335*	17.99	*86000*	9.75	*86332*	34.05	*86652*	18.43
84702	16.29	*85337*	14.56	*86001*	7.30	*86334*	31.21	*86653*	18.43
84703	10.49	*85345*	6.01	*86003*	7.30	*86335*	41.00	*86654*	18.43
84703 QW	10.49	*85347*	5.95	*86005*	11.14	*86336*	21.77	*86658*	18.20
84704	16.29	*85348*	5.20	*86021*	21.03	*86337*	23.20	*86663*	18.33
84830	14.02	*85360*	11.74	*86022*	25.66	*86340*	21.06	*86664*	21.38
85002	6.29	*85362*	9.62	*86023*	17.40	*86341*	27.65	*86665*	25.35
85004	9.04	*85366*	12.03	*86038*	16.89	*86343*	17.41	*86666*	14.22
85007	4.81	*85370*	15.87	*86039*	15.60	*86344*	11.16	*86668*	14.53
85008	4.41	*85378*	9.97	*86060*	10.20	*86353*	68.49	*86671*	17.13
85009	4.88	*85379*	14.22	*86063*	8.07	*86355*	19.97	*86674*	20.56
85013	3.31	*85380*	14.22	*86140*	7.23	*86356*	37.41	*86677*	20.28
85014	3.31	*85384*	11.87	*86141*	18.09	*86357*	19.97	*86682*	18.17
85014 QW	3.31	*85385*	11.87	*86146*	35.54	*86359*	19.97	*86684*	22.14
85018	3.31	*85390*	7.22	*86147*	35.54	*86360*	65.65	*86687*	11.72
85018 QW	3.31	*85400*	12.36	*86148*	22.44	*86361*	37.41	*86688*	19.57
85025	10.86	*85410*	10.77	*86155*	22.33	*86367*	19.97	*86689*	27.05
85027	9.04	*85415*	24.02	*86156*	9.36	*86376*	17.54	*86692*	23.98
85032	6.01	*85420*	9.13	*86157*	11.27	*86378*	27.51	*86694*	20.11
85041	4.02	*85421*	8.70	*86160*	16.78	*86382*	23.62	*86695*	18.43
85044	6.01	*85441*	5.88	*86161*	16.78	*86384*	15.91	*86696*	27.05
85045	5.59	*85445*	9.52	*86162*	28.39	*86403*	14.24	*86698*	17.46
85046	7.80	*85460*	10.81	*86171*	13.52	*86406*	14.87	*86701*	12.41
85048	3.55	*85461*	9.26	*86185*	12.50	*86430*	7.93	*86701* QW	12.41
85049	5.47	*85475*	12.40	*86200*	18.09	*86431*	7.93	*86702*	18.88
85055	37.41	*85520*	12.22	*86215*	18.51	*86480*	86.59	*86703*	19.17
85130	6.06	*85525*	16.55	*86225*	19.20	*86590*	12.22	*86703* QW	19.17
85170	5.05	*85530*	19.81	*86226*	16.92	*86592*	5.96	*86704*	16.84
85175	5.47	*85536*	9.04	*86235*	25.06	*86593*	6.16	*86705*	16.44
85210	18.14	*85540*	12.02	*86243*	28.68	*86602*	14.22	*86706*	15.01
85220	24.66	*85547*	12.02	*86255*	16.84	*86603*	17.98	*86707*	16.16
85230	25.02	*85549*	26.21	*86256*	16.84	*86606*	21.03	*86708*	17.31
85240	25.02	*85555*	9.34	*86277*	21.99	*86609*	18.00	*86709*	15.73
85244	28.53	*85557*	18.66	*86280*	11.44	*86611*	14.22	*86710*	18.94
85245	32.06	*85576*	30.01	*86294*	27.41	*86612*	18.03	*86713*	21.39
85246	32.06	*85576* QW	30.01	*86294* QW	27.41	*86615*	18.43	*86717*	17.12
85247	32.06	*85597*	25.12	*86300*	29.07	*86617*	21.64	*86720*	18.43
85250	26.60	*85610*	5.49	*86301*	29.07	*86618*	23.80	*86723*	18.43
85260	25.02	*85610* QW	5.49	*86304*	29.07	*86618* QW	23.80	*86727*	17.98
85270	25.02	*85611*	5.51	*86308*	7.23	*86619*	18.69	*86729*	16.69
85280	27.04	*85612*	13.37	*86308* QW	7.23	*86622*	12.48	*86732*	18.43
85290	22.83	*85613*	13.37	*86309*	9.04	*86625*	18.33	*86735*	18.23
85291	12.42	*85635*	13.76	*86310*	10.30	*86628*	16.78	*86738*	18.51
85292	26.46	*85651*	4.96	*86316*	29.07	*86631*	16.52	*86741*	18.43
85293	26.46	*85652*	3.77	*86317*	20.95	*86632*	17.74	*86744*	18.43
85300	15.35	*85660*	7.26	*86318*	18.09	*86635*	16.03	*86747*	21.00
85301	15.11	*85670*	8.07	*86318* QW	18.09	*86638*	16.94	*86750*	18.43
85302	16.80	*85675*	9.58	*86320*	31.32	*86641*	20.14	*86753*	17.32
85303	19.32	*85705*	13.45	*86325*	31.24	*86644*	20.11	*86756*	18.01
85305	16.20	*85730*	8.38	*86327*	31.70	*86645*	23.54	*86757*	27.05
85306	21.41	*85732*	9.04	*86329*	19.62	*86648*	21.25	*86759*	18.43

Update for Connecticut Clinical Laboratory Fee Schedule, continued

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
86762	20.11	*87084*	12.03	*87272*	16.76	*87482*	58.33	*87591*	49.04
86765	18.00	*87086*	11.28	*87273*	16.76	*87485*	28.02	*87592*	59.85
86768	18.43	*87088*	11.31	*87274*	16.76	*87486*	49.04	*87620*	28.02
86771	18.43	*87101*	10.77	*87275*	16.76	*87487*	59.85	*87621*	49.04
86774	20.68	*87102*	11.74	*87276*	16.76	*87490*	28.02	*87622*	58.33
86777	20.11	*87103*	12.60	*87277*	16.76	*87491*	49.04	*87640*	49.04
86778	20.12	*87106*	14.42	*87278*	16.76	*87492*	22.93	*87641*	49.04
86781	18.50	*87107*	14.42	*87279*	16.76	*87495*	28.02	*87650*	28.02
86784	17.55	*87109*	21.50	*87280*	16.76	*87496*	49.04	*87651*	49.04
86787	18.00	*87110*	27.37	*87281*	16.76	*87497*	59.85	*87652*	58.33
86788	23.54	*87116*	15.10	*87283*	16.76	*87498*	49.04	*87653*	49.04
86789	20.11	*87118*	15.29	*87285*	16.76	*87500*	49.04	*87660*	28.02
86790	18.00	*87140*	7.79	*87290*	16.76	*87510*	28.02	*87797*	28.02
86793	18.43	*87143*	17.51	*87299*	16.76	*87511*	49.04	*87798*	49.04
86800	20.28	*87147*	7.23	*87300*	16.76	*87512*	58.33	*87799*	59.85
86803	19.94	*87149*	28.02	*87301*	16.76	*87515*	28.02	*87800*	56.03
86804	21.64	*87152*	7.31	*87305*	16.76	*87516*	49.04	*87801*	98.07
86805	73.05	*87158*	7.31	*87320*	16.76	*87517*	59.85	*87802*	16.76
86806	66.49	*87164*	15.01	*87324*	16.76	*87520*	28.02	*87803*	16.76
86807	55.29	*87166*	15.78	*87327*	16.76	*87521*	49.04	*87804*	16.76
86808	41.47	*87168*	5.96	*87328*	16.76	*87522*	59.85	*87804* QW	16.76
86812	36.06	*87169*	5.96	*87329*	16.76	*87525*	28.02	*87807*	16.76
86813	81.02	*87172*	5.96	*87332*	16.76	*87526*	49.04	*87807* QW	16.76
86816	38.92	*87176*	8.22	*87335*	16.76	*87527*	58.33	*87808*	16.76
86817	89.95	*87177*	12.43	*87336*	16.76	*87528*	28.02	*87809*	16.76
86821	78.88	*87181*	1.27	*87337*	16.76	*87529*	49.04	*87810*	16.76
86822	51.07	*87184*	9.63	*87338*	20.10	*87530*	59.85	*87850*	16.76
86880	7.50	*87185*	1.27	*87339*	16.76	*87531*	28.02	*87880*	16.76
86885	7.99	*87186*	12.08	*87340*	14.43	*87532*	49.04	*87880* QW	16.76
86886	7.23	*87187*	14.48	*87341*	14.43	*87533*	58.33	*87899*	16.76
86900	4.17	*87188*	9.27	*87350*	16.10	*87534*	28.02	*87899* QW	16.76
86901	4.17	*87190*	7.90	*87380*	22.94	*87535*	49.04	*87900*	182.11
86903	13.19	*87197*	20.99	*87385*	16.76	*87536*	118.89	*87901*	359.69
86904	13.28	*87205*	5.96	*87390*	24.65	*87537*	28.02	*87902*	359.69
86905	5.34	*87206*	7.50	*87391*	24.65	*87538*	49.04	*87903*	682.72
86906	10.83	*87207*	5.73	*87400*	16.76	*87539*	59.85	*87904*	36.42
86940	11.46	*87209*	17.19	*87420*	16.76	*87540*	28.02	*88130*	21.02
86941	16.92	*87210*	5.96	*87425*	16.76	*87541*	49.04	*88140*	11.17
87001	18.47	*87210* QW	5.96	*87427*	16.76	*87542*	58.33	*88142*	28.31
87003	23.52	*87220*	5.96	*87430*	16.76	*87550*	28.02	*88143*	28.31
87015	9.33	*87230*	27.59	*87449*	16.76	*87551*	49.04	*88147*	15.90
87040	13.00	*87250*	27.32	*87449* QW	16.76	*87552*	59.85	*88148*	21.23
87045	13.18	*87252*	36.42	*87450*	13.39	*87555*	28.02	*88150*	14.76
87046	13.18	*87253*	28.22	*87451*	13.39	*87556*	49.04	*88152*	14.76
87070	10.53	*87254*	27.32	*87470*	28.02	*87557*	59.85	*88153*	14.76
87071	13.18	*87255*	47.31	*87471*	49.04	*87560*	28.02	*88154*	14.76
87073	13.18	*87260*	16.76	*87472*	59.85	*87561*	49.04	*88155*	7.78
87075	13.22	*87265*	16.76	*87475*	28.02	*87562*	59.85	*88164*	14.76
87076	11.29	*87267*	16.76	*87476*	49.04	*87580*	28.02	*88165*	14.76
87077	11.29	*87269*	16.76	*87477*	59.85	*87581*	49.04	*88166*	14.76
87077 QW	11.29	*87270*	16.76	*87480*	28.02	*87582*	58.33	*88167*	14.76
87081	9.26	*87271*	16.76	*87481*	49.04	*87590*	28.02	*88174*	29.85

Update for Connecticut Clinical Laboratory Fee Schedule, continued

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
88175	37.01	*88249*	241.96	*88274*	30.33	*89051*	7.70	*89310*	12.03
88230	162.77	*88261*	246.93	*88275*	30.33	*89055*	5.96	*89320*	16.84
88233	196.63	*88262*	174.14	*88280*	35.07	*89060*	9.99	*89321*	16.84
88235	205.74	*88263*	209.97	*88283*	95.84	*89125*	6.03	*89321* QW	16.84
88237	176.47	*88264*	174.14	*88285*	26.54	*89160*	5.15	*89322*	21.65
88239	206.12	*88267*	251.17	*88289*	48.11	*89190*	6.64	*89325*	14.91
88240	14.11	*88269*	232.38	*88371*	31.05	*89225*	4.67	*89329*	29.30
88241	14.11	*88271*	29.93	*88372*	31.79	*89235*	6.74	*89330*	13.83
88245	207.98	*88272*	30.33	*88400*	7.02	*89300*	12.45	*89331*	27.37
88248	241.96	*88273*	30.33	*89050*	6.61	*89300* QW	12.45		

2008 FLORIDA FEES

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
ATP02	7.28	Q0112	5.96	*80178*	9.24	*80434*	141.30	*82075*	16.84
ATP03	9.29	Q0113	7.56	*80178* QW	9.24	*80435*	143.85	*82085*	13.56
ATP04	9.80	Q0114	9.99	*80182*	18.93	*80436*	127.36	*82088*	56.94
ATP05	10.93	Q0115	13.83	*80184*	16.01	*80438*	70.41	*82101*	41.94
ATP06	10.96	*36415*	3.00	*80185*	18.52	*80439*	93.88	*82103*	18.77
ATP07	11.42	*78267*	10.98	*80186*	19.23	*80440*	81.24	*82104*	20.20
ATP08	11.83	*78268*	94.11	*80188*	23.18	*81000*	4.43	*82105*	23.44
ATP09	12.13	*80047*	30.51	*80190*	23.41	*81001*	4.43	*82106*	23.44
ATP10	12.13	*80048*	11.83	*80192*	23.41	*81002*	3.57	*82107*	89.99
ATP11	12.34	*80051*	9.80	*80194*	20.39	*81003*	3.14	*82108*	35.60
ATP12	12.62	*80053*	14.77	*80195*	19.17	*81003* QW	3.14	*82120*	4.02
ATP16	14.77	*80061*	18.72	*80196*	9.92	*81005*	3.03	*82120* QW	4.02
ATP18	14.87	*80061* QW	18.72	*80197*	19.17	*81007*	3.59	*82127*	19.37
ATP19	15.45	*80069*	12.13	*80198*	19.77	*81007* QW	3.59	*82128*	19.37
ATP20	15.95	*80074*	66.54	*80200*	22.52	*81015*	4.02	*82131*	23.57
ATP21	16.45	*80076*	11.42	*80201*	16.66	*81020*	5.15	*82135*	23.00
ATP22	16.95	*80100*	20.32	*80202*	18.93	*81025*	8.84	*82136*	23.57
ATP23	16.95	*80101*	19.24	*80299*	19.13	*81050*	4.19	*82139*	23.57
G0027	9.09	*80101* QW	19.24	*80400*	45.56	*82000*	17.31	*82140*	20.36
G0103	25.70	*80102*	18.51	*80402*	121.46	*82003*	28.28	*82143*	9.61
G0123	28.21	*80150*	21.06	*80406*	109.34	*82009*	6.31	*82145*	21.72
G0143	28.21	*80152*	25.01	*80408*	175.34	*82010*	9.99	*82150*	9.06
G0144	29.39	*80154*	25.84	*80410*	112.23	*82010* QW	9.99	*82154*	40.29
G0145	34.70	*80156*	20.34	*80412*	460.50	*82013*	15.61	*82157*	40.90
G0147	14.76	*80157*	18.52	*80414*	72.16	*82016*	19.37	*82160*	34.94
G0148	14.76	*80158*	24.31	*80415*	78.08	*82017*	23.57	*82163*	28.68
G0306	10.86	*80160*	24.05	*80416*	184.38	*82024*	53.97	*82164*	20.39
G0307	9.04	*80162*	18.55	*80417*	61.46	*82030*	18.08	*82172*	19.80
G0328	22.22	*80164*	18.93	*80418*	809.76	*82040*	5.73	*82175*	26.51
G0328 QW	22.22	*80166*	21.66	*80420*	100.64	*82042*	2.46	*82180*	13.81
G0394	4.54	*80168*	22.83	*80422*	64.38	*82043*	2.46	*82190*	17.08
P2038	7.02	*80170*	22.90	*80424*	66.56	*82044*	6.39	*82205*	16.01
P3000	14.76	*80172*	22.76	*80426*	207.40	*82044* QW	6.39	*82232*	22.61
P9612	3.00	*80173*	20.34	*80428*	93.16	*82045*	47.43	*82239*	23.94
P9615	3.00	*80174*	24.05	*80430*	109.60	*82055*	15.10	*82240*	24.31
Q0111	5.96	*80176*	16.26	*80432*	177.43	*82055* QW	15.10	*82247*	7.02

Update for Florida Clinical Laboratory Fee Schedule, continued

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
82248	7.02	*82492*	24.35	*82679* QW	34.88	*82978*	19.91	*83525*	15.98
82252	2.73	*82495*	28.34	*82690*	21.99	*82979*	9.62	*83527*	18.09
82261	23.57	*82507*	38.85	*82693*	13.75	*82980*	24.31	*83528*	22.22
82270	4.54	*82520*	21.17	*82696*	32.95	*82985*	21.06	*83540*	9.05
82271	4.54	*82523*	26.11	*82705*	7.11	*82985* QW	21.06	*83550*	12.21
82271 QW	4.54	*82523* QW	26.11	*82710*	22.12	*83001*	25.97	*83570*	12.36
82272	4.54	*82525*	17.34	*82715*	24.05	*83001* QW	25.97	*83582*	19.80
82272 QW	4.54	*82528*	31.45	*82725*	12.08	*83002*	25.88	*83586*	17.89
82274	22.22	*82530*	23.35	*82726*	24.35	*83002* QW	25.88	*83593*	36.75
82274 QW	22.22	*82533*	22.78	*82728*	19.03	*83003*	23.29	*83605*	14.92
82286	9.62	*82540*	6.48	*82731*	89.99	*83008*	23.45	*83605* QW	14.92
82300	13.25	*82541*	24.35	*82735*	12.62	*83009*	94.11	*83615*	8.44
82306	41.36	*82542*	24.35	*82742*	27.66	*83010*	17.58	*83625*	17.88
82307	45.02	*82543*	24.35	*82746*	20.54	*83012*	24.02	*83630*	27.42
82308	37.41	*82544*	24.35	*82747*	4.30	*83013*	94.11	*83631*	27.42
82310	7.20	*82550*	9.10	*82757*	16.89	*83014*	10.98	*83632*	28.24
82310 QW	7.20	*82552*	18.71	*82759*	30.01	*83015*	26.31	*83633*	7.69
82330	19.09	*82553*	13.00	*82760*	15.64	*83018*	30.68	*83634*	11.17
82331	7.23	*82554*	13.00	*82775*	29.43	*83020*	17.99	*83655*	16.91
82340	8.43	*82565*	7.16	*82776*	11.71	*83021*	24.35	*83655* QW	16.91
82355	16.17	*82565* QW	7.16	*82784*	12.99	*83026*	3.30	*83661*	27.56
82360	12.22	*82570*	7.23	*82785*	23.01	*83030*	11.56	*83662*	26.43
82365	17.30	*82570* QW	7.23	*82787*	4.36	*83033*	6.50	*83663*	26.43
82370	17.51	*82575*	13.20	*82800*	4.88	*83036*	13.56	*83664*	26.43
82373	24.35	*82585*	11.98	*82803*	27.04	*83036* QW	13.56	*83670*	12.80
82374	6.83	*82595*	9.04	*82805*	39.65	*83037*	21.06	*83690*	9.62
82375	17.22	*82600*	27.11	*82810*	12.20	*83037* QW	21.06	*83695*	18.09
82376	7.94	*82607*	21.06	*82820*	13.96	*83045*	4.88	*83698*	47.43
82378	26.51	*82608*	20.01	*82926*	7.61	*83050*	5.86	*83700*	15.73
82379	23.57	*82610*	19.00	*82928*	7.32	*83051*	10.21	*83701*	17.30
82380	12.89	*82615*	11.41	*82938*	24.72	*83055*	6.87	*83704*	29.52
82382	24.02	*82626*	35.31	*82941*	24.64	*83060*	8.12	*83718*	11.44
82383	35.01	*82627*	31.07	*82943*	19.97	*83065*	6.00	*83718* QW	11.44
82384	33.28	*82633*	43.28	*82945*	5.48	*83068*	11.83	*83719*	16.26
82387	29.07	*82634*	40.90	*82946*	21.06	*83069*	5.51	*83721*	13.33
82390	15.01	*82638*	17.11	*82947*	5.48	*83070*	6.64	*83721* QW	13.33
82397	19.74	*82646*	27.81	*82947* QW	5.48	*83071*	9.61	*83727*	24.02
82415	17.70	*82649*	35.91	*82948*	4.43	*83080*	23.57	*83735*	9.36
82435	6.42	*82651*	36.07	*82950*	6.64	*83088*	41.26	*83775*	10.30
82436	4.55	*82652*	53.78	*82950* QW	6.64	*83090*	23.57	*83785*	34.36
82438	6.83	*82654*	19.11	*82951*	17.99	*83150*	17.30	*83788*	24.35
82441	8.38	*82656*	16.12	*82951* QW	17.99	*83491*	24.47	*83789*	24.35
82465	6.08	*82657*	24.35	*82952*	5.48	*83497*	18.01	*83805*	24.63
82465 QW	6.08	*82658*	24.35	*82952* QW	5.48	*83498*	37.95	*83825*	22.72
82480	9.93	*82664*	48.00	*82953*	6.63	*83499*	35.22	*83835*	23.67
82482	8.31	*82666*	30.01	*82955*	13.55	*83500*	31.65	*83840*	22.81
82485	20.02	*82668*	26.26	*82960*	8.12	*83505*	33.96	*83857*	15.01
82486	24.35	*82670*	39.04	*82962*	3.27	*83516*	16.12	*83858*	18.72
82487	20.02	*82671*	45.13	*82963*	30.01	*83518*	11.85	*83864*	27.82
82488	20.02	*82672*	30.30	*82965*	7.28	*83518* QW	11.85	*83866*	13.76
82489	20.02	*82677*	33.79	*82975*	22.13	*83519*	18.88	*83872*	8.19
82491	24.35	*82679*	34.88	*82977*	10.06	*83520*	18.09	*83873*	24.04

Update for Florida Clinical Laboratory Fee Schedule, continued

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
83874	18.04	*84081*	23.09	*84300*	6.79	*84583*	7.02	*85291*	12.42
83880	47.43	*84085*	9.42	*84302*	6.79	*84585*	21.66	*85292*	7.28
83880 QW	47.43	*84087*	11.31	*84305*	27.55	*84586*	26.81	*85293*	7.28
83883	19.00	*84100*	6.63	*84307*	21.61	*84588*	47.43	*85300*	8.12
83885	7.94	*84105*	6.50	*84311*	9.77	*84590*	16.20	*85301*	15.11
83887	33.09	*84106*	5.99	*84315*	3.50	*84591*	16.20	*85302*	16.80
83890	3.56	*84110*	11.80	*84375*	12.22	*84597*	9.77	*85303*	19.32
83891	3.56	*84119*	12.03	*84376*	7.69	*84600*	22.45	*85305*	16.20
83892	3.56	*84120*	20.55	*84377*	7.69	*84620*	16.55	*85306*	21.41
83893	3.56	*84126*	35.59	*84378*	11.17	*84630*	15.91	*85307*	21.41
83894	3.56	*84127*	16.28	*84379*	11.17	*84681*	26.81	*85335*	17.99
83896	3.56	*84132*	6.42	*84392*	6.64	*84702*	21.03	*85337*	14.56
83897	3.56	*84133*	6.01	*84402*	35.57	*84703*	10.49	*85345*	6.01
83898	23.42	*84134*	20.38	*84403*	36.08	*84703* QW	10.49	*85347*	5.95
83900	46.84	*84135*	26.73	*84425*	12.22	*84704*	21.03	*85348*	5.20
83901	23.42	*84138*	26.46	*84430*	16.26	*84830*	14.02	*85360*	11.17
83902	15.17	*84140*	23.53	*84432*	22.44	*85002*	6.29	*85362*	9.62
83903	23.42	*84143*	31.89	*84436*	9.61	*85004*	9.04	*85366*	12.03
83904	23.42	*84144*	29.15	*84437*	7.94	*85007*	4.81	*85370*	14.83
83905	23.42	*84146*	27.08	*84439*	12.60	*85008*	4.81	*85378*	9.97
83906	23.42	*84150*	34.88	*84442*	20.66	*85009*	5.19	*85379*	14.22
83907	18.66	*84152*	25.70	*84443*	23.47	*85013*	3.31	*85380*	14.22
83908	23.42	*84153*	25.70	*84443* QW	23.47	*85014*	3.31	*85384*	11.87
83909	23.42	*84154*	25.70	*84445*	24.31	*85014* QW	3.31	*85385*	11.87
83912	3.56	*84155*	5.12	*84446*	19.81	*85018*	3.31	*85390*	6.63
83913	18.66	*84156*	5.12	*84449*	21.05	*85018* QW	3.31	*85400*	12.36
83914	23.42	*84157*	5.12	*84450*	7.22	*85025*	10.86	*85410*	10.77
83915	15.58	*84160*	7.23	*84450* QW	7.22	*85027*	9.04	*85415*	13.25
83916	27.42	*84163*	21.03	*84460*	7.40	*85032*	6.01	*85420*	9.13
83918	21.19	*84165*	15.01	*84460* QW	7.40	*85041*	4.20	*85421*	14.23
83919	21.19	*84166*	24.92	*84466*	17.84	*85044*	6.01	*85441*	5.88
83921	21.19	*84181*	23.80	*84478*	8.04	*85045*	5.59	*85445*	9.52
83925	27.19	*84182*	25.15	*84478* QW	8.04	*85046*	7.80	*85460*	10.81
83930	9.24	*84202*	10.67	*84479*	9.04	*85048*	3.55	*85461*	9.26
83935	9.52	*84203*	10.67	*84480*	19.81	*85049*	6.25	*85475*	12.40
83937	28.73	*84206*	18.72	*84481*	21.97	*85055*	5.86	*85520*	13.25
83945	17.99	*84207*	26.00	*84482*	21.97	*85130*	16.62	*85525*	13.25
83950	89.99	*84210*	15.17	*84484*	13.75	*85170*	5.05	*85530*	13.25
83970	57.67	*84220*	7.28	*84485*	10.01	*85175*	6.35	*85536*	9.04
83986	5.00	*84228*	7.94	*84488*	10.01	*85210*	8.12	*85540*	12.02
83986 QW	5.00	*84233*	89.99	*84490*	10.01	*85220*	24.66	*85547*	12.02
83992	20.54	*84234*	90.64	*84510*	12.22	*85230*	25.02	*85549*	26.21
83993	27.42	*84235*	73.12	*84512*	7.58	*85240*	25.02	*85555*	9.34
84022	21.76	*84238*	51.09	*84520*	5.51	*85244*	28.53	*85557*	18.66
84030	7.69	*84244*	30.73	*84525*	4.02	*85245*	32.06	*85576*	30.01
84035	5.11	*84252*	17.81	*84540*	6.64	*85246*	32.06	*85576* QW	30.01
84060	10.32	*84255*	35.67	*84545*	9.23	*85247*	32.06	*85597*	25.12
84061	11.06	*84260*	21.19	*84550*	6.31	*85250*	26.60	*85610*	5.49
84066	13.50	*84270*	11.17	*84560*	6.64	*85260*	25.02	*85610* QW	5.49
84075	7.23	*84275*	10.28	*84577*	17.43	*85270*	25.02	*85611*	5.51
84078	10.20	*84285*	32.90	*84578*	4.54	*85280*	27.04	*85612*	13.37
84080	20.66	*84295*	6.72	*84580*	9.92	*85290*	22.83	*85613*	13.37

Update for Florida Clinical Laboratory Fee Schedule, continued

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
85635	13.76	*86310*	10.30	*86628*	11.31	*86738*	18.51	*87046*	13.18
85651	4.96	*86316*	28.50	*86631*	16.52	*86741*	18.43	*87070*	12.03
85652	3.77	*86317*	20.95	*86632*	17.74	*86744*	18.43	*87071*	13.18
85660	7.71	*86318*	18.09	*86635*	16.03	*86747*	21.00	*87073*	13.18
85670	8.07	*86318* QW	18.09	*86638*	16.94	*86750*	13.00	*87075*	13.22
85675	6.50	*86320*	31.32	*86641*	15.86	*86753*	17.32	*87076*	11.29
85705	11.17	*86325*	31.24	*86644*	20.11	*86756*	18.01	*87077*	11.29
85730	8.38	*86327*	31.70	*86645*	23.54	*86757*	27.05	*87077* QW	11.29
85732	9.04	*86329*	19.62	*86648*	21.25	*86759*	18.43	*87081*	9.26
85810	16.32	*86331*	16.75	*86651*	18.43	*86762*	20.11	*87084*	12.03
86000	9.75	*86332*	34.05	*86652*	18.43	*86765*	18.00	*87086*	11.28
86001	7.30	*86334*	31.21	*86653*	18.43	*86768*	16.26	*87088*	11.31
86003	7.30	*86335*	41.00	*86654*	18.43	*86771*	18.33	*87101*	10.77
86005	11.14	*86336*	21.77	*86658*	18.20	*86774*	20.68	*87102*	11.74
86021	21.03	*86337*	29.92	*86663*	18.33	*86777*	20.11	*87103*	12.60
86022	25.66	*86340*	21.06	*86664*	21.38	*86778*	20.12	*87106*	14.42
86023	17.40	*86341*	27.65	*86665*	25.35	*86781*	18.50	*87107*	14.42
86038	16.89	*86343*	17.41	*86666*	8.11	*86784*	11.31	*87109*	21.50
86039	15.60	*86344*	11.16	*86668*	14.53	*86787*	18.00	*87110*	23.73
86060	10.20	*86353*	68.49	*86671*	17.13	*86788*	23.54	*87116*	15.10
86063	8.07	*86355*	52.70	*86674*	19.64	*86789*	20.11	*87118*	15.29
86140	7.23	*86356*	5.86	*86677*	20.28	*86790*	18.00	*87140*	7.79
86141	18.09	*86357*	52.70	*86682*	18.17	*86793*	18.33	*87143*	17.51
86146	23.12	*86359*	52.70	*86684*	22.14	*86800*	22.22	*87147*	7.23
86147	23.12	*86360*	9.77	*86687*	11.72	*86803*	19.94	*87149*	17.79
86148	22.44	*86361*	5.86	*86688*	19.57	*86804*	21.64	*87152*	7.31
86155	22.33	*86367*	52.70	*86689*	27.05	*86805*	73.05	*87158*	7.31
86156	9.36	*86376*	20.33	*86692*	23.98	*86806*	66.49	*87164*	15.01
86157	11.27	*86378*	27.51	*86694*	20.11	*86807*	55.29	*87166*	15.78
86160	16.78	*86382*	23.62	*86695*	18.43	*86808*	41.47	*87168*	5.96
86161	16.78	*86384*	15.91	*86696*	27.05	*86812*	36.06	*87169*	5.96
86162	28.39	*86403*	14.24	*86698*	17.46	*86813*	81.02	*87172*	5.96
86171	14.00	*86406*	14.87	*86701*	12.41	*86816*	38.92	*87176*	8.22
86185	12.50	*86430*	7.93	*86701* QW	12.41	*86817*	89.95	*87177*	12.43
86200	18.09	*86431*	7.93	*86702*	18.88	*86821*	78.88	*87181*	1.17
86215	18.51	*86480*	86.59	*86703*	19.17	*86822*	51.07	*87184*	9.63
86225	19.20	*86590*	12.22	*86703* QW	19.17	*86880*	7.50	*87185*	1.17
86226	16.92	*86592*	5.96	*86704*	16.84	*86885*	7.99	*87186*	12.08
86235	25.06	*86593*	6.16	*86705*	16.44	*86886*	7.23	*87187*	14.48
86243	28.68	*86602*	8.11	*86706*	15.01	*86900*	4.17	*87188*	8.12
86255	16.84	*86603*	17.98	*86707*	16.16	*86901*	4.17	*87190*	7.90
86256	16.84	*86606*	21.03	*86708*	17.31	*86903*	8.46	*87197*	20.99
86277	21.99	*86609*	18.00	*86709*	15.73	*86904*	13.28	*87205*	5.96
86280	11.44	*86611*	8.11	*86710*	18.94	*86905*	5.34	*87206*	7.50
86294	27.41	*86612*	18.03	*86713*	21.39	*86906*	10.83	*87207*	8.37
86294 QW	27.41	*86615*	18.43	*86717*	17.12	*86940*	11.46	*87209*	25.11
86300	28.50	*86617*	21.64	*86720*	18.43	*86941*	13.27	*87210*	5.96
86301	28.50	*86618*	21.05	*86723*	18.43	*87001*	18.47	*87210* QW	5.96
86304	28.50	*86618* QW	21.05	*86727*	17.98	*87003*	23.52	*87220*	5.96
86308	7.23	*86619*	18.69	*86729*	16.69	*87015*	9.33	*87230*	27.59
86308 QW	7.23	*86622*	12.48	*86732*	18.43	*87040*	14.42	*87250*	27.32
86309	9.04	*86625*	18.33	*86735*	18.23	*87045*	13.18	*87252*	36.42

Update for Florida Clinical Laboratory Fee Schedule, continued

Code	Fees	Code	Fees	Code	Fees	Code	Fees	Code	Fees
87253	28.22	*87391*	15.61	*87529*	41.65	*87801*	83.30	*88241*	14.11
87254	27.32	*87400*	16.76	*87530*	59.85	*87802*	16.76	*88245*	190.23
87255	47.31	*87420*	16.76	*87531*	17.79	*87803*	16.76	*88248*	241.96
87260	16.76	*87425*	16.76	*87532*	41.65	*87804*	16.76	*88249*	241.96
87265	16.76	*87427*	16.76	*87533*	58.33	*87804* QW	16.76	*88261*	246.93
87267	16.76	*87430*	16.76	*87534*	17.79	*87807*	16.76	*88262*	174.14
87269	16.76	*87449*	16.76	*87535*	41.65	*87807* QW	16.76	*88263*	190.23
87270	16.76	*87449* QW	16.76	*87536*	98.47	*87808*	16.76	*88264*	174.14
87271	16.76	*87450*	13.39	*87537*	17.79	*87809*	16.76	*88267*	251.17
87272	16.76	*87451*	13.39	*87538*	41.65	*87810*	16.76	*88269*	190.23
87273	16.76	*87470*	17.79	*87539*	59.85	*87850*	16.76	*88271*	20.22
87274	16.76	*87471*	41.65	*87540*	17.79	*87880*	16.76	*88272*	35.39
87275	16.76	*87472*	59.85	*87541*	41.65	*87880* QW	16.76	*88273*	44.89
87276	16.76	*87475*	17.79	*87542*	58.33	*87899*	16.76	*88274*	48.63
87277	16.76	*87476*	41.65	*87550*	17.79	*87899* QW	16.76	*88275*	56.11
87278	16.76	*87477*	59.85	*87551*	41.65	*87900*	182.11	*88280*	35.07
87279	16.76	*87480*	17.79	*87552*	59.85	*87901*	359.69	*88283*	95.84
87280	16.76	*87481*	41.65	*87555*	17.79	*87902*	359.69	*88285*	26.54
87281	16.76	*87482*	58.33	*87556*	41.65	*87903*	682.72	*88289*	40.56
87283	16.76	*87485*	17.79	*87557*	59.85	*87904*	36.42	*88371*	31.05
87285	16.76	*87486*	41.65	*87560*	17.79	*88130*	21.02	*88372*	31.79
87290	16.76	*87487*	59.85	*87561*	41.65	*88140*	11.17	*88400*	7.02
87299	16.76	*87490*	17.79	*87562*	59.85	*88142*	28.21	*89050*	6.61
87300	16.76	*87491*	41.65	*87580*	17.79	*88143*	28.21	*89051*	7.70
87301	16.76	*87492*	48.84	*87581*	41.65	*88147*	14.76	*89055*	5.96
87305	16.76	*87495*	17.79	*87582*	58.33	*88148*	14.76	*89060*	9.99
87320	16.76	*87496*	41.65	*87590*	17.79	*88150*	14.76	*89125*	6.03
87324	16.76	*87497*	59.85	*87591*	41.65	*88152*	14.76	*89160*	5.15
87327	16.76	*87498*	41.65	*87592*	59.85	*88153*	14.76	*89190*	6.64
87328	16.76	*87500*	41.65	*87620*	17.79	*88154*	14.76	*89225*	4.67
87329	16.76	*87510*	17.79	*87621*	41.65	*88155*	8.37	*89235*	7.69
87332	16.76	*87511*	41.65	*87622*	58.33	*88164*	14.76	*89300*	12.45
87335	16.76	*87512*	58.33	*87640*	41.65	*88165*	14.76	*89300* QW	12.45
87336	16.76	*87515*	17.79	*87641*	41.65	*88166*	14.76	*89310*	12.03
87337	16.76	*87516*	41.65	*87650*	17.79	*88167*	14.76	*89320*	16.84
87338	17.19	*87517*	59.85	*87651*	41.65	*88174*	29.39	*89321*	16.84
87339	16.76	*87520*	17.79	*87652*	58.33	*88175*	34.70	*89321* QW	16.84
87340	14.43	*87521*	41.65	*87653*	41.65	*88230*	162.77	*89322*	21.65
87341	14.43	*87522*	59.85	*87660*	17.79	*88233*	196.63	*89325*	14.91
87350	16.10	*87525*	17.79	*87797*	17.79	*88235*	205.74	*89329*	29.30
87380	22.94	*87526*	41.65	*87798*	41.65	*88237*	176.47	*89330*	13.83
87385	16.76	*87527*	58.33	*87799*	59.85	*88239*	206.12	*89331*	27.37
87390	15.61	*87528*	17.79	*87800*	35.58	*88240*	14.11		

PULMONARY SERVICES

Pulmonary Rehabilitation Services

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

Provider Types Affected

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

Impact on Providers

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5834 detailing the decision regarding a national coverage determination (NCD) for pulmonary rehabilitation services.

- Effective with dates of service on and after September 25, 2007, Medicare contractors will continue to process claims for pulmonary rehabilitation services using their local coverage determination (LCD) process or case-by-case adjudication.
- No changes to process or policy are made with CR 5834.

Background

Currently, CMS does not cover pulmonary rehabilitation as a single entity. However, there is a limited benefit for some pulmonary rehabilitation services provided in a comprehensive outpatient rehabilitation facility (CORF). Also, certain components of pulmonary rehabilitation may fall under other existing benefit categories and may be provided independently outside of a CORF. On November 15, 2006, CMS received a request for a national coverage determination that would address components of pulmonary rehabilitation services in the hospital outpatient, physician office, and CORF settings. CR 5834 communicates the findings resulting from that request. To see the complete analysis, visit the CMS Web site at *http://www.cms.hhs.gov/mcd/viewnca.asp?where=index&nca_id=199*.

Additional Information

You may see the official instruction (CR 5834) issued to your Medicare Carrier, A/B MAC, FI, DME MAC or RHHI by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R78NCD.pdf*.

The actual revision to the *National Coverage Determination* manual containing this NCD is attached to CR 5834.

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

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

MLN Matters Number: MM5834
Related Change Request (CR) Number: 5834
Related CR Release Date: December 5, 2007
Related CR Transmittal Number: R78NCD
Effective Date: September 25, 2007
Implementation Date: January 7, 2008

RADIOLOGY

Mammography: Change Certification-Based Action from Return to Provider/Return as Unprocessable to Denial

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

Provider Types Affected

Providers who bill Medicare fiscal intermediaries, carriers, and Part A/B Medicare administrative contractors (MACs) for mammography services.

What You Need to Know

CR 5577, from which this article is taken, instructs FIs, carriers and A/B MACs to deny claims for mammography services (rather than returning them as unprocessable) if the appropriate Food and Drug Administration (FDA) certification status is not listed on the FDA-created, CMS-supplied, Mammography Quality Standard Act (MQSA) data file.

You should make sure that your billing staffs list the FDA certification status as required.

Background

Depending on which contractor you bill, FIs and A/B MACs return to provider (RTP), and carriers or A//B MACs return as unprocessable, claims for mammography services when:

Mammography: Change Certification-Based Action from Return to Provider/Return as Unprocessable to Denial, continued

- A film mammography Healthcare Common Procedure Coding System (HCPCS) code is submitted on a claim, and the facility is FDA-certified for only digital mammography.
- A digital mammography HCPCS code is submitted on a claim, and the facility is FDA-certified for only film mammography.
- Either a film or digital mammography HCPCS code is submitted (*carriers/B MACs only*) on a claim and there is no FDA certification number on the claim's Mammography Quality Standard Act (MQSA) data file.

In order to ensure that the facility has a right to appeal an inappropriate denial based on the status of its FDA certification, CR 5577, from which this article is taken, instructs Medicare FIs, carriers and A/B MACs to deny all claims for screening or diagnostic mammography services (rather than return them to the provider, or return as unprocessable to the supplier), if the appropriate FDA certification status is not listed on the claim. Please note, however, that carriers/B MACs will continue to return the claim as unprocessable if the facility's FDA-assigned certification number is missing from the claim.

The MQSA requires that all facilities providing mammography services meet national quality standards, and provides the specific standards for those qualified to perform screening and diagnostic mammograms and how they should be certified.

The FDA Center for Devices and Radiological Health is responsible for collecting certificate fees and surveying mammography facilities; and effective October 1, 1994, all facilities that provide screening and mammography services (except those in the Veterans Administration) must have an FDA-issued certificate to continue to operate.

In addition, Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000 provided new payment methodologies for both diagnostic and screening mammograms that use digital technology. Medicare pays for film mammography and digital mammography at different rates, and moreover, pays for a service only if the provider or supplier is certified by the FDA to perform those types of mammograms for which payment is sought.

Medicare determines whether the mammography facility is certified to perform the mammography services billed by using data that the FDA sends to CMS on a weekly basis. This information indicates whether a mammography facility is certified to perform digital mammography.

To verify that the facility is certified by the FDA to perform mammography services, carriers/B MACs match the supplier's (i.e., independent facility) mammography certification number submitted on the claim to the 6-digit FDA-assigned certification number appearing on the file for the billing facility (in item 32 of the CMS-1500 for paper claims, or in the 2400 loop (REF02 segment, where 01=EW segment) of the ASC X12 837 professional claim format, version 4010A1, for electronic claims). If the facility's FDA-assigned 6-digit number is not on the claim, the carrier/B MAC will return the claim as unprocessable using remittance reason code 16 (Claim/service lacks information which is needed for adjudication.) and remark code MA128 (Missing/incomplete/invalid FDA approval number.).

Intermediaries/A MACs identify the facility using the provider number submitted on the claim and use the certification data contained on the MQSA file. In addition, both intermediaries/A MACs and carriers/B MACs look for the film indicator (designated by "1") or the digital indicator (designated by "2") on the MQSA file to verify the type of mammography (film and/or digital) that the facility is certified to perform.

Therefore, effective April 1, 2008:

- FIs/A MACs will verify that the provider number on the claim corresponds with a certified mammography facility on the MQSA file, and if it does not, they will deny the claim. In denying these claims submitted by providers not listed as certified facilities on the MQSA file, the Medicare contractor will use:
  - Medicare summary notice (MSN) message 16.2 (This service cannot be paid when provided in this location/facility);
  - Remittance advice (RA) reason code B7 (This provider was not certified/eligible to be paid for this procedure/service on this date of service) and
  - RA remark code N110 (This facility is not certified for film mammography).
- Carriers/B MACs will verify that the FDA-assigned, 6-digit mammography certification number on the claim corresponds to the FDA mammography certification number appearing on the billing facility's file. They will deny the claim if:
  - The facility's certification number submitted on the claim does not match the certification number on the MQSA file.
  - The facility certification number on the claim matches the facility certification number on the MQSA file, but the facility name reported on the claim does not match the facility name on the MQSA file.
  - The facility certification number reported on the claim matches the facility certification number on the MQSA file, but the facility address reported on the claim does not match the facility address on the MQSA file.
- In denying the claim because of an invalid facility certification number, they will use MSN message 9.4 (This item or service was denied because information required to make payment is missing); and RA reason code 125 (Payment adjusted due to a submission/billing error[s]) and remark code MA128 (Missing/incomplete/invalid FDA approval number).

Further, Medicare contractors will use the FDA certification data to verify that the billing facility is eligible to bill for the type of mammography service submitted on the claim.

They will deny the claim if the facility is not certified by the FDA to perform such service (if the HCPCS code on the claim, for either film or digital mammogram, does not match the type of certification indicated on the MQSA file).

In denying these claims because the facility is not FDA-certified to perform either a screening or diagnostic mammography service, Medicare contractors will use:

Mammography: Change Certification-Based Action from Return to Provider/Return as Unprocessable to Denial, continued

- MSN 16.2 (This service cannot be paid when provided in this location/facility)
- RA reason code B7 (This provider was not certified/ eligible to be paid for this procedure/service on this date of service)
- Remark code N110 (This facility is not certified for film mammography).
- They will deny the claim if it contains a film mammography HCPCS code and the facility is certified for digital mammography only. In denying these claims because the facility is not certified to perform film mammography, they will use MSN message MSN 16.2. In this instance, carriers/B MACs will use RA reason code B6 (this payment is adjusted when performed/ billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty) and remark code N110 and FIs/A MACs will use reason code B7.

Similarly, Medicare contractors will deny the claim if it contains a digital mammography HCPCS code and the facility is certified for film mammography only. In denying these claims because the facility is not certified to perform digital mammography, they will again use MSN message 16.2. In this instance:

- Carriers/B MACs will use:
- RA reason code 171 (Payment is denied when performed/billed by this type of provider in this type of facility).
- Remark code N92 (This facility is not certified for digital mammography).
- FIs/A MACs will use reason code B7.
- Carriers/B MACs will continue to use the MQSA file to verify the facility's FDA-assigned 6-digit certification number submitted on the claim, and will return claims to the supplier as unprocessable if it does not contain the facility's certification number.

Additional Information

You may find the official instruction, CR 5577, issued to your carrier, FI, or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1387CP.pdf* on the CMS Web site. Additionally, you can find the revised sections of the *Medicare Claims Processing Manual*, chapter 18 (Preventive and Screening Services), section 20.2 (HCPCS and Diagnosis Codes for Mammography Services) as an attachment to CR 5577.

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

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: MM5577
Related Change Request (CR) #: 5577
Related CR Release Date: December 7, 2007
Effective Date: April 1, 2008
Related CR Transmittal #: R1387CP
Implementation Date: April 7, 2008

SURGERY

Multiple Procedure Payment Reduction for Mohs Micrographic Surgery

Under the multiple procedure payment reduction policy, payment for subsequent surgical procedures performed during the same operative session by the same physician is reduced by 50 percent. The Mohs surgery codes have been exempt from the multiple procedure payment reduction rules since the inception of the physician fee schedule.

Effective for dates of service on or after **January 1, 2008**, the multiple procedure indicator for *CPT* codes *17311* and *17313* will be changed **from** "No payment adjustment rules for multiple procedures apply" **to** "Standard payment adjustment rules for multiple procedures apply." Therefore, subsequent procedures will be subject to the 50 percent reduction when performed on the same date of service.

More information is available in the Final Rule Physician Fee Schedule at *http://www.cms.hhs.gov/physicianfeesched/downloads/CMS-1385-FC.pdf*.

Source: Pub. 100-04 #1358, Change Request: 5774

ELECTRONIC DATA INTERCHANGE

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

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

Provider Types Affected

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

Impact on Providers

CR 5800, from which this article is taken, announces the latest update of remittance advice remark codes (RARC) used in electronic and paper remittance advice and claim adjustment reason codes (CARC) used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective January 1, 2008. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits transactions.

The remittance advice remark code list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at *http://wpc-edi.com/codes* on the Internet. The lists at the end of this article summarize the latest changes to the remark code lists, as announced in CR 5800, effective on January 1, 2008. As a reminder, CMS notes that the claim adjustment reason code of A2 (Contractual adjustment) is deactivated effective January 1, 2008.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of code. At this site, you can find some other information that is also available from the Washington Publishing Company (WPC) Web site. The new Web site address is *http://www.cmsremarkcodes.info/* on the Internet.

Note that this Web site does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You may see the official instruction (CR 5800) issued to your Medicare Carrier, A/B MAC, FI, DME MAC or RHHI by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1384CP.pdf* on the CMS Web site.

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

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

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

Remittance Advice Remark Code Changes
New Codes

Code	Current Narrative	Comment
N388	Missing/incomplete/invalid prescription number. Note: (New code 8/1/07)	Medicare initiated
N389	Duplicate prescription number submitted. Note: (New code 8/1/07)	Medicare initiated
N390	This service cannot be billed separately. Note: (New code 8/1/07)	Medicare initiated
N391	Missing emergency department records. Note: (New code 8/1/07)	Not Medicare initiated
N392	Incomplete/invalid emergency department records. Note: (New code 8/1/07)	Not Medicare initiated

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

Code	Current Narrative	Comment
N393	Missing progress notes or report. Note: (New code 8/1/07)	Not Medicare initiated
N394	Incomplete/invalid progress notes or report. Note: (New code 8/1/07)	Not Medicare initiated
N395	Missing laboratory report. Note: (New code 8/1/07)	Not Medicare initiated
N396	Incomplete/invalid laboratory report. Note: (New code 8/1/07)	Not Medicare initiated
N397	Benefits are not available for incomplete service(s)/undelivered item(s). Note: (New code 8/1/07)	Not Medicare initiated
N398	Missing elective consent form. Note: (New code 8/1/07)	Not Medicare initiated
N399	Incomplete/invalid elective consent form. Note: (New code 8/1/07)	Not Medicare initiated
N400	Alert: Electronically enabled providers should submit claims electronically. Note: (New code 8/1/07)	Not Medicare initiated
N401	Missing periodontal charting. Note: (New code 8/1/07)	Not Medicare initiated
N402	Incomplete/invalid periodontal charting. Note: (New code 8/1/07)	Not Medicare initiated
N403	Missing facility certification. Note: (New code 8/1/07)	Not Medicare initiated
N404	Incomplete/invalid facility certification. Note: (New code 8/1/07)	Not Medicare initiated
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service. Note: (New code 8/1/07)	Not Medicare initiated
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service. Note: (New code 8/1/07)	Not Medicare initiated
N407	You are not an approved submitter for this transmission format. Note: (New code 8/1/07)	Medicare Initiated
N408	This payer does not cover deductibles assessed by a previous payer. Note: (New code 8/1/07)	Not Medicare initiated
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident. Note: (New code 8/1/07)	Not Medicare initiated
N410	This is not covered unless the prescription changes. Note: (New code 8/1/07)	Not Medicare initiated
N411	This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New code 8/1/07)	Not Medicare initiated

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

Code	Current Narrative	Comment
N412	This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New code 8/1/07)	Not Medicare initiated
N413	This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New code 8/1/07)	Not Medicare initiated
N414	This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New code 8/1/07)	Not Medicare initiated
N415	This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New code 8/1/07)	Not Medicare initiated
N416	This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New code 8/1/07)	Not Medicare initiated
N417	This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New code 8/1/07)	Not Medicare initiated
N418	Misrouted claim. See the payer's claim submission instructions. Note: (New code 8/1/07)	Not Medicare initiated
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change. Note: (New code 8/1/07)	Not Medicare initiated
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery. Note: (New code 8/1/07)	Not Medicare initiated
N421	Claim payment was the result of a payer's retroactive adjustment due to a Peer Review Organization decision. Note: (New code 8/1/07)	Not Medicare initiated
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. Note: (New code 8/1/07)	Not Medicare initiated
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program. Note: (New code 8/1/07)	Not Medicare initiated
N424	Patient does not reside in the geographic area required for this type of payment. Note: (New code 8/1/07)	Medicare initiated
N425	Statutorily excluded service(s).Note: (New code 8/1/07)	Medicare initiated
N426	No coverage when self-administered. Note: (New code 8/1/07)	Medicare initiated
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery. Note: (New code 8/1/07)	Medicare initiated
N428	Service/procedure not covered when performed in this place of service.Note: (new code 8/1/07)	Medicare initiated
N429	This is not covered since it is considered routine. Note: (new code 8/1/07)	Medicare initiated

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

***Note:** Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, in some cases another/other remark code(s), for an adjustment. Codes that are informational will have "Alert" in the text to identify them as informational rather than explanatory codes. For example, this informational code is sent per state regulation, but does not explain any adjustment: *N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.*

These informational codes will be used only if specific information needs to be communicated but not as default codes.

Modified Codes

Code	Current Modified Narrative	Comment
M27	Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07
M70	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
MA14	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
M62	Alert: This is a telephone review decision.	Modified 4/1/07, 8/1/07
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.)	Modified 8/1/07
N84	Alert: Further installment payments are forthcoming.	Modified 4/1/07, 8/1/07
N85	Alert: This is the final installment payment.	Modified 4/1/07, 8/1/07
N129	Not eligible due to the patient's age.	New code 10/31/02, Modified 8/1/07

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Related Change Request (CR) #: 5800
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Related CR Transmittal #: R1384CP
Implementation Date: January 7, 2008

GENERAL INFORMATION

Update to Medicare Deductible, Coinsurance and Premium Rates for 2008

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

Provider Types Affected

Providers who bill Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC], durable medical equipment Medicare administrative contractors [DME MAC] and carriers) for care rendered to Medicare beneficiaries.

What You Need to Know

CR 5830, from which this article is taken, instructs Medicare contractors to update the claims processing system with new Medicare rates for deductible, coinsurance and premium payment amounts for calendar year (CY) 2008, as published in the *Federal Register*, CMS-8033-N, on October 2, 2007.

Background

The details of CR 5830 follow:

2008 Part A – Hospital Insurance (HI)

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements.

Hospital

- A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode.
- When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Please note that an individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

Skilled Nursing Facility

- A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a illness episode.

These details are summarized in Table 1A, below.

Table 1A

2008 Part A – Hospital Insurance (HI)			
Deductible	$1,024.00		
Coinsurance	Hospital		Skilled Nursing Facility
	Days 61-90	Days 91-150 (Lifetime Reserve Days)	Days 21-100
	$256.00	$512.00	$128.00

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for health insurance (HI) benefits without a premium payment. In addition, the Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium.

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a two-year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A.

Details of this coverage are summarized in Table 1B, on the following page.

Update to Medicare Deductible, Coinsurance and Premium Rates for 2008, continued

Table 1B

Voluntary Enrollees Part A Premium Schedule	
Base premium (BP)	$423.00 per month
Base premium with 10 percent Surcharge	$465.30 per month
Base premium with 45 percent Reduction	$233.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45 percent peduction and 10 percent surcharge	$256.30 per month

2008 Part B - Supplementary Medical Insurance (SMI)

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2008, the standard premium for SMI services is $96.40 a month; the deductible is $135.00 a year; and the coinsurance is 20 percent.

You should be aware that the Part B premium is influenced by the beneficiary's income. This influence is summarized in Table 2 below.

Table 2

Income Parameters for Determining Part B Premium			
Premium per Month	Individual Income*	Joint Income (Married)^	Married but File Separate#
$ 96.40	$ 82,000.00 or less	$164,000.00 or less	$82,000.00 or less
$122.20	$ 82,000.01 - $102,000.00	$164,000.01 - $204,000.00	
$160.90	$102,000.01 - $153,000.00	$204,000.01 - $306,000.00	
$199.70	$153,000.01 - $205,000.00	$306,000.01 - $410,000.00	$82,000.01 - $123,000.00
$238.40	$205,000.01 or more	$410,000.01 or more	$123,000.01 or more

*Individual Income = Beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year)

^Joint Income = Beneficiaries who are married and lived with their spouse at any time during the taxable year, and also file a joint tax return.

#Married but File Separate = Beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse

Additional Information

You may find the official instruction, CR 5830, issued to your Medicare contractor by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R49GI.pdf* on the CMS Web site.

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

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

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Related Change Request (CR) #: 5830
Related CR Release Date: December 14, 2007
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Related CR Transmittal #: R49GI
Implementation Date: January 7, 2008

Handling Personally Identifiable Information on the Medicare Summary Notice

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare carriers, fiscal intermediaries, (FIs), Medicare administrative contractors (A/B MACs), and durable medical equipment Medicare administrative contractors (DME MACs).

What You Need to Know

When the health insurance claim number (HICN) and name of the beneficiary do not match on the submitted claim, Medicare carriers, intermediaries, and A/B MACs will return the claim to the provider as unprocessable. When non-institutional providers submit claims to Medicare carriers or A/B MACs that do not result in a match on name and HICN, the claim is returned with reason code 140 (Patient/Insured health identification number and name do not match).

In addition, effective January 7, 2008, on ALL MSNs, the first 5 digits of the HICN will be replaced with "XXX-XX" to avoid displaying the Medicare beneficiary's personally identifiable information (PII). This applies to pay, no-pay, and duplicate copies of the MSN.

Background

This article is based on CR 5770, which describes new procedures resulting from the Centers for Medicare & Medicaid Services (CMS) implementation of the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA). CR 5770 ensures that (1) MSNs are not issued when the HICN and name do not match, and (2) beneficiaries' PII is protected on the MSN.

Additional Information

You may see the official instruction, CR 5770, issued to your Medicare carrier, FI, A/B MAC or DME MAC at *http://www.cms.hhs.gov/Transmittals/downloads/R1399CP.pdf* on the CMS Web site.

If you have questions, please contact your Medicare 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: MM5770
Related Change Request (CR) #: 5770
Related CR Release Date: December 19, 2007
Effective Date: January 7, 2008
Related CR Transmittal #: R1399CP
Implementation Date: January 7, 2008

Centers for Medicare & Medicaid Services Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

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

Provider Types Affected

Sample of 35,000 Medicare providers served by Medicare fee-for-service (FFS) contractors, including Medicare administrative contractors (A/B MACs), carriers, fiscal intermediaries (FIs), durable medical equipment Medicare administrative contractors (DME/MACs) and regional home health intermediaries (RHHIs).

Provider Action Needed

STOP – Impact to You

CMS offers providers the opportunity to voice your opinions about the services you receive from your FFS contractors. CMS announced it has begun its third annual provider satisfaction survey of Medicare FFS contractors who process and pay more than $280 billion in Medicare claims each year. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to gather quantifiable data on provider satisfaction with the performance of FFS contractors as well as aid future process improvement efforts at the contractor level. The survey is used by CMS as an additional measure to evaluate contractor performance. In fact, all MACs will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

CAUTION – What You Need to Know

CMS is sending the 2008 survey to about 35,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. Those providers selected to participate in the survey will be notified by December 2007. The survey is designed so that it can be completed in about 15 minutes. Providers can submit their responses via a secure Web site, mail, fax, or over the telephone. CMS is urging all Medicare providers selected to participate in the survey by completing and returning their surveys upon receipt.

GO – What You Need to Do

Be alert for a notification via e-mail, phone or mail by the survey contractor, Westat. If you are selected to participate in the survey, please take the time to complete and submit your survey responses upon receipt.

Background

The 2008 MCPSS is designed to gather quantifiable data on provider satisfaction levels with the key services that comprise the provider-contractor relationship. The survey focuses on seven major parts of the relationship:

CMS Seeks Provider Input on Satisfaction with MCPSS, continued

- Provider inquiries
- Provider outreach and education
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement.

Respondents are asked to rate their experience working with contractors using a scale of 1 to 6 with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The results of the second MCPSS are available to health care providers and contractors on the CMS Web site at *http://www.cms.hhs.gov/MCPSS*.

Last year's findings showed that 85 percent of respondents rated their contractors between 4 and 6.

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

Additional Information

CMS plans to make the survey results publicly available in July 2008. For questions or additional information about the MCPSS please visit on the CMS Web site at *http://www.cms.hhs.gov/MCPSS*.

MLN Matters Number: SE0750
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Individuals Authorized Access to CMS Computer Services—Provider Community

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

The Second in a Series of Articles

This article contains:

- Three questions and answers about the registration process for provider organizations. (See Note below.)
- Information on the Guides available for completing the registration process for provider organizations. (See Note below.)

Note: For purposes of the IACS-PC, "Provider Organizations" include individual practitioners who will delegate IACS-PC work to staff as well as their staff using IACS-PC.

Provider Types Affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special Note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first *MLN Matter*s article in this new series on IACS-PC, which may be found on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Provider Action Needed

Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider and/or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider Community (IACS-PC).

What Providers Need to Know

In the near future, the CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

Registering in IACS-PC

The provider community is the first in a series of IACS communities, which are the front door to protecting and allowing access to CMS enterprise applications. Communities are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (ex. Providers need access to provider-related CMS applications). The next community which will become available in early 2008 is the FI/carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FI's, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the "Provider Community."

The first *MLN Matters* article in this series provided an overview of the IACS-PC registration process as well as registration instructions for security officials (SOs) and individual practitioners using IACS-PC personally. This article may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Individuals Authorized Access to CMS Computer Services—Provider Community, continued

Three Questions and Answers about the Provider Organization Registration Process

1. **How can I get registered in IACS-PC? Can I just figure it out by myself?**

   We recommend that you use the reference guides as they contain detailed explanations of the role responsibilities, acceptable data formats and interpretations of error messages. To directly access IACS-PC go to *https://applications.cms.hhs.gov*, then click on **Enter CMS Applications Portal.**

2. **I want to register as an SO. I do not have my organization's IRS CP-575. What else can I send?**
   In addition to the CP-575, SOs may also submit copies of other official Internal Revenue Service (IRS) documentation. An official IRS document should have the following information:

   Required:

   - IRS letterhead
   - Legal Business Name (not handwritten)
   - TIN/EIN (not handwritten).

   Optional:

   - Form Number in upper right; and
   - Reference to a letter or form number in body of text.

   Examples of acceptable IRS documents include, but are not limited to:

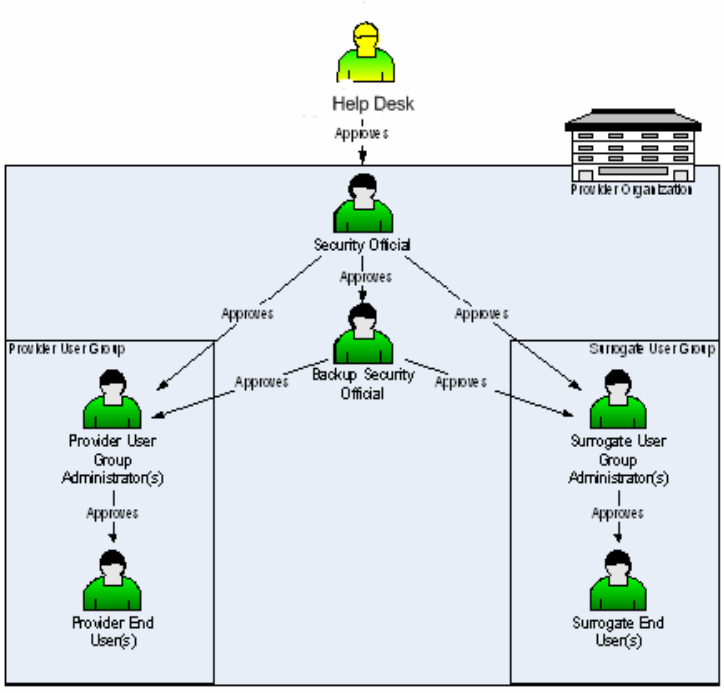
   - Copy of IRS CP-575
   - Copy of IRS 147C Letter; or
   - Copy of Federal Tax Deposit Coupon.

   All documents received must be legible.

3. **My organization is too small to fill all these roles. What should I do?**

   As few as two staff can be registered in IACS-PC for a provider organization to access CMS enterprise applications. The first person must register as a security official (SO), the second registers as a user group administrator (UGA). The UGA may access CMS applications as approved by the SO.
   The backup security official is an optional role. End users are only required for provider organizations with 10 or more IACS-PC users.
   If you are an individual practitioner who will be using IACS-PC personally, please refer to the first *MLN Matters* article, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Quick Reference Guides for Completing the Provider Organization Registration Process



Individuals Authorized Access to CMS Computer Services—Provider Community, continued

IACS-PC Registration Approval Process

1. **Backup Security Official Guide**

   Backup security officials (BSOs) will request access to an organization using the BSO Registration Quick Reference Guide on the CMS Web site at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_backup_security_official_registration_qrg_12_06_07.pdf*.

2. **User Group Administrator Guide**

   User group administrators (UGAs) are the first user type able to request access to CMS Web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.
   Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which s/he is responsible, so they should know everyone in their user group.
   The *UGA Registration Quick Reference Guide* may be found at on the CMS Web site *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_user_group_administrator_registration_qrg_12_06_07.pdf*.

   Special note for UGAs of Surrogate User Groups
   A surrogate user group is established by individuals or a company outside of the provider organization, which performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: *Surrogate Billing Company ABC will work on behalf of Provider Organization XYZ. Once the Provider Organization XYZ is approved in IACS, the Surrogate Billing Company ABC can register in IACS and request to create a surrogate user group under the Provider Organization XYZ.* Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.
   At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of three different provider organizations, the UGA for the surrogate user group will need to make three different requests to create three different surrogate user groups, one for each provider with which the UGA needs to associate. If a provider organization does not appear in IACS-PC, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider appears in IACS-PC.
   If the provider organization does appear in IACS-PC, each provider's SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS-PC. In the future, CMS will explore options for simplifying this process for contractors which perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to individual practitioners within IACS.

3. **An End User Registration Quick Reference Guide may be found on the CMS Web site at** *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_end_user_registration_qrg_12_06_07.pdf*.

4. **Approver Quick Reference Guide**

   The *Approver Quick Reference Guide* provides step-by-step instructions that SOs, BSOs and UGAs will use to approve or deny user requests to register in IACS-PC. The *Approver Quick Reference Guide* may be found on the CMS Web site at *http://www.cms.hhs.gov/MMAHelp/downloads/iacs_approver_qrg_12_07_07.pdf*.

Next Steps in Accessing a CMS Enterprise Application

A third MLN article discussing the final steps in accessing CMS enterprise applications has been released on this issue, and may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf*.

Additional Help

CMS has established an end user support (EUS) help desk to assist with your access to IACS-PC. The EUS help desk may be reached by E-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you can find an informative reference chart outlining the steps for accessing CMS enterprise applications on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf*.

MLN Matters Number: SE0753
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Change in the Amount in Controversy Requirements for Administrative Law Judge and Federal District Court Appeals

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides for annual reevaluation of the dollar amount in controversy (AIC) required for an administrative law judge (ALJ) hearing and federal district court review.

For requests made on or after January 1, 2008, the amount that must remain in controversy for ALJ hearing requests is increased to $120. The amount that must remain in controversy for federal district court review is increased to $1,180.

Source: CMS JSM/TDL 08089, dated December 19, 2007

Clarification on the National Provider Identifier Enumerator's Responsibilities

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

Provider Types Affected

All physicians, providers, and suppliers who submit claims to Medicare contractors (fiscal intermediaries [FIs], carriers, and Medicare administrative contractors [A/B MACs]).

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is issuing this special edition *MLN Matters* article SE0751 to clarify the type of assistance that the NPI enumerator can and cannot provide to health care providers.

CAUTION – What You Need to Know

CMS is providing this information so you and your staff will know what issues should be referred to the NPI Enumerator and to identify issues on which the NPI enumerator will not be able to help you. This will save you valuable time in resolving your Medicare questions.

GO – What You Need to Do

Please share this information with your office staff.

Background

The NPI enumerator is responsible for assisting health care providers in applying for their NPIs and updating their information in the National Plan and Provider Enumeration System (NPPES). The NPI enumerator's responsibilities include:

- Processing NPI applications/updates/deactivations
- Providing blank NPI application forms to health care providers upon request
- Assisting health care providers with questions or problems regarding the processing of their NPI applications, updates, or deactivations (web-based or paper)
- Resolving errors on applications/updates/deactivations
- Investigating potential duplicate applications/updates/deactivations to ensure the uniqueness of the provider
- Resetting web users' NPPES passwords
- Tracking NPPES accessibility and reporting NPPES inaccessibility issues to the CMS
- Maintaining a call center for health care providers' questions regarding NPI application processing
- Working with Electronic File Interchange Organizations (EFIOs) (approval of EFIOs, resolving problems with EFI files).

Health care providers needing the above types of assistance may contact the NPI enumerator at 1-800-465-3203, TTY 1-800-692-2326 or email the request to the NPI Enumerator at *CustomerService@NPIEnumerator.com* on the Internet. Please note that application-processing times may vary based on current inventories. Please allow 15 working days to process your application/updates before contacting the NPI Enumerator.

Health care providers should **NOT contact** the NPI Enumerator for the following issues:

- The NPI enumerator cannot provide assistance with the Medicare NPI crosswalk and Medicare claims processing issues.
  - The NPI Enumerator does **not** generate, maintain or have access to the Medicare NPI Crosswalk.
  - The NPI Enumerator does **not** have the means/authority to alter/add/remove any information on the Medicare NPI Crosswalk.
  - The NPI Enumerator **cannot** report problems to CMS or to the Medicare Fee-for-Service contractors concerning the Medicare NPI Crosswalk or claims processing problems.
  - The NPI Enumerator does **not** send updates to the Medicare NPI Crosswalk.
  - The NPI Enumerator does **not** know how/when the Medicare NPI Crosswalk will be updated.
  - The NPI Enumerator **cannot** advise a provider as to how to complete the paper or electronic claim.
  - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- The NPI enumerator cannot provide assistance with information disseminated or not disseminated via the NPI registry or the NPPES downloadable file:
  - The NPI Enumerator **cannot** assist providers with questions regarding "temporarily suppressed" information found on the NPI Registry or downloadable file.

Clarification on the NPI Enumerator's Responsibilities, continued

- Although the NPI Enumerator can confirm whether or not the information still exists in the provider's active NPPES record; this confirmation is limited to the health care provider or contact person on the provider's NPPES record. Third party sources, including Medicare contractors, **cannot** call the NPI Enumerator for confirmation of information in a health care provider's NPPES record. If this type of confirmation is needed, the third party should request the information from the provider directly.

- The NPI Enumerator cannot provide assistance with Medicare-related provider enrollment information:
  - The NPI Enumerator **cannot** determine how providers are enrolled with Medicare (e.g., as an individual or as a group).
  - The NPI Enumerator **cannot** determine which identifiers (Unique Physician Identification Number (UPIN), Provider Identification Number (PIN), Online Survey Certification and Reporting System (OSCAR), or National Supplier Clearinghouse (NSC)) should be included on health care providers' NPPES records.
  - The NPI Enumerator has no way of knowing which type(s) of legacy number(s) were assigned to a provider by the Medicare contractor(s).
  - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- The NPI Enumerator cannot provide assistance with NPI-to-legacy number linkages (i.e., how to properly link multiple legacy numbers to one NPI or how to properly link one legacy number to multiple NPIs).
- The NPI Enumerator cannot provide assistance with questions related to:
  - Defining subparts
  - Which subparts should receive NPIs
  - Where NPIs or legacy identifiers are to be placed in claims transactions
  - Health Insurance Portability and Accountability Action (HIPAA) regulations or regulatory policies
  - Proper use of NPIs in transactions with health plans
  - Determining if the provider is a sole proprietor or an incorporated individual.

Additional Information

CMS advises providers to read the information available on the CMS NPI Web site at *http://www.cms.hhs.gov/NationalProvIdentStand/*.

Included on this site are NPI frequently asked questions and answers that may assist you with issues for which the NPI enumerator is not responsible.

In addition, the NPI Application/Update form itself is also a good source of information. Providers should refer to the instructions (they are part of the form) for clarification on information to be submitted in order to obtain NPIs or update their records. You can also refer to the *"Application Help"* tab located on the NPPES Web site at: *https://nppes.cms.hhs.gov* for additional assistance when you are online.

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

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

MLN Matters Number: SE0751
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

2008 PQRI National Provider Question & Answer Session Presentation Materials

Physician Quality Reporting Initiative (PQRI) PowerPoint Presentation – Module VI

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the PowerPoint presentation used during the December 19th, 2008 PQRI National Provider call is available on the CMS Web site.

This presentation provides a basic overview of the 2008 Physician Quality Reporting Initiative and the 119 quality reporting measures.

To access the presentation, go to, *http://www.cms.hhs.gov/PQRI*, and select the Educational Resources tab on the left side of the page. Next, scroll down to the Downloads section and under the heading PowerPoint Presentations, select "2008 PQRI - Module VI."

Visit the Medicare Learning Network – it's free!

Source: CMS Provider Education Resource 200712-08

Start Testing Your NPI on Your Medicare Claims Now and Other Important Reminders

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

Reminder: Clarification on NPI Enumerator's Responsibilities

The topics with which the national provider identifier (NPI) enumerator can assist providers are listed below:

- Status of an NPI application, update, or deactivation
- How to apply, update, or deactivate
- Forgotten/lost NPI
- Lost NPI notification
- Trouble accessing NPPES
- Forgotten password/user ID
- Need to request a paper application

Health care providers should not contact the NPI enumerator for questions other than those related to the above topics. A new *MLN Matters* article clarifies the specific responsibilities of the NPI enumerator. This article is located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0751.pdf*.

Important Information for Medicare Providers

Reminder: NPI Requirement on Medicare Electronic and Paper Institutional Claims Begins January 1, 2008!

Effective January 1, 2008, NPIs will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on January 1, 2008. (Pay-to Provider is identified only if it is different from the Billing Provider.)

You may continue to use only legacy identifiers for the secondary provider fields in the 837I and UB-04 claims, until May 23, 2008, if you choose.

Urgent: Test Your Claims Now!

After you have submitted claims containing both NPIs and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with **only the NPI** in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch.

Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.

If Your Claims Are Rejecting…

If you are submitting an NPI and a legacy identifier pair on your claims and they are being rejected first go into the NPPES Web site located at *https://nppes.cms.hhs.gov/* and validate that your NPPES information is correct and that you reported your Medicare legacy identifier in the appropriate Medicare sections of the "Other Provider Identification Numbers" field.

Your Medicare legacy identifier is the identifier that Medicare assigned to you upon enrollment.

Sometimes, Medicare assigned multiple identifiers to a single provider, usually because the provider had multiple locations or, if the provider is an individual and worked in multiple locations. An enrolled physician/non-physician practitioner and the group practice to which the physician/non-physician practitioner assigns his/her benefits would both have unique legacy identifiers. Legacy identifiers are the ones that were used prior to using NPIs to identify Billing/Pay-to and Rendering Providers.

If the information in your NPPES record is correct and contains your Medicare legacy identifier(s), print the screen (so you have a copy of this portion of your NPPES record on paper), call your Medicare contractor, and ask that they confirm that this information is present in the Medicare NPI Crosswalk. If your contractor confirms you are not on the crosswalk, please ask them to validate what information they have in their provider file.

Reminder – Medicare's Key Dates

Start Testing Your NPI on Your Medicare Claims Now and Other Important Reminders, continued

Date	Implementation Steps
May 23, 2008	◆ In keeping with the Contingency Guidance issued on April 3, 2007, CMS will lift its NPI contingency plan, meaning that, for all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, DDE, 276/277, 270/271 and 835), paper claims (UB-04 and CMS-1500) and SPR remittance advice. ◆ The reporting of legacy identifiers will result in the rejection of the transaction. ◆ CMS will also stop sending legacy identifiers on COB crossover claims at this time.

Need More Information?

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

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

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

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

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

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

Source: Provider Education Resources Listserv, Message 200712-09

Medicare Provides Coverage for Many Preventive Services and Screenings

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

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for Medicare-covered preventive services and screenings provided to Medicare beneficiaries.

Provider Action Needed

This article conveys no new Medicare policy but serves as a reminder of the many preventive services and screenings now covered by Medicare and provides a list of related provider educational resources developed by the Centers for Medicare & Medicaid Services (CMS) to inform FFS health care professionals and their staff about the preventive services and screenings now covered by Medicare. CMS needs your help in spreading the word about preventive health care and ensuring that people with Medicare take full advantage of preventive benefits covered by Medicare that are appropriate for them.

- Keep this special edition *MLN Matters* article and refer to it often.
- Order appropriate provider resources for yourself and your staff.
- Talk with your Medicare patients about their risk factors for disease and benefits of preventive health care, and encourage utilization of appropriate preventive services covered by Medicare for which they may be eligible.

Introduction

Heart disease, stroke, cancer, diabetes, osteoporosis, influenza, pneumonia, and other chronic diseases have a significant impact on the health and well-being of seniors in the United States. Yet the reality is, many of these diseases can be prevented and complications can be reduced. Medicare now provides coverage for a full range of preventive services and screenings that can help seniors and other people with Medicare stay healthy, detect disease early, and manage conditions to reduce complications. Preventive services and screenings now covered by Medicare include:

Medicare Provides Coverage for the Following Preventive Services and Screenings (subject to certain eligibility and other limitations)

- Adult Immunizations
  - Influenza (Flu)
  - Pneumococcal
  - Hepatitis B
- Bone Mass Measurements
- Cancer Screenings
  - Breast (mammogram and clinical breast exam)
  - Cervical & Vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate

Medicare Provides Coverage for Many Preventive Services and Screenings, continued

- Cardiovascular Disease Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Diabetes Supplies
- Medical Nutrition Therapy (beneficiaries diagnosed with diabetes or renal disease)
- Glaucoma Screening
- Initial Preventive Physical Exam (IPPE) ("Welcome to Medicare" Physical Exam)
- Smoking and Tobacco-Use Cessation Counseling Services
- Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)

Help in Spreading the Word

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about potentially life saving preventive services and screenings. While Medicare now helps to pay for more preventive benefits than ever before, many Medicare beneficiaries are not yet taking full advantage of them, leaving significant gaps in their preventive health program. Statistics show that while Medicare beneficiaries visit their physician on an average of six or more times a year, many of them are not aware of their risk for disease or even that they may already have a condition that preventive services are intended to detect. As a health care professional, you can help your patients with Medicare understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life.

CMS hopes that you will join with us in spreading the word about preventive health care by educating your patients about their risk for disease. Talk with them about the importance of preventive health care, early detection, and the preventive services covered by Medicare that are right for them, and encourage utilization of these benefits when appropriate. As people with Medicare increase their knowledge of their risk for disease and understand the benefits of early detection and disease prevention, they will be better prepared to take full advantage of the preventive benefits covered by Medicare.

Educational Products and Informational Resources for Health Care Professionals

As a trusted source, a physician's recommendation is one of the most important factors in increasing the use of preventive services and screenings by people with Medicare. However, we know the discussion can be complicated. Therefore, CMS has developed a variety of educational products to:

1) Help increase your awareness of Medicare's coverage of disease prevention and early detection.
2) Provide you with information and tools to help you communicate with your Medicare patients about these potentially life saving benefits for which they may be eligible.
3) Give you resources to help you effectively file claims for these services.

These provider education products may be ordered, free of charge, from the CMS *Medicare Learning Network* (*MLN*). All print products are available as downloadable PDF files and may be viewed online, reprinted, and redistributed as needed. Some print products may only be available as a downloadable PDF file. To order *MLN* products, visit the *MLN* Product Ordering page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS Web site.

Attention: The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and their staff and **are not** intended for distribution to Medicare beneficiaries.

Bookmark

Medicare Preventive Services Bookmark - This bookmark, available at *http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf* on the CMS Web site, lists the preventive services and screenings covered by Medicare and serves as a handy reminder to health care professionals and their staff about the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider/supplier related education and outreach events. Available in print or as a downloadable PDF file.

Brochures

The Medicare Preventive Services Brochure Series for Physicians, Providers, Suppliers, and Other Health Care Professionals - This series of seven tri-fold brochures provides an overview of Medicare's coverage of preventive services and screenings. Available in print and as downloadable PDF files.

- **Adult Immunizations** (influenza, pneumococcal, and hepatitis B) available at *http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization.pdf*.
- **Bone Mass Measurements** – available at *http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass.pdf*.
- **Cancer Screenings** – (colorectal, prostate, and breast cancer screenings, and pap tests and pelvic examinations) available at *http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.pdf*.
- **Diabetes-Related Services** – (diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other covered services for beneficiaries with diabetes) available at *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.
- **Expanded Benefits** – (initial preventive physical examination (IPPE), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests) available at *http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf*.
- **Glaucoma Screening** available at *http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf*.
- **Smoking and Tobacco** – Use Cessation Counseling Services available at *http://www.cms.hhs.gov/MLNProducts/downloads/smoking.pdf* on the CMS Web site.

Medicare Provides Coverage for Many Preventive Services and Screenings, continued

Guide

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, 2nd Edition – This updated comprehensive guide, available at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf,* for Medicare FFS providers/suppliers and their staff provides information on coverage, coding, billing, and reimbursement guidelines for preventive services and screenings covered by Medicare. Available as a downloadable PDF file.

Quick Reference Information Charts

Medicare Preventive Services – This two-sided laminated chart, available at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf***,** gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifies coding requirements, eligibility, frequency parameters, and co-payment/coinsurance and deductible information for each benefit. Available in print or as a downloadable PDF file.

Medicare Immunization Billing – This two-sided laminated chart at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf* provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file.

The ABCs of Providing the Initial Preventive Physical Examination – This two-sided laminated chart at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf* may be used by Medicare FFS physicians and qualified nonphysician practitioners as a guide when providing the initial preventive physical examination (IPPE). This handy tool identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information. Available in print and as a downloadable PDF file.

Video Program

An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – This educational video program provides health care professionals and their staff with an overview of preventive services and screenings covered by Medicare. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered, free of charge, through the *MLN* Product Ordering Web page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS Web site.

Web-Based Training Courses

- ***Medicare Preventive Services Series Web-Based Training (WBT) Course*** – This series of three WBT courses has been designed to help fee-for-services providers/suppliers and their staff understand Medicare's coverage and billing guidelines for preventive services and screenings covered by Medicare. (To register, to take these WBT courses, free of charge, visit the *MLN* Product Ordering Page - *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*
- ***Medicare Preventive Services Series: Part 1 Adult Immunizations Web-Based Training (WBT) Course*** – This WBT course contains four learning modules that provide information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Information is also included about mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion.
- ***Medicare Preventive Services Series: Part 2 Women's Health Web-Based Training (WBT) Course*** – This WBT course contains five learning modules that provide information about Medicare's coverage of mammography services, pap tests, pelvic exams, colorectal cancer screenings, and bone mass measurements. This course was updated October 2007 and has been approved for .2 IACET* CEUs for successful completion.
- ***Medicare Preventive Services Series: Part 3 Expanded Benefits Web-Based Training (WBT) Course*** – This WBT course contains seven learning modules that provide information about Medicare's coverage and billing guidelines for the three services added to the Medicare program in 2005, as a result of the Medicare Modernization Act of 2003: the initial preventive physical exam (a.k.a. "Welcome to Medicare" physical exam), and diabetes and cardiovascular disease screenings. The course also includes information about diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as detailed information on colorectal, prostate, and glaucoma screenings, and bone mass measurement services. This course was updated November 2007 and has been approved for .2 IACET* CEUs for successful completion.

Web Page

MLN Preventive Services Educational Products Web Page – This *Medicare Learning Network (MLN)* Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS providers/suppliers. PDF files provide product ordering information and links to all downloadable products. This Web page is updated as new product information becomes available. Bookmark this page for easy access. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage* on the CMS Web site.

Other Useful Provider Resources

The Medicare Learning Network (MLN) – is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information, visit the *Medicare Learning Network's* Web page at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS Web site.

CMS Prevention Web Pages – CMS has created preventive services web pages. For additional information, visit *http://www.cms.hhs.gov/home/medicare.asp* and scroll down to the "Prevention" section.

Medicare Provides Coverage for Many Preventive Services and Screenings, continued

Preventive Benefit Information for Medicare Beneficiaries – For literature to share with your Medicare patients, please visit *http://www.medicare.gov*. Medicare beneficiaries can also obtain information about Medicare preventive benefits at this Web site or they may call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

*The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. The authors of the video program and web-based training course have no conflicts of interest to disclose. The video program and Web-based training course were developed without any commercial support.

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Implementation Date: N/A

Initial Preventive Physical Examination Quick Reference Chart

The ABCs of Providing the Initial Preventive Physical Examination quick reference chart is now available in hardcopy. Medicare fee-for-service physicians and qualified nonphysician practitioners may use this two-sided laminated chart as a guide when providing the initial preventive physical examination (IPPE) (also known as the "Welcome to Medicare" Physical Exam or the "Welcome to Medicare" Visit). This chart identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, frequently asked questions, suggestions for preparing patients for the IPPE, and lists references for additional information. To order, free of charge, go to the *MLN* Product Ordering page at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*. To download and view, go to *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf* on the CMS Web site.

Source: Provider Education Resources Listserv, Message 200712-03

Medicare Provides Coverage for Many Preventive Services and Screenings

The Centers for Medicare & Medicaid Services (CMS) has released the special edition *MLN Matters* article SE0752 *Medicare Provides Coverage for Many Preventive Services and Screenings*, located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0752.pdf*.

This article serves as a reminder of the many preventive services and screenings now covered by Medicare and provides a list of related provider educational resources developed by CMS to inform fee-for-service health care professionals and their staff about the preventive services and screenings now covered by Medicare.

Source: CMS Provider Education Resource 200712-12

Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the November 2007 Medicare B Update (pages 17-18)

Note: This article was revised on November 28, 2007 to clarify that services covered under the Part D benefit are not subject to skilled nursing facility (SNF) consolidated billing. The clarification is in bold. All other information remains unchanged.

Provider Types Affected

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

Provider Action Needed

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

Clarification:

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

Background

When the SNF prospective payment system (PPS) was introduced in the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432), it changed the way SNFs are paid, and the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered

SNF Consolidated Billing and Preventive/Screening Services, continued

Part A stay. See *MLN Matters* article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf*.

Preventive and Screening Services

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

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

Billing for Preventive and Screening Services

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

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

Priority of Payments

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

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

Example of Special Circumstance

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

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

Further, it is worth noting that unlike preventive services covered under Part B, those services covered under Part D are not subject to CB, even when furnished to an SNF's Part A resident. This is because Section 1862(a)(18) of the Social Security Act specifies that CB applies to ". . . **covered skilled nursing facility services described in section 1888(e)(2)(A)(i) . . . ." Section 1888(e)(2)(A)(i), in turn, defines "covered skilled nursing facility services" specifically in terms of (I) Part A SNF services, along with (II) those non-excluded services that (if not for the enactment of CB) would be types of services ". . . for which payment may be made under Part B ..."**

Additional Information

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

SNF CB and Preventive/Screening Services, continued

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

It includes the following relevant information:

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

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

It includes the following relevant information:

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

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2008 Holiday Schedule

First Coast Service Options, Inc. will observe the following holiday schedule in 2008:

Date	Holiday
January 1, (Tuesday)	New Year's Day
January 21, (Monday)	Martin Luther King Jr. Day
March 21, (Friday)	Good Friday
May 26, (Monday)	Memorial Day
July 4, (Friday)	Independence Day
September 1, (Monday)	Labor Day
November 27, (Thursday)	Thanksgiving Holiday
November 28, (Friday)	Thanksgiving Holiday
December 25, (Thursday)	Christmas Holiday
December 26, (Friday)	Christmas Holiday

Medicare Diabetes Coverage

American Diabetes Month is just about over, but the importance of talking with your Medicare patients about the seriousness of diabetes, their risk factors for the disease, and the importance of early detection and treatment remains, as millions of people in the United States are living with diabetes and don't know it. Together, we can make a difference in the lives of people with Medicare by encouraging eligible beneficiaries to take advantage of the diabetes screening services covered by Medicare. And we can help those already diagnosed with diabetes manage their condition by recommending diabetes self-management training and medical nutrition therapy services, also covered by Medicare.

To Learn More

Health care providers and their staff can learn more about Medicare's coverage of diabetes screening tests, supplies and other services for beneficiaries with diabetes, including coding, billing, and reimbursement details, by referring to the following provider education resources:

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
Diabetes-Related Services brochure *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.
National Diabetes Education Program (NDEP) *http://ndep.nih.gov/*.
Educational literature for beneficiaries *http://www.medicare.gov*.

Thank you for helping the Centers for Medicare & Medicaid spread the word about the importance of diabetes education and the benefits covered by Medicare for the early detection and treatment of diabetes.

Source: Provider Education Resources Listserv Message 200711-23

December Flu Shot Reminder

It's seasonal flu time again! If you have Medicare patients who haven't yet received their flu shot, you can help them reduce their risk of contracting the seasonal flu and potential complications by recommending an annual influenza and a one-time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends.

Get Your Flu Shot – Not the Flu!

Remember – Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing 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 200712-01

Update to Place of Service Code Set: New Code for Temporary Lodging

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

Provider Types Affected

Providers, physicians, and suppliers who submit claims to Medicare carriers, Medicare administrative contractors (A/B MAC), or durable medical equipment Medicare administrative contractors (DME MACs) for services rendered to Medicare beneficiaries living in temporary lodging settings

What You Need to Know

Change request (CR) 5777, from which this article is taken updates the current Centers for Medicare & Medicaid Services (CMS) place of service (POS) code set to add a new code, "16," for temporary lodging and implements the systems and local-contractor-level changes needed for Medicare to adjudicate claims with the new code.

You should make sure that your billing staffs are aware of this new POS code and also aware that (effective for claims initiated as of April 1, 2008) carriers, A/B MACs, and DME MACs will pay for covered services that are payable in the temporary lodging setting (POS code 16) at the non-facility rate.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for non-medical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not the date of service. Therefore, you may begin using this code, if appropriate, on claims initiated on or after April 1, 2008, regardless of date of service.

Background

Medicare, as a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, must comply (by regulation) with the statute's standards and their implementation guides. The implementation guide currently adopted for the ASC X12N 837 standard requires that each electronic claim transaction include a POS code from the CMS POS code set.

One requirement of this standard's implementation guide is that each professional claim contain a valid POS code from the POS code set maintained by CMS. Under HIPAA, as a payer, Medicare complies with this requirement by itself requiring a valid POS code on each 837 professional claim it receives. Similarly, when processing professional claims, Medicare must recognize as valid all valid codes from the POS code set. In addition, although not required by HIPAA, Medicare also requires a valid POS code on professional claims submitted on paper (CMS-1500).

The POS code set provides setting information necessary to pay appropriately both Medicare and Medicaid claims. Historically, Medicaid has had a greater need for POS specificity than Medicare, and many of the new codes developed over the past few years have been to meet Medicaid's needs. While Medicare does not always need this greater specificity in order to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

Effective for claims initiated on or after April 1, 2008, CMS is adding to the POS code set a new code for temporary lodging, "16," and Medicare is preparing its systems to accept and adjudicate professional claims with this code when it is in effect. Under HIPAA, the effective date for non-medical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Additional Information

You may find the official instruction, CR 5777, issued to your carrier, A/B MAC, or DME MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1366CP.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, 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: MM5777
Related Change Request (CR) #: 5777
Related CR Release Date: November 2, 2007
Effective Date: April 1, 2008
Related CR Transmittal #: R1366CP
Implementation Date: April 7, 2008

How to Handle the National Provider Identifier for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the December 2007 Medicare B Update! page 45.

Note: This article was revised on December 18, 2007, to add DME MACs as affected providers. In addition, references to change requests (CR) 5328, 5416 and 4169 at the end of the article were remove. These CRs were incorrect. All other information remains unchanged.

Provider Types Affected

Physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), durable medical equipment Medicare administrative contractors (DME MACs) and Part A/B MACs for claims for services provided to Medicare beneficiaries.

What Providers Need to Know

Be cognizant of the fact that in accordance with the national provider identifier (NPI) final rule, when an identifier is reported on a claim for ordering/referring/attending provider, operating/other/service facility provider, or for any provider that is not a billing, pay-to or rendering provider, that identifier **must be an NPI**. **For Medicare purposes, this means that submission of an NPI for an ordering/referring provider is mandatory effective May 23, 2008. Legacy numbers cannot be reported on any claims sent to Medicare on or after May 23, 2008.**

Medicare has always required that a provider identifier be reported for ordering/referring providers. Effective May 23, 2008, that number **must be an NPI,** regardless of whether that referring or ordering provider participates in the Medicare program or not or is a covered entity.

Key Points

- Medicare will not pay for referred/ordered services or items unless the name and NPI number of the referring/ordering/attending/operating/other/service facility provider is on the claim.
- It is the responsibility of the claim/bill submitter to obtain the ordering/referring/attending/operating/other/service facility NPI for health care providers.
- Providers whose business is largely based upon provision of services or items referred/ordered by other providers must be careful furnishing such services/items unless they first obtain the NPI of the referring/ordering individual. If they furnish services/items and do not obtain that person's NPI prior to billing Medicare, their claim will be denied.
- If the NPI is not directly furnished by the ordering/referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/her NPI prior to delivery of the services/items.
- Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries.
- Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.
- Physicians and the following non physician practitioners are the only types of providers allowed to refer/order services or items for beneficiaries:
  - Nurse practitioners (NP)
  - Clinical nurse specialists (CNS)
  - Physician assistants (PA)
  - Certified nurse midwives (CNM)

Background

This article is based on CR 5674. Please note that the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS-045-F). All entities covered under HIPAA must comply with the requirements of the NPI final rule.

Additional Information

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

You may see the official instruction (CR 5674) issued to your Medicare A/B MAC, DME MAC, FI, or carrier by going *to http://www.cms.hhs.gov/Transmittals/downloads/R225PI.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: MM5674 *Revised*
Related Change Request (CR) #: 5674
Related CR Release Date: October 26, 2007
Effective Date: May 23, 2008
Related CR Transmittal #: R225PI
Implementation Date: April 7, 2008

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

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.

Local Coverage Determinations - Table of Contents

NEW LCD

J9025: Azacitidine (Vidaza®)—New LCD

Azacitidine (Vidaza®) is believed to exert its antineoplastic effects by causing hypomethylation of DNA and direct cytotoxicity on abnormal hematopoetic cells in bone marrow. The concentration of azacitidine required for maximum inhibition of DNA methylation in vitro does not cause major suppression of DNA synthesis. Hypomethylation may restore normal function to genes that are critical for differentiation and proliferation. The cytotoxic effects of azacitidine cause the death of rapidly dividing cells, including cancer cells that are no longer responsive to normal growth control mechanism. Non-proliferating cells are relatively insensitive to Vidaza.

This new local coverage determination (LCD) was written to outline the medical necessity criteria for Vidaza® and to clarify the appropriate coding for the indications covered by Medicare. This new LCD includes indications, limitations, ICD-9-CM codes, documentation requirements and utilization requirements.

Effective Date

This new LCD will be effective for services rendered on or after February 29, 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.

REVISIONS TO THE LCDS

EPO: Epoetin alfa—Revision to the LCD

The local coverage determination (LCD) for epoetin alfa was last revised on October 1, 2007. Since that time, the LCD has been revised. Revisions are being made to clarify coverage of the off-label indication for myelodysplastic syndrome (MDS). In addition, a statement is being added to the LCD regarding the national coverage decision (NCD) issued on July 30, 2007.

For revisions related to the off-label indication of MDS, First Coast Service Options, Inc. (FCSO) is revising the language to clarify that chronic myelomonocytic leukemia (CMML) **not** chronic myeloid leukemia (CML) can be considered a form of MDS, and as such the anemia associated with CMML may be eligible for coverage with epoetin alfa. If the patient does not meet this requirement, the epoetin alfa will be considered not medically necessary.

If a physician is classifying a patient with CMML they must code with one of the MDS ICD-9-CM diagnosis codes (238.71-238.76) in the LCD. In addition, FCSO will be removing the ICD-9-CM diagnosis codes for CML (205.10-205.11), that are found in the LCD, as these diagnosis codes are in conflict with the NCD issued on July 30, 2007, that indicates CML for ESA therapy as noncovered.

Effective Date

These revisions will effective for services rendered on or after January 18, 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.

Additional Information

FCSO has not received final instruction from the Centers for Medicare & Medicaid Services (CMS) regarding implementing the NCD for ESA use in non-ESRD conditions. FCSO will issue a revised LCD once final instruction is issued by CMS. FCSO would like to remind providers that CMS issued the NCD on July 30, 2007, as effective on that date, meaning providers must be following the coverage and noncoverage criteria outlined.

J1566: Intravenous Immune Globulin—Revision to the LCD

The local coverage determination (LCD) for intravenous immune globulin (IVIG) was last updated on July 1, 2007. Since that time, the LCD has been revised. First Coast Service Options, Inc. (FCSO) received an external request to add the off-label indication of stiff-man syndrome to the LCD as medically reasonable and necessary. FCSO has determined that this request is valid and has revised the LCD to include this off-label indication as medically reasonable and necessary when specific coverage related criteria are met. Those coverage criteria are as follows:

- The patient must be under the care of a physician who is competent in the diagnosis of the syndrome. Criteria for the diagnosis must be met.
- The patient would have to demonstrate failure of conservative treatments
- Initial coverage would be limited to up to 2g of immune globulin per kilogram of body weight per month.
- The patient's medical record must document the response to therapy after initial treatment (0 and 1 month). Documentation must support objective response for continued coverage each month or at longer intervals.

The "Documentation Requirements" and "Utilization Guidelines" sections of the LCD have been revised to

J1566: Intravenous Immune Globulin—Revision to the LCD, continued

incorporate the above coverage criteria. In addition, ICD-9-CM code 333.91 has been added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

Effective Date

This LCD revision is effective for services rendered on or after December 17, 2007. 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.

J3487: Zoledronic Acid (Zometa®)—Revision to the LCD

The local coverage determination (LCD) for zoledronic acid (Zometa®) was last updated on January 1, 2008. Since that time, the LCD has been revised. First Coast Service Options, Inc. (FCSO) published this LCD as a draft for notice and comment on September 20, 2007. Language was added for the newly approved Food and Drug Administration (FDA) drug zoledronic acid (Reclast®), whose indications are different from those for zoledronic acid (Zometa). Reclast was approved by the FDA on April 16, 2007, for the treatment of paget's disease of the bone in both men and women. On August 17, 2007, Reclast was also approved by the FDA for the treatment of post-menopausal osteoporosis in women. This LCD revision incorporates indications and limitations, ICD-9-CM codes, documentation requirements and utilization guidelines for Reclast. In addition, the title of the LCD was changed to "Zoledronic Acid".

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

J9055: Cetuximab (Erbitux®)—Revision to the LCD

The local coverage determination (LCD) for cetuximab (Erbitux®) was effective on September 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label.

Under the "Indications and Limitations of Coverage and/or Medical Necessity"section of the LCD for FDA-approved indications, a revision to the LCD was made to include "cetuximab for treatment of EGFR-expressing, metastatic colorectal carcinoma after failure of both irinotecan and oxaliplatin-based regimens." In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD is effective for services rendered on or after October 2, 2007. 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.

J9178: Epirubicin Hydrochloride (Ellence™)—Revision to the LCD

The local coverage determination (LCD) for epirubicin hydrochloride (Ellence™) was last updated on October 1, 2007. Since that time, a revision was made to update the language for approved indications based on the Food and Drug Administration (FDA) drug label and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI).

Revisions for FDA-approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

J9181: Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16)—Revision to the LCD

The local coverage determination (LCD) for etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) was last updated on October 1, 2007. Since that time, a revision was made to update the language for approved indications based on the Food and Drug Administration (FDA) drug label and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI).

Revisions for FDA-approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

J9185: Fludarabine (Fludara®)-Revision to the LCD

The local coverage determination (LCD) for fludarabine (Fludara®) was last revised on October 1, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, and to update the off-labeled indications based on the United States Pharmacopeia Drug Information (USP DI) for fludarabine (Fludara®) (HCPCS code J9185).

Revisions for FDA-approved indications and off-labeled indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD will be effective for services rendered on or after February 29, 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.

J9201: Gemcitabine (Gemzar®)—Revision to the LCD

The local coverage determination (LCD) for gemcitabine (Gemzar®) was last revised on October 1, 2007. Since that time, a revision was made to update off-labeled indications based on the United States Pharmacopeia Drug Information (USP DI) for gemcitabine (Gemzar) (HCPCS code J9201).

Revisions for off–labeled indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. ICD-9-CM code 198.1 was added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD will be effective for services rendered on or after February 29, 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.

J9265: Paclitaxel (Taxol®)—Revision to the LCD

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

Revisions for FDA-approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

J9280: Mitomycin (Mutamycin®, Mitomycin-C)—Revision to the LCD

The local coverage determination (LCD) for mitomycin (Mutamycin®, Mitomycin-C) was last updated on April 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, and to update the off-label indications based on the United States Pharmacopeia Drug Information (USP DI) for mitomycin – J9280.

Revisions for FDA-approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD will be effective for services rendered on or after February 29, 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.

J9310: Rituximab (Rituxan®)—Revision to the LCD

The local coverage determination (LCD) for rituximab (Rituxan®) was last revised on October 1, 2007. Since that time, the LCD has been revised. First Coast Service Options, Inc. (FCSO) received a request to add the off-label indication of autoimmune hymolytic anemia to the LCD. Supporting literature was submitted and reviewed and the request was found to be valid. The indications and limitations, documentation requirements, and utilization guidelines were revised to incorporate this indication. In addition, the "ICD-9 Codes that Support Medical Necessity" section of the LCD was revised to include ICD-9-CM diagnosis code 283.0 (Autoimmune hemolytic anemias) as appropriate for this off-label indication.

Effective Date

This LCD revision is effective for services rendered on or after January 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.

J9395: Fulvestrant (Faslodex®)—Revision to the LCD

The local coverage determination (LCD) for fulvestrant (Faslodex®) was last updated on April 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, and to update the off-label indication to include male breast cancer.

Revisions for FDA-approved indications and off-label indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections of the LCD were updated. Under the "Utilization Guidelines" section of the LCD, dosage and administration information was added.

Effective Date

This revision to the LCD will be effective for services rendered on or after February 29, 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.

NESP: Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP])—Revision to the LCD

The local coverage determination (LCD) for darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) was last revised on October 1, 2007. Since that time, the LCD has been revised. Revisions are being made to clarify coverage of the off-label indication for myelodysplastic syndrome (MDS). In addition, a statement is being added to the LCD regarding the national coverage decision (NCD) issued on July 30, 2007.

For revisions related to the off-label indication of MDS, First Coast Service Options, Inc. (FCSO) is revising the language to clarify that chronic myelomonocytic leukemia (CMML) can be considered a form of MDS, and as such the anemia associated with CMML may be eligible for coverage with Aranesp. If a physician is classifying a patient with CMML they must code the service with one of the MDS ICD-9-CM diagnosis codes (238.71-238.76) in the LCD. If the patient does not meet this requirement, the Aranesp will be considered not medically necessary.

Effective Date

These revisions will effective for services rendered on or after December 18, 2007. 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.

Additional Information

FCSO has not received final instruction from the Centers for Medicare & Medicaid Services (CMS) regarding implementing the NCD for ESA use in non-ESRD conditions. FCSO will issue a revised LCD once final instruction is issued by CMS. FCSO would like to remind providers that CMS issued the NCD on July 30, 2007 as effective on that date, meaning providers must be following the coverage and noncoverage criteria outlined.

90901: Biofeedback—Revision to the LCD

The local coverage determination (LCD) for biofeedback was last updated on October 1, 2005. Since that time, the LCD has been revised. First Coast Service Options, Inc. (FCSO) published this LCD as a draft for notice and comment on September 20, 2007. Language was added to clarify the appropriate use of the diagnostic tests described in *CPT* codes *51784* (Electromyography studies [EMG] of anal or urethral sphincter, other than needle, any technique) and *91122* (Anorectal manometry). FCSO came across the issue of providers billing these diagnostic tests on a frequent basis for services that were more accurately described by *CPT* code *90911* (Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry). Language has been added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD and to the "Coding Guideline" attachment to address the appropriateness and utilization of these codes.

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

ADDITIONAL INFORMATION

Electrocardiogram, 64 leads or greater—Coding and Billing

Body surface potential mapping (BSPM), also known as body surface mapping (BSM) is an electrocardiographic (ECG) technique that uses numerous leads (as many as 120) to record and measure electrocardiac activity over a much larger portion of the torso than the traditional 12 lead-ECG to provide a comprehensive 3-dimensional picture of the effects of electrical currents from the heart on the body surface.

This service should be billed with *CPT* code *93799* (Unlisted cardiovascular service or procedure) for services rendered prior to July 1, 2007. For services rendered on or after July 1, 2007, the following *CPT* category III codes should be billed:

0178T Electrocardiogram, 64 leads or greater with graphic presentation and analysis; with interpretation and report
0179T tracing and graphics only, without interpretation and report
0180T interpretation and report only

Note that based on medical necessity, payment would be made for either BSPM/BSM or a standard electrocardiogram (EKG/ECG), but not both, during the same occurrence. EKG/ECG services are represented by *CPT* codes *93000-93010*.

J0881: Erythropoietin Stimulating Agents (ESA)—Draft LCD Implementation Delayed

The draft local coverage determination (LCD) for erythropoietin stimulating agents (ESA) was issued for notice and comment on September 20, 2007. The comment period ended on November 3, 2007. First Coast Service Options, Inc. (FCSO) issued this draft LCD with language from the national coverage decision (NCD) for ESA use for non-ESRD conditions issued on July 30, 2007. FCSO has not received final instruction from the Centers for Medicare & Medicaid Services (CMS) for implementing the NCD.

Because of this, FCSO has elected to delay implementing this draft LCD until final instruction is issued to contactors. Until then, providers are reminded that the NCD was issued by CMS as effective on July 30, 2007, and they should be following the coverage and noncoverage criteria outlined in the NCD. For conditions not addressed in the NCD, providers can refer to FCSOs current active LCDs for epoetin alfa and darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]).

FCSO has published the comment summary for this draft LCD. FCSO will publish an article once the draft LCD is posted for final notice. The effective date will be included in that article.

CONNECTICUT ONLY - NEW LCDS

IDTF: Independent Diagnostic Testing Facility—New LCD

An independent diagnostic testing facility (IDTF) is an entity independent of a hospital or physician's office in which diagnostic tests are performed. It was created by regulation (42CFR, section 410.33) as published in the *Federal Register*, Vol. 62, number 211, October 31, 1997.

Effective for diagnostic procedures performed on or after March 15, 1999, carriers will pay for diagnostic procedures under the physician fee schedule only when performed by a physician, a group practice of physicians, an approved supplier of portable x-ray services, a nurse practitioner, or a clinical nurse specialist when he or she performs a test he or she is authorized by the state to perform, or an independent diagnostic testing facility (IDTF).

This local coverage determination (LCD) addresses the structure, approved services, credentialing requirements and coding and billing for an IDTF. Diagnostic testing performed in an IDTF must follow the supervision and credentialing guidelines set forth in this LCD. All enrolling IDTFs must meet the supervising physician qualification/proficiency requirements and technician qualification requirements at the time of their enrollment.

IDTF regulations in this LCD do not apply to approved portable x-ray suppliers or to procedures (e.g., pathology and laboratory) furnished in a physician's offices, group practices, multi-specialty clinics or groups.

Required characteristics of an IDTF:

- It may be in a fixed location or be a mobile entity or supplied by an individual nonphysician practitioner.
- Is independent of a physician's office or hospital; however, these rules apply when an IDTF furnishes diagnostic procedures in a physician's office.
- *Performs only diagnostic tests by licensed, certified nonphysician personnel under appropriate physician supervision.
- The sole purpose is to furnish diagnostic testing.
- Is not engaged in any form of patient treatment.
- Is properly enrolled with Medicare as an IDTF and approved for the specific tests to be provided.

However, if a substantial portion of the entity's business involves the performance of diagnostic tests, the diagnostic testing services may constitute a sufficiently separate business to warrant enrollment as an IDTF (It will be considered "independent" for purposes of enrollment). In such a case, the entity can be enrolled as a physician or a group practice of physicians, but must also enroll as an IDTF. The physician or group can bill for professional fees and the diagnostic tests they perform on their own patients using their billing number; the practice must bill as an IDTF for diagnostic tests furnished to Medicare beneficiaries who are not patients of the practice.

Note: An IDTF must enroll with the carrier that has jurisdiction in the area where the beneficiary will receive the technical services of the procedure.

*The CMS On-line Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, chapter 13, section 13.5.1) outlines that "reasonable and necessary" services are "ordered and/or furnished by qualified personnel." Services will be considered medically reasonable and necessary only if performed by appropriately trained providers.

Effective Date

This LCD will be effective for services rendered on or after February 29, 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.

J2778: Ranibizumab (Lucentis®)—New LCD

Ranibizumab (Lucentis®), a recombinant humanized immunoglobulin G1 kappa (IgG1 kappa) monoclonal antibody fragment designed for intraocular use is a vascular endothelial growth factor A (VEGF-A) antagonist. Ranibizumab binds to active forms of human VEGF-A, including the cleaved form (VEGF 110), and inhibits their biologic activity.

VEGF-A induces neovascularization (angiogenesis) and increases vascular permeability, which appears to play a role in the pathogenesis and progression of the neovascular (wet) form of age-related macular degeneration, a leading cause of blindness in adults older than 60 years of age in developed countries. Binding of ranibizumab to VEGF-A prevents VEGF-A from binding to VEGF receptors (i.e., VEGFR-1, VEGFR-2) on the surface of endothelial cells, reducing endothelial cell proliferation, angiogenesis, and vascular permeability.

Ranibizumab was approved by the Food and Drug Administration (FDA) on June 30, 2006 for treatment of patients with exudative senile macular degeneration. The recommended dosage and frequency of treatment is 0.5 mg/0.05mL (10mg/mL), administered by intravitreal injection once a month (approximately 28 days). Treatment may be continued monthly or reduced to one injection every three months after the first four injections, if monthly treatments are not feasible. Compared to monthly dosing, however, it is expected that quarterly dosing may be less effective, and as such, patients should be evaluated regularly.

First Coast Service Options, Inc. (FCSO) Medicare will consider ranibizumab (Lucentis) medically reasonable and necessary for patients with established exudative senile macular degeneration for services rendered on or after the FDA approval date of June 30, 2006.

This local coverage determination (LCD) has been developed to provide the indications and limitations of coverage and/or medical necessity, documentation requirements and coding guidelines for this medication.

Effective Date

This new LCD will be effective for services rendered on or after February 29, 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.

CONNECTICUT ONLY - REVISIONS TO LCDS

J9200: Floxuridine (FUDR)—Revision to the LCD

The local coverage determination (LCD) for floxuridine (FUDR) was last revised on April 30, 2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, and to update the off-labeled indications based on the United States Pharmacopeia Drug Information (USP DI) for floxuridine (FUDR) (HCPCS code J9200).

Revisions for FDA-approved indications and off-labeled indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD will be effective for services rendered on or after February 29, 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.

J9390: Vinorelbine Tartrate (Navelbine®)—Revision to the LCD

The local coverage determination (LCD) for vinorelbine tartrate (Navelbine®) was last revised on April 30, 2007. Since that

time, the LCD has been revised in the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD in accordance with the Food and Drug Administration (FDA) approval language regarding vinorelbine for use as a single agent or in combination with cisplatin for the first-line treatment of ambulatory patients with unresectable, advanced non-small cell lung cancer (NSCLC) and the "off-label" language has been revised under the third bullet to read: *metastatic breast carcinoma in patients who did not respond to standard first-line chemotherapy for metastatic disease.*

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

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.

J9600: Porfimer (Photofrin®)—Revision to the LCD

The local coverage determination (LCD) for porfimer (Photofrin®) was last revised on April 30, 2007. Since that time, the LCD has been revised in the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD in accordance with the Food and Drug Administration (FDA) approval language in regard to the treatment of microinvasive endobronchial non-small cell lung cancer and an additional FDA-approved indication has been added for reduction of obstruction and palliation of symptoms in patients with completely or partially obstructing endobronchial non-small cell lung cancer.

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

NCSVCS: The List of Medicare Noncovered Services—Revision to the LCD

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised on January 1, 2008. Since that time, the LCD has been revised to add Category III *CPT* codes *0062T (Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level)* and *0063T (Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels [List separately in addition to 0062T for primary procedure])* to the "*CPT*/HCPCS Codes, Local Noncoverage Decisions, Procedures" section of the LCD, as these procedures are considered experimental and investigational.

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

93875: Non-invasive Extracranial Arterial Studies—Revision to the LCD

The local coverage determination (LCD) for non-invasive extracranial arterial studies was last revised on August 7, 2006. Since that time, the LCD has been revised in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to reword the second sentence in the first bullet and move the 7th bullet and the 15th bullet under the first bullet. The "Documentation Requirements" section of the LCD was revised to add a paragraph regarding the requirement for documentation to support the criteria for coverage as set forth in this LCD and to also reflect how the results of this test will be used in the patient's plan of care.

Effective Date

This LCD revision is effective for services rendered on or after December 18, 2007. 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.

Sign up to our *eNews* electronic mailing list

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

CONNECTICUT ONLY - ADDITIONAL INFORMATION

Local Coverage Determination Changes Related to the 2008 HCPCS Update

LCD Title	Changes
EPO Epoetin alfa **(Coding Guidelines only)**	Added Modifiers EA, EB, and EC for HCPCS code J0885
J1566 Intravenous Immune Globulin	• Descriptor change for HCPCS code J1566 • Deleted HCPCS codes Q4087, Q4088, Q4091, and Q4092 • Added HCPCS codes J1568, J1569, J1572, and J1561. • Changed contractor's determination number to J1561.
J1950 Luteinizing Hormone-Releasing Hormone (LHRH) Analogs	Descriptor change for HCPCS code J9225
J2792 Rho (D) Immune Globulin Intravenous	• Deleted HCPCS code Q4089 • Added HCPCS code J2791
J3487 Zoledronic Acid (Zometa®)	Descriptor change for HCPCS code J3487
NCSVCS The List of Medicare Non-covered Services	• Deleted *CPT* codes *0153T*, 0135T**, and *0154T** from the Local Noncoverage Decisions section of the LCD (* investigational) • Added *CPT 0183T*, 0186T*, 0187T*, 20985*, 20986*, 20987*, 34806*, 50593*, 90661*, 90662*, 90663**, and *93982** to the Local Noncoverage Decisions section of the LCD (* investigational) • Added *CPT*/HCPCS codes J7307, *0185T, 21073, 99605, 99606,* and *99607* to the Local Noncoverage Decisions section of the LCD • Added HCPCS code A9155 to the National Noncoverage Decisions section of the LCD
NESP Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) **(Coding Guidelines only)**	Added Modifiers EA, EB, and EC for HCPCS code J0881
VISCO Viscosupplementation Therapy For Knee	• Deleted HCPCS codes Q4083, Q4084, Q4085, and Q4086 • Added HCPCS codes J7321, J7322, J7323, and J7324
0145T Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries	• Descriptor changes for *CPT* codes *0145T, 0146T, 0147T, 0148T, 0149T, 0150T, and 0151T* • Descriptor change for *CPT* code *71275* • Deleted HCPCS codes Q9945, Q9946, Q9947, Q9948, Q9949, and Q9950 from the "Coding Guideline" attachment of the LCD • Added HCPCS codes Q9965, Q9966, and Q9967 to the "Coding Guideline" attachment of the LCD
88230 Cytogenetic Studies	Deleted HCPCS codes G0265 and G0266
92135 Scanning Computerized Ophthalmic Diagnostic Imaging	Descriptor change for *CPT* code *92135*

FLORIDA ONLY - NEW LCDS

IDTF: Independent Diagnostic Testing Facility—New LCD

An independent diagnostic testing facility (IDTF) is an entity independent of a hospital or physician's office in which diagnostic tests are performed. It was created by regulation (42CFR, section 410.33) as published in the *Federal Register*, Vol. 62, number 211, October 31, 1997.

Effective for diagnostic procedures performed on or after March 15, 1999, carriers will pay for diagnostic procedures under the physician fee schedule only when performed by a physician, a group practice of physicians, an approved supplier of portable x-ray services, a nurse practitioner, or a clinical nurse specialist when he or she performs a test he or she is authorized by the state to perform, or an independent diagnostic testing facility (IDTF).

This local coverage determination (LCD) addresses the structure, approved services, credentialing requirements and coding and billing for an IDTF. Diagnostic testing performed in an IDTF must follow the supervision and credentialing guidelines set forth in this LCD. All enrolling IDTFs must meet the supervising physician qualification/proficiency requirements and technician qualification requirements at the time of their enrollment.

IDTF regulations in this LCD do not apply to approved portable x-ray suppliers or to procedures (e.g., pathology and laboratory) furnished in a physician's offices, group practices, multi-specialty clinics or groups.

Required characteristics of an IDTF:

- It may be in a fixed location or be a mobile entity or supplied by an individual nonphysician practitioner.
- Is independent of a physician's office or hospital; however, these rules apply when an IDTF furnishes diagnostic procedures in a physician's office.
- *Performs only diagnostic tests by licensed, certified nonphysician personnel under appropriate physician supervision.
- The sole purpose is to furnish diagnostic testing.
- Is not engaged in any form of patient treatment.
- Is properly enrolled with Medicare as an IDTF and approved for the specific tests to be provided.

However, if a substantial portion of the entity's business involves the performance of diagnostic tests, the diagnostic testing services may constitute a sufficiently separate business to warrant enrollment as an IDTF (It will be considered "independent" for purposes of enrollment). In such a case, the entity can be enrolled as a physician or a group practice of physicians, but must also enroll as an IDTF. The physician or group can bill for professional fees and the diagnostic tests they perform on their own patients using their billing number; the practice must bill as an IDTF for diagnostic tests furnished to Medicare beneficiaries who are not patients of the practice.

Note: An IDTF must enroll with the carrier that has jurisdiction in the area where the beneficiary will receive the technical services of the procedure.

*The CMS On-line Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, chapter 13, section 13.5.1) outlines that "reasonable and necessary" services are "ordered and/or furnished by qualified personnel." Services will be considered medically reasonable and necessary only if performed by appropriately trained providers.

Effective Date

This LCD will be effective for services rendered on or after February 29, 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.

J2778: Ranibizumab (Lucentis®)—New LCD

Ranibizumab (Lucentis®), a recombinant humanized immunoglobulin G1 kappa (IgG1 kappa) monoclonal antibody fragment designed for intraocular use is a vascular endothelial growth factor A (VEGF-A) antagonist. Ranibizumab binds to active forms of human VEGF-A, including the cleaved form (VEGF 110), and inhibits their biologic activity.

VEGF-A induces neovascularization (angiogenesis) and increases vascular permeability, which appears to play a role in the pathogenesis and progression of the neovascular (wet) form of age-related macular degeneration, a leading cause of blindness in adults older than 60 years of age in developed countries. Binding of ranibizumab to VEGF-A prevents VEGF-A from binding to VEGF receptors (i.e., VEGFR-1, VEGFR-2) on the surface of endothelial cells, reducing endothelial cell proliferation, angiogenesis, and vascular permeability.

Ranibizumab was approved by the Food and Drug Administration (FDA) on June 30, 2006 for treatment of patients with exudative senile macular degeneration. The recommended dosage and frequency of treatment is 0.5 mg/0.05mL (10mg/mL), administered by intravitreal injection once a month (approximately 28 days). Treatment may be continued monthly or reduced to one injection every three months after the first four injections, if monthly treatments are not feasible. Compared to monthly dosing, however, it is expected that quarterly dosing may be less effective, and as such, patients should be evaluated regularly.

First Coast Service Options, Inc. (FCSO) Medicare will consider ranibizumab (Lucentis) medically reasonable and necessary for patients with established exudative senile macular degeneration for services rendered on or after the FDA-approval date of June 30, 2006.

This local coverage determination (LCD) has been developed to provide the indications and limitations of coverage and/or medical necessity, documentation requirements and coding guidelines for this medication.

J2778: Ranibizumab (Lucentis®)—New LCD, continued

Effective Date

This new LCD will be effective for services rendered on or after February 29, 2008. The full text of this LCD is available through our provider education Web site at *http://www.fcso.com* on or after this effective date.

FLORIDA ONLY - REVISIONS TO LCDS

J9200: Floxuridine (FUDR)- Revision to the LCD

The local coverage determination (LCD) for floxuridine (FUDR) was last revised on April 30,2007. Since that time, a revision was made to update language for approved indications based on the Food and Drug Administration (FDA) drug label, and to update the off-labeled indications based on the United States Pharmacopeia Drug Information (USP DI) for floxuridine (FUDR) (HCPCS code J9200).

Revisions for FDA-approved indications and off-labeled indications were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD will be effective for services rendered on or after February 29, 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.

J9390: Vinorelbine Tartrate (Navelbine®)—Revision to the LCD

The local coverage determination (LCD) for vinorelbine tartrate (Navelbine®) was last revised on April 30, 2007. Since that time, the LCD has been revised in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD in accordance with the Food and Drug Administration (FDA) approval language regarding vinorelbine for use as a single agent or in combination with cisplatin for the first-line treatment of ambulatory patients with unresectable, advanced non-small cell lung cancer (NSCLC) and the "off-label" language has been revised under the third bullet to read: *metastatic breast carcinoma in patients who did not respond to standard first-line chemotherapy for metastatic disease*.

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

J9600: Porfimer (Photofrin®)—Revision to the LCD

The local coverage determination (LCD) for porfimer (Photofrin®) was last revised on April 30, 2007. Since that time, the LCD has been revised in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD in accordance with the Food and Drug Administration (FDA) approval language in regard to the treatment of microinvasive endobronchial non-small cell lung cancer and an additional FDA-approved indication has been added for reduction of obstruction and palliation of symptoms in patients with completely or partially obstructing endobronchial non-small cell lung cancer.

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

NCSVCS: The List of Medicare Noncovered Services—Revision to the LCD

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised on January 1, 2008. Since that time, the LCD has been revised to add category III *CPT* codes *0062T (Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level)* and *0063T (Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels [List separately in addition to 0062T for primary procedure])* to the "*CPT*/HCPCS Codes, Local Noncoverage Decisions, Procedures" section of the LCD, as these procedures are considered experimental and investigational.

Effective Date

This LCD revision will be effective for services rendered on or after February 29, 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.

62310: Epidural—Revision to LCD

The local coverage determination (LCD) for epidural was last revised on April 9, 2007. Since that time, revisions were made to the following sections of the LCD:

- Language was added to the "Indications and Limitations of Coverage and/or Medical Necessity" section regarding fluoroscopic or CT-guided imaging.
- The ICD-9-CM code V58.61 (Long term [current use] of anticoagulants) was added as a secondary diagnosis. This ICD-9-CM code is a supplemental code and should be billed in addition to the primary diagnosis for patients who have temporarily discontinued anticoagulant therapy to support multiple interventional spinal procedures on the same day.
- Additional utilization guidelines were developed for epidural injections.
- *CPT* codes *62318* and *62319* were removed from the "*CPT*/HCPCS Codes" section and the indication for acute pain was removed from the "Indications and Limitations of Coverage and/or Medical Necessity" section.
- Language was added to the "Documentation Requirements" section for the assessment of the outcome of the procedure including the patient's response.
- The coding guidelines section has been updated.

Effective Date

This revision to the LCD will be effective for services rendered on or after February 29, 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.

93875: Non-invasive Extracranial Arterial Studies—Revision to the LCD

The local coverage determination (LCD) for non-invasive extracranial arterial studies was last revised on August 7, 2006. Since that time, the LCD has been revised in the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD to reword the second sentence in the first bullet and move the 7th bullet and the 15th bullet under the first bullet. The "Documentation Requirements" section of the LCD was revised to add a paragraph regarding the requirement for documentation to support the criteria for coverage as set forth in this LCD and to also reflect how the results of this test will be used in the patient's plan of care.

Effective Date

This LCD revision is effective for services rendered on or after December 18, 2007. 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.

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.

FLORIDA ONLY - ADDITIONAL INFORMATION

Local Coverage Determination Changes Related to the 2008 HCPCS Update

LCD Title	Changes
EPO Epoetin alfa **(Coding Guidelines only)**	Added Modifiers EA, EB, and EC for HCPCS code J0885
J1566 Intravenous Immune Globulin	• Descriptor change for HCPCS code J1566 • Deleted HCPCS codes Q4087, Q4088, Q4091, and Q4092 • Added HCPCS codes J1568, J1569, J1572, and J1561. • Changed contractor's determination number to J1561.
J1950 Luteinizing Hormone-Releasing Hormone (LHRH) Analogs	Descriptor change for HCPCS code J9225
J2792 Rho (D) Immune Globulin Intravenous	• Deleted HCPCS code Q4089 • Added HCPCS code J2791
J3487 Zoledronic Acid (Zometa®)	Descriptor change for HCPCS code J3487
J7187 Hemophilia Clotting Factors	Descriptor change for HCPCS code J7187
NCSVCS The List of Medicare Non-covered Services	• Deleted *CPT* codes *0153T**, *0135T**, and *0154T** from the Local Noncoverage Decisions section of the LCD (* investigational) • Added *CPT 0183T**, *0186T**, *0187T**, *20985**, *20986**, *20987**, *34806**, *50593**, *90661**, *90662**, *90663**, and *93982** to the Local Noncoverage Decisions section of the LCD (* investigational) • Added *CPT*/HCPCS codes J7307, *0185T, 21073, 99605, 99606,* and *99607* to the Local Noncoverage Decisions section of the LCD • Added HCPCS code A9155 to the National Noncoverage Decisions section of the LCD
NESP Darbepoetin alfa (Aranesp®) (novel erythropoiesis stimulating protein [NESP]) **(Coding Guidelines only)**	Added Modifiers EA, EB, and EC for HCPCS code J0881
VISCO Viscosupplementation Therapy For Knee	• Deleted HCPCS codes Q4083, Q4084, Q4085, and Q4086 • Added HCPCS codes J7321, J7322, J7323, and J7324
0145T Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries	• Descriptor changes for *CPT* codes *0145T, 0146T, 0147T, 0148T, 0149T, 0150T, and 0151T* • Descriptor change for *CPT* code *71275* • Deleted HCPCS codes Q9945, Q9946, Q9947, Q9948, Q9949, and Q9950 from the "Coding Guideline" attachment of the LCD • Added HCPCS codes Q9965, Q9966, and Q9967 to the "Coding Guideline" attachment of the LCD
11000 Debridement Services	Descriptor change for *CPT* code *11008*
43644 Surgical Management of Morbid Obesity	Descriptor changes for *CPT* codes *43770, 43771, 43772, 43773, 43774, and 43848*
92135 Scanning Computerized Ophthalmic Diagnostic Imaging	Descriptor change for *CPT* code *92135*
95004 Allergy Skin Tests	Descriptor change for *CPT* codes *95004, 95024,* and *95027*

CONNECTICUT EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

January 2008 – February 2008

Preventive Services Webcast

Learn about coverage, coding requirements and reimbursement for Medicare's preventive services benefits during this interactive webcast.

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

Evaluation & Management Education Series Webcast

Topic: Incident To

When: January 22, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Ask-the-Contractor Teleconference (ACT)/Webcast – Topic to be determined

When: February 13, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

Evaluation & Management Education Series Webcast

Topic: Emergency Services

When: February 19, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast

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

Two Easy Ways To Register!

Online - Simply log on to your account on our provider training Web site at *www.fcsomedicaretraining.com* and select the course you wish to register for. Class materials will be available under "My Courses" no later than one day before the event. If you need assistance with the provider training Web site, please contact our FCSO Medicare training help desk by calling 866-756-9160 or sending an email to *fcsohelp@geolearning.com*.

- To locate any of these courses on the provider training Web site, click on the following links/buttons in this order:
  - "Course Catalog" from the top navigation bar, then "Catalog" in the middle of the page;
  - Type a keyword in the search box for the course you are interested in (such as "preventive" or "Hot Topics") and hit the "Search" button.
  - In the short list of courses that will appear, click the link for the course you've chosen and then click the "Preview Schedule" button at the bottom of the class description page;
  - On the Instructor-Led Training (ILT) Schedule page, locate the line that has the course you are registering for and click the "Register" link in the Options column.
- **First-time user?** Please set up an account using the instructions located at *www.connecticutmedicare.com/Education/108651.asp*.

Fax - If you would like to participate in any of these events and do not have access to the Internet, please complete the registration section below, circle your selection(s) above and fax to (904) 361-0407.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

FLORIDA EDUCATIONAL RESOURCES

Upcoming Provider Outreach and Education Events

January 2008 – February 2008

Preventive Services Webcast When: January 16, 2008 Time: 11:30 a.m. – 1:00 p.m. Type of Event: Webcast	**Evaluation & Management – "Incident To" Webcast** When: January 22, 2008 Time: 11:30 a.m. – 1:00 p.m. Type of Event: Webcast
Hot Topics Teleconference/Updates Webcast When: January 17, 2008 Time: 11:30 a.m. – 12:30 p.m. Type of Event: Webcast	**Ask the Contractor Teleconference/Webcast** Topics to be determined When: February 14, 2008 Time: 11:30 a.m. – 1:00 p.m. Type of Event: Webcast

Note: Dates and times are subject to change prior to opening of event registration.

Two Easy Ways To Register

Online – Simply log on to your account on our provider training Web site at www.fcsomedicaretraining.com and select the course you wish to register for. Class materials will be available under "My Courses" no later than one day before the event.

First-time user?– Please set up an account using the instructions located at *www.floridamedicare.com/Education/108651.asp* in order to register for a class and obtain materials.

Tips for Using the FCSO Provider Training Web site

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

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

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

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

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.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

CONNECTICUT MEDICARE PART B MAIL DIRECTORY

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

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

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

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

Attention: Correspondence

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

Attention: Financial Services

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

Attention: Fraud and Abuse

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

Attention: Freedom of Information (FOIA)

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

Attention: Medical Review

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

Attention: MSP

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

Attention: Pricing/ Provider Maintenance

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

Attention: Resolutions

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

MAILING ADDRESS EXCEPTIONS

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

Redeterminations/Appeals

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

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

Post Office Box for Appeals:

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

Post Office Box for EDI:

Electronic Media Claims/EDI

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

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

Claims

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

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

CONNECTICUT MEDICARE PHONE NUMBERS

Beneficiary Services
1-800-MEDICARE ***(toll-free)***
1-866-359-3614 *(hearing impaired)*
First Coast Service Options, Inc.
Provider Services
Medicare Part B
1-888-760-6950

Appeals
1-866-535-6790, option 1

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

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

Interactive Voice Response
1-866-419-9455

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

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

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

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

Electronic Funds Transfer Information
1-203-639-3219

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

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

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

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

OTHER HELPFUL NUMBERS

Social Security Administration
1-800-772-1213

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

Health Insurance Counseling Program (CHOICES)/Area Agency on Aging
1-800-994-9422

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

ConnPACE/ Assistance with Prescription Drugs
1-800-423-5026 or 1-860-832-9265 (Hartford area or from out of state)

MEDICARE WEB SITES

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

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

Florida Medicare Part B Mail Directory

CLAIMS SUBMISSIONS

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

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

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

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

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

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

COMMUNICATIONS

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

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

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

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

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

DURABLE MEDICAL EQUIPMENT (DME)

DME, Orthotic or Prosthetic Claims
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

ELECTRONIC MEDIA CLAIMS (EMC)

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

MEDICARE PART B ADDITIONAL DEVELOPMENT

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

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

MISCELLANEOUS

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

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

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

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

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

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

Medicare Claims for Railroad Retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

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

Florida Medicare Phone Numbers

PROVIDERS

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

BENEFICIARY

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

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

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

EMC

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

DME, ORTHOTIC OR PROSTHETIC CLAIMS

Cigna Government Services
1-866-270-4909

MEDICARE PART A

Toll-Free:
1-866-270-4909

Medicare Web sites

PROVIDERS

Florida Medicare Contractor
www.floridamedicare.com

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

BENEFICIARIES

Centers for Medicare & Medicaid Services
www.medicare.gov

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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.

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ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
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		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.	700400	Hardcopy: FL $12.00		
		Hardcopy: CT $12.00		
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		CD-ROM CT $6.00		
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			Tax (***add % for your area***)	$
			Total	$

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First Coast Service Options, Inc.
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P.O. Box 406443
Atlanta, GA 30384-6443

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Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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P.O. BOX 44234 JACKSONVILLE, FL 32231-4234 (CONNECTICUT)

* ATTENTION BILLING MANAGER *