

# Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



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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 <https://www.cahabagba.com>.



## The Inside Story

### News From CMS

	News Flash Messages from CMS.....	2
	Mammography: Change Certification.....	6
	2008 Annual Update for HPSA Bonus Payment.....	10
	Handling Personally Identifiable Information.....	11
	Fee Schedule Update for Durable Medicare Equipment, Prosthetics, Orthotics and Supplies.....	12
	2008 Annual Update for Clinical Laboratory.....	15
	Nebulized Beta Adrenergic Agonist Therapy For Lung Diseases.....	20
	Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement.....	22
	Update to Medicare Deductible, Coinsurance and Premium Rates for 2008.....	24
	Revision to Certification for Hospital Service Covered by Supplementary Medical Insurance.....	27
	Pulmonary Rehabilitation Services .....	29
	January 2008 Integrated Outpatient Code Editor Specifications- Version 9.0.....	30
	Medicare Payments for Ambulance Transports- Revised.....	33
	An Overview of Medicare Covered Diabetes Supplies and Services- Revised.....	36
	Clarification on the National Provider Identifier Enumerator's Responsibilities.....	44

	Medicare Provider Coverage for Many Preventive Services and Screenings.....	47
	Individuals Authorized to Access CMS Computer Services- Provider Community- The Second Article..	52
	Individuals Authorized to Access CMS Computer Services- Provider Community- The Third Article....	57
	January 2008 Quarterly Average Sales Price (ASP) for Drug Pricing Files.....	61
	Medicare Payment for Pre-Administration Related Services Associated with IVIG.....	66
	Reprocessing of Certain Inpatient Hospital Payment (IPPS) Claims.....	69
	How to Handle the National Provider Identifier (NPI) for Ordering/Referring and Attending/ Operating/Other/Service Facility-Revised.....	71
	Implementation of Changes in End Stage Renal Disease (ESRD) Payment for CY 2008.....	73
	Supplemental Security Income (SSI)/Medicare Beneficiary Data for FY 2006 for IPPS.....	75

### News From Cahaba GBA, LLC

	Availability of the Provider Contact Center.....	77
	Frequently Asked Questions- Top Inquiries.....	77
	SNF Prospective Payment Fact Sheet.....	78
<b>Cahaba GBA, LLC Learning Corner.....</b>		<b>79</b>

#### Key for Icons:

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

**Disclaimer**

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## *News Flash Messages from CMS For All Providers*

**Smoking and Tobacco-Use Cessation Counseling Services**

A new preventive services brochure entitled Smoking and Tobacco-Use Cessation Counseling Services, ICN# 006767, is now available on the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN). This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of smoking cessation services. The brochure is available at <http://www.cms.hhs.gov/MLNproducts/downloads/smoking.pdf> on the CMS website.

**It's Seasonal Flu Time Again!**

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

Get Your Flu Shot – Not the Flu! Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing Special Edition MLN Matters article SE0748 at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf> on the CMS website.



## Physician Quality Reporting Initiative

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that reporting for the 2007 PQRI on claims for dates of service as of July 1, 2007, has begun. Eligible professionals can now start participating in the PQRI by simply reporting the appropriate quality measure data on claims submitted to their Medicare claims processing contractor. Remember, all your informational needs can be met by visiting the PQRI website at <http://www.cms.hhs.gov/PQRI>. Here you will find educational resources, including the PQRI Tool Kit, and links to our most Frequently Asked Questions (FAQs).



## News Flash - Test Your Medicare Claims Now!

After you have submitted claims containing both National Provider Identifiers (NPIs) and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with only the NPI in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch. (Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)



## Understanding the Remittance Advice

A Guide for Medicare Providers, Physicians, Suppliers, and Billers serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. The RA Guide is available as a downloadable document from the Medicare Learning Network Publications web page. To download and view, please go to [http://www.cms.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf) on the CMS website.



## Bone Mass Measurements

A new preventive services brochure entitled Bone Mass Measurements, ICN# 006437, is now available on the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN). This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of bone mass measurement services. The brochure is available at [http://www.cms.hhs.gov/MLNProducts/downloads/Bone\\_Mass.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Bone_Mass.pdf) on the CMS website.



## Acute Inpatient Prospective Payment System Fact Sheet

The Acute Inpatient Prospective Payment System Fact Sheet (revised November 2007), which provides general information about the Acute Inpatient Prospective Payment System (IPPS) and how IPPS rates are set, is now available in downloadable format at <http://www.cms.hhs.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf> from the Centers for Medicare & Medicaid Services Medicare Learning Network. If the url above does not take you directly to the fact sheet, please copy and paste the url in your web browser.

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## Cancer Screening Brochures Available

A new preventive services brochure entitled Cancer Screenings, ICN# 006434, is now available on the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN). This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of the following screening services: mammography, colorectal, prostate, Pap test, and pelvic exam. The brochure is available at [http://www.cms.hhs.gov/MLNProducts/downloads/Cancer\\_Screening.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf) on the CMS website.



## National Provider Identifier (NPI)

Effective January 1, 2008, National Provider Identifiers (NPIs) will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on January 1, 2008. (Pay-to Provider is identified only if it is different from the Billing Provider.) You may continue to use only legacy identifiers for the secondary provider fields in the 837I and UB-04 claims until May 23, 2008, if you choose.

Test Your Medicare Claims Now! After you have submitted claims containing both National Provider Identifiers (NPIs) and legacy identifiers and those claims have been paid, Medicare urges you to send a small batch of claims now with only the NPI in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch. (Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)

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## **Medicare Advantage**

If you treat a Medicare Advantage enrolled beneficiary and you have questions about their Medicare Advantage 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 CMS website. CMS updates this site on a monthly basis.

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## **Medicare Remit Easy Print (MREP)**

Still using Standard Paper Remittance Advices (SPRs)? Did you know that with the new MREP software that is available to you (for free!), you can view and print as many or as few claims as needed? With the MREP software, you can navigate and view an Electronic Remittance Advice (ERA) using your personal computer. This is especially helpful when you need to print only one claim from the Remittance Advice (RA) when forwarding a claim to a secondary payer. CMS developed the MREP software to enable you to read and print the HIPAA-compliant ERA, also known as Transaction 835 or “the 835”. Contact your carrier, A/B MAC or DME MAC to find out more about MREP and/or for information on how to receive HIPAA compliant ERAs.



## **Mammography: Change Certification-Based Action from Return to Provider (RTP)/Return as Unprocessable to Denial**

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:** MM5577

**Related Change Request (CR) #:** 5577

**Related CR Release Date:** December 7, 2007

**Effective Date:** April 1, 2008

**Related CR Transmittal #:** R1387CP

**Implementation Date:** April 7, 2008

### **Provider Types Affected**

Providers who bill Medicare Fiscal Intermediaries (FIs), carriers, and Part A/B Medicare Administrative Contractors (MACs) for mammography services.

### **What You Need to Know**

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

### **Background**

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

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

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

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

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

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

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

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

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

Therefore, effective April 1, 2008:

- FIs/A MACs will verify that the provider number on the claim corresponds with a certified mammography facility on the MQSA file, and if it does not, they will deny the claim. In denying these claims submitted by providers not listed as certified facilities on the MQSA file, the Medicare contractor will use:
  - Medicare Summary Notice (MSN) message 16.2 (This service cannot be paid when provided in this location/facility);
  - Remittance Advice (RA) reason code B7 (This provider was not certified/eligible to be paid for this procedure/service on this date of service); and
  - RA remark code N110 (This facility is not certified for film mammography).
- Carriers/B MACs will verify that the FDA-assigned, 6 digit mammography certification number on the claim corresponds to the FDA mammography certification number appearing on the billing facility's file. They will deny the claim if:

- The facility's certification number submitted on the claim does not match the certification number on the MQSA file;
  - The facility certification number on the claim matches the facility certification number on the MQSA file, but the facility name reported on the claim does not match the facility name on the MQSA file; or
  - The facility certification number reported on the claim matches the facility certification number on the MQSA file, but the facility address reported on the claim does not match the facility address on the MQSA file.
- In denying the claim because of an invalid facility certification number, they will use MSN message 9.4 (This item or service was denied because information required to make payment is missing), and RA reason code 125 (Payment adjusted due to a submission/billing error(s).) and remark code MA128 (Missing/incomplete/ invalid FDA approval number).

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

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

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

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

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

- Carriers/B MACs will use:
  - RA reason code 171 (Payment is denied when performed/billed by this type of provider in this type of facility); and
  - Remark code N92 (This facility is not certified for digital mammography).
- FIs/A MACs will use reason code B7

- Carriers/B MACs will continue to use the MQSA file to verify the facility's FDA-assigned 6-digit certification number submitted on the claim, and will return claims to the supplier as unprocessable if it does not contain the facility's certification number.

### **Additional Information**

You can find the official instruction, CR5577, issued to your carrier, FI, or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1387CP.pdf> on the CMS Web site. Additionally, you can find the revised sections of the *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section 20.2 (HCPCS and Diagnosis Codes for Mammography Services) as an attachment to CR5577.

If you have any questions regarding this issue, refer to the "[Contact Us](#)" page of our Web site and select "Telephone Us" to call the Provider Contact Center.

### **Disclaimer**

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## **2008 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payment**

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:** MM5698

**Related Change Request (CR) #:** 5698

**Related CR Release Date:** August 14, 2007

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** R1320CP

**Implementation Date:** January 7, 2008

### **Provider Types Affected**

Physicians and providers submitting claims to Medicare Administrative Contractors (A/B MACs), carriers, and fiscal intermediaries (FIs) for services provided in HPSAs.

### **Impact on Providers**

This article is based on Change Request (CR) 5698, which alerts affected physicians, carriers, A/B MACs and FIs that the new HPSA bonus payment information for 2008 will be available soon. This article is informational only for physicians that the 2008 automated bonus payments applies to claims with dates of service on or after January 1, 2008 through December 31, 2008.

### **Background**

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Section 413(b)) mandated an annual update to the automated HPSA bonus payment files, and the Centers for Medicare & Medicaid Services (CMS) creates these new automated HPSA bonus payment files annually. The 2008 HPSA bonus payment file will be used for the automated bonus payment for claims with dates of service on or after January 1, 2008, through December 31, 2008. Physicians and providers should review the CMS website to determine whether a HPSA bonus will automatically be paid for services provided in their ZIP code area or whether a modifier must be submitted.

In addition, physicians will find annual HPSA bonus payment files, as they become available, and other important HPSA information at <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/> on the CMS Web site.

### **Additional Information**

The official instruction (CR5698) issued to your Medicare A/B MAC, carrier, or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1320CP.pdf> on the CMS Web site.

For the CMS information about HPSA/PSA (Physician Bonuses), you may visit: <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## Handling Personally Identifiable Information (PII) on the Medicare Summary Notice (MSN)

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:** MM5770

**Related Change Request (CR) #:** 5770

**Related CR Release Date:** December 19, 2007

**Effective Date:** January 7, 2008

**Related CR Transmittal #:** R1399CP

**Implementation Date:** January 7, 2008

### Provider Types Affected

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

### What You Need to Know

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

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

### Background

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

### Additional Information

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

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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

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:** MM5803

**Related Change Request (CR) #:** 5803

**Related CR Release Date:** December 7, 2007

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** R1388CP

**Implementation Date:** January 7, 2008

### Provider Types Affected

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

### Provider Action Needed

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

### Background

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

The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (CMS Pub. 100-04), Ch. 23, §60; (<http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>) on the CMS Web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at [http://www.cms.hhs.gov/DMEPOSFeeSched/01\\_overview.asp](http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp) on the CMS Web site.

### Key Points

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

B4086	L3800	L3850	L3926	L3946
E2618	L3805	L3855	L3928	L3948
K0553	L3810	L3860	L3930	L3950
K0554	L3815	L3907	L3932	L3952
K0555	L3820	L3910	L3934	L3954
L0960	L3825	L3916	L3936	L3985

L1855	L3830	L3918	L3938	L3986
L1858	L3835	L3820	L3940	
L1870	L3840	L3922	L3942	
L1880	L3845	L3924	L3944	

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

A4252	A9276	E0329	L3925	L7614
A5083	A9277	E0856	L3927	L7621

A6413	A9278	E2227	L3929	L7622
A7027	A9283	E2228	L3931	V2787
A7028	B4087	E2312	L7611	
A7029	B4088	E2313	L7612	
A9274	E0328	E2397	L7613	

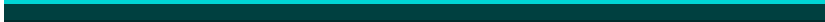
**Additional Information**

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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

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

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:** MM5813

**Related Change Request (CR) #:** 5813

**Related CR Release Date:** December 20, 2007

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** R1400CP

**Implementation Date:** January 7, 2008

### Provider Types Affected

Clinical laboratories billing Medicare Carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs).

### What Providers Need to Know

This article and related CR5813 contain important information regarding:

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

### Key Points

#### *Updates to Fees*

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

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

#### *National Minimum Payment Amounts*

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

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

#### *National Limitation Amounts (Maximum)*

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

### ***Access to 2008 Clinical Laboratory Fee Schedule***

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

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

### ***Public Comments***

On July 16, 2007, CMS hosted a public meeting to solicit input on the payment relationship between 2007 codes and new 2008 Current Procedural Terminology codes. Notice of the meeting was published in the Federal Register on May 25, 2007 and on the CMS Web site on June 18, 2007. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the CMS Web site. Additional written comments from the public were accepted until October 5, 2007.

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

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

### ***Additional Pricing Information***

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

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

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

### ***Organ or disease Oriented Panel Codes***

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

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

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

- Calcium, ionized (82330);
- Carbon Dioxide (82374);
- Chloride (82435);
- Creatinine (82565);
- Glucose (82947);
- Potassium (84132);
- Sodium (84295); and
- Urea Nitrogen (BUN) (84520).

Note that 80047 cannot be billed for services ordered through an ESRD facility. All tests billed for services ordered through an ESRD facility must be billed individually, not in an organ disease panel.

### ***Mapping Information***

CMS advises the following:

- New code 80047 is priced at the same rate as 80048 with final payment determined by the AMCC Panel Payment Algorithm;
- New code 82310QW is priced at the same rate as 82310;
- New code 82565QW is priced at the same rate as 82565;
- New code 82610 is priced at the same rate as 83883;
- New code 83655QW is priced at the same rate as 83655;
- New code 83993 is priced at the same rate as 83631;
- New code 84704 is priced at the same rate as 84702;

- New code 86356 is priced at the same rate as 86361;
- New code 87500 is priced at the same rate as 87641;
- New code 87809 is priced at the same rate as 87802;
- New code 89321QW is priced at the same rate as 89321;
- New code 89322 is priced at the sum of the rates of 89320 and 85007;
- New code 89331 is priced at the sum of the rates of 89320 and 87015; and
- New AMCC code ATP23 is priced at the same rate as ATP22.

### ***Laboratory Costs Subject to Reasonable Charge Payment in 2008***

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

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

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

### **Blood Products**

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

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

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

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

### Transfusion Medicine

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

### Reproductive Medicine Procedures

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

### Additional Information

To see the official instruction, CR5813, issued to your Medicare FI, Carrier or A/B MAC, go to <http://www.cms.hhs.gov/Transmittals/downloads/R1400CP.pdf> on the CMS Web site.

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

If you have any questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## **Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases**

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:** MM5820

**Related Change Request (CR) #:** 5820

**Related CR Release Date:** December 21, 2007

**Effective Date:** September 10, 2007

**Related CR Transmittal #:** R79NCD

**Implementation Date:** January 22, 2008

### **Provider Types Affected**

Providers and suppliers who bill Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, Medicare administrative contractors (A/B MACs), and durable medical equipment contractors (DME MACs) for nebulized beta adrenergic agonist therapy services for lung diseases.

### **What You Need to Know**

CR 5820, from which this article is taken, provides that (effective September 10, 2007) no National Coverage Determination (NCD) for nebulized beta adrenergic agonist therapy for lung diseases is appropriate. Therefore, you should make sure that your billing staffs are aware that local contractors will continue to make Section 1862(a)(1)(A) reasonable and necessary decisions through a local coverage determination process or case-by-case adjudication.

*Note: No changes to process or policy are being made with CR 5820.*

### **Background**

Lung diseases such as chronic obstructive pulmonary disease (COPD) and asthma are characterized by airflow limitation that may be partially or completely reversible. Pharmacologic treatment with bronchodilators (intended to improve the movement of air into and from the lungs by relaxing and dilating the bronchial passageways) is used to prevent and/or control daily symptoms that may cause disability for persons with these diseases.

Beta adrenergic agonists (which can be administered via nebulizer, metered dose inhaler, orally, or dry powdered inhaler) are a commonly prescribed class of bronchodilator drug. For example, nebulized beta adrenergic agonist with racemic albuterol has been used for many years, and more recently, levalbuterol, the (R) enantiomer of racemic albuterol, has been used in some patient populations.

Because of concerns regarding the appropriate use of nebulized beta adrenergic agonist therapy for lung disease, CMS internally generated a formal request for a national coverage determination (NCD) to determine when treatment with a nebulized beta adrenergic agonist is reasonable and necessary for Medicare beneficiaries with COPD.

The examination of the published medical evidence did not provide sufficient information that would enable CMS to define, at this time, specific populations of patients who would benefit from a particular treatment with particular medications. Moreover, because an NCD is defined, in part, as including “whether or not a particular item or service is covered nationally” under title XVIII, sections 1862(l), 1869(f)(1)(B); CMS does not believe a national policy is possible or prudent at this time.

Therefore, effective with dates of service on and after September 10, 2007, Medicare contractors will continue to make 1862(a)(1)(A) reasonable and necessary decisions and process claims for nebulized beta adrenergic agonist therapy for lung disease through their local coverage determination process or case-by-case adjudication.

***Note: No changes to process or policy are being made with CR 5820.***

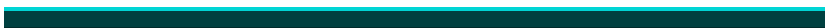
### **Additional Information**

You can find the official instruction, CR 5820, issued to your FI, RHHI, Carrier, A/B MAC, or DME MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R79NCD.pdf> on the CMS Web site. You will find the *Medicare National Coverage Determinations Manual*, (CMS Pub. 100-03), Ch. 1, Part 4 (§§200 – 310.1) Coverage Determinations, §200.2 - Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases – (Effective September 10, 2007) as an attachment to that CR.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## Annual Update of Healthcare Common Procedure Codes System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement

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:** MM5829

**Related Change Request (CR) #:** 5829

**Related CR Release Date:** December 14, 2007

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** R1391CP

**Implementation Date:** January 7, 2008

### Provider Types Affected

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

### What Providers Need to Know

CMS periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2008. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the “Additional Information” section of this article.

### Background

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

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

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

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

**Table 1: Non Routine Supplies**

Code	Description	Action
A5083	CONTINENT DEVICE, STOMA ABSORPTIVE COVER FOR CONTINENT STOMA	Add
A5105	URINARY SUSPENSORY WITH LEG BAG WITH OR WITHOUT TUBE, EACH	Redefine
A6200	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	Delete
A6201	COMPOSITE DRESSING, PAD SIZE MORE	Delete

**Table 2: Therapies**

Code	Description	Action	Replacement Code or Code being Replaced
96125	STANDARDIZED COGNITIVE PERFORMANCE TESTING PER HOUR	Add	96125

**Additional Information**

For details regarding this CR, please see the official instruction issued to your Medicare FI, carrier, A/B MAC, RHHI, or DME MAC. This may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1391CP.pdf> on the CMS Web site.

A complete historical listing of codes subject to HH consolidated billing can be found at [http://www.cms.hhs.gov/HomeHealthPPS/03\\_coding&billing.asp](http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp) on the CMS Web site.

To review the Medicare manual instructions discussed in this article see the *Medicare Claims Processing Manual*, (CMS Pub. 100-04), Ch. 10, §20.1 at <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf> on the CMS Web site.

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

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:** MM5830

**Related CR Release Date:** December 14, 2007

**Related CR Transmittal #:** R49GI

**Related Change Request (CR) #:** 5830

**Effective Date:** January 1, 2008

**Implementation Date:** January 7, 2008

### Provider Types Affected

Providers who bill Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs) and carriers) for care rendered to Medicare beneficiaries.

### What You Need to Know

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

### Background

The details of CR5830 follow:

#### *2008 Part A – Hospital Insurance (HI)*

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

#### **Hospital**

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

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

#### **Skilled Nursing Facility**

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

These details are summarized in table 1A, below.

**Table 1A**

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

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

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A.

Details of this coverage are summarized in table 1B, below.

**Table 1B**

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

### **2008 Part B - Supplementary Medical Insurance (SMI)**

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

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

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

**Table 2**

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

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

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

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

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

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## **Revision to Certification for Hospital Services Covered by the Supplementary Medical Insurance Program as it Pertains to Ambulance Services. CR5833 rescinds and fully replaces CR 5684**

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:** MM5833

**Related Change Request (CR) #:** 5833

**Related CR Release Date:** December 21, 2007

**Effective Date:** September 17, 2007 2008

**Related CR Transmittal #:** R50G19

**Implementation Date:** January 7, 2008

### **Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for ambulance services provided to Medicare beneficiaries.

### **Provider Action Needed**

The article is based on Change Request (CR) 5833, which updates the Section 20 of Chapter 4 of the Medicare General Information, Eligibility, and Entitlement Manual as it pertains to Physician Certification Statement requirements for all ambulance providers. CR5833 deletes from that manual section the paragraph that requires a physician certification of ambulance services provided by a hospital to transport a patient during an emergency situation, such as transport from the scene of an accident.

The Centers for Medicare & Medicaid Services (CMS) discovered there was a problem with a paragraph in the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 20 regarding language not allowing the current exception under Physician Certification Statement (PCS), i.e., that the PCS is NOT required during an emergency situation (such as the scene of an accident).

Therefore, Change Request (CR) 5833 deleted the following paragraph in Chapter 4 (Section 20) of the Medicare General Information, Eligibility, and Entitlement Manual (Pub 100-01) that pertained to Physician Certification and Recertification of Services and Ambulance Services because it conflicted with Title 42 of the Code of Federal Regulations (CFR), Sections 410.40(d) (2) and (3):

Certification by a physician in connection with ambulance services furnished by a participating hospital is required. In cases in which the hospital provides ambulance service to transport the patient from the scene of an accident and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify as to the medical need for the ambulance service.

Deletion of this paragraph brings the manual into alignment with current regulations, which eliminate the PCS requirement in these emergency situations.

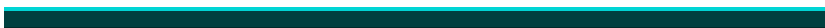
### **Additional Information**

The official instruction, CR 5833, issued to your Medicare carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R50GI.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## Pulmonary Rehabilitation 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:** MM5834

**Related CR Release Date:** December 5, 2007

**Related CR Transmittal #:** R78NCD

**Related Change Request (CR) #:** 5834

**Effective Date:** September 25, 2007

**Implementation Date:** January 7, 2008

### Provider Types Affected

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

### Impact on Providers

CMS issued CR 5834 detailing the decision regarding a national coverage determination (NCD) for Pulmonary Rehabilitation Services.

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

### Background

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

### Additional Information

You may see the official instruction (CR 5834) issued to your Medicare carrier, A/B MAC, FI, DME MAC or RHHI by going to <http://www.cms.hhs.gov/Transmittals/downloads/R78NCD.pdf> on the CMS Web site. The actual revision to the *National Coverage Determination Manual* containing this NCD is attached to CR 5834.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## January 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.0

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:** MM5865

**Related CR Release Date:** December 28, 2007

**Related CR Transmittal #:** R1403CP

**Related Change Request (CR) #:** 5865

**Effective Date:** January 1, 2008

**Implementation Date:** January 7, 2008

### Provider Types Affected

All providers who submit institutional outpatient claims (including non-outpatient prospective payment system (non-OPPS) hospitals) to Part A/B Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

### Impact on Providers

This article is based on CR 5865 and notifies providers that the I/OCE Specifications Version 9.0, is effective January 1, 2008. Note that claims with dates of service **prior to July 1, 2007**, are routed through the non-integrated versions of the OCE software that **coincide with the versions in effect for the date of service on the claim**.

### Background

This article is based on CR 5865 and informs providers that the I/OCE routes all institutional outpatient claims (including non-OPPS hospital claims) through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis. **This integration does not change the current logic that is applied to outpatient bill types that already pass through the OPSS OCE software.** It expands the software usage to include non-OPPS hospitals.

There are numerous changes/additions/deletions to diagnosis codes, Ambulatory Payment Classification (APC) codes, and Health Care Common Procedure Codes (HCPCS) in January 2008. All of the changes will not be detailed in this article. Instead, please see CR 5865 for those details. CR 5865 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1403CP.pdf> on the CMS Web site.

The key changes for the January 2008 I/OCE are as follows: (Some I/OCE modifications in the release may also be retroactively added to prior releases. If so, the retroactive date will appear in the 'Effective Date' column.)

Effective Date	Modification
1/1/08	Modify appendix D to prevent double discounting: <ol style="list-style-type: none"> <li>1. Replace discount formula #6 with formula #3 in applicable rows, to prevent application of both multiple procedures &amp; terminated procedure discounting to the same procedure.</li> <li>2. Create new discount formula #9 to replace discount formula #7 (to pay 100% of the APC rate, 50% x 2, for a bilateral T procedure that is not the highest).</li> </ol>

1/1/08	Discontinue use of discount formulae #6 and #7
1/1/08	Create new payment adjustment flag (PAF) 8: Item provided with partial credit to provider. 1. Assign to procedures subject to 50% of off-set, when modifier FC is present.  2. Reduce APC payment rate by 50% of offset amount before application of discounting logic.
1/1/08	Expand edit 75 to apply to modifier FC in addition to FB – to trigger if modifier FB or FC is appended to a code with status indicator (SI) other than S, T, X or V.
1/1/08	Expand use of SI of “Q” – to include other codes (not packaged services only) subject to SI change based on criteria.
1/1/08	Implement new ‘composite’ APC assignment logic as specified in appendix K and Appendix H-c of the I/OCE specifications attached to CR 5865.
1/1/08	Implement 2-character payment adjustment flags, 91-99; use for composite APCs (see appendix G of CR 5865).
1/1/08	Deactivate observation logic that is based on payable G0378 (appendix H-a).
1/1/08	Remove criterion for ‘payable G0378’ from G0379 processing (appendix H-b).
1/1/08	Implement logic for assignment of new composite APCs which include observation (appendix K)
1/1/08	Bypass edit 48 for rev code 0948.
1/1/08	Apply wound care logic to all revenue codes in the therapy series: 042x, 043x and 044x (not 04x0 only).
1/1/08	Modify PHP and MH per-diem logic (appendix C)- <ul style="list-style-type: none"> <li>• Replace APC numbers with specified lists of codes <ul style="list-style-type: none"> <li>- PH services = list of codes that count toward Partial Hospitalization APC</li> <li>- MH services = list of codes that are included in the Daily Mental Health services cap</li> </ul> </li> <li>• Assign SI of ‘N’ to all codes that are packaged into APC 33 &amp; 34</li> <li>• Count multiple occurrences of OT (G0129) as separate units in determining “3 or more” for PHP</li> </ul>
1/1/08	Modify the current special packaged codes logic to package only in the presence of codes with SI of S,T,V or X on the same date of service = “STVX-packaged” codes.
1/1/08	Expand special packaged codes logic to add codes that will be packaged in the presence of a code with SI of T on the same date of service = “T-packaged” codes
<b>8/1/00</b>	Bypass edit 48 for rev codes 099x. Assign edit 9 (SI-E) if submitted without a HCPCS.
<b>10/1/07</b>	Rescind previous program modification - re-apply edit 71 to bill type 12x.
<b>1/1/07</b>	Modify the program to exclude bill type 12x from edit 77 (change effective date from 10/1 to <b>1/1/07</b> ).
1/1/08	New edit 78 – Claim lacks required radiopharmaceutical ( <b>RTP</b> ). Assign to specified nuclear medicine procedure if no specified radiopharmaceutical on the claim.
1/1/08	Make Non-OPPS bill type 83x invalid for the I/OCE – assign claim processed flag of “1” (claim could not be processed, invalid bill type).
7/1/07	Modify the program to bypass edit 17 for bill type 85x with rev codes 096x, 097x and 098x.
7/1/07	Modify the processing flow such that no values are returned for the following OPPS-related flags on Non-OPPS claims (OPPS flag = 2). Return blank fields in the APC/ASC Return buffer.

	<ul style="list-style-type: none"> <li>• status indicator,</li> <li>• payment indicator,</li> <li>• discounting formula number,</li> <li>• line item denial or rejection,</li> <li>• packaging,</li> <li>• payment adjustment,</li> <li>• payment method</li> <li>• line item action.</li> </ul> <p>Return “0” in the payment APC/ASC field.</p>
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	Make HCPCS/APC/SI changes as specified by CMS
	Implement version <b>13.3</b> of the NCCI file, removing all code pairs which include Anesthesia (00100-01999; 99143-99150), E&M (92002-92014, 99201-99499), or MH (90804-90911).
	Add new modifiers (FC, EA, EB, EC, KG, KK, KU, KW, KY, Q0, Q1) and delete modifiers QA, QR, and QV as specified by CMS.
	Modify description for edit 75: Incorrect billing of modifier FB or FC.
10/1/07	Add new revenue code 0948 to the valid revenue code list, no pre-assigned SI.
	Modify description for SI ‘H’ – Pass-through device categories.
	Modify description for SI ‘K’ – Non pass-through drugs and biologicals, therapeutic radiopharmaceuticals and brachytherapy sources.
	Modify description for SI ‘M’ (Service not billable to the FI/MAC)... also modify descriptions for SI A, and K, and N, and Q, and V, and Y.
	Rename OCE Overview as appendix L; Rename Summary of Modifications as appendix M.

***Readers should also read through the specifications attached to CR 5865 and note the yellow highlighted sections, which indicate change from the prior release of the I/OCE software.***

**Additional Information**

For complete details regarding CR 5865, please see the official instruction (CR 5865) issued to your Medicare A/B MAC, RHHI, or FI. To view the instruction, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1403CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## Medicare Payments for Ambulance Transports- **Revised**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Special Edition (SE) Medicare Learning Network (MLN) Matters* article entitled “Medicare Payments for Ambulance Transports”, which is published in the February 2008 *Medicare A Newslines*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles>

<b>MLN Matters Number:</b> SE0724 Revised	<b>Related Change Request (CR) #:</b> N/A
<b>Related CR Release Date:</b> N/A	<b>Effective Date:</b> N/A
<b>Related CR Transmittal #:</b> N/A	<b>Implementation Date:</b> N/A

**Note:** This article was revised on December 12, 2007, to provide additional clarification. Some language regarding emergency and non-emergency transports and the Physician Certification Statement was removed and readers are referred instead to the actual regulations. In addition, some language was added as reflected in print that is bold, italicized and underscored.

### Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), carriers, and Part A/B Medicare Administrative Contractors (A/B MACs) for ambulance services or who initiate ambulance transports for their Medicare patients.

### Provider Action Needed STOP – Impact to You

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

### CAUTION – What You Need to Know

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

### GO – What You Need to Do

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

### Background

Some key provisions of the OIG Report are as follows:

### Medicare Coverage of Ambulance Transports

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

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

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

- a) Basic Life Support (BLS)
- b) Advanced Life Support (ALS) – Level 1 (ALS1) and Level 2 (ALS2)
- c) Specialty Care Transport (SCT)
- d) Air transport – fixed wing and rotary wing

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

### **Documentation Requirements**

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

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

### **How to Avoid Improper Billing**

- Be sure that coverage criteria and level of service criteria for ambulance transport are met and that it is backed up with the appropriate documentation. For guidance, you may wish to refer to change request (CR) 5442 “Ambulance Fee Schedule – Medical Conditions List – Manualization,” which contains an educational guideline that was developed to assist ambulance providers and suppliers **in communicating** the patient's condition to Medicare FIs, carriers, and A/B MACs as reported by the dispatch center and as observed by the ambulance crew. The link to this CR is provided below.

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

### **Additional Information**

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

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

The regulations at 42 CFR 410.40(d)(2) and (3) state the circumstances when a PCS is required and may be found at [http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410\\_40.pdf](http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410_40.pdf) on the CMS Web site.

If you have any questions regarding this issue, refer to the "[Contact Us](#)" page of our website and select "Telephone Us" to call the Provider Contact Center.

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## **An Overview of Medicare Covered Diabetes Supplies and Services—Revised**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Special Edition Medicare Learning Network* (MLN) article entitled “An Overview of Medicare Covered Diabetes Supplies and Services,” which was published in the January 1, 2008, Medicare A Newline. 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:** SE0738 Revised

**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

**Note: This article was revised on December 12, 2007, to remove a bullet point which indicated an initial prescription needed to specify how many lancets and test strips were needed for a month and to remove a second bullet that stated a new prescription is needed every 12 months for lancets and test strips. Both of these requirements were eliminated from local policy.**

### **Provider Types Affected**

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

### **Provider Action Needed**

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

### **Background**

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

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

### **Medicare Part B Covered Diabetic Supplies**

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

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

## **Blood Glucose Self-testing Equipment and Supplies**

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

- Blood glucose monitors;
- Blood glucose test strips;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

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

If the beneficiary

- **Uses insulin**, they may be able to get up to 100 test strips and lancets every month, and 1 lancet device every 6 months.
- **Does not use insulin**, they may be able to get 100 test strips and lancets every 3 months, and 1 lancet device every 6 months.

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

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

Their prescription should include the following information:

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

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

- Can order and pick up their supplies at their pharmacy;
- Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order; and
- Must ask for refills for their supplies.

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

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor test strips. A beneficiary cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly.

Beneficiaries should only pay their coinsurance amount when they get their supply from their pharmacy or supplier for assigned claims. If a beneficiary's pharmacy or supplier **does not** accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

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

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

If the answer to either of these two (2) questions is “no,” they should call another supplier or pharmacy in their area who answers “yes” to be sure their purchase is covered by Medicare, and to save them money. If a beneficiary can not find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.

### **Therapeutic Shoes and Inserts**

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

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

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

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

- They have diabetes;
- They have at least 1 of the following conditions in one or both feet:
  - Partial or complete foot amputation;
  - Past foot ulcers;
  - Calluses that could lead to foot ulcers;
  - Nerve damage because of diabetes with signs of problems with calluses;
  - Poor circulation; or
  - Deformed foot;
- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

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

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

## **Insulin Pumps and the Insulin Used in the Pumps**

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

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

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

## **Medicare Part D Covered Diabetic Supplies and Medications**

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

- Diabetes supplies;
- Insulin; and
- Anti-diabetic drugs.

## **Diabetes Supplies**

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

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

## **Insulin**

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

## **Anti-diabetic Drugs**

Medicare drug plans can cover anti-diabetic drugs such as:

- Sulfonylureas (i.e. Glipizide, Glyburide);
- Biguanides (i.e. metformin);
- Thiazolidinediones (i.e. Starlix<sup>®</sup> and Prandin<sup>®</sup>); and
- Alpha glucosidase inhibitors (i.e. Precose<sup>®</sup>).

## **Medicare Part B Covered Diabetic Services**

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

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

## **Diabetes Screenings**

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

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

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

- Are you age 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, siblings)? •
- Do you have a history of gestational diabetes (diabetes during pregnancy)? , or
- Did you deliver a baby weighing more than 9 pounds?

Based on the results of these tests, a beneficiary may be eligible for up to 2 diabetes screenings every year at no cost (no coinsurance, or copayment or Part B deductible). Medicare will pay for a beneficiary to get 2 diabetes screening tests in a 12-month period, but not less than 6 months apart. After the initial diabetes screening test, the beneficiary’s doctor will determine when to do the second test. Diabetes screening tests that are covered include the following:

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

## **Diabetes Self-management Training (DSMT)**

Diabetes self-management training helps a beneficiary learn how to successfully manage their diabetes. Their doctor or qualified non-physician practitioner must prescribe this training for them for Medicare to cover it. A beneficiary can get diabetes self-management training if they met one (1) of the following conditions during the last twelve (12) months:

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

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

A beneficiary is covered by Medicare to get a total of 10 hours of initial training within a continuous 12-month period. One of the hours can be given on a one-on-one basis. The other 9 hours must be training in a group class. The initial training must be completed no more than 12 months from the time the beneficiary starts the training.

A doctor or qualified non-physician practitioner may prescribe 10 hours of individual training if the beneficiary is blind or deaf, has language limitations, or no group classes have been available within 2 months of the doctor's order. To be eligible for 2 more hours of follow-up training each year after the year the beneficiary received initial training, they must get another written order from their doctor. The 2 hours of follow-up training can be with a group or they may have one-on-one sessions. A doctor or qualified non-physician practitioner must prescribe the follow-up training each year for Medicare to cover it.

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

- General information about diabetes, and the benefits and risks of blood glucose control;
- Nutrition and how to manage ones diet;
- Options to manage and improve blood glucose control;
- Exercise and why it is important to ones health;
- How to take ones medications properly;
- Blood glucose testing and how to use the information to improve ones diabetes control;

- How to prevent, recognize, and treat acute and chronic complications from ones diabetes;
- Foot, skin, and dental care;
- How diet, exercise, and medication affect blood glucose;
- How to adjust emotionally to having diabetes;
- Family involvement and support; and
- The use of the health care system and community resources.

**Note:** If a patient lives in a rural area, they may be able to get DSMT in a Federally Qualified Health Center (FQHC). For more information about FQHCs, visit <http://www.cms.hhs.gov/center/fqhc.asp> on the CMS Web site. FQHCs are special health centers, usually located in urban or rural areas, and they can give routine health care at a lower cost. Some FQHCs are Community Health Centers, Tribal FQHC Clinics, Certified Rural Health Clinics, Migrant Health Centers, and Health Care for the Homeless Programs.

### **Medical Nutrition Therapy (MNT) Services**

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

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

Medicare covers 3 hours of one-on-one medical nutrition therapy services the first year the service is provided, and 2 hours each year after that. Additional MNT hours of service may be obtained if the beneficiary's doctor determines there is a change in their diagnosis, medical condition, or treatment regimen related to diabetes or renal disease and orders additional MNT hours during that episode of care.

### **Foot Exams and Treatment**

If a beneficiary has diabetes-related nerve damage in either of their feet, Medicare will cover 1 foot exam every 6 months by a podiatrist or other foot care specialist, unless they have seen a foot care specialist for some other foot problem during the past 6 months. Medicare may cover more frequent visits to a foot care specialist if a beneficiary has had a non-traumatic (not because of an injury) amputation of all or part of their foot or their feet have changed in appearance which may indicate they have serious foot disease.

### **Hemoglobin A1c Tests**

A hemoglobin A1c test is a lab test ordered by the beneficiary's doctor. It measures how well a beneficiary's blood glucose has been controlled over the past 3 months. Anyone with diabetes is covered for this test if it is ordered by their doctor. Medicare may cover this test when a beneficiary's doctor orders it.

### **Glaucoma Tests**

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

## Special Eye Exam

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

## Supplies and Services Not Covered by Medicare

The Original Medicare Plan and Medicare drug plans (Part D) don't cover everything. Diabetes supplies and services not covered by Medicare include:

- Eye exams for glasses (eye refraction);
- Orthopedic shoes;
- Routine or yearly physical exams (Medicare will cover a one-time initial preventive physical exam (the "Welcome to Medicare" physical exam) within the first 6 months of the beneficiary enrolling in Part B—coinsurance and Part B deductible applies.); and
- Weight loss programs.

## Additional Information

- CMS has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit [http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) on the CMS Web site.
- **Medicare Learning Network**—The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNGenInfo> on the CMS Web site.
- **Patient Resources**—For literature to share with Medicare patients, please visit <http://www.medicare.gov> on the Internet.
- **The National Diabetes Education Program**—NDEP (<http://ndep.nih.gov/>) provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.

If you have questions regarding this issue, refer to the "[Contact Us](#)" page of our Web site and select "Telephone Us" to call the Provider Contact Center.

## 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.



## Clarification on the National Provider Identifier (NPI) Enumerator's Responsibilities

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition 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:** SE0751

**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 physicians, providers, and suppliers who submit claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and Part A/B Medicare administrative contractors (A/B MACs))

### Provider Action Needed STOP – Impact to You

CMS is issuing this *Special Edition* (SE) 0751 article to clarify the type of assistance that the NPI Enumerator can and cannot provide to health care providers.

### CAUTION – What You Need to Know

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

### GO – What You Need to Do

Please share this information with your office staff.

### Background

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

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

Health care providers needing the above types of assistance may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326 or email the request to the NPI Enumerator at

[CustomerService@NPIEnumerator.com](mailto:CustomerService@NPIEnumerator.com) on the Internet. Please note that application processing times may vary based on current inventories. Please allow 15 working days to process your application/updates before contacting the NPI Enumerator.

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

- The NPI Enumerator cannot provide assistance with the Medicare NPI Crosswalk and Medicare claims processing issues.
  - The NPI Enumerator does **not** generate, maintain or have access to the Medicare NPI Crosswalk.
  - The NPI Enumerator does **not** have the means/authority to alter/add/remove any information on the Medicare NPI Crosswalk.
  - The NPI Enumerator **cannot** report problems to CMS or to the Medicare Fee-for-Service contractors concerning the Medicare NPI Crosswalk or claims processing problems.
  - The NPI Enumerator does **not** send updates to the Medicare NPI Crosswalk.
  - The NPI Enumerator does **not** know how/when the Medicare NPI Crosswalk will be updated.
  - The NPI Enumerator **cannot** advise a provider as to how to complete the paper or electronic claim.
  - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- The NPI Enumerator cannot provide assistance with information disseminated or not disseminated via the NPI Registry or the NPPES downloadable file:
  - The NPI Enumerator **cannot** assist providers with questions regarding “temporarily suppressed” information found on the NPI Registry or downloadable file.
  - Although the NPI Enumerator can confirm whether or not the information still exists in the provider’s active NPPES record; this confirmation is limited to the health care provider or contact person on the provider’s NPPES record. Third party sources, including Medicare contractors, **cannot** call the NPI Enumerator for confirmation of information in a health care provider’s NPPES record. If this type of confirmation is needed, the third party should request the information from the provider directly.
- The NPI Enumerator cannot provide assistance with Medicare-related provider enrollment information:
  - The NPI Enumerator **cannot** determine how providers are enrolled with Medicare (e.g., as an individual or as a group).
  - The NPI Enumerator **cannot** determine which identifiers (Unique Physician Identification Number (UPIN), Provider Identification Number (PIN), Online Survey Certification and Reporting System (OSCAR), or National Supplier Clearinghouse (NSC)) should be included on health care providers’ NPPES records.
  - The NPI Enumerator has no way of knowing which type(s) of legacy number(s) were assigned to a provider by the Medicare contractor(s).
  - The NPI Enumerator **cannot** tell a provider how many legacy numbers to report on the NPPES record in order to assist in populating information on the Medicare NPI Crosswalk.
- The NPI Enumerator cannot provide assistance with NPI-to-legacy number linkages (i.e., how to properly link multiple legacy numbers to one NPI or how to properly link one legacy number to multiple NPIs).
- The NPI Enumerator cannot provide assistance with questions related to:
  - Defining subparts;
  - Which subparts should receive NPIs;

- Where NPIs or legacy identifiers are to be placed in claims transactions;
- Health Insurance Portability and Accountability Act (HIPAA) regulations or regulatory policies;
- Proper use of NPIs in transactions with health plans; and
- Determining if the provider is a sole proprietor or an incorporated individual.

### **Additional Information**

CMS advises providers to read the information available at <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS NPI Web site. Included on this site are NPI Frequently Asked Questions and Answers that can assist you with issues for which the NPI Enumerator is not responsible.

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

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## Medicare Provides Coverage for Many Preventive Services and Screenings

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition 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>.

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**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, providers, suppliers, and other health care professionals, who furnish or provide referrals for and/or file claims for Medicare-covered preventive services and screenings provided to Medicare beneficiaries

### Provider Action Needed

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

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

### Introduction

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

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

**Adult Immunizations**

- Influenza (Flu)
- Pneumococcal
- Hepatitis B

**Bone Mass Measurements**

**Diabetes Self Management Training**

**Diabetes Self-Management Training**

**Diabetes Supplies**

**Medical Nutrition Therapy (beneficiaries)**

- Cancer Screenings**
  - Breast (mammogram and clinical breast exam)
  - Cervical & Vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- Cardiovascular Disease Screening**
- Diabetes Screening**
- Glaucoma Screening**
- Initial Preventive Physical Exam (IPPE) (“Welcome to Medicare” Physical Exam)**
- Smoking and Tobacco-Use Cessation Counseling Services**
- Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)**

### Help in Spreading the Word

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

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

### Educational Products and Informational Resources for Health Care Professionals

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

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

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

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

## Bookmark

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

## Brochures

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

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

## Guide

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

## Quick Reference Information Charts

**Medicare Preventive Services** - This two-sided laminated chart, available at [http://www.cms.hhs.gov/MLNProducts/downloads/MPS\\_QuickReferenceChart\\_1.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf), gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifies coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. Available in print or as a downloadable PDF file.

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

**The ABCs of Providing the Initial Preventive Physical Examination** - This two-sided laminated chart at [http://www.cms.hhs.gov/MLNProducts/downloads/MPS\\_QRI\\_IPPE001a.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf) can be used by Medicare FFS physicians and qualified non-physician practitioners as a guide when providing the initial preventive physical examination (IPPE). This handy tool identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information. Available in print and as a downloadable PDF file.

### **Video Program**

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

### **Web-Based Training Courses**

**Medicare Preventive Services Series Web-Based Training (WBT) Course** - This series of three WBT courses has been designed to help fee-for-services providers/suppliers and their staff understand Medicare's coverage and billing guidelines for preventive services and screenings covered by Medicare. To register, to take these WBT courses, free of charge, visit the MLN Product Ordering Page - [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5)

- **Medicare Preventive Services Series: Part 1 Adult Immunizations Web-Based Training (WBT) Course** - This WBT course contains four learning modules that provide information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Information is also included about mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET\* CEU for successful completion.
- **Medicare Preventive Services Series: Part 2 Women's Health Web-Based Training (WBT) Course** - This WBT course contains five learning modules that provide information about Medicare's coverage of mammography services, pap tests, pelvic exams, colorectal cancer screenings, and bone mass measurements. This course was updated October 2007 and has been approved for .2 IACET\* CEUs for successful completion.
- **Medicare Preventive Services Series: Part 3 Expanded Benefits Web-Based Training (WBT) Course** - This WBT course contains seven learning modules that provide information about Medicare's coverage and billing guidelines for the three services added to the Medicare program in 2005, as a result of the Medicare Modernization Act of 2003: the initial preventive physical exam (a.k.a. "Welcome to Medicare" physical exam), and diabetes and cardiovascular disease screenings. The course also includes information about diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as detailed information on colorectal, prostate, and glaucoma screenings, and bone mass measurement services. This course was updated November 2007 and has been approved for .2 IACET\* CEUs for successful completion.

## Web Page

**MLN Preventive Services Educational Products Web Page** - This Medicare Learning Network (MLN) Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS providers/suppliers. PDF files provide product ordering information and links to all downloadable products. This Web page is updated as new product information becomes available. Bookmark this page for easy access.

[http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) on the CMS Web site.

## Other Useful Provider Resources:

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

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

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

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

## 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.



## **Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE SECOND IN A SERIES OF ARTICLES ON THE IACS**

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition 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:** SE0753 Revised

**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

This article contains:

- 4 questions and answers about the registration process for provider organizations. (See NOTE below.)
- Links to the Quick Reference Guides for completing the registration process for provider organizations. (See NOTE below.)

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

### **Provider Types Affected**

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

### **Special Note for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers. Do not register for IACS-PC at this time.**

DMEPOS suppliers may want to review the first MLN Matters article in this new series on IACS-PC, which can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf> on the CMS Web site.

### **Provider Action Needed**

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

### **What Providers Need to Know**

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

### **Registering in IACS-PC**

The provider community is the first in a series of IACS communities which are the front-door to protecting and allowing access to CMS enterprise applications. Communities are comprised of groups of users who provide a similar service to CMS and who need access to similar applications

(ex. Providers need access to provider-related CMS applications). The next community which will become available in early 2008 is the FI/Carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FIs, Carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

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

The first MLN Matters article in this series provided an overview of the IACS-PC registration process as well as registration instructions for Security Officials (SOs) and individual practitioners using IACS-PC personally. This article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf> on the CMS Web site.

**Four Questions and Answers about the Provider Organization Registration Process**

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

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

**2. I want to register as an SO. I do not have my organization's IRS CP-575. What else can I send?**

In addition to the CP-575, SOs may also submit copies of other official IRS documentation. An official IRS document should have the following information:

**Required:**

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

**Optional:**

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

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

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

**All documents received must be legible**

**3. I will work for more than one provider, or serve in multiple roles in the same organization. Do I need to register in IACS separately for each organization or role?**

No. Each user will receive only one IACS-PC User ID and password. If you will work for more than one provider, or have multiple roles in the same provider, register in IACS for one role. Once you receive approval and your user ID and password, you can add additional roles to your account.

Instructions for modifying your IACS profile will be released shortly. In the meantime, questions may be directed to the help desk as shown in the “Additional Help” section at the end of this article.

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

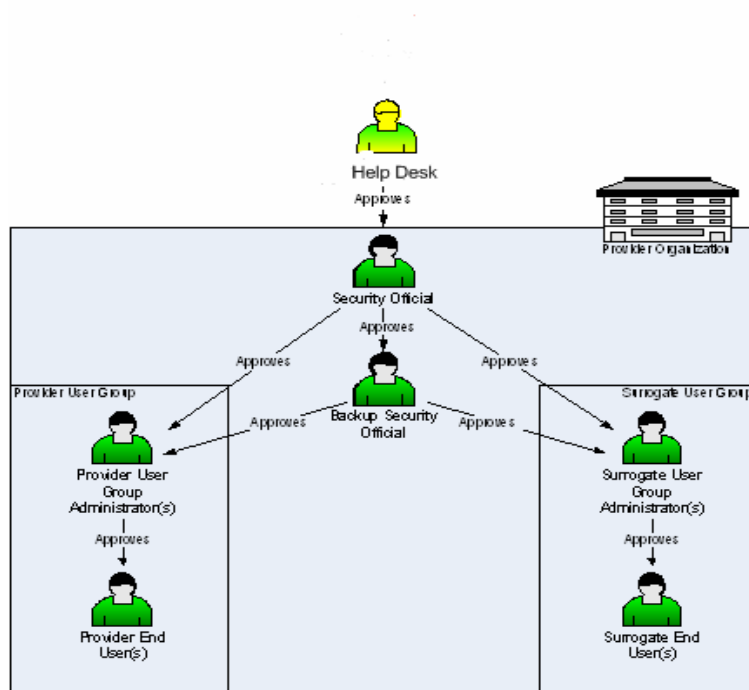
As few as 2 staff can be registered in IACS-PC for a provider organization to access CMS enterprise applications. The first person must register as a Security Official (SO), the second registers as a User Group Administrator (UGA). The UGA may access CMS applications as approved by the SO.

The Backup Security Official is an optional role. End users are only required for provider organizations with 10 or more IACS-PC users.

**If you are an individual practitioner who will be using IACS-PC personally**, please refer to the first MLN article which may be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf> on the CMS Web site.

#### Quick Reference Guides for Completing the Provider Organization Registration Process



## IACS-PC Registration Approval Process

### 1. Backup Security Official (BSO) Guide

BSOs will request access to an organization using the BSO Registration Quick Reference Guide at [http://www.cms.hhs.gov/MMAHelp/downloads/iacs\\_backup\\_security\\_official\\_registration\\_qrg\\_12\\_06\\_07.pdf](http://www.cms.hhs.gov/MMAHelp/downloads/iacs_backup_security_official_registration_qrg_12_06_07.pdf) on the CMS Web site.

### 2. User Group Administrator (UGA) Guide

UGAs are the first user type able to request access to CMS web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.

Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which s/he is responsible, so they should know everyone in their user group.

The UGA Registration Quick Reference Guide may be found at [http://www.cms.hhs.gov/MMAHelp/downloads/iacs\\_user\\_group\\_administrator\\_registration\\_qrg\\_12\\_06\\_07.pdf](http://www.cms.hhs.gov/MMAHelp/downloads/iacs_user_group_administrator_registration_qrg_12_06_07.pdf) on the CMS Web site.

#### *Special note for UGAs of Surrogate User Groups*

A surrogate user group is established by individuals or a company outside of the provider organization which performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: *Surrogate Billing Company ABC will work on behalf of Provider Organization XYZ. Once the Provider Organization XYZ is approved in IACS, the Surrogate Billing Company ABC can register in IACS and request to create a surrogate user group under the Provider Organization XYZ. Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.*

At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of 3 different provider organizations, the UGA for the surrogate user group will need to make 3 different requests to create 3 different surrogate user groups, one for each provider with which the UGA needs to associate. If a provider organization does not appear in IACS-PC, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider appears in IACS-PC.

If the provider organization does appear in IACS-PC, each provider's SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS-PC.

In the future, CMS will explore options for simplifying this process for contractors which perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to Individual Practitioners within IACS.

**3. An End User Registration Quick Reference Guide may be found at**

**[http://www.cms.hhs.gov/MMAHelp/downloads/iacs\\_end\\_user\\_registration\\_qrg\\_12\\_06\\_07.pdf](http://www.cms.hhs.gov/MMAHelp/downloads/iacs_end_user_registration_qrg_12_06_07.pdf) on the CMS Web site.**

**4. Approver Quick Reference Guide**

The Approver Quick Reference Guide provides step-by-step instructions that SOs, BSOs and UGAs will use to approve or deny user requests to register in IACS-PC. The Approver Quick Reference Guide can be found at [http://www.cms.hhs.gov/MMAHelp/downloads/iacs\\_approver\\_qrg\\_12\\_07\\_07.pdf](http://www.cms.hhs.gov/MMAHelp/downloads/iacs_approver_qrg_12_07_07.pdf) on the CMS Web site.

**Next Steps in Accessing a CMS Enterprise Application**

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

**Additional Help**

The CMS has established an end user support (EUS) Help Desk to assist with your access to IACS-PC. The EUS Help Desk may be reached by E-mail at [EUSsupport@cgi.com](mailto:EUSsupport@cgi.com) or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

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

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## **Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): THE THIRD IN A SERIES OF ARTICLES ON THE IACS-PC**

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Special Edition 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:** SE0754

**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

This article contains 3 steps to accessing a CMS Enterprise Provider Application including how to request a provider application role in IACS-PC (See step 2).

### **Provider Types Affected**

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

### **Special Note for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

**suppliers: Do not register for IACS -PC at this time.** DMEPOS suppliers may want to review the first MLN Matters article in a new series on IACS-PC which can be found at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf> on the CMS Web site.

### **Provider Action Needed**

CMS enterprise applications to be made available via the web soon include the Provider Enrollment, Chain and Ownership System (PECOS) and the Provider Statistical and Reimbursement Report (PS&R) System. Even though these new Internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC).

### **What Providers Need to Know**

In the near future, the CMS will be formally announcing new online enterprise applications that will allow Medicare Fee-For-Service (FFS) providers to access, update, and submit information over the Internet.

CMS enterprise applications are those hosted and managed by CMS and for the most part do not include internet applications offered by FI/carrier/MAC. Details of these provider applications will be announced as they become available.

The first article in this series provided an overview of the IACS-PC registration process as well as registration instructions for Security Officials (SOs) and individual practitioners. This article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf> on the CMS Web site.

The second article addressed questions and gave remaining instructions for registering provider organizations including registering as a Backup Security Official (BSO), User Group Administrator (UGA),

and End User (EU). It also discussed approving user requests. This article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf> on the CMS Web site.

**Note: IACS Provider Community (IACS-PC) includes individual practitioners who will be working on their own accord and will not have any other company staff (they may have surrogates or “contractors” who are not their employees which they may contract with to work on their behalf), and also includes “Provider Organizations” defined in IACS as practices, groups, single and multi-specialty offices etc. where the provider may have additional staff in IACS and delegate IACS-PC work to staff as well as their staff using IACS-PC.**

### **The 3 Steps to Access a CMS Enterprise Application**

Provider IACS-PC users must take 3 steps to access a CMS enterprise application:

#### ***Step 1: Be Approved for an IACS-PC Role.***

The first two MLN Matters Articles in this series discussed how to register in IACS-PC.

The purpose of the IACS-PC registration process is to:

- Confirm the identity of the person requesting registration;
- Assure registrants have a legitimate business need to access CMS provider systems;
- Provide the registrant an IACS-PC role (e.g., SO, BSO, UGA, or end User) that defines their responsibilities (if any) for approving the registration requests of others in their organization; and
- Provide the registrant a User ID and Password for IACS-PC.

#### ***Step 2: Be Approved for an Application Role***

After receiving approval for an IACS-PC role, a registered user in a Provider Organization may then request to be an “Application Approver” or an “End User.” (Note: Because Individual Practitioners do work in the application themselves, they do not designate “Application Approver” roles).

This role determines:

- Their responsibilities (if any) to approve application access requests from others in their organization;
- What CMS enterprise applications (if any) they have a legitimate need to access; and
- The appropriate level of access to each application for their job function (which application “role” they require).

Users who received approval in IACS-PC in Step 1, may now request access to specific CMS enterprise applications using their IACS-PC account.

This can be done by requesting either an “Application Approver” or an application “User” role for each application needed to perform Medicare related job functions. For provider applications, there are specific roles within the application that define what the user can do. For example, some application users may be limited to viewing information and printing reports, while others can enter, edit and submit information to CMS. These roles will be specific to each application.

Each user must request a specific application role in IACS-PC for each CMS enterprise provider application they wish to use.

The “Request Access to CMS Application Quick Reference Guide” provides instructions for requesting an application role. It may be found at [http://www.cms.hhs.gov/MMAHelp/downloads/IACS\\_Request\\_Access\\_to\\_CMS\\_Application\\_QRG\\_111607.pdf](http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Request_Access_to_CMS_Application_QRG_111607.pdf) on the CMS Web site.

### **Application Approvers**

Organizations must have designated persons that approve each end user’s request for an application role. The person who performs this task is an “Application Approver” and as such cannot personally access applications for which they serve in this role.

Though the UGA may frequently be the appropriate persons to have this role, organizations have discretion in how they designate the Application Approvers so that it is appropriate for their particular organization. For example, the UGA may be designated by the SO or BSO to serve in this role for their user group, or an end User may be approved for this role by the SO or BSO for the user group with which they are associated.

**Note: If a user group does not have an Application Approver for an application, the requests will, by default, be routed to the SO and BSO for a decision.**

### **Application Approver Key Points**

- An Application Approver must be a member of the user group(s) for which they serve as an Application Approver (this does not apply if the SOs/BSOs is the Application Approver).
- Providers have flexibility in assigning the Application Approver role:
  - The UGA does not have to be the Application Approver within the user group.
  - An end User within a user group may serve in the role of the Application Approver.
  - A different person may serve as an Application Approver in a user group for each application.
  - The same person can be the Application Approver for multiple applications in a user group.
  - The same person can be the Application Approver for multiple user groups (though they must be a member of each group.)
  - There can be multiple Application Approvers for the same application within the same user group. In this situation, the first approver who approves or denies the request will serve as the decision authority. All of the application approvers within the user group do not need to act on each request.
  - A person can be an Application Approver for one application, and an application user for a different application, just not for the same one.
  - If an Application Approver does not exist for an application in a user group, the user group requests for that application will go to the SO and BSO for a decision.
  - Organizations with a large number of IACS-PC users are encouraged to have Application Approvers in each user group for each application (can be the same person) so that all of the application requests are not routed to the SO and BSO as the default application approvers.

***Note: System security requires a “separation of duties” – which means that those who approve user requests for CMS enterprise application roles will not have access to the applications for which they have an approver role. Therefore those in Application Approver roles will not have access to the application for which they are an approver. Security Officials and Backup Security Officials, by definition, can never access any applications as they serve as the default Application Approvers as noted above.***

Instructions for approving Application Approver and application user role requests are the same as for approving IACS-PC registration requests. The Approver Quick Reference Guide may be found at [http://www.cms.hhs.gov/MMAHelp/downloads/iacs\\_approver\\_qrg\\_12\\_07\\_07.pdf](http://www.cms.hhs.gov/MMAHelp/downloads/iacs_approver_qrg_12_07_07.pdf) on the CMS Web site.

***Step 3: Enter the application when it becomes available.***

You will be notified as CMS enterprise applications become available. After you have been approved in steps 1 and 2, you will be able to access available CMS enterprise applications using your approved application specific roles via the CMS Web site.

**Additional CMS Partner and Customer Communities will use IACS**

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

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

**Additional Help**

CMS has established the End User Services (EUS) Help Desk to support access to IACS-PC. The EUS Help Desk may be reached by e-mail at [EUSsupport@cgi.com](mailto:EUSsupport@cgi.com) or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

**COMING SOON**

- CMS enterprise applications to be made available via the web include the Provider Enrollment, Chain and Ownership System (PECOS) and the Provider Statistical and Reimbursement Report (PS&R)
- IACS Web site
- Instructions for modifying your user profile
- What to do if you forget your user ID or password
- Tools for SOs, BSOs and UGAs to manage user accounts

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## **January 2008 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly 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:** MM5852

**Related Change Request (CR) #:** 5852

**Related CR Release Date:** January 8, 2008

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** R1406CP

**Implementation Date:** January 7, 2008

### **Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (Carriers, Durable Medical Equipment 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

### **What You Need to Know**

CR 5852, from which this article is taken, instructs Medicare contractors to download and implement the January 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised January 2007, April 2007, July 2007, October 2007, April 2006, July 2006, and October 2006 files.

### **Background**

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs has been performed by the local contractor.

Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), are paid based on the ASP methodology.

The ASP methodology is based on quarterly data that drug manufacturers submit to the Centers for Medicare & Medicaid Services (CMS), which CMS then provides (quarterly) to Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” have been operationalized in the context of payment under section 1847A.

For the purpose of identifying “single source drugs” and “biological products” subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

1. The FDA approval,
2. Therapeutic equivalents as determined by the FDA, and
3. The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of “not otherwise classified, (NOC)” HCPCS codes.

### **ASP Methodology**

In general, 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% of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on the ASP methodology 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.

### **Summary of Exceptions to this General Rule**

1. Except for blood clotting factors, the payment allowance limits for **blood and blood products** (that are not paid on a prospective payment basis) are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95% of the average wholesale price (AWP) as reflected in the published compendia; and 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 APC to which the product is assigned.

**Note:** 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 a new blood clotting factor when a new blood clotting factor is not included on the ASP file. For 2008, a separate fee of \$0.158 per I.U. of blood clotting factor furnished is payable when 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.

2. Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment (DME)** on or after January 1, 2005, will continue to be 95% of the AWP

reflected in the published compendia as of October 1, 2003, unless the drug is compounded or incident to a professional service. **The payment allowance limits will not be updated in 2008.**

Similarly, 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 AWP unless the drug is compounded or furnished incident to a professional service.

3. The payment allowance limits for **influenza, Pneumococcal and Hepatitis B vaccines** are 95% of the AWP as reflected in the published compendia except, when administered in a hospital outpatient department, the vaccines are paid at reasonable cost.
4. Except for new drugs and biologicals that are produced, or distributed, under a new drug application (or other application) approved by the Food and Drug Administration (FDA), the payment allowance limits for **drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File**, are based on the published wholesale acquisition cost (WAC) or invoice pricing (except under OPPS in which the payment allowance limit is 95% of the published AWP).

In determining the payment limit based on WAC, contractors will follow the methodology specified in the Medicare Claims Processing Manual, Chapter 17, Drugs and Biologicals, for calculating the AWP but will substitute WAC for AWP. The payment limit is 100% of the lesser of the lowest-priced brand or median generic WAC.

5. The payment allowance limits for **new drugs and biologicals** that were first sold on or after January 1, 2005; and are: 1) Produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration, and 2) Not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File; are based on 106% of the WAC (or invoice pricing if the WAC is not published) except under OPPS in which the payment allowance limit is 95% of the published AWP.
6. The payment allowance limits for **radiopharmaceuticals** are not subject to the ASP payment methodology. Contractors should determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.
7. The payment methodology for **drugs furnished incident to the filling or refilling of an implantable pump or reservoir** is determined under the ASP methodology (as described above) unless the drug furnished incident to the filling or refilling of an implantable pump or reservoir is a compounded drug, then pricing is performed by the local contractor.

Physicians (or a practitioner described in Section 1842(b) (18) (C)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary that they perform the service. 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.

On or after December 18, 2007, the January 2008 ASP file and ASP NOC files will be available for retrieval from the CMS ASP webpage. If CMS determines that revisions to the January 2007, April 2007, July 2007, October 2007, April 2006, July 2006 and October 2006 ASP payment files are necessary, the revised files will also be available for retrieval from the CMS webpage on or after December 18, 2007. The revised payment files will be applied to claims processed or reprocessed on or after this CR’s (5852) effective date.

Table 1 below displays the payment allowance limit revision dates, and the applicable dates of service.

**Table 1**

<b>Payment Allowance Limit Revision Date</b>	<b>Applicable Dates of Service</b>
January 2008	January 1, 2008 through March 31, 2008
Revised January 2007*	January 1, 2007 through March 31, 2007
Revised April 2007*	April 1, 2007 through June 30, 2007
Revised July 2007*	July 1, 2007, through September 30, 2007
Revised October 2007*	October 1, 2007 through December 31, 2007
Revised April 2006*	April 1, 2006 through June 30, 2006
Revised July 2006*	July 1, 2006, through September 30, 2006
Revised October 2006*	October 1, 2006, through December 31, 2006

\*If made available by CMS

**Note:** The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

**Final Notes:** The absence or presence of a 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.

Contractors (at their discretion) may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files, or that CMS has not otherwise made available on its website. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

Contractors will not search for, and adjust, a claim that has already been processed unless you bring it to their attention.

**Implementation**

The implementation date is January 7, 2008.

**Additional Information**

For complete details, please see the official instruction (CR 5852) issued to your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change, by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1406CP.pdf> on the CMS Web site.

If you have any questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## **Medicare Payment for Pre-administration-Related Services Associated with Intravenous Immune Globulin (IVIG) Administration—Payment Extended through CY 2008**

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:** MM5713

**Related Change Request (CR) #:** 5713

**Related CR Release Date:** September 1, 2007

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** R1338CP

**Implementation Date:** January 7, 2008

### **Provider Types Affected**

Physicians or hospital outpatient facilities billing Medicare contractors (carriers, fiscal intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services related to the pre-administration of Intravenous Immune Globulin (IVIG) for Medicare beneficiaries.

### **Provider Action Needed**

In 2006 and 2007, Medicare made a separate payment to physicians and hospital outpatient departments for pre-administration-related services associated with administration of IVIG, Healthcare Common Procedure Coding System (HCPCS) code G0332.

### **What You Need to Know**

CR5713, from which this article was taken, states that the Centers for Medicare & Medicaid Services (CMS) is **extending the temporary IVIG pre-administration-related services payment to hospital outpatient departments and physicians that administer IVIG through calendar year (CY) 2008**. This IVIG pre-administration service can only be billed by the physician or outpatient hospital providing the IVIG infusion once per patient per day of IVIG administration. **For services on or after January 1, 2008, the service must be billed on the same claim form as the IVIG product (J1566, J1568, J1569, J1561 and/or J1572) and have the same date of service as the IVIG product and a drug administration service.**

### **What You Need to Do**

Make certain that your billing staff is aware of these billing requirements.

### **Background**

Under Section 1861(s)(1) and 1861(s)(2), Medicare Part B covers IVIG administered by physicians in physician offices and by hospital outpatient departments. More specifically, when you administer IVIG to a Medicare beneficiary in the physician office or hospital outpatient department, Medicare makes separate payments to the physician or hospital for both the IVIG product itself and for its administration via intravenous infusion.

This payment is for the additional pre-administration-related services required to locate and acquire adequate IVIG product during this current period where there may be potential market issues.

As a reminder, here are some important details that you should know:

- The policy and billing requirements concerning the IVIG pre-administration-related services payment are the same in 2008 as they were in 2007 and 2006.
- This IVIG pre-administration service payment is in addition to Medicare’s payments to the physician or hospital for the IVIG product itself and for its administration by intravenous infusion.
- Medicare Carriers, FIs, or A/B MACs will pay for these services, that are provided in a physician office, under the physician fee schedule; and FIs or A/B MACs will pay for them under the outpatient prospective payment system (OPPS), for hospitals subject to OPPS (bill types: 12x, 13x) or under current payment methodologies for all non-OPPS hospitals (bill types: 12x, 13x, 85x).
- You need to use HCPCS code G0332, Pre-administration-Related Services for IVIG, to bill for this service.
- You can bill for only one IVIG pre-administration per patient per day of IVIG administration.
- For services on or after January 1, 2008, the service must be billed on the same claim form as the IVIG product (HCPCS codes J1566, J1568, J1569, J1561, and/or J1572) and have the same date of service as the IVIG product and a drug administration service. Physicians’ claims will be rejected as unprocessable and hospital claims will be returned by your FI, carrier, or A/B MAC if one of the IVIG product HCPCS codes is not included with G0332 for that date of service. In doing so, the contractor will use one or both of the following codes:
  - M67-“Missing other procedure codes;” and/or
  - 16-“Claim/service lacks information which is needed for adjudication.”
- Physicians’ claims will be rejected as unprocessable and hospital claims will be returned for pre-administration-related services by your FI, carrier, or A/B MAC if more than 1 unit of service of G0332 is indicated on the same claim for the same date of service. They will use the appropriate reason/remark code such as:
  - M80-“Not covered when performed during the same session/date as a previously processed service for the patient;” and/or
  - B5-“Payment adjusted because coverage/program guidelines were not met or were exceeded.”

**Note: The definition for J1566 is changed effective January 1, 2008. The new definition is “Injection, immune globulin, intravenous, lyophilized (e.g., powder), NOS, 500MG.**

### **Additional Information**

For complete details regarding this issue, please see the official instruction (CR5713) 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/R1338CP.pdf> on the CMS Web site.

You may also want to view CR 5635, which implemented HCPCS Coding Changes for Immune Globulin, effective for services on or after July 1, 2007. For the article related to this CR, please visit <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM5635.pdf> on the CMS site.

If you have any questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## Reprocessing of Certain Inpatient Hospital Prospective Payment (IPPS) Claims

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:** MM5845

**Related CR Release Date:** January 4, 2008

**Related CR Transmittal #:** R405CP

**Related Change Request (CR) #:** 5845

**Effective Date:** October 1, 2007

**Implementation Date:** February 4, 2008

### Provider Types Affected

Hospitals that bill Medicare fiscal intermediaries (FI) or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries

### What Providers Need to Know

CR 5845, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) has corrected the incorrect listing of twenty five diagnostic related groups (DRG) in the regular post acute care transfer list, which had resulted in transfer claims for these DRGs receiving an incorrect payment.

Please note that FIs and A/B MACs will reprocess your claims that contain these 25 DRGs. **You need take no action to initiate the reprocessing of the claims.**

In addition, CR 5845 also contains revisions to the wage indices (WI) for a few core based statistical areas (CBSA). You should make sure that your billing and reimbursement staffs are aware of these revisions and understand that they will necessitate the adjustment of a few hospital claims. **Providers impacted by these changes should note that your FI or A/B MAC will reprocess the affected claims. You need take no action to initiate the reprocessing of the claims.**

### Background

The post acute care transfer DRGs that should receive a special pay transfer payment have been receiving a payment error. CR 5845, from which this article is taken, announces CMS' correction of this error within the inpatient hospital prospective payment (IPPS) Pricer.

These twenty five DRGs (28, 29, 30, 40, 41, 42, 219, 220, 221, 477, 478, 479, 480, 481, 482, 492, 493, 494, 500, 501, 502, 515, 516, 517, and 956) are considered fiscal year 2008, "special pay" DRGs within the post acute care (PAC) transfer policy. Further, you should note that in a PAC transfer situation, claims are paid 50% of the appropriate PPS rate for the first day of the stay and 50% of the graduated per diem rate for each day of the stay up to the full DRG.

You may want to refer to the regulations at 42 CFR 412.4(f)(2) for additional information.

CR 5845 also announces that CMS has made changes to a few CBSA wage indices based on the October 10, 2007 correction notice to the FY 2008 Inpatient Hospital Prospective Payment IPPS final rule (72 FR 57634), and a subsequent correction notice that will be published in the Federal Register in early November, 2007. In accordance with the regulations at 42 CFR 412.64(k)(1), these corrections are retroactive to October 1, 2007.

These WI changes impact certain providers in CBSAs 13820, 26620, 16180, 39900, 16974, 14484, and 53. The specific hospitals affected and their revised WIs and geographic adjustment factors (GAF) are listed in CR5845, which can be seen at the Web address provided in the next section of this article.

### **Additional Information**

You can find more information about the correction of post acute care transfer DRG payment errors and of the specific revised CBSA wage indices by going to CR 5845, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1405CP.pdf> on the CMS Web site.

If you have any questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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## **How to Handle the National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims—Revised**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) article entitled “How to Handle the National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service Facility for Medicare Claims,” which was published in the December 1, 2007, *Home Health & Hospice Medicare A Newslines*. 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:** MM5674 Revised  
**Related CR Release Date:** October 26, 2007  
**Related CR Transmittal #:** R225PI

**Related Change Request (CR) #:** 5674  
**Effective Date:** May 23, 2008  
**Implementation Date:** April 7, 2008

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

### **Provider Types Affected**

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

### **What Providers Need to Know**

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

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

### **Key Points**

- Medicare will not pay for referred/ordered services or items unless the name and NPI number of the referring/ordering/attending/operating/other/service facility provider is on the claim.
- It is the responsibility of the claim/bill submitter to obtain the ordering/referring/attending/operating/other/service facility NPI for health care providers.
- Providers whose business is largely based upon provision of services or items referred/ordered by other providers must be careful furnishing such services/items unless they first obtain the NPI of the referring/ordering individual. If they furnish services/items and do not obtain that person’s NPI prior to billing Medicare, their claim will be denied.

- If the NPI is not directly furnished by the ordering/referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/her NPI prior to delivery of the services/items.
- Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries.
- Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.
- Physicians and the following non physician practitioners are the only types of providers allowed to refer/order services or items for beneficiaries:
  - Nurse practitioners (NP);
  - Clinical nurse specialists (CNS);
  - Physician assistants (PA); and
  - Certified nurse midwives (CNM).

### **Background**

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

### **Additional Information**

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

You may see the official instruction (CR 5674) issued to your Medicare A/B MAC, DME MAC, FI, or carrier by going to <http://www.cms.hhs.gov/Transmittals/downloads/R225PI.pdf> on the CMS Web site.

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## Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2008

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:** MM5827

**Related Change Request (CR) #:** 5827

**Related CR Release Date:** December 7, 2007

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** R1389CP

**Implementation Date:** January 7, 2008

Physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for ESRD services provided to Medicare beneficiaries.

### Provider Action Needed

#### STOP – Impact to You

This article is based on Change Request CR 5827 which provides payment updates for ESRD facilities.

### CAUTION – What You Need to Know

ESRD facilities payment changes include a growth update to the drug add-on adjustment to the composite rate and an update to the wage index adjustments to reflect current wage data, including a revised budget neutrality adjustment. CR 5827 also clarifies weight calculation instructions for double amputee dialysis patients.

### GO – What You Need to Do

See the Background and Additional Information of this article for further details regarding these updates and clarifications.

### Background

The Social Security Act (Section 1881(b)), as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 623), directed revisions to the composite rate payment system as well as payment for separately billable drugs furnished by ESRD facilities.

For calendar year (CY) 2008, the CMS did not propose any significant changes to composite rate payment methodology.

However, with CR 5827, CMS makes the following payment changes (effective January 1, 2008) to ESRD facilities, and upon the implementation of CR 5827, these payment changes will be applied to all Medicare certified ESRD facilities:

- **Update the drug add-on adjustment to the composite rate for 2008 of 0.5 percent. As a result, the drug add-on adjustment to the composite payment rate for 2008 will increase from 14.9 percent to 15.5 percent; and**

- **Update the wage data, and implement the third year of the wage index transition using a 25/75 blended wage adjusted composite rate.**

#### **Wage Index Transition Example:**

An ESRD facility has a wage-adjusted composite rate (without regard to any case-mix adjustments) of \$135.00 per treatment in CY 2007. Using Core Based Statistical Area (CBSA) based geographic area designations, the facility's CY 2008 wage-adjusted composite rate, reflecting its wage index value, would be \$145.00. During the third year (CY 2008) of the 4-year transition period to the new CBSA based wage index values, this facility's blended rate would be calculated as follows:

CY 2008:  $(0.25 \times \$135.00) + (0.75 \times \$145.00) = \$142.50$ .

CR 5827 also clarifies weight calculation instructions for double amputee dialysis patients. Previously reported in CR 4196, the requirement for value code A8 (Weight) is that it should be calculated with pre-amputation weight. In CR 4196, the formula for pre-amputation weight was incorrectly stated as actual weight x 1.5. The correct formula for pre-amputation weight is actual weight x 1.15. Through CR 5827, the instruction for how to calculate the height and weight of double amputee dialysis patients is being placed into Publication 100-04, which is the *Medicare Claims Processing Manual*.

#### **Additional Information**

The official instruction, CR 5827, issued to your Medicare FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1389CP.pdf> on the CMS Web site.

If you have any questions regarding this issue, refer to the "[Contact Us](#)" page of our Web site and select "Telephone Us" to call the Provider Contact Center.

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## **The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year (FY) 2006 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)**

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:** MM5846

**Related CR Release Date:** December 14, 2007

**Related CR Transmittal #:** R1396CP

**Related Change Request (CR) #:** 5846

**Effective Date:** January 4, 2008

**Implementation Date:** January 4, 2008

### **Provider Types Affected**

IPPS hospitals, IRFs, and LTCHs submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries

### **Provider Action Needed**

This article is based on Change Request (CR) 5846 which 1) provides updated Supplemental Security Income (SSI)/Medicare beneficiary data for determining additional payment amounts for hospitals with a disproportionate share of low income patients and 2) furnishes links to the electronic files containing the data used for interim payments and for cost settlement purposes.

### **Background**

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA; Section 9105) provides additional payment amounts for Inpatient Prospective Payment System (IPPS) hospitals with a disproportionate share of low-income patients. This is done by making adjustments to the prospective payment rate.

Under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS), IRFs receive additional payment amounts to account for the cost of furnishing care to low-income patients (See 42 CFR §412.624(e)(2) at <http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi> on the internet). This is done by making adjustments to the prospective payment rate. The SSI data is updated on an annual basis, and these data are one of the components used to determine an appropriate low-income percentage adjustment for each IRF.

Under the Long Term Care Hospital Prospective Payment System (LTCH PPS), the payment adjustment for short-stay outlier (SSO) cases is based on the calculation of an amount comparable to equivalent to an amount that would otherwise be paid under the IPPS, i.e., the “IPPS comparable amount.” (See 42 CFR §412.529 at <http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi> on the internet). The calculation of the “IPPS comparable amount” in the LTCH PPS SSO payment adjustment includes an IPPS comparable adjustment for the costs of serving a disproportionate share of low-income patients, where applicable, which utilizes SSI data (see §412.529(d)(4)). The best available SSI data are used in this calculation and generally is updated on an annual basis.

CR5846 provides links to the electronic files containing updated SSI/Medicare beneficiary data for determining additional payment amounts for hospitals with a disproportionate share of low-income patients.

The data are used for settlement purposes for IPPS hospitals and Inpatient Rehabilitation Facilities (IRFs) with cost reporting periods beginning during FY 2006 (cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006).

The files are located at the following CMS Web site addresses:

- The IPPS data is available at [http://www.cms.hhs.gov/AcuteInpatientPPS/05\\_dsh.asp#TopOfPage](http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage) on the CMS Web site;
- The IRF PPS data is at [http://www.cms.hhs.gov/InpatientRehabFacPPS/05\\_SSIData.asp#TopOfPage](http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopOfPage) and The LTCH PPS data is at [http://www.cms.hhs.gov/LongTermCareHospitalPPS/08\\_download.asp#TopOfPage](http://www.cms.hhs.gov/LongTermCareHospitalPPS/08_download.asp#TopOfPage).

Note that the cost settlement requirements (requirements 5846.2 and 5846.3) in CR5846 do not apply to LTCH PPS as the SSI ratio is only used in determining the payment adjustment for short stay outlier cases.

### **Additional Information**

The official instruction, CR5846, issued to your Medicare FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1396CP.pdf> on the CMS Web site.

If you have any questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

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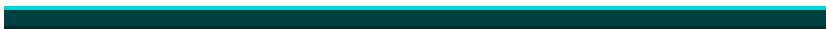
### **Availability of the Provider Contact Center**

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). 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*.

<b>CSR Training Date</b>	<b>Time</b>
February 8, 2008	9:00 a.m.–11:00 p.m. CT
February 29, 2008	9:00 a.m.–11:00 p.m. CT
March 7, 2008	9:00 a.m.–11:00 p.m. CT
March 28, 2008	9:00 a.m.–11:00 p.m. CT

### **February Federal Holiday**

In observance of the federal holiday, President's Day, Monday, February 18, 2008, the Provider Contact Center will not be available. The Fiscal Intermediary Standard System (FISS) will be available and providers can submit claims and receive reports electronically. The Interactive Voice Response (IVR) unit will also be available to providers to check beneficiary eligibility or the status of claims.



### **Update to the 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 billing 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](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.



### **Skilled Nursing Facility Prospective Payment System Fact Sheet**

The Skilled Nursing Facility Prospective Payment System Fact Sheet (October 2007), which provides the elements of the Skilled Nursing Facility Prospective Payment System, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit <http://www.cms.hhs.gov/mlngeninfo/>, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." If the URL above does not take you directly to the MLN product ordering page, please copy and paste the URL into your web browser.

## **Cahaba GBA, LLC Learning Corner**

### **February 2008 Education Events**

To register go to the "[Calendar of Educational Events](#)" page on our Web site. Select the event title for registration instructions.

#### **["FISS 201: Exploring Eligibility and Mapping FI Claim Entry"](#) Webinar**

**Date:** February 7, 2008

**Time:** 1:00-3:00 p.m. Central Time

**Registration Deadline:** February 1, 2008

**Intended Audience:** This event is tailored for Part A providers and staff (except home health and hospice).

**Description:** This event will demonstrate how to use the eligibility screens ELGH/ELGA to determine Medicare eligibility for Medicare-covered hospital and skilled nursing facility (SNF) services, and how to use the Fiscal Intermediary Standard System (FISS) to submit Medicare Part A claims.

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#### **["FISS 301: The Billing World Series"](#) Webinar**

**Date:** February 19, 2008

**Time:** 1:00-3:00 p.m. Central Time

**Registration Deadline:** February 14, 2008

**Intended Audience:** This event is tailored for all Medicare Part A providers and staff.

**Description:** This Webinar will discuss the Fiscal Intermediary Standard System (FISS), specifically addressing the FISS resources, FISS shortcuts and how to submit your roster bills in FISS. This session will also address Medicare Secondary Payer (MSP), determining whether Medicare is primary or secondary and how to use FISS to submit the most common types of MSP claims.

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#### **["FISS 401: Did I Do That?"](#) Webinar**

**Date:** February 26, 2008

**Time:** 1:00-3:00 p.m. Central Time

**Registration Deadline:** February 21, 2008

**Intended Audience:** This event is tailored for all Medicare Part A providers and staff.

**Description:** This Webinar will discuss using the Fiscal Intermediary Standard System (FISS) to correct claims that have gone to the Return to Provider (RTP) file, adjust claims and cancel claims.

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<b>Course Title</b>	<b>Description</b>
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.
FISS 101: Introduction to FISS	Learn how to access FISS and receive an overview of FISS functions.
Insight into Medicare Coding	Learn the basics about Medicare coding.
Introduction to Medicare Cost Report	Learn the basics about the Medicare Cost Report.
Medicare Secondary Payer	Learn the basics of Medicare Secondary Payer.
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 identify various eligibility information by using ELGA and ELGH.

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](#).