

Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



May 1, 2007

Vol. 14, No. 8

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no cost from our Web site at: www.cahabagba.com



The Inside Story

News from CMS

- ☺ CMS Clarifies Guidelines for National Provider Identifier (NPI) Deadline Implementation 3
- ☺ Change in the Amount in Controversy Requirement for Federal District Court Appeals 4
- ☺ Part C Plan Type Description Display on Medicare’s Common Working File (CWF)—**Revised** 5
- ☺ April 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective April 1, 2007, and Revisions to the January 2007 Quarterly ASP Medicare Part B Drug Pricing Files 7
- ☺ April 2007 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes 10
- ☺ Program Instructions Designating the Competitive Bidding Areas and Product Categories Included in the CY 2007 DMEPOS Competitive Bid Program 15
- ☺ Initial Supplier Registration for Competitive Bidding Program for DMEPOS is Now Open 16
- ☺ Extracorporeal Photopheresis 19

- ☺ Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumors 21
- ☺ New “K” Codes for Oral/Mask for Use with Continuous Positive Airway Pressure (CPAP) Device 22
- ☺ Update to Medicare Claims Processing Manual, Publication 100-04, Chapter 18, Section 60.1 Regarding Colorectal Screening Services 23
- ☺ Colorectal Cancer: Preventable, Treatable, and Beatable—Medicare Coverage and Billing for Colorectal Cancer Screening 24
- ☺ Reminder – Medicare Now Provides Coverage for Eligible Medicare Beneficiaries of a One-Time Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) When Referred for this Screening as a Result of the Initial Preventive Physical Examination (“Welcome to Medicare” Physical Exam) 29
- ☺ Ambulance Fee Schedule - Ground Ambulance Services - Manualization Revision to the Specialty Care Transport (SCT) Definition 31
- ☺ **H** **R** **O** April 2007 Non-Outpatient Prospective Payment System (Non-OPPS) Outpatient Code Editor (OCE) Specifications Version 22.2 33
- ☺ **H** **S** Reporting of Type of Bill (TOB) 12X for Billing of Diagnostic Mammographies 34

The Inside Story Continued on the Next Page

Key for Icons:

- | | | |
|---|---|--|
| ☺ All Providers | R Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Providers | C Community Mental Health Center (CMHC) Providers |
| H Hospital/Critical Access Hospital (CAH) Providers | E Renal Dialysis Facility (RDF) | O Comprehensive Outpatient Rehabilitation Facility (CORF) Providers and Outpatient Physical Therapy (OPT) Providers |
| S Skilled Nursing Facility (SNF) / Swing Bed Providers | | |

The Medicare A Newsline provides information for those providers who submit claims to Cahaba Government Benefit Administrators®, LLC as their Fiscal Intermediary or Regional Home Health Intermediary. The CPT codes, descriptors and other data only are copyright © 2006 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

News from Cahaba GBA, LLC

☺	Steps to Ensure Legible Documentation to CERT35	☺	Provider Enrollment.....42
☺	Updated Top Inquiries Frequently Asked Questions (FAQs).....36	☺	Availability of the Provider Contact Center44
☺	Resources for the Most Common Medicare Part A Provider Questions.....36	H	Billing of Self-Administered Drugs (SADs).....44
☺	Updated FISS Reference Guide (Attachment #1)40	S	Medicare Forum.....45
☺	How to Prevent Common Errors on Claims.....40		Contact Us47
☺	Part A Local Coverage Determination Update42		Cahaba GBA, LLC Learning Corner48
			May 1, 2007, Medicare A Newsline
			Glossary of Acronyms and Abbreviation51

Disclaimer

This educational material was prepared as a tool to assist Medicare providers and other interested parties and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within this module, the ultimate responsibility for the correct submission of claims lies with the provider of services. Cahaba GBA, LLC employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of these materials. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

We encourage users to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. Although this material is not copyrighted, CMS prohibits reproduction for profit making purposes.

American Medical Association Notice and Disclaimer

CPT codes, descriptors and other data only are copyright 2006 American Medical Association. All rights reserved.

ICD-9 Notice

The ICD-9-CM codes and descriptors used in this material are copyright 2006 under uniform copyright convention. All rights reserved.

News from CMS For All Providers

Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS Web site.

The “**Medicare Guide to Rural Health Services: Information for Providers, Suppliers, and Physicians (Second Edition)**,” which provides rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005 is now available in downloadable format at: <http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.pdf>

Flu Shot Reminder

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

The peak of flu season typically occurs between late December and March; however, flu season can last until May. **Protect yourself, your patients, and your family and friends by getting and giving the flu shot.** Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination. Remember – influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' Web site: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf>

PQRI Information Available

A new CMS web page dedicated to providing information on the Physician Quality Reporting Initiative (PQRI) is now available.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the Physician Quality Reporting Initiative. For more information, visit <http://www.cms.hhs.gov/pqri> on the CMS Web site.

The “Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet,” which provides information about Inpatient Rehabilitation Facility Prospective Payment System rates and classification criterion, is now available in downloadable format on the Centers for Medicare & Medicaid Services Medicare Learning Network Publications Page located at: <http://www.cms.hhs.gov/MLNProducts/downloads/IRFPPSFactSheet0307.pdf>

Medicare Advantage Plan Questions

If you have questions regarding the plan of a specific Medicare patient enrolled in a Medicare Advantage (MA) plan, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/> on the Centers for Medicare & Medicaid Services (CMS) Web site. CMS updates this site on a monthly basis.

Physician Quality Reporting Initiative (PQRI) Measures and Specifications

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2007 Physician Quality Reporting Initiative (PQRI) Quality Measures and Specifications are now available. In addition to posting the 2007 PQRI Measures Specifications, CMS has also updated the list of 2007 PQRI measure statements and descriptions. To access both the measures and measure specifications documents, visit the PQRI web page at <http://www.cms.hhs.gov/PQRI> on the CMS Web site. Once there, go to the Measures/Codes section of the page and scroll down to the Downloads section. Providers may want to test their systems to be certain that claims containing the codes associated with the measures will be processed. **Please note that many of the quality codes are new and will be rejected by Medicare claims processing systems prior to the July 1, 2007 HCPCS update.** CMS will be issuing further information about which measures may be used for testing systems prior to the July 1 start date.



CMS Clarifies Guidelines for National Provider Identifier (NPI) Deadline Implementation

The Centers for Medicare & Medicaid Services (CMS) announced that it is implementing a contingency plan for covered entities (other than small health plans) who will not meet the May 23, 2007, deadline for compliance with the National Provider Identifier (NPI) regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The final rule establishing the NPI as the standard unique health provider identifier for health care providers was published in 2004 and requires all covered entities to be in compliance with its provisions by May 23, 2007, except for small health plans, which must be in compliance by May 23, 2008.

“The enforcement guidance released today clarifies that covered entities that have been making a good faith effort to comply with the NPI provisions may, for up to 12 months, implement contingency plans that could include accepting legacy provider numbers on HIPAA transactions in order to maintain operations and cash flows.” said CMS Acting Administrator Leslie V. Norwalk, Esq.

The NPI is an identifier that will be used by covered entities to identify health care providers, eliminating the current need for multiple identifiers for the same provider. The NPI replaces all “legacy” identifiers that are currently being used, such as Medicaid provider IDs, individual plan provider IDs, UPINs, etc., and will be required for use on health care claims and other HIPAA transactions.

CMS made the decision to announce this guidance on its enforcement approach after it became apparent that many covered entities would not be able to fully comply with the NPI standard by May 23, 2007. This guidance would protect covered entities from enforcement action if they continue to act in good faith to come into compliance, and they develop and implement contingency plans to enable them and their trading partners to continue to move toward compliance. HHS recognizes that transactions often require the participation of two covered entities and that non-compliance by one covered entity may put the second covered entity in a difficult position.

The enforcement process is complaint driven and will allow covered entities to demonstrate good faith efforts and employ contingency plans. If a complaint is filed against a covered entity, CMS will evaluate the entity's "good faith efforts" to comply with the standards and would not impose penalties on covered entities that have deployed contingencies to ensure that the smooth flow of payment continues. Each covered entity will determine the specifics of its contingency plan. Contingency plans may not extend beyond May 23, 2008, but entities may elect to end their contingency plans sooner. Medicare will announce its own contingency plan shortly.

CMS encourages health plans to assess the readiness of their provider communities to determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance. Likewise, we encourage health care providers that have not yet obtained NPIs to do so immediately, and to use their NPIs in HIPAA transactions as soon as possible. Applying for an NPI is fast, easy and free. Visit the National Plan/Provider Enumeration System (NPPES) Web site at:

<https://nppes.cms.hhs.gov/>

A critical aspect of implementing the NPI is the ability for covered entities to match a provider's NPI with the many legacy provider identifiers that have been used to process administrative transactions. CMS plans to make data available from the NPPES system that will assist covered entities in developing these "crosswalks."

Further information concerning this issue is available at <http://www.cms.hhs.gov> on the CMS Web site. The site also contains contingency plan guidance for the industry in a document titled "Guidance on Compliance with the HIPAA National Provider Identifier Rule."



Change in the Amount in Controversy Requirement for Federal District Court Appeals

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5518

Related Change Request (CR) #: 5518

Related CR Release Date: March 30, 2007

Effective Date: January 1, 2007

Related CR Transmittal #: R1211CP

Implementation Date: July 2, 2007

Provider Types Affected

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

Provider Action Needed

This article is based on CR 5518, which notifies Medicare contractors of an increase in the amount in controversy required to sustain Federal District Court appeal rights beginning January 1, 2007.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an annual reevaluation, beginning in 2005, of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or Federal District Court review. Therefore, **CR 5518 updates the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 29, §§330.1 and 345.1) to announce the amount in controversy requirements for ALJ or Federal District Court Appeals during 2007.**

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2006, was \$100. The amount in controversy requirement increased to \$110 for requests made on or after January 1, 2006. **CR 5518 announces that for ALJ hearing requests made on or after January 1, 2007, the amount that must remain in controversy did not change and remains at \$110.**

The amount remaining in controversy requirement for Federal District Court review prior to January 1, 2006, was \$1,000. That amount increased to \$1,090 on or after January 1, 2006. **CR 5518 announces that for Federal District Court review requests made on or after January 1, 2007, the amount that must remain in controversy is increased to \$1,130.**

Additional Information

The official instruction, CR 5518, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1211CP.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Part C Plan Type Description Display on Medicare’s Common Working File (CWF)— Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network (MLN) Matters* article entitled “Part C Plan Type Description Display on Medicare’s Common Working File (CWF),” which was published in the March 1, 2007, *Medicare A Newsline*. This MLN Matters article and other CMS articles can be found on the CMS Web site at:

<http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5349 Revised

Related CR Release Date: February 2, 2007

Related CR Transmittal #: R1175CP

Related Change Request (CR) #: 5349

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Note: This article was revised on March 27, 2007, to reflect that the Medicare Advantage (MA) plan directory has been posted on the CMS Web site. The directory is located at:

<http://www.cms.hhs.gov/MCRAdvPartDENrolData/> on the CMS Web site. See the “Additional Information” section of this article for more details.

Provider Types Affected

Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through CWF eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).

Provider Action Needed

Be aware of the expanded list of MA Plan Type Descriptions that are being displayed by Medicare’s CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in Private Fee-For-Service (PFFS) plans.

A plan directory, which is quite descriptive, contains the list of all active Medicare contracts and their corresponding plan type. The directory is posted at the following URL:

<http://www.cms.hhs.gov/MCRAdvPartDENrolData/>

Background

When you query Medicare regarding a beneficiary's entitlement and eligibility, Medicare's CWF system responds with information on the Medicare managed care contract number in which a beneficiary is enrolled, including the plan type description associated with the contract. Currently, CWF largely displays the label "HMO" for these contracts. In many cases, the "HMO" label is incorrect since the list of possible plan type values has grown far larger since the creation of the Medicare Advantage program.

For example, under the MA Part C program, Medicare beneficiaries can enroll in Private Fee-for-Service (PFFS) plans. PFFS plans are very different from the more traditional MA HMO type plan.

PFFS PLANS

PFFS plans generally have no plan specific provider network. Enrollees in a PFFS plan can obtain plan covered health care services from any Medicare FFS enrolled provider in the U.S. who is willing to furnish services to a PFFS plan beneficiary. It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan.

In most cases, a PFFS enrollee will inform a provider before obtaining a service that they are enrolled in a PFFS plan. In addition, the PFFS enrollee will have an enrollment card provided by the PFFS plan identifying them as enrollees in a PFFS plan. The card will specify a phone number and/or a web address where the provider can obtain the PFFS plan's terms and conditions of participation.

At a minimum, the terms and conditions will specify:

- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures, including
- The amount the provider is permitted to collect from the enrollee; and
- Whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers in the U.S. from whom its enrollees seek health care services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a Web site and also make them available upon written or phoned request.

To be paid by a PFFS organization, the provider must send their bill to the address (or electronic address) provided in the PFFS plan's terms and conditions of participation.

For more detailed information on PFFS plans as they relate to providers, see the "Provider Q&A" downloadable document on: <http://www.cms.hhs.gov/PrivateFeeforServicePlans/>

Additional Information

If you have questions regarding the plan of a specific Medicare MA enrolled patient, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at <http://www.cms.hhs.gov/MCRAdvPartDENrolData/> on the CMS Web site. CMS updates this site on a monthly basis.

To view the official instruction (CR 5349) issued to your Medicare FI, carrier, MAC, DMERC or RHHI, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1175CP.pdf> on the CMS Web site.

To review a related article that explains Medicare's Common Working File (CWF) Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5118.pdf> on the CMS Web site.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



April 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective April 1, 2007, and Revisions to the January 2007 Quarterly ASP Medicare Part B Drug Pricing Files

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5517

Related CR Release Date: March 16, 2007

Related CR Transmittal #: R1204CP

Related Change Request (CR) #: 5517

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

Provider Types Affected

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

Provider Action Needed

This article is based on CR 5517, which informs Medicare contractors to download the April 2007 average sales price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 ASP files.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all end stage renal disease (ESRD) drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the outpatient prospective payment system (OPPS), will be paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers, and CMS supplies Medicare contractors (carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

For 2007, a separate fee of \$0.152 per international unit (I.U.) of blood clotting factor furnished is payable when a separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent (106%) of the ASP.

Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the Ambulatory Payment Classifications (APC) to which the product is assigned.
- Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. **The payment allowance limits will not be updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of DME that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published Average Wholesale Price (AWP) unless the drug is compounded.
- Payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent (95%) of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for **drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File** (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration) are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual* (CMS Publication 100-04, Chapter 17, Drugs and Biologicals) for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent (100%) of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.
- The payment allowance limits for **new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration (FDA)** and that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent (106%) of the WAC or invoice pricing, if the WAC is not published. This policy applies only to new drugs that were first sold on or after January 1, 2005.

- The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after March 19, 2007, the revised January 2007 and April 2007 ASP files and ASP NOC files will be available for retrieval from the CMS ASP webpage, and the payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP webpage is located at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/> on the CMS site. The revised files are applicable to claims based on dates of service as shown in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
January 2007	January 1, 2007, through March 31, 2007.
April 2007	April 1, 2007, through June 30, 2007

NOTE: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code, and its associated payment limit, does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above.

Additional Information

For complete details, please see the official instruction issued to your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1204CP.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the "Contact Us" page of this *Medicare A Newslines*.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



April 2007 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5544

Related Change Request (CR) #: 5544

Related CR Release Date: March 21, 2007

Effective Date: April 1, 2007

Related CR Transmittal #: R1209CP

Implementation Date: April 2, 2007

Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for radiation therapy services provided to Medicare beneficiaries and paid under the OPSS.

Provider Action Needed

This article is based on CR 5544, which describes changes to, and billing instructions for, various payment policies implemented by CMS in the April 2007 OPSS update.

Background

The April 2007 OPSS Outpatient Code Editor (OCE) and OPSS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 5544.

CR 5544 describes the following changes to, and billing instructions for, payment policies implemented in the April 2007 OPSS update.

Additional Payment Information for Current Pass-Through Category C1820

Section 1833(t)(6)(D)(ii) of the Social Security Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8).

For calendar year (CY) 2006, when creating new category C1820, (Generator, neurostimulator (implantable), with rechargeable battery and charging system), CMS determined that it could identify the portion of the APC payment amount associated with the cost of the historically utilized device, that is, the nonrechargeable neurostimulator generator implanted through procedures assigned to APC 222, Implantation of Neurological Device, which C1820 replaces in some cases. The device offset from the pass-through payment for C1820 represents the deduction from the pass-through payment for category C1820 that will be made when C1820 is billed with a service assigned to APC 222. In Transmittal 1139, CR 5438, issued December 22, 2006, CMS indicated that for CY 2007, the device offset portion for C1820, when billed with a procedure in APC 0222, is \$8,668.94.

CMS has recently been informed that at least some rechargeable neurostimulators described by C1820 may also be used and therefore be billed with CPT code 61885, Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to single array, and CMS has changed the procedure to device edits accordingly. This change is effective January 1, 2006, and is implemented in the April 2007 OPSS OCE.

CPT code 61885 maps to APC 0039, which has a CY 2007 offset percent of 78.85 percent. (71 FR 68077) Based on this percent, the device offset to be subtracted from the payment for C1820, when it is billed with CPT code 61885, is \$9,081.94. Note that the offset amount from the APC payment is wage adjusted before it is subtracted from the device cost.

Payment for Certain Laboratory Services

Effective for services furnished on or after the date listed in the table below, the unlisted laboratory CPT codes in the table are assigned to a status indicator of “A.” The clinical lab fee schedule does not provide a payment amount for these unlisted laboratory codes, since the Medicare carrier prices them. Therefore, your FI must review the narrative description of the test submitted by the hospital to determine if a specific HCPCS code is available to describe the laboratory test. If a specific HCPCS code is available, this code should be reported by the hospital for the laboratory test, rather than an unlisted laboratory CPT code. If there is no appropriate specific code, the FI will contact the carrier in your jurisdiction to obtain an appropriate payment amount for services reported with these laboratory CPT codes. If that carrier cannot provide a payment amount for the services, then to obtain a payment rate, the FI must contact the carrier in the jurisdiction of the reference laboratory that performed the test. If neither carrier has a payment amount for the test, and the FI determines that the service is covered, the FI will determine the payment amount. (Note that FIs will not search their files to adjust previously processed claims, but will adjust claims affected by this issue if you bring those claims to your FI’s attention.) FIs will follow this same procedure to develop payment amounts for such laboratory tests when it is paying a non-OPSS claim for an unlisted laboratory CPT code.

Beneficiary coinsurance and deductible are not applied to unlisted clinical laboratory services.

HCPCS Code	Long Descriptor	Effective Date
81099	Unlisted urinalysis procedure	08/01/00
84999	Unlisted chemistry procedure	08/01/00
85999	Unlisted hematology and coagulation procedure	08/01/00
86849	Unlisted immunology procedure	08/01/00
87999	Unlisted microbiology procedure	08/01/00

Clarification to Billing and Payment for IMRT Planning

Payment for services identified by the CPT codes in the following table is included in the Ambulatory Payment Classification (APC) payment for Intensity Modulated Radiation Therapy (IMRT) planning when these services are performed as part of developing an IMRT plan that is reported using CPT code 77301:

CPT Code(s)	Descriptor(s)
77280-77295	Simulation for Brachytherapy
77305-77321	Tele-therapy Isodose Plan
77331	Special Dosimetry
77336	Continuing Medical Radiation Physics Consultation
77370	Special Medical Radiation Physics Consultation

When these services are performed as part of developing an IMRT plan, these CPT codes should not be billed in addition to CPT code 77301 for IMRT planning.

However, payment for IMRT planning does not include payment for services described by the following CPT codes:

CPT Code(s)	Descriptor(s)
77332 - 77334	Treatment Devices, Designs and Construction

When provided, the services identified by CPT Codes 77332-77334 should be billed in addition to the IMRT planning code (CPT Code 77301).

Clarification to Payment policy for 77435, Stereotactic Body Radiation Therapy, Treatment Management, per Treatment Course, to One or More Lesions Including Image Guidance, Entire Course not to Exceed 5 Fractions.

CR 5544 clarifies payment policy for stereotactic radiosurgery (SRS) service described by CPT code 77435. In CR 5438, issued December 22, 2006, CMS inadvertently listed 77435 with status indicator of “B.” However, the January 2007 update of the OPPS Addendum B posted on the CMS Web site and the January 2007 OPPS OCE contained the correct status indicator of “N.”

Payment Status Indicators for “Special” Packaged CPT Codes: 36540, Collection of Blood Specimen from a Completely Implantable Venous Access Device; and 96523, Irrigation of Implanted Venous Access Device for Drug Delivery Systems

“Special” packaged CPT codes 36540 and 96523 were erroneously listed with status indicator “S” in CR 5438, issued on December 22, 2006, and in the CY 2007 OPPS final rule. Although this error does not affect payment rates for the services described by these CPT codes, CMS is clarifying that the correct status indicator assigned by the OCE for separate payment is “X,” as assigned to APC 624, Minor Vascular Access Device Procedures, in the January 2007 OPPS update of Addendum A.

Billing for Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2007

In the CY 2007 OPPS final rule, CMS stated that payments for separately payable drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the April 2007 release of the OPPS PRICER. The updated payment rates effective April 1, 2007, will be included in the April 2007 update of the OPPS Addendum A and Addendum B, which was posted on the CMS Web site at the end of March.

Updated Payment Rates for Certain Drugs and Biologicals Effective July 1, 2006, through September 30, 2006

The payment rates for the drugs and biologicals listed below were incorrect in the January 2007 OPPS PRICER. The corrected payment rates will be installed in the April 2007 OPPS PRICER effective for services furnished on July 1, 2006, through September 30, 2006.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	1630	Hep b ig, im	\$118.29	\$23.66
J2430	0730	Pamidronate disodium /30 MG	\$36.17	\$7.23
J7340	1632	Metabolic active D/E tissue	\$25.66	\$5.13
J7344	9156	Nonmetabolic active tissue	\$93.06	\$18.61
J9015	0807	Aldesleukin/single use vial	\$723.38	\$144.68

Updated Payment Rates for Certain Drugs and Biologicals Effective October 1, 2006, through December 31, 2006

The payment rates for the drugs and biologicals listed below were incorrect in the January 2007 OPPS PRICER. The corrected payment rates will be installed in the April 2007 OPPS PRICER effective for services furnished on October 1, 2006, through December 31, 2006.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	1630	Hep b ig, im	\$113.27	\$22.65
J2430	0730	Pamidronate disodium /30 MG	\$35.46	\$7.09
J7340	1632	Metabolic active D/E tissue	\$21.37	\$4.27
J7344	9156	Nonmetabolic active tissue	\$89.31	\$17.86
90716	9142	Chicken pox vaccine, sc	\$72.28	\$14.46
J0637	9019	Caspofungin acetate	\$32.22	\$6.44
J9265	0863	Paclitaxel injection	\$15.11	\$3.02

Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be one. As another example, if the description for the drug code is 50 mg but 200 mg of the drug was administered to the patient, the units billed should be four. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg, and a 10 mg vial of the drug was administered to the patient, bill ten units, even though only one vial was administered. HCPCS short descriptors are limited to twenty-eight characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

The full descriptors for the Level II HCPCS codes can be found in the latest code books or from the latest Level II HCPCS file, which is available for downloading from the CMS Web site at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage>

Providers are reminded to check HCPCS descriptors for any changes to the units per HCPCS when HCPCS definitions or codes are changed.

Modification of Blood Deductible Edits

CMS notified your Medicare contractor (FI, MAC, or RHHI) on January 26, 2007, that blood deductible is acceptable for ALL 038X revenue codes, instead of only revenue codes 0380-0382.

Changes to Device Edits in the April 2007 OCE

CMS has made the following changes to the device edits in the April 2007 OCE. Providers who have claims that were returned for failure to pass the device edits that were in place before April 1, 2007, should review the changes to determine if the claims will now pass the edits. If the provider believes that the changes made in the April 2007 OCE enable the claims to satisfy (and thus pass) the edits, the provider should submit the claims for payment.

Device to Procedure Edit Changes Being Implemented in the April 2007 OCE; Effective for Services Furnished on or After January 1, 2007

C1820 (Generator, neuro rechg bat sys) is now allowed with 61885 (Insrt/redo neurostim 1 array)

C1898 (Lead, pmkr, other than trans) is now allowed with G0300 (Insert reposit lead dual+gen)

C1779 (Lead, pmkr, transvenous VDD) is now allowed with G0300 (Insert reposit lead dual+gen)

Procedure to Device Edit Changes Being Implemented in the April 2007 OCE with Effective Dates as Shown:

93651 (Ablate heart dysrhythm focus) is now allowed with C2630 (Cath EP, Cool tip); effective 1/1/07

33206 (Insertion of heart pacemaker) is now allowed with C2621 (Pmkr, single, non rate- resp); effective 10/01/05

33212 (Insertion of pulse generator) is now allowed with C2621 (Pmkr, single, non rate- resp); effective 04/01/05

61885 (Insrt/redo neurostim 1 array) is now allowed with C1820 (Generator, neuro rechg bat sys); effective 1/01/06

Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. FIs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR 5544, issued to your Medicare FI, RHHI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1209CP.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the "Contact Us" page of this *Medicare A Newslines*.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Program Instructions Designating the Competitive Bidding Areas and Product Categories Included in the CY 2007 DMEPOS Competitive Bid Program

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5574

Related Change Request (CR) #: 5574

Related CR Release Date: April 3, 2007

Effective Date: April 2, 2007

Related CR Transmittal #: R1218CP

Implementation Date: April 9, 2007

Provider Types Affected

Section 1847 of the Social Security Act requires the Secretary of the Department of Health and Human Services (HHS) to establish and implement programs for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) under which competitive bidding areas are established throughout the United States for the furnishing of certain competitively priced items and services for which payment is made under Part B (the “Medicare DMEPOS Competitive Bidding Program”). **Suppliers who bill Medicare for DMEPOS must be aware of this program.**

Provider Action Needed

This article and CR 5574, recently released by the CMS, provide an overview of the DMEPOS Competitive Bidding Program that will be implemented starting in 2007. **Suppliers who bill Medicare for DMEPOS must be aware of this program.**

Background

Section 1847 of the Social Security Act requires Medicare to establish and implement programs under which competitive bidding areas are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items for which payment is made under Medicare Part B (the “Medicare DMEPOS Competitive Bidding Program”). Competitive bidding provides a way to harness marketplace dynamics to create incentives for suppliers to provide quality items in an efficient manner, at a reasonable cost to the Medicare beneficiaries while producing significant savings to the Medicare program.

Section 1847(a)(1)(A) of the Act requires that competitive bidding programs be established and implemented in areas throughout the United States. Section 1847(a)(1)(B) of the Act provides CMS with the authority to phase-in competitive bidding programs so that the competition under the programs occurs in 10 of the largest Metropolitan Statistical Areas (MSAs) in 2007; 70 additional MSAs in 2009; and additional areas after 2009.

The CMS will conduct competitive bidding programs in which certain suppliers will be awarded contracts to provide certain DMEPOS items to Medicare beneficiaries. Suppliers must submit bids for items that fall within product categories for which they want to be considered for selection as a contract supplier.

The Medicare DMEPOS Competitive Bidding Program will apply to a variety of DMEPOS product categories. The product categories will be comprised of products identified by individual Healthcare

Common Procedure Coding System (HCPCS) codes. Contract suppliers will be selected from the suppliers that have the lowest bids and that meet all relevant Medicare program requirements.

The MSAs, product categories and HCPCS codes for each product category are available at http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/01_overview.asp on the CMS Web site.

Exceptions to this program may be granted for items and services for which the application of competitive acquisition is not likely to result in significant savings or to permit continuity of an existing relationship between a beneficiary and supplier with respect to furnishing either a rental item or oxygen. The statute also allows CMS to exempt certain areas from the program, such as rural areas or areas with low population density within urban areas that are not competitive, unless there is a significant national market for mail order for a particular item or service.

Additional Information

To view the official instruction, CR 5574 issued to your Medicare contractor, go to <http://www.cms.hhs.gov/Transmittals/downloads/R1218CP.pdf> on the CMS Web site.

Information on the final rule is available by going to http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/02_regnotices.asp on the CMS site. Once there, click on the download for CMS-1270-F.

If you have questions or need assistance regarding competitive bidding, contact the Competitive Bidding Program Helpline at 1-877-577-5331 or use the “Contact Us” feature at <http://www.dmecompetitivebid.com> on the Web.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Initial Supplier Registration for Competitive Bidding Program for DMEPOS is Now Open

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition Medicare Learning Network (MLN) Matters*. This MLN Matters article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

CMS has announced that the Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Final Regulation is now on display at the Office of the Federal Register. CMS has also announced the first ten metropolitan areas in which competition will occur as well as the first items to be competitively bid. Visit the CMS Web site at <http://www.cms.hhs.gov/competitiveacqfordmepos/> to view the rule and obtain additional information.

MLN Matters Number: SE0717
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: 5574
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

All suppliers of durable medical equipment (DME) that wish to participate in the Medicare Competitive Bidding Program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Provider Action Needed

STOP – Impact to You

Suppliers wishing to participate in the program must register and obtain a user identification (USER ID) number and password in order to submit their bids electronically to Medicare.

CAUTION – What You Need to Know

Without the USER ID and password, suppliers will not be able to submit electronic, on-line bids. Further, incorrect information could delay issuance of your USER ID and password.

GO – What You Need to Do

Register for the USER ID early in order to confirm that correct information is on file with Medicare and the National Supplier Clearinghouse (NSC) so you can avoid any delays in submitting bids. The background and additional information sections of this article provide important information about the registration process.

Background

CMS will be using an on-line system to accept bids for the Medicare DMEPOS Competitive Bidding Program. To take advantage of this opportunity, bidders must first complete an on-line registration process. The name of the on-line registration program is the Individuals Authorized Access to CMS Computer Services (IACS) system. To complete the initial registration and obtain a USER ID and password, please go to <https://applications.cms.hhs.gov> on the CMS Web site. The on-line registration will be available up to fourteen days prior to the close of the bidding window.

The process will require the supplier to have its authorizing official, the person identified in Section 15 on the CMS-855S application form, register and receive a USER ID and password. The authorized official's information must match the information on file at the NSC.

If an organization has one authorizing official but many NSC numbers, the organization needs to submit only one (1) registration request to obtain access to the IACS system. During the registration process, the bidding organization will have to report one of its NSC numbers—the correspondence address associated with that NSC number will be used for mailing the IACS system USER ID and Password.

If an organization has multiple authorizing officials for the same NSC number, only one authorizing official needs to obtain access to the IACS system.

An authorizing official only needs one USER ID and password in order to submit bids for every company for which he/she was listed as such on the CMS-855S.

Potential registrants should first read the CMS document entitled, “Individuals Authorized Access to CMS Computer Services (IACS): Competitive Bid Submission System/Durable Medical Equipment (CBSS/DME) User Guide.” You may view this guide at [http://www.dmecompetitivebid.com/cbic/cbic.nsf/\(pages\)/home](http://www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home) on the Competitive Bidding

Implementation Contractor's (CBIC) Web site. If you have any questions about the initial registration process, please contact the Competitive Bidding Implementation Contractor's helpdesk at 1-877-577-5331. The helpdesk will be available Monday – Friday 6:00 a.m. – 9:00 p.m. prevailing Eastern Standard Time and on Saturday 9:00 a.m. – 3:00 p.m. prevailing Eastern Standard Time.

Suppliers are required to register through IACS and get USER IDs and passwords before access to the CBSS/DME will be granted. The bidding window is not scheduled to open until late April 2007; however, suppliers planning to bid are strongly urged to register now, so any issues with USER IDs and passwords can be resolved before the bidding window opens. The issues could include:

- Incorrect authorized official information maintained by the NSC as identified in Section 15 of your CMS-855S.
- Incorrect authorized official Date of Birth or Social Security number.
- NSC number does not match the Authorizing Official information.
- Incorrect correspondence address maintained by the NSC as listed on your CMS-855S in Section 2A.2.

The USER ID and password will be mailed to the authorized official if his/her submitted information matches exactly the data on file for last name, date of birth, Social Security number and supplier number. The USER ID and password will be delivered in two separate mailings to the authorized official at the correspondence address (Section 2A.2) listed on the CMS 855S.

It can take up to fifteen days for the NSC to correct authorized official information. Correcting a correspondence address can take up to forty-five days. These timeframes for correcting NSC data may be longer depending on the number of requests received by the NSC. This underscores the need to start early.

Important note: For added security, when suppliers use their USER IDs and passwords to access the Competitive Bid Submission System for the first time, they will need to complete a brief authentication process. The information required for this process must also match the information in the National Supplier Clearinghouse file. If you successfully completed the initial registration and received your USER ID and password, please enter your information exactly as you did for initial registration when completing the Competitive Bid Submission System authentication process. Failure to do so may delay your ability to use the system.

Additional Information

Detailed instructions on how to register for CMS Application Access can be found in the Guide at: [http://www.dmecompetitivebid.com/cbic/cbic.nsf/\(pages\)/home](http://www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home)

Remember that this first step is the registration to gain access to on-line bidding materials—it is not the actual bidding process.

The CBIC Help Desk can help you with any problems or questions you have regarding the IACS registration process. The Help Desk number is 1-877-577-5331.

You may also want to review a related MLN Matters article that covers accreditation requirements for suppliers wishing to participate in the Competitive Bidding Program. That article, SE0713, is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf> on the CMS Web site.

Periodically, you may also want to visit http://cms.hhs.gov/CompetitiveAcqforDMEPOS/01_overview.asp to stay abreast of developments for this program.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Extracorporeal Photopheresis

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5464

Related CR Release Date: March 16, 2007

Related CR Transmittal #: R1206CP and R66NCD

Related Change Request (CR) #: 5464

Effective Date: December 19, 2006

Implementation Date: April 2, 2007

Provider Types Affected

All providers who bill Medicare carriers, fiscal intermediaries (FI), or Part A/B Medicare administrative contractors (A/B MACs) for rendering extracorporeal photopheresis services

Provider Action Needed

STOP – Impact to You

For services provided on or after December 19, 2006, coverage for extracorporeal photopheresis is now expanded to include additional health conditions.

CAUTION – What You Need to Know

CR 5464, from which this article is taken, announces (effective December 19, 2006), the expansion of coverage of extracorporeal photopheresis to include patients with acute cardiac allograft rejection and chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

GO – What You Need to Do

Make sure that your billing staffs are aware of this expanded coverage for extracorporeal photopheresis, and bill accordingly.

Background

Extracorporeal photopheresis is a medical procedure in which a patient's white blood cells are exposed first to a drug called 8-methoxypsoralen (8-MOP) and then to an ultraviolet A (UVA) light. The procedure starts with the removal of the patient's blood, which is centrifuged to isolate the white blood cells. The drug is typically administered directly to the white blood cells after they have been removed from the patient (referred to as *ex vivo* administration), but the drug can alternatively be administered directly to the patient before the white blood cells are drawn. After UVA light exposure, the treated white blood cells are then re-infused into the patient.

Formerly, Medicare covered extracorporeal photopheresis only when used in the palliative treatment of the skin manifestations of cutaneous T-cell lymphoma that has not responded to other therapy. On April 6, 2006, a request for reconsideration of this national coverage determination (NCD) to allow additional indications initiated a national coverage analysis.

CR 5464 announces the NCD resulting from that analysis. It provides that CMS has reviewed the evidence and determined that extracorporeal photopheresis is reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act for patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment, and for patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment. Therefore, effective December 19, 2006, coverage has been expanded to include these conditions.

Billing Requirements for Extracorporeal Photopheresis

You should use Healthcare Common Procedure Coding System (HCPCS) procedure code 36522 (Photopheresis, extracorporeal) when submitting your outpatient or physician claims for this service under these expanded coverage guidelines. Effective for dates of service on or after December 19, 2006, Medicare contractors will pay hospital inpatient, including CAH, claims for extracorporeal photopheresis, based on the normal payment methodology for type of bills (TOBs) 11X, 13X or 85X, according to the expanded coverage conditions. Specifically, Medicare will accept claims for extracorporeal photopheresis:

- With HCPCS code 36522 when submitted for the treatment of hospital outpatients and for physician services with ICD-9-CM diagnosis codes: 996.83 or 996.85; and
- With ICD-9-CM procedure code 99.88 when submitted for the treatment of hospital inpatients, including CAHs, with ICD-9-CM diagnosis codes: 996.83 or 996.85.

Medicare contractors will not search for claims for services on or after December 19, 2006, but processed prior to the April 2, 2007, implementation date for this change. However, they will adjust such claims if you bring them to their attention.

Note: All other indications for extracorporeal photopheresis remain noncovered. Further, note that contractors will edit for an appropriate oncological and autoimmune disorder diagnosis prior to paying **according to the NCD.**

Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RAs) and Claim Adjustment Reason Code

Contractors will continue to use the appropriate existing messages that they have in place when denying claims submitted that do not meet the Medicare coverage criteria for extracorporeal photopheresis.

Contractors will deny claims when the service is not rendered to an inpatient or outpatient of a hospital, including critical access hospitals (CAHs), using the following codes:

- Claim adjustment reason code: 58 – “Claim/service denied/reduced because treatment was deemed by payer to have been rendered in an inappropriate or invalid place of service.”
- MSN 16.2 - “This service cannot be paid when provided in this location/facility.” Spanish translation: “Este servicio no se puede pagar cuando es suministrado en esta sitio/facilidad.” (Include either MSN 36.1 or 36.2 dependant on liability.)
- RA MA 30 - “Missing/incomplete/invalid type of bill.” (FIs and A/MACs only)
- Group Code - CO (Contractual Obligations) or PR (Patient Responsibility) dependant on liability.

Advance Beneficiary Notice and Hospital Issued Notice of Noncoverage Information

- If this service is not reasonable and necessary under 1862(a)(1)(A) of the Act (falls outside the scope of the revised NCD found in CMS Publication 100-03, Chapter 1, §110.4), the physicians and/or hospital outpatient departments, including CAHs, will be held liable for charges unless the physician and/or hospital has the beneficiary sign an Advance Beneficiary Notice (ABN) in advance of providing the service.
- If this service is provided to a hospital inpatient, including CAHs, for a reason unrelated to the admission (outside of the bundled payment), the hospital billing for the inpatient services will be held liable for charges unless the hospital has the beneficiary sign a Hospital Issued Notice of Noncoverage (HINN) letter 11 in advance of providing the service.

Note: This addition/revision of section 110.4 of the *Medicare National Coverage Determinations Manual* (CMS Pub. 100-03) is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

Additional Information

You can find the official instruction, CR 5464, issued to your carrier, FI or A/B MAC by visiting:

- <http://www.cms.hhs.gov/Transmittals/downloads/R66NCD.pdf> for the updated *Medicare National Coverage Determinations Manual* (CMS Pub. 100-03), Chapter 1, Part 2 (§90-160.25) (Coverage Determinations), §110.4 (Extracorporeal Photopheresis); and
- <http://www.cms.hhs.gov/Transmittals/downloads/R1206CP.pdf> for the updated *Medicare Claims Processing Manual* (CMS Pub. 100-04), Chapter 32 (Billing Requirements for Special Services), §190 (Billing Requirements for Extracorporeal Photopheresis).

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumors

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network* (MLN) *Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5530

Related CR Release Date: April 6, 2007

Related CR Transmittal #: R67NCD

Related Change Request (CR) #: 5530

Effective Date: March 20, 2007

Implementation Date: May 7, 2007

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part Medicare administrative contractors (MACs) and carriers)

What Providers Need to Know

Effective for claims with dates of service on or after March 20, 2007, the use of osmotic blood brain barrier disruption is not considered reasonable and necessary when it is used as part of a treatment regimen for brain tumors in Medicare patients.

Background

This article, and CR 5530 states that Medicare does not currently have a national coverage determination (NCD) for osmotic blood brain barrier disruption (BBBD) as part of a treatment regimen for brain tumors. CMS accepted a formal request for **noncoverage** of BBBD used for this indication.

CMS determined that the use of osmotic blood brain barrier disruption is not reasonable and necessary when it is used as part of a treatment regimen for brain tumors.

Be aware that the BBBD process includes all items and services necessary to perform the procedure, including hospitalization, monitoring, and repeated imaging procedures.

This NCD does not alter in any manner the coverage of anti-cancer chemotherapy.

Additional Information

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the "Contact Us" page of this *Medicare A Newsline*.

CR 5530 is the official instruction issued to your Medicare FI, Carrier or MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R67NCD.pdf> on the CMS Web site.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



New "K" Codes for Oral/Mask for Use with Continuous Positive Airway Pressure (CPAP) Device

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5525

Related CR Release Date: March 23, 2007

Related CR Transmittal #: R1210CP

Related Change Request (CR) #: 5525

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Durable Medical Equipment Regional Carrier (DMERCs), DME Medicare administrative contractors (DME MAC)), for services to Medicare beneficiaries for CPAP.

Provider Action Needed

Be sure billing staff are aware that, effective July 1, 2007, three new “K” codes will be established for oral/mask for use with a CPAP device.

Background

This article is based on CR 5525 and you need to be aware that effective July 1, 2007, the following codes will be added to the system, i.e.:

K0553	Combination oral/nasal mask, used with continuous positive airway pressure device, each
K0554	Oral cushion for combination oral/nasal mask, replacement only, each
K0555	Nasal pillows for combination oral/nasal mask, replacement only, pair

Additional Information

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

To see the official instruction (CR 5525) issued to your Medicare FI, DME MAC, DMERC or A/B MAC, go to <http://www.cms.hhs.gov/Transmittals/downloads/R1210CP.pdf> on the CMS Web site.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Update to Medicare Claims Processing Manual, Publication 100-04, Chapter 18, Section 60.1 Regarding Colorectal Screening Services

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5541

Related CR Release Date: March 30, 2007

Related CR Transmittal #: R1217CP

Related Change Request (CR) #: 5541

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

Provider Types Affected

Physicians, suppliers, and providers who submit claims for screening and diagnostic colorectal services to Medicare contractors (fiscal intermediaries (FIs), carriers, Part A/B Medicare administrative contractors (A/B MACs)).

Background

CMS is aware that Chapter 60, §60.1 of the *Medicare Claims Processing Manual* (Publication 100-04) needed clarification regarding application of the annual Part B deductible for **diagnostic** colorectal services. Section 5113 of the Deficit Reduction Act (DRA) of 2005 **waived** the requirement for the annual Part B deductible for **screening** colorectal services, **NOT diagnostic** colorectal services. CR 5541 clarifies that portion of the manual.

Key Points

The following are the key points of the revised portion of Chapter 18, §60.1 of the *Medicare Claims Processing Manual*, which is attached to CR 5541 (the web address for CR 5541 is provided in the Additional Information section of this article).

- **Prior to January 1, 2007**, deductible and coinsurance apply to HCPCS codes G0104, G0105, G0106, G0120, and G0121. **On or after January 1, 2007**, the annual Part B deductible is waived for the listed HCPCS coded screening services. **Coinsurance still applies.**
- **Coinsurance and deductible applies to the diagnostic colorectal service codes 45330, 45378, and 74280.**

Additional Information

You may see the official instruction (CR 5541) issued to your Medicare carrier, FI, or A/B MAC by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1217CP.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newslines*.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Colorectal Cancer: Preventable, Treatable, and Beatable—Medicare Coverage and Billing for Colorectal Cancer Screening

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition Medicare Learning Network (MLN) Matters*. This MLN Matters article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: SE0710

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, nurse practitioners, physician assistants, clinical nurse specialists, outpatient hospital departments, and community surgical centers that furnish or provide referrals for and /or file claims for Medicare-covered colorectal cancer screening services.

Provider Action Needed

STOP – Impact to You

March was National Colorectal Cancer Awareness Month. CMS would like to remind providers to encourage their eligible patients, age fifty and older, to get screened for colorectal cancer. This *Special Edition MLN Matters* article highlights coverage changes that became effective January 1, 2007, and reviews Medicare coverage and billing processes for colorectal cancer screening.

CAUTION – What You Need to Know

Medicare has covered colorectal cancer screening since 1998, but the benefit is underused. Claims data from 1998-2002 indicate that less than half of Medicare beneficiaries had any screening test during this five-year period, and less than one-third were tested according to recommended intervals.

GO – What You Need to Do

Be sure your staff is aware of this coverage and the CMS urges physicians to encourage their patients to take advantage of this important coverage.

Background

Colorectal cancer is the second leading cause of cancer death in the U.S., and the third most common type of cancer. In 2006, colorectal cancer was expected to account for 55,170 deaths and 148,610 new cases. Colorectal cancer primarily affects men and women ages fifty and older, and risk increases with age. If detected early, colorectal cancer can be treated and cured.

In January 1998, Medicare began covering colorectal cancer screening. **The data currently available (1998- 2002) indicate the Medicare colorectal cancer screening benefit is underused. Less than half of enrollees had any colorectal cancer test during the five-year period** and less than one-third were tested according to recommended intervals.

The U.S. Preventive Services Task Force (USPSTF) evaluates the clinical merits of preventive measures, and strongly recommends (“A” rating) that clinicians screen men and women ages fifty and older for colorectal cancer. The choice of screening strategy should be based on patient preferences, medical contraindications, patient adherence, and resources for testing and follow-up. There are insufficient data to determine which screening strategy is best in terms of the balance of benefits and potential harms or cost-effectiveness. Studies reviewed by the USPSTF indicate that colorectal cancer screening is likely to be cost-effective (less than \$30,000 per additional year of life gained) regardless of the strategy chosen. To read the full recommendation, go to the following link: <http://www.ahrq.gov/clinic/uspstf/uspcolo.htm> on the Web.

The Partnership for Prevention conducted a systematic assessment of the clinical preventive services recommended by the USPSTF to help decision-makers identify those services that provide the most value based on two criteria—burden of disease prevented and cost-effectiveness. Screening adults for colorectal cancer screening was among the services considered to be of the greatest value. To read about the ranking of clinical preventive services, go to the following link: <http://prevent.org/content/view/46/96/> on the Web.

Risk Factors

Beneficiaries are considered to be at high risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

Coverage Information

Medicare covers the following colorectal cancer screening tests and procedures:

- **Fecal occult blood test (FOBT):** Medicare covers 1 FOBT annually for beneficiaries fifty and older. A written order from the beneficiary's attending physician is required. Medicare will pay for an immunoassay-based FOBT as an alternative to the guaiac-based FOBT, but will only pay for 1 FOBT, not both, per year. Beneficiaries do not have to pay coinsurance for the FOBT, and do not have to meet the annual Medicare Part B deductible.

Note: In 2006, and effective for services provided January 1, 2007, and later, CMS adopted the more specific CPT code 82270 (patient was provided three single cards or single triple card for consecutive collection) and discontinued the G code G0107 (FOBT, 1-3 simultaneous determinations) to encourage quality colorectal cancer screening practices. Two studies published in January 2005 in the *Annals of Internal Medicine* suggested that the office-based single sample screening fecal occult blood test is of limited value, and that many physicians are not following practice guidelines for screening and follow-up.

- **Screening flexible sigmoidoscopy:** Medicare covers a screening flexible sigmoidoscopy once every four years for beneficiaries fifty and older. If a beneficiary had a screening colonoscopy in the previous ten years, then the next screening flexible sigmoidoscopy would be covered only after 119 months have passed following the month in which the last screening colonoscopy was performed. A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist may perform a screening flexible sigmoidoscopy.
- **Screening colonoscopy:** Medicare coverage for a screening colonoscopy is based on beneficiary risk. For beneficiaries fifty and older not considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every ten years, but not within forty-seven months of a previous screening flexible sigmoidoscopy. For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every two years, regardless of age. A screening colonoscopy must be performed by a doctor of medicine or osteopathy.
- **Screening barium enema:** Medicare covers a screening barium enema as an alternative to a screening flexible sigmoidoscopy for all beneficiaries under the same coverage requirements and at the same frequency as for the screening flexible sigmoidoscopy. Medicare will cover only one such service during the coverage timeframe: it will cover either the screening flexible sigmoidoscopy or the barium enema, but not both.

Medicare also covers a barium enema as an alternative to a screening colonoscopy rendered to a beneficiary at high risk for developing colorectal cancer under the same coverage requirements, at the same frequency. Medicare will cover only one such service during the coverage timeframe: it will cover either the screening colonoscopy for the high-risk beneficiary or the barium enema rendered in lieu of it, but not both.

A screening barium enema must be ordered in writing and collected by a doctor of medicine or osteopathy once it is determined that it is the appropriate screening method for a beneficiary. A double contrast barium enema is preferable, but the physician may order a single contrast barium enema if it is more appropriate for the beneficiary.

The beneficiary is liable for paying twenty percent of the Medicare-approved amount (the coinsurance) for screening flexible sigmoidoscopy, screening colonoscopy, and screening barium enema. **See “2007 Changes” for changes to coinsurance amount.**

2007 Changes

- **Starting January 1, 2007**, the Medicare Part B deductible has been waived for **screening** colonoscopy, sigmoidoscopy, and barium enema (as an alternative to colonoscopy or sigmoidoscopy). However, the deductible is not waived if the colorectal cancer screening test becomes a diagnostic colorectal test; that is the service actually results in a biopsy or removal of a lesion or growth.
- **Starting January 1, 2007**, for a screening flexible sigmoidoscopy or a screening colonoscopy performed in a non-outpatient prospective payment system hospital outpatient department, the beneficiary is liable for paying twenty-five percent of the Medicare-approved amount (the coinsurance). The twenty-five percent coinsurance is currently being applied in the Outpatient Prospective Payment System (OPPS) for OPPS hospitals. However, it is not being applied to non-OPPS hospitals.
- **Starting January 1, 2007**, for a screening colonoscopy performed in an ambulatory surgical center, the beneficiary is liable for paying twenty-five percent of the Medicare-approved amount (the coinsurance).

In addition, G0107 (FOBT, 1-3 simultaneous determinations) has been discontinued. CPT code 82270 (patient was provided three single cards or single triple card for consecutive collection) has been adopted to encourage quality colorectal cancer screening.

How to Bill Medicare

The following Healthcare Common Procedure Coding System/Current Procedure Terminology (HCPCS/CPT) codes should be used to bill for colorectal cancer screening services:

HCPCS/CPT Code	Code Descriptors
G0104	Colon cancer screening; flexible sigmoidoscopy
G0105*	Colon cancer screening; colonoscopy on individual at high risk
G0106	Colon cancer screening; barium enema as an alternative to G0104
82270	Colon cancer screening; FOBT, patient was provided three single cards or single triple card for consecutive collection
G0120	Colon cancer screening; barium enema as an alternative to G0105
G0121	Colon cancer screening; colonoscopy for individuals not meeting criteria for high risk
G0122**	Colon cancer screening; barium enema (noncovered)
G0328	Colon cancer screening; fecal occult blood test, immunoassay

* When billing for the “high risk” beneficiary, the screening diagnosis code on the claim must reflect at least one of the high risk conditions mentioned previously. Examples of diagnostic codes are in the colorectal cancer screening chapter of the “Guide to Preventive Services.” This guide is available at: <http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf> on the CMS Web site.

**Medicare covers colorectal barium enemas only in lieu of covered screening flexible sigmoidoscopies (G0104) or covered screening colonoscopies (G0105). However, there may be instances when the beneficiary has elected to receive the barium enema for colorectal cancer screening other than specifically for these purposes. In such situations, the beneficiary may require a formal denial of the service from Medicare in order to bill a supplemental insurer who may cover the service. These noncovered barium enemas are to be identified by G0122 (colorectal cancer screening; barium enema). Code G0122 should not be used for covered barium enema services, that is, those rendered in place of the covered screening colonoscopy or covered flexible sigmoidoscopy. The beneficiary is liable for payment of the noncovered barium enema.

If billing carriers, the appropriate HCPCS and corresponding diagnosis codes must be provided on Form CMS-1500 (or the HIPAA 837 Professional electronic claim record).

If billing intermediaries, the appropriate HCPCS, revenue, and corresponding diagnosis codes must be provided on Form CMS-1450 (or the HIPAA Institutional electronic claim record). Information on the type of bill and associated revenue code is also provided in the colorectal cancer screening chapter of the “Guide to Preventive Services.” Once again, this guide is available at: <http://www.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf> on the CMS Web site.

Reimbursement information is also provided in this guide.

Additional Information

- CMS has developed a comprehensive prevention website that provides information and resources for all Medicare preventive benefits. The following link is to the colorectal cancer screening section, and includes website links to information and resources developed by other organizations interested in promoting colorectal cancer screening, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American Cancer Society.
<http://www.cms.hhs.gov/ColorectalCancerScreening/>
- Other *MLN Matters* articles on colorectal cancer screening changes mentioned in this special edition are MM5387 (coinsurance changes) <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf> and MM5127 (deductible change)
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf>

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

- The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS Web site.
- The CMS website provides information for each preventive service covered by Medicare. Visit <http://www.cms.hhs.gov/>, select “Medicare”, and scroll down to “Prevention”.

For products to share with your Medicare patients, visit <http://www.medicare.gov> on the Web.

Medicare beneficiaries can obtain information about Medicare preventive benefits at <http://www.medicare.gov/> and then click on “Preventive Services”. They can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For more information about National Colorectal Cancer Awareness Month, please visit <http://www.crfa.org/colorectal/> on the Web.



Reminder – Medicare Now Provides Coverage for Eligible Medicare Beneficiaries of a One-Time Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) When Referred for this Screening as a Result of the Initial Preventive Physical Examination (“Welcome to Medicare” Physical Exam)

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition Medicare Learning Network (MLN) Matters*. This MLN Matters article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: SE0711

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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 the initial preventive physical examination (IPPE) and the ultrasound screening for abdominal aortic aneurysms (AAA).

Provider Action Needed

This article conveys no new policy information. This article is for informational purposes only and serves as a reminder that Medicare provides coverage of a one-time initial preventive physical examination and a one-time preventive ultrasound screening for abdominal aortic aneurysms subject to certain coverage, frequency, and payment limitations. CMS needs your help to get the word out and to encourage eligible beneficiaries to take full advantage of these benefits and all preventive services and screenings covered by Medicare.

Background

In January 2005, the Medicare program expanded the number of preventive services available to Medicare beneficiaries, as a result of Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, to include coverage under Medicare Part B of a one-time IPPE, also referred to as the “Welcome to Medicare” physical exam, for all Medicare beneficiaries whose Medicare Part B effective date began on or after January 1, 2005.

On January 1, 2007, Medicare further expanded the number of preventive benefits, as provided for in Section 5112 of the Deficit Reduction Act (DRA) of 2005, to include coverage under Medicare Part B of a one-time preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at risk beneficiaries as part of the IPPE. Both benefits (the IPPE and AAA) are subject to certain eligibility and other limitations.

The information in this *Special Edition MLN Matters* article reminds health care professionals that Medicare now pays for these benefits as well as a broad range of other preventive services and screenings. CMS needs your help to ensure that patients new to Medicare receive their “Welcome to Medicare” physical exam within the first six months of their effective date in Medicare Part B and those beneficiaries at risk for AAA receive a referral for the preventive ultrasound screening as part of their “Welcome to Medicare” physical exam.

Benefit Coverage Summary

The Initial Preventive Physical Examination (“Welcome to Medicare” Physical Exam)

Effective for dates of service on or after January 1, 2005: Medicare beneficiaries whose Medicare Part B effective date is on or after January 1, 2005, are covered for a one-time IPPE visit. The IPPE must be received by the beneficiary within the first six months of their Medicare Part B effective date. The IPPE is a preventive evaluation and management (E/M) service that includes the following seven components:

1. A review of an individual's medical and social history with attention to modifiable risk factors,
2. A review of an individual's potential (risk factors) for depression,
3. A review of the individual's functional ability and level of safety,
4. An examination to include an individual's height, weight, blood pressure measurement, and visual acuity screen,
5. Performance of an electrocardiogram (EKG) and interpretation of the EKG,
6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements, and
7. Education, counseling, and referral (including a brief written plan such as a checklist provided to the individual for obtaining the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits).

Important reminders about the IPPE:

1. The IPPE is a unique benefit available only for beneficiaries new to the Medicare Program and must be received within the first six months of the effective date of their Medicare Part B coverage.
2. This exam is a preventive physical exam and not a “routine physical checkup” that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare does not provide coverage for routine physical exams.

The Part B deductible and coinsurance/copayment apply to this benefit.

Note: The deductible does not apply for an IPPE provided in a Federally Qualified Health Center (FQHC). Only the coinsurance/copayment applies.

Other preventive services and screenings covered under Medicare Part B include: Adult immunizations (flu, pneumococcal, and hepatitis B), bone mass measurements, cardiovascular screening, diabetes screening, glaucoma screening, screening mammograms, screening Pap test and pelvic exam, colorectal and prostate cancer screenings, diabetes self-management training, medical nutrition therapy for beneficiaries diagnosed with diabetes or renal disease, and smoking and tobacco-use cessation counseling. Benefits are subject to certain eligibility and other limitations.

NOTE: The IPPE/“Welcome to Medicare” physical exam does not include any clinical laboratory tests. The physician, qualified non-physician practitioner, or hospital may also provide and bill separately for the preventive services and screenings that are currently covered and paid for by Medicare Part B. (See the “Additional Information” section below for links to MLN Matters articles MM3771 and MM3638, which provide detailed coverage criteria and billing information about the IPPE benefit.)

Preventive Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)

Effective for dates of service on or after January 1, 2007, Medicare will pay for a one-time preventive ultrasound screening for AAA for beneficiaries who are at risk (has a family history of AAA or is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime). Eligible beneficiaries must receive a

referral for the screening as a result of their “Welcome to Medicare” physical exam. There is no Part B deductible applied to this benefit, but coinsurance/copayment applies.

IMPORTANT NOTE: Only Medicare beneficiaries who receive a referral from their physician or other qualified non-physician practitioner for the preventive ultrasound screening, as part of their “Welcome to Medicare” physical exam, will be covered for the AAA benefit. (See the “Additional Information” section below for a link to MLN Matters article MM5235, which provides detailed coverage criteria and billing information about the AAA benefit.)

Additional Information

For more information about Medicare’s coverage criteria and billing procedures for the AAA and IPPE benefits, refer to the following MLN Matters articles:

- MM5235 (2006), Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination, <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5235.pdf>
- MM3771 (2005), MMA – Clarification for Outpatient Prospective Payment system (OPPS) Hospitals Billing the Initial Preventive Physical Exam (IPPE), <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3771.pdf>
- MM3638 (2004), MMA – Initial Preventive Physical Examination, <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf>

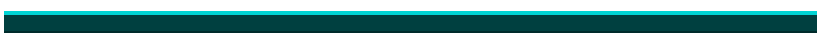
CMS has also developed a variety of educational products and resources to help health care professionals and their staff, become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS Web site.
- The CMS Web site provides information for preventive service covered by Medicare. Visit <http://www.cms.hhs.gov>, select “Medicare”, and scroll down to “Prevention”.

For products to share with your Medicare patients, visit <http://www.medicare.gov/> on the Web.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Ambulance Fee Schedule - Ground Ambulance Services - Manualization Revision to the Specialty Care Transport (SCT) Definition

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network* (MLN) *Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5533
Related CR Release Date: March 30, 2007
Related CR Transmittal #: R68BP

Related Change Request (CR) #: 5533
Effective Date: January 1, 2007
Implementation Date: April 30, 2007

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs) and carriers), for ambulance services to Medicare beneficiaries

Provider Action Needed

Providers and suppliers are reminded that CMS expanded the interpretation of “interfacility” to include both hospitals and skilled nursing facilities (SNFs) in the December 1, 2006, (71 FR 69716) final rule.

Background

In the February 27, 2002 *Federal Register* (67 FR 9100) a final rule was published with comment period entitled “Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services” that implemented the ambulance fee schedule. In that rule, CMS defined SCT at Section 414.605. In the December 1, 2006 (71 FR 69716) final rule, CMS expanded the definition of “interfacility” to include both hospitals and skilled nursing facilities (SNFs).

In addition, CMS further clarified the kinds of facilities included as origin or destination points for “interfacility” transport for Specialty Care Transport (SCT) purposes. Therefore, for purposes of SCT payment, CMS considers a “facility” to include:

- Only a SNF or a hospital that participates in the Medicare program, or
- A hospital-based facility that meets the requirements for provider-based status.

Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children’s hospitals, psychiatric hospitals, critical access hospitals (CAHs), inpatient acute-care hospitals, and sole community hospitals (SCHs).

Note: Contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

Additional Information

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

For complete details regarding this CR please see the official instruction (CR 5533) issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R68BP.pdf> on the CMS Web site.

Providers may review the Federal Regulations for the Ambulance Fee Schedule located at http://www.cms.hhs.gov/AmbulanceFeeSchedule/04_CFRAFS.asp#TopOfPage on the CMS Web site.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



April 2007 Non-Outpatient Prospective Payment System (Non-OPPS) Outpatient Code Editor (OCE) Specifications Version 22.2

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5523	Related Change Request (CR) #: 5523
Related CR Release Date: March 9, 2007	Effective Date: April 1, 2007
Related CR Transmittal #: R1199CP	Implementation Date: April 2, 2007

Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for outpatient services rendered to Medicare beneficiaries, where those services are not paid under the OPPTS.

Provider Action Needed

This article is based on CR 5523 which informs FIs that the April 2007 Non-Outpatient Prospective Payment System (Non-OPPS) Outpatient Code Editor (OCE) specifications have been updated to ensure correct billing and payment of claims. Be sure your billing staff is aware of the code changes in CR 5523.

Background

The Non-OPPS OCE has been updated with numerous new additions, changes, and deletions to Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes. Rather than duplicate all the additions, deletions and changes in this article, CMS directs you to CR 5523, which contains the lengthy lists of these items. CR 5523 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1199CP.pdf> on the CMS Web site.

Providers may want to be aware that the new version of the Non-OPPS OCE with updated HCPCS/CPT codes listed in CR 5523 is effective April 1, 2007, but they need to look at the specific HCPCS/CPT code changes that are, in some instances, effective earlier than April 1, 2007.

Additional Information

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the "Contact Us" page of this *Medicare A Newslines*.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Reporting of Type of Bill (TOB) 12X for Billing of Diagnostic Mammographies

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network* (MLN) *Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5377

Related Change Request (CR) #: 5377

Related CR Release Date: November 24, 2006

Effective Date: April 1, 2007

Related CR Transmittal #: R1117CP

Implementation Date: April 2, 2007

Provider Types Affected

Hospitals that bill Medicare administrative contractors (A/B MACs) or fiscal intermediaries (FIs) for diagnostic mammography services provided to hospital inpatients under Medicare Part B.

Provider Action Needed

A previous instruction, CR 5050, from CMS, erroneously removed TOB 12X as an applicable TOB for diagnostic mammography services supplied to Medicare inpatients and billable under Medicare Part B. CR 5377 announces that, effective April 1, 2007, TOB 12X is acceptable by FIs and A/B MACS as an appropriate bill type for such services. Be sure your billing staffs are aware.

Background

Effective April 1, 2007, hospitals should use TOB 12X to bill Medicare FIs and/or A/B MACs for diagnostic mammography services provided to hospital inpatients, where those services are being billed to Medicare Part B. As appropriate, hospitals should continue to use TOBs 13X, 22X, 23X, or 85X when billing for diagnostic mammographies provided to Medicare patients who are other than hospital inpatients.

Additional Information

To view the official instruction, CR 5377, issued to your FI or A/B MAC, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1117CP.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the "Contact Us" page of this *Medicare A Newslines*.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



Steps to Ensure Legible Documentation to CERT

We have been informed by the Comprehensive Error Rate Testing (CERT) Documentation Contractor (CDC) that some of the documentation received in response to CERT requests is not legible. As a result, the CDC must contact providers and request the information be faxed or mailed a second time to ensure readability. The CDC does recommend that documentation be faxed; however, this may affect the legibility of the documentation. As a result, the CDC has provided some suggestions to help providers ensure their faxed documentation is legible. If, after reviewing the problems and resolutions below, a record cannot be faxed legibly, a hardcopy of the documentation may be mailed to the CDC.

- **Problem:** Medical records with any color, including highlighted or grayed areas, results in obscured text in the colored area. Examples include lab results that are highlighted, and documentation templates with grayed boxes.

Resolution: If faxing a document with a shaded background, or for light colored text, use a resolution mode of “photo” or “gray scale” if available on your fax machines. The resolution setting on most fax machines can easily be changed by using the “resolution” button. However, the document may need to be inserted before the “resolution” changed.

- **Problem:** Documentation contains small fonts or writing, which compromises legibility when faxed.

Resolution: For documents with small font, your fax machine’s resolution mode should be set to “fine”.

- **Problem:** Records were produced from microfiche or photocopied copies may produce a double image when faxing.

Resolution: Photocopy the copy. This will help you to determine the appearance of the document when faxed, and may allow you to adjust the appearance of the document once faxed, either through adjusting the fax resolution or the lightness or darkness of the copy.

- **Problem:** Documents that are larger than 11 x 8 which are scanned and reduced in size result in a loss in pixels and thereby reduce the readability of the image.

Resolution: Fax the document in the original size. The CDC uses a fax imager which enables the document to be received in the same size as the faxed document.

- **Problem:** Faxed records that are put in crooked end up with missing portions of the record on image prevent full view of the document.

Resolution: Ensure that the fax is inserted evenly to prevent uneven faxing of the document.

- **Problem:** Bond weight of the paper does not copy or fax well due to the thinness or thickness of the paper.
Resolution: Copy the documentation on standard weight paper. Adjust the copier settings as needed to ensure legibility of the copy. Fax the copy, rather than the original.
- **Problem:** Documentation is a carbon paper and does not fax well.
Resolution: Try to copy the documentation, adjusting the lightness/darkness of copy. Fax the documentation if it appears legible.

By recognizing these potential problems and trying to resolve them before faxing your medical records to the CDC, you will greatly increase the quality of the imaged records. The time spent in preparing the faxed documentation will significantly reduce the need to contact providers individually due to illegible images. In addition, ensuring clarity of your documentation will greatly reduce the risk of your claim being denied because the documentation cannot be read by the CERT reviewer. If you have questions or concerns about faxing your documentation, you may call the CERT Documentation Contractor at 301-957-2380 between 8:00 a.m. and 8:00 p.m. EDT.



Updated Top Inquiries Frequently Asked Questions (FAQs)

The FAQs for the top inquiries received in Cahaba GBA, LLC Provider Call Centers have been updated. Please use these to assist your staff with their Medicare questions. The updated FAQs can be accessed on our Web site using the following link: http://www.cahabagba.com/part_a/education_and_outreach/faq.htm

Providers without Internet access may request a copy of the FAQs by calling the Provider Outreach and Education department at 515-471-7335.



Resources for the Most Common Medicare Part A Provider Questions

The topics listed below were some of those most frequently received in the Cahaba GBA, LLC Provider Contact Centers (PCCs) for the quarter ending March 31, 2007. This includes the call center in Iowa for home health and hospice providers (1-877-299-4500 and 1-866-539-5592) and for all other Part A providers in Iowa and Alabama (1-877-567-3092 and 1-866-539-5598).

Along with the topic, we have listed resources providers can use to reduce the number of phone calls to Cahaba GBA, LLC for these reasons:

Total Number of Inquiries Received: 41,999		
Inquiry Topic	Number Received	Resource
Explanation of RTP Reason Code	1,745	Return to Provider (RTP) Reason Codes Frequently Asked Questions www.cahabagba.com/part_a/education_and_outreach/faq_rtp.htm
Filing/Billing Instructions	1,372	Types of billing instructions most requested: <ul style="list-style-type: none"> ➤ Home Health <ul style="list-style-type: none"> ○ <i>Request for Anticipated Payment (RAP) and Final Claims</i> <ul style="list-style-type: none"> ▪ CMS Pub. 100-02, Ch. 7, §§ 10.5, 10.6, 10.11, and 30.2.5 www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf and CMS Pub. 100-04, Ch. 10, §§ 10.1.10.3, 10.1.10.4, 10.1.12, 40.1 and 40.2 www.cms.hhs.gov/manuals/downloads/clm104c10.pdf ▪ <i>Medicare Reference Guide for Home Health Agencies</i>, “Claims Filing” section, 60.5.10 and 80.5 www.cahabagba.com/part_a/education_and_outreach/educational_materials/hh_claims.pdf ▪ “Home Health Prospective Payment System” and “Home Health Medicare Billing Codes Sheet” quick reference tools www.cahabagba.com/part_a/education_and_outreach/educational_materials/hha.htm ▪ “Beginner Home Health Billing” online course www.cahabagba.com/part_a/education_and_outreach/online_courses/index.htm ➤ Hospice <ul style="list-style-type: none"> ○ <i>Add-on bills</i> <ul style="list-style-type: none"> ▪ CMS Pub. 100-04, Ch 11, § 30.3 www.cms.hhs.gov/manuals/downloads/clm104c11.pdf and CMS Pub. 100-04, Ch. 3, § 50.3 www.cms.hhs.gov/manuals/downloads/clm104c03.pdf ▪ <i>Medicare Reference Guide for Hospice Agencies</i>, “Claims Filing” section, 80.35 www.cahabagba.com/part_a/education_and_outreach/educational_materials/hospice_claims.pdf ▪ “Billing Hospice Physician Services” quick reference tool www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_hospice_dr.pdf

Inquiry Topic	Number Received	Resource
Filing/Billing Instructions		<ul style="list-style-type: none"> ○ <i>Notice of Election (NOE)</i> <ul style="list-style-type: none"> ▪ CMS Pub. 100-02, Ch. 9, § 20 www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf and CMS Pub. 100-04, Ch. 11, § 20 www.cms.hhs.gov/manuals/downloads/clm104c11.pdf ▪ <i>Medicare Reference Guide for Hospice Agencies</i>, “Claims Filing” section, 50.10, 60.15 and 60.20 www.cahabagba.com/part_a/education_and_outreach/educational_materials/hospice_claims.pdf ▪ “Hospice Billing Codes” quick reference tool www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_hospice_codes.pdf ○ <i>Physician billing</i> <ul style="list-style-type: none"> ▪ CMS Pub. 100-02, Ch. 9, §§ 30.3, 40.1 - 40.2 www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf and CMS Pub. 100-04, Ch. 11, § 40 www.cms.hhs.gov/manuals/downloads/clm104c11.pdf ▪ <i>Medicare Reference Guide for Hospice Agencies</i>, “Claims Filing” section, 70.2.5 and 100 www.cahabagba.com/part_a/education_and_outreach/educational_materials/hospice_claims.pdf ▪ May 1, 2006, <i>Home Health and Hospice Medicare A Newsline</i>, pgs. 46-47 www.cahabagba.com/part_a/education_and_outreach/newsletter/index.htm ▪ Billing Hospice Physician Services quick reference tool www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_hospice_dr.pdf ○ <i>Revocation</i> <ul style="list-style-type: none"> ▪ CMS Pub. 100-02, Ch. 9, § 20.2 www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf ▪ <i>Medicare Reference Guide for Hospice Agencies</i>, “Coverage Guidelines” section, 130.15 www.cahabagba.com/part_a/education_and_outreach/educational_materials/hospice_coverage.pdf ▪ <i>Medicare Reference Guide for Hospice Agencies</i>, “Claims Filing” section, 80.20 www.cahabagba.com/part_a/education_and_outreach/educational_materials/hospice_claims.pdf
Rejected Claims	1,271	<ul style="list-style-type: none"> ➤ Return to Provider (RTP) Reason Codes Frequently Asked Questions www.cahabagba.com/part_a/education_and_outreach/faq_rtp.htm ➤ “Checking Claims Status” online course www.cahabagba.com/part_a/education_and_outreach/online_courses/index.htm

Inquiry Topic	Number Received	Resource
<p>Claim Information Change (Adjustments)</p> <p>Cancellation of Claim</p>	1,050	<ul style="list-style-type: none"> ➤ Adjustment/Cancel Claims Frequently Asked Questions www.cahabagba.com/part_a/education_and_outreach/faq_adjustcancel.htm <ul style="list-style-type: none"> ○ Home health provider may also access the Home Health/Hospice Frequently Asked Questions for information on canceling RAPs www.cahabagba.com/part_a/education_and_outreach/faq_hh_hospice.htm ➤ “Claims Correction Menu” section, <i>FISS Reference Guide</i> www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_correct.pdf ➤ “Adjusting and Canceling Claims” online course www.cahabagba.com/part_a/education_and_outreach/online_courses/index.htm
Coding Errors/Modifiers	529	<p>These questions typically come from hospital providers. Please see the April 1, 2006, <i>Medicare A Newslines</i>, pg. 65 www.cahabagba.com/part_a/education_and_outreach/newsletter/0406_a.pdf</p>
How to read the remittance advice (RA)	361	<ul style="list-style-type: none"> ➤ Manual: “<i>Understanding the Remittance Advice: A Guide for Medicare Providers, Suppliers, Physicians and Billers</i>” ➤ Web-based training course: “<i>Understanding the Remittance Advice for Institutional Providers</i>” (Also available via CD-ROM). <p>Available to download or order through the CMS MLN Products Catalog or the MLN Product Ordering Page, accessible from www.cms.hhs.gov/MLNProducts/</p>
Contractual Obligation Not Met (Untimely Filing of Claims)	312	<ul style="list-style-type: none"> ➤ November 1, 2006, <i>Medicare A Newslines</i> www.cahabagba.com/part_a/education_and_outreach/newsletter/1106_fi.pdf ➤ November 1, 2006, <i>Home Health & Hospice Medicare A Newslines</i> www.cahabagba.com/part_a/education_and_outreach/newsletter/1106_rhhi.pdf <p>The information begins on page 5 in these resources.</p>



Updated FISS Reference Guide

Medicare billing staff that uses the Fiscal Intermediary Standard System (FISS) can now access the updated *FISS Reference Guide* on Cahaba GBA's Web site. Go to https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/index.htm and then select your specific provider type.

The *FISS Reference Guide* includes revisions to the following sections:

- FISS Overview
- Inquiry Menu
- Claim Corrections
- Checking Beneficiary Eligibility
- Claims and Attachments

All revisions appear in red text with revision marks in the border.

This resource provides step-by-step billing instructions, and is a great educational tool for your billing staff, particularly if they are new to FISS or Medicare claim submission.

Providers without Internet access may purchase a copy of the *FISS Reference Guide* for \$35. To order, please complete Attachment #1. Your check or money order, made payable to Cahaba GBA, LLC, must be included with the order form, and mailed to Cahaba GBA, LLC at the address on the form.



How to Prevent Common Errors on Claims

The following information is applicable only to providers submitting claims to the Cahaba GBA, LLC office in Birmingham, Alabama.

Based on an analysis of claims submitted by providers to our Alabama office, the following clarifications are offered to assist in the appropriate billing of Medicare claims. The following three problems have been identified through an analysis of claims:

- Claims are rejecting for reason code 38035 (duplicate claim)
- Adjustments are being submitted on fully denied claims (reason code 30940)
- Claims are rejecting due to the outpatient therapy caps.

There are a number of claims rejecting for reason code 38035. There are a number of claims rejecting for reason code 38035. Primarily, this occurs when the provider submits a new claim to Medicare and a previously processed claim with the same dates of service has been fully denied. Reason code 38035 indicates a possible duplicate claim submission. A large number of claims are rejecting for this reason code because the providers are submitting a new claim for the same dates of service as a previously processed claim that was fully or partially denied. In addition, reason code 30940 is editing because providers are submitting adjustments on fully denied claims.

If providers disagree with a determination made on a fully denied claim or a detail line denied on a partially paid claim, the appropriate action is to submit an appeal within 120 days of the date of denial. This includes requesting a change in the diagnosis codes billed on the claim. More information on Medicare appeals is available through the Cahaba GBA, LLC online course, “Appeals Process” available at:

https://www.cahabagba.com/part_a/education_and_outreach/online_courses/index.htm

In addition, CMS has the following resources available for understanding Medicare appeals:

- *Medicare Claims Processing Manual* (Pub. 100-04, Ch. 29)
<http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf>
- “The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers” brochure <http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf>

To avoid the need to request appeals, which can be time consuming and costly for Medicare providers, please ensure that the information included on claims is correct and complete, prior to submitting them to Medicare.

The second problem identified through data analysis shows claims are rejecting when the outpatient therapy caps are met. Subsequently, the provider submits an adjustment to include the KX modifier for the line items that rejected. The provider then receives Medicare reimbursement as the KX modifier causes the line items to be payable. Providers should be checking page 1 of either ELGA or ELGH to determine whether the therapy caps have been met. More information on ELGA or ELGH can be found in the “Checking Beneficiary Eligibility” section of the *FISS Reference Guide*:

https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_elig.pdf

Furthermore, the KX modifier is appropriately billed when there is an exception to the therapy caps. Inclusion of the KX modifier when an exception is not warranted is considered fraudulent.

The following resources are available to assist in appropriately billing the KX modifier on Medicare claims:

- July 1, 2006, *Medicare A Newsline* (pgs. 21 – 23)
https://www.cahabagba.com/part_a/education_and_outreach/newsletter/0706_fi.pdf
- February 1, 2007, *Medicare A Newsline* (pgs. 14 – 29)
https://www.cahabagba.com/part_a/education_and_outreach/newsletter/0207_fi.pdf

Remember, it is your responsibility as a Medicare provider to ensure that the information submitted on billing transactions is correct and according to Medicare regulations. A pattern of inappropriate billing may lead to identification as an abusive biller, and a fraud investigation if a pattern of abusive billing is determined.

Please share this information with your staff. If you have questions regarding this information, please call a Customer Service Representative at the number listed in the “Contact Us” section of this *Newsline*.



Part A Local Coverage Determination (LCD) Updates

Our Medical Review department continues to develop local coverage determinations (LCDs) and review existing LCDs to ensure policies remain accurate and up-to-date. As a result, please review the following LCD updates.

- Erythropoietin Analogues (EA)—Due to FDA black box warnings, effective May 1, 2007, Erythropoietin Analogues (EA) will not be covered in the treatment of anemia in malignancy. In order to comply, the following revisions will be made in the LCD:
 - ◆ The Indications section will reflect the above;
 - ◆ The Limitations section will be updated to include the above; and
 - ◆ The ICD-9 section will be modified.

Also, the treatment of anemia secondary to chemotherapy will not be covered beyond 90 days from the last chemotherapy administration.

This LCD will be effective May 1, 2007, and can be viewed at https://www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm on our Web site.

Providers are encouraged to review these revisions to ensure compliance, effective May 1, 2007.



Provider Enrollment

The following is instructional information pertaining to the Provider Enrollment process and completion of the CMS-855A Medicare Enrollment Application.

Item #1—Ensure the documentation submitted to support the National Provider Identifier (NPI) is from the NPI Enumerator. Alternative documentation is not acceptable. Also, ensure the documentation correctly identifies your facility's legal business name (LBN) and tax identification number (TIN). The LBN and TIN must also match information that is on file with the Internal Revenue Service (IRS) for your facility. The CMS-855A application cannot be processed unless the NPI documentation is accurate. Please verify the accuracy of this information prior to submitting the enrollment application.

Item #2—It is not necessary to submit the application instructions, sections of the application that do not apply to the reason for which the change is being requested (e.g., Section 12, HHA capital, is not needed if the provider type is a hospital), or a copy of the information that goes to the state agency (i.e., resumes, position descriptions, etc.). Cahaba GBA, LLC does not need this information in order to process the application. This will also reduce the applicant's cost of mailing the enrollment packet.

Item #3—When completing Sections 3 and 6B, identifying whether the applicant, owner, director, officer, manager, etc. currently has or has ever had an adverse legal action, please ensure this is completed accurately and that all actions, whether current or in the past, have been disclosed. This includes state disciplinary actions. If in doubt of the action, it is best to disclose it. The authorized official should not sign off on the certification statement until he/she has confirmed with all parties listed on the application that this question was answered properly. If, during the course of the review, it is determined that an action exists; however, it was not disclosed, the application will be denied for falsification of records, regardless of whether the omission was intentional. When this denial reason is used, the provider may be subject to the penalties identified in Section 14 of the application, and revocation of the provider's Medicare provider number.

Item #4—As a reminder, if the provider is not currently in the Provider Enrollment Chain and Ownership System (PECOS), the CMS-855A application must be completed in full. If the provider has never completed and submitted an enrollment application, or has not submitted one since July 29, 2002, the provider would not be in PECOS. Note that the application must have been approved by Cahaba GBA, LLC in order for the information to be input into PECOS. In submitting a full application, it is important that every section be completed, including the disclosure of all owning/controlling organizations and individuals in Sections 5 and 6. If the application is not completed in full, a request will be made to submit this information. If the information is not resubmitted timely, this could result in a revocation of the provider's Medicare provider number, i.e., the provider would not be able to bill and be paid for services performed.

Refer to the July 1, 2006, through March 1, 2006, *Medicare A Newslines* for frequently asked questions (FAQs) regarding the NPI, Electronic Funds Transfer (EFT), and submission of the varying types of CMS-855A applications.

Provider Enrollment Contact and Web site Information is as follows:

Contact our Alabama office if your provider is located in the state of Alabama or is a component provider or a national chain organization that has single intermediary status with Cahaba GBA, LLC.

Medicare Part A

Attention: Provider Reimbursement

P.O. Box 361930

Birmingham, AL 35236-1930

Helpline Number (Medicare Provider Customer Service): (866)-539-5598

CMS Web site: <http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

Cahaba Web site: http://www.cahabagba.com/part_a/enroll_update_your_records/index.htm

Contact our Iowa office if your provider is located in the state of Iowa or is a component provider or a national chain organization that has single intermediary status with Cahaba GBA, LLC.

Cahaba GBA, LLC

Attention: Provider Enrollment

401 Douglas, Suite 410

P.O. Box 7501

Sioux City, IA 51101

Helpline Number (Provider Enrollment/EFT/Provider-Based): (712) 293-5764

CMS Web site: <http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

Cahaba Web site: http://www.cahabagba.com/part_a/enroll_update_your_records/index.htm



Availability of the Provider Contact Center

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our Customer Service Representatives (CSRs). The Provider Contact Center in Birmingham, Alabama (1-866-539-5598 and 1-877-567-3092) will conduct training for CSRs on a weekly basis, on Thursdays from 10:30 a.m. to 12:30 p.m. Central Time (CT). Listed below are the dates and times the Provider Contact Center will be closed for training. We will continue to notify you of future CSR training dates in the *Medicare A Newslines*.

CSR Training Date	Time
May 3, 2007	10:30 a.m.–12:30 p.m. CT
May 10, 2007	10:30 a.m.–12:30 p.m. CT
May 17, 2007	10:30 a.m.–12:30 p.m. CT
May 24, 2007	10:30 a.m.–12:30 p.m. CT

News from Cahaba GBA, LLC for Hospital/CAH Providers



Billing of Self-Administered Drugs (SADs)

The following information clarifies an article that was published in the December 1, 2006, *Medicare A Newslines*. Due to FISS limitations, providers are now required to follow the instructions below when billing for self-administered drugs.

Proper coding and billing of SADs are necessary for accurate claims processing. Providers submitting claims on or after March 1, 2007, which contain SADs, are required to bill as follows:

- Revenue code 0637
- Charges are billed as noncovered charges
- HCPCS A9270 (**required**)
- GY modifier (**required** to correctly assign liability to the beneficiary)

If you have any questions regarding this change, please contact a Customer Service Representative at 1-877-567-3092 (Iowa hospitals) or 1-866-539-5598 (Alabama hospitals).



Medicare Forum

Do you have a Medicare question or topic that you would like addressed in the *Home Health & Hospice Medicare A Newsline*? If so, fax it to the Provider Outreach and Education (POE) department at 515-471-7584, or e-mail it to ianewsline@cahabagba.com. Please include your facility's name, provider number, your name, and your telephone number. Responses to the inquiries received in this e-mail box will be provided only through the *Medicare Forum* article, if appropriate. If you need an immediate response to a question, please contact a Customer Service Representative (CSR) for assistance. The CSR telephone numbers are listed under the "Contact Us" page of this newsletter. We also welcome your comments or suggestions on this publication and other Cahaba GBA, LLC customer service activities.

The following answers are in response to questions from the February 15, 2007, Skilled Nursing/Swing Bed PPS Consolidated Billing teleconference.

Q1. A SNF resident is seen at a rural health clinic (RHC) in the a.m. and has lab tests and x-rays that are billed by the hospital to the SNF. Later that day, the SNF resident is seen in the ER and is admitted to the hospital. The hospital is notified by the SNF that the patient was discharged that same day. Are the earlier lab tests and x-rays billed to the SNF or should they be billed to Medicare?

A1. If the RHC is independently owned, the lab and x-ray tests are services covered under consolidated billing and are billed to the SNF. If the RHC is wholly owned or wholly operated by the admitting hospital, the lab, x-ray tests and other admission-related services performed by the admitting hospital within three days prior to the date of the beneficiary's admission are deemed to be inpatient services and are included in the inpatient payment.

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e. conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

Medicare Claims Processing Manual, (CMS Pub. 100-04, Ch. 3, §40.3)

(<http://www.cms.hhs.gov/manuals/downloads/clm104c03.pdf>)

Please refer to §70.15 in the "Claims Filing" section of the *Medicare Reference Guide for Hospitals* (https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/hospital.htm), and §80.35.5 in the "Claims Filing" section of the *Medicare Reference Guide for SNF/SB* (https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/snf.htm)

Q2. A SNF patient is sent to hospital for an MRI. Due to the size of the patient, the hospital is unable to perform the MRI and the patient is transported to another free-standing facility that can provide the service (MRI). Since the MRI could not be performed at the original hospital, why should the SNF be responsible for the bill? Isn't there a rule about hospitals have to accept bills if they cannot provide the service?

- A2. For certain radiological procedures, such as an MRI, these fall under Major Category I – Exclusion of Services Beyond the Scope of a SNF. These services are beyond the scope of a SNF and are only excluded if performed in a hospital or critical access hospital (CAH). If performed in a freestanding radiology facility, they must be bundled to the SNF for beneficiaries in a Part A stay. Based on the scenario you presented there are no exceptions to this rule. The hospital cannot bill for the excluded service (MRI) if it has not been provided to the patient. Refer to CMS’ “General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing”:
<http://www.cms.hhs.gov/SNFConsolidatedBilling/Downloads/06MajorCategoryExplanation.pdf>

You are encouraged to make a contact at the hospital or CAH and other suppliers where you send your patients. CMS recommends that SNFs have an arrangement in place for their outside suppliers. If the SNF isn’t being notified when the patient is being transported to another facility for treatment, it is important to include verbiage in the agreement that the supplier will notify the SNF before providing the service. For sample arrangement forms, refer to CMS Best Practices Web site at:
http://www.cms.hhs.gov/SNFPPS/08_BestPractices.asp

Contact Us

Medicare Customer Service Representatives (CSR)

If you have any questions about this newsletter, please call the Provider Contact Center at the designated telephone number below, anytime Monday through Friday, between 8:00 a.m. – 4:30 p.m. Central Time.

- If you submit your Medicare claims to the Cahaba GBA, LLC office in Des Moines, call: **1-877-567-3092**, M–F, 8:00 a.m.–4:30 p.m. CT.
- If you submit your Medicare claims to the Cahaba GBA, LLC office in Birmingham, Alabama, call: **1-866-539-5598**, M–F, 8:00 a.m.–5:00 p.m. CT.

Beneficiaries can talk to a Medicare customer service representative by calling the Medicare Call Center **1-800-MEDICARE (1-800-633-4227)**. The Call Center is available 24 hours a day and 7 days a week.

Medicare A Newsline Forum

If you have a Medicare Part A question or issue you would like addressed in the *Medicare A Newsline* Forum, please sent your questions to:

Medicare Part A Newsline Forum
400 East Court Ave, Station 69
Des Moines, IA 50309

Questions can also be faxed to **515-471-7584** or e-mailed to ianewsline@cahabagba.com

Please include your name and telephone number. We also welcome your comments or suggestions on this publication and other Cahaba GBA, LLC customer service activities.

Important Web Sites

Cahaba GBA, LLC's site – www.cahabagba.com

CMS Web site – <http://cms.hhs.gov/>

CMS Medicare Learning Network (MLN) Matters Web site –
<http://www.cms.hhs.gov/MLNMattersArticles/>

CMS Medicare Learning Network Web site – <http://www.cms.hhs.gov/MLNGenInfo/>

CMS Manuals – <http://www.cms.hhs.gov/manuals/>

CMS Transmittals – <http://www.cms.hhs.gov/Transmittals/2006Trans/list.asp#TopOfPage>

Quarterly Provider Update – <http://www.cms.hhs.gov/QuarterlyProviderUpdates/>

The following highlights the educational resources and upcoming events offered by the Provider Outreach and Education (POE) department and the Medical Review department.

To receive immediate notification about new education events posted to our Web site, go to <https://www.cahabagba.com/forms/subscribeForm.htm> to subscribe to the Cahaba GBA, LLC E-mail Notification Service.

How To Register - Information on how to register for the following workshops/teleconferences can be found on our Web site on the “Calendar of Educational Events” page. Our “Calendar of Educational Events” Web page is updated frequently. To check for the most current information, go to:

https://www.cahabagba.com/apps/course_registration/ia/calendar.jsp

✓ **Teleconference Title/Information:**

- ***The Medicare Part A Appeals Process for Small Providers***—This teleconference is tailored to the staff of providers with fewer than twenty-five full time equivalents. This teleconference will provide information about each appeal level, including how to request an appeal, the timeframes to request an appeal, and the amount of the denied claim, which must be in controversy.

May 16, 2007

10:00 a.m.–11:00 a.m. CT

The registration deadline for this educational event is **May 11, 2007**. Registration is limited; therefore, we encourage you to register early to ensure your participation in this event.

- ***Provider Based Rural Health Clinic (RHC) Billing Updates***—This teleconference is intended for billing managers and staff from provider-based rural health clinics (RHCs). Information to be discussed includes a variety of topics, such as: Medicare Administrative Contractors (MACs); National Provider Identifier (NPI); and billing of RHC services.

June 13, 2007

1:00 p.m.–2:00 p.m. CT

The registration deadline for this educational event is **June 8, 2007**. Registration is limited; therefore, we encourage you to register early to ensure your participation in this event.

✓ **Webinar Information:**

- ***Navigating the Medicare Resource Sea***—This webinar will explore critical Medicare resources for Part A providers found on the Cahaba GBA, LLC and the Centers for Medicare & Medicaid Services (CMS) Web site.

June 7, 2007

10:00 a.m.–11:30 a.m CT

The registration deadline for this educational event is **June 4, 2007**. Registration is limited; therefore, we encourage you to register early to ensure your participation in this event.

✓ **Visit Our Web Site**

Cahaba GBA, LLC's Web site at <https://www.cahabagba.com/> provides a variety of valuable information for Medicare providers. We encourage you to visit our site.

The Web site is continuously updated with information. Bookmark the Medicare Part A page (https://www.cahabagba.com/part_a/index.htm) for the most current Medicare A headlines.

- ✓ **Online Courses** are computer-based and can be launched from the convenience of your own desk. All courses are free and open to anyone. Online courses are available on our Web site at: https://www.cahabagba.com/part_a/education_and_outreach/online_courses/index.htm

Course Title	Description
Adjusting and Canceling Claims	Learn how to adjust or cancel claims.
Appeals Process	Learn about the Medicare appeals process.
CERT (Comprehensive Error Rate Test)	Learn about the CERT Program.
Checking Claims Status	Learn how to use the Fiscal Intermediary Standard System (FISS) to check the status of your claims.
Comprehending Medicare Claims Processing	Learn about Medicare claims processing.
Electronic Data Interchange	Learn about the Electronic Data Interchange (EDI) process

Cahaba GBA, LLC Learning Corner

- ✓ **Online Courses** (continued) Online courses are available on our Web site at:
https://www.cahabagba.com/part_a/education_and_outreach/online_courses/index.htm

Course Title	Description
Insight into Medicare Coding	Learn the basics about Medicare coding.
Introduction to FISS	Learn the basics of using the Fiscal Intermediary Standard System (FISS) to enter claims.
Introduction to Medicare Cost Report	Learn the basics about the Medicare Cost Report
Medicare Secondary Payer	Learn the basics of Medicare Secondary Payer.
NPI (National Provider Identifier)	Learn about the NPI (National Provider Identifier). Additional Resource: CMS NPI Training Package http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Training_Package.pdf
Overview of Medicare	Learn the basics about the Medicare program.
Provider Enrollment	Learn about provider enrollment and how to apply.
Rural Health Clinic Billing	View a presentation on rural health clinic billing.
Skilled Nursing/Swing Bed PPS Consolidated Billing	View a presentation on skilled nursing facility/swing bed prospective payment system (PPS) consolidated billing.
Verifying Beneficiary Eligibility	Learn how to use the Fiscal Intermediary Standard System to check if a beneficiary is eligible for Medicare benefits.

Please note these courses were designed specifically for providers served by Cahaba GBA, LLC. You can find additional national courses under the Medicare Learning Network at:
<http://www.cms.hhs.gov/medlearn/default.asp>

Glossary of Acronyms and Abbreviations for the May 1, 2007, Medicare A Newline

- A -

AAA Abdominal Aortic Aneurysms
 A/B MAC Part A/B Medicare Administrative Contractors
 ABN Advance Beneficiary Notice
 ALJ Administrative Law Judge
 APC Ambulatory Payment Classification
 ASP Average Sales Price
 AWP Average Wholesale Price

- B -

BBBD Blood Brain Barrier Disruption

- C -

CAH Critical Access Hospital
 CBIC Competitive Bidding Implementation Contractor
 CBSS/ DME Competitive Bid Submission System/Durable Medical Equipment
 CDC CERT Documentation Contractor
 CERT Comprehensive Error Rate Testing
 CMS Centers for Medicare & Medicaid Services
 CO Contractual Obligations
 CPAP Continuous Positive Airway Pressure
 CR Change Request
 CSR Customer Service Representative
 CT Central Time
 CWF Common Working File

- D -

DME MAC Durable Medical Equipment Medicare Administrative Contractor
 DMEPOS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
 DMERC Durable Medical Equipment Regional Carrier
 DRA Deficit Reduction Act

- E -

EA Erythropoietin Analogues
 EFT Electronic Funds Transfer
 EKG Electrocardiogram
 E/M Evaluation and Management
 ESRD End Stage Renal Disease

- F -

FAQ Frequently Asked Question
 FDA Food and Drug Administration
 FI Fiscal Intermediary
 FISS Fiscal Intermediary Standard System
 FFS Fee-For-Service
 FOBT Fecal Occult Blood Test
 FQHC Federally Qualified Health Center

- H -

HCPCS Healthcare Common Procedure Code System
 HHS Department of Health and Human Services
 HINN Hospital Issued Notice of Noncoverage
 HIPAA Health Insurance Portability and Accountability Act

- I -

IACS Individuals Authorized Access to CMS Computer Services
 IMRT Intensity Modulated Radiation Therapy
 IPPE Initial Preventive Physical Examination
 IRS Internal Revenue Service
 IU International Unit

- L -

LBN Legal Business Name
 LCD Local Coverage Determination

***Glossary of Acronyms and Abbreviations for the April 1, 2007, Medicare A Newsline
(continued)***

- M -

MA Medicare Advantage
MLN Medicare Learning Network
MMA Medicare Prescription Drug,
Improvement and Modernization Act
of 2003
MSA Metropolitan Statistical Area
MSN Medicare Summary Notice

- N -

NCD National Coverage Determination
NOC Not Otherwise Classified
NPI National Provider Identifier
NPPES National Plan/Provider Enumeration
System
NSC National Supplier Clearinghouse

- O -

OCE Outpatient Code Editor
OPPS Outpatient Prospective Payment
System

- P -

PECOS Provider Enrollment Chain and
Ownership System
PCC Provider Contact Center
PFFS Private Fee-For-Service
POE Provider Outreach and Education
PQRI Physician Quality Reporting
Initiative

- R -

RA Remark Codes
RHC Rural Health Clinic
RHHI Regional Home Health Intermediary

- S -

SAD Self-Administered Drugs
SCH Sole Community Hospitals
SCT Specialty Care Transport
SNF Skilled Nursing Facility
SRS Stereotactic Radiosurgery

- T -

TIN Taxpayer Identification Number
TOB Type of Bill

- U -

USPSTF U.S. Preventive Services Task Force
UVA Ultraviolet A

- W -

WAC Wholesale Acquisition Cost

Request for Medicare A Educational Materials

Cahaba Government Benefit Administrators®, LLC



Instructions: Use this form to order materials directly from Cahaba GBA, LLC. **Orders received without payment will not be processed.** These publications are available for printing at no cost on our Web site <http://www.cahabagba.com/>. Return this form and your check payable to "Cahaba GBA, LLC" to:

Provider Education and Outreach
Cahaba GBA, LLC
400 East Court, Station 69
Des Moines, IA 50309

Please send me the following items:

FISS Materials	Price (each)	Quantity	Total
FISS Reference Guide.....	\$35	_____	_____

Medicare A Newsline Home Health & Hospice Medicare A Newsline

	Price (each)	Quantity	Total
A yearly subscription of the <i>Newsline</i>	\$120	_____	_____
Individual issues of <i>Newsline</i>	\$10	_____	_____

Send me these issues: Vol. No. _____ Date. _____ Vol. No. _____ Date. _____
Vol. No. _____ Date. _____ Vol. No. _____ Date. _____

GRAND TOTAL _____

Send Requested Materials To:

Name:

Facility/Agency Name:

Street Address:
(no P.O. Box)

City:

State

ZIP Code:

Telephone Number:

Provider Number:

