

# Home Health & Hospice Medicare A Newsline



Important Information from Cahaba Government Benefit Administrators®, LLC

February 1, 2008





















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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: [www.cahabagba.com](http://www.cahabagba.com)











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#### Key for Icons:



Home Health Providers



Hospice Providers

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## News Flash Messages from CMS for Home Health and Hospice Providers



### It's seasonal flu time again!

If you have Medicare patients who haven't yet received their flu shot, you can help them reduce their risk of contracting the seasonal flu and potential complications by recommending an annual influenza and a one-time pneumococcal vaccination. Medicare provides coverage for flu and pneumococcal vaccines and their administration. – And don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. **Get Your Flu Shot – Not the Flu!** Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of adult immunizations and related provider education resources, by reviewing *Special Edition MLN Matters* article SE0748

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



### Understanding the Remittance Advice

“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 Web site.



### **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.



### **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.)



### **National Provider Identifiers (NPIs)**

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.



### **New Preventive Services Brochure Entitled Cancer Screenings**

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 Web site.

## *News from CMS for Home Health and Hospice Providers*



### **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), regional home health intermediaries (RHHIs), 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 Action (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.

### **Disclaimer**

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



## Update to Medicare 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 Change Request (CR) #:** 5830

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

**Effective Date:** January 1, 2008

**Related CR Transmittal #:** R49GI

**Implementation Date:** January 7, 2008

### Provider Types Affected

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

### What You Need to Know

CR 5830, from which this article is taken, instructs Medicare contractors to update the claims processing system with new Medicare rates for deductible, coinsurance and premium payment amounts for 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 an 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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**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  
**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

This article contains:

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

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

### **Provider Types Affected**

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

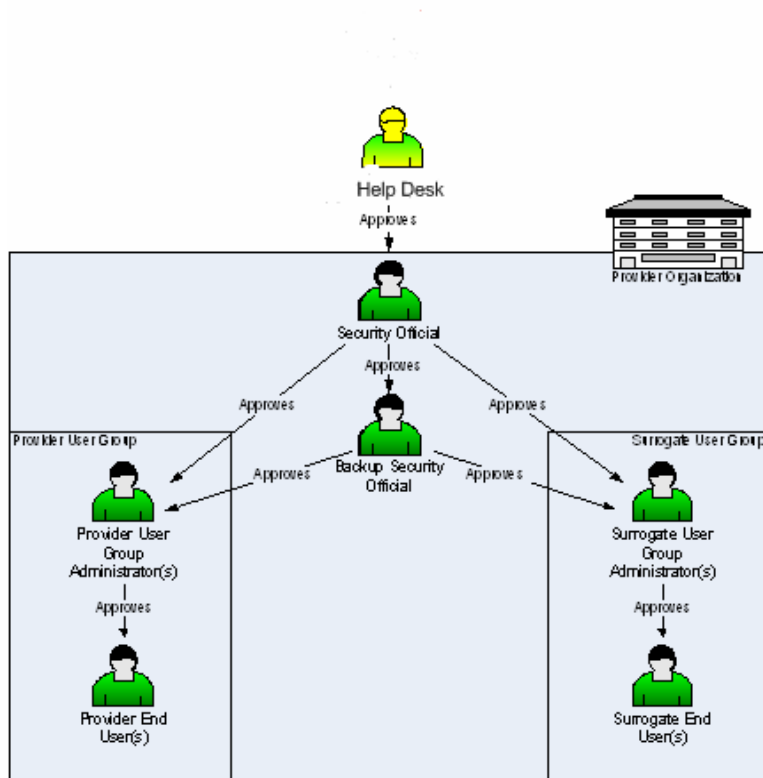
### **4. My organization is too small to fill all these roles. What should I do?**

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.

## Disclaimer

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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 CR Release Date:** N/A

**Related CR Transmittal #:** N/A

**Related Change Request (CR) #:** N/A

**Effective Date:** 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 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. <ol style="list-style-type: none"> <li>1. Assign to procedures subject to 50% of off-set, when modifier FC is present.</li> <li>2. Reduce APC payment rate by 50% of offset amount before application of discounting logic.</li> </ol>
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
8/1/00	Bypass edit 48 for rev codes 099x. Assign edit 9 (SI-E) if submitted without a HCPCS.
10/1/07	Rescind previous program modification - re-apply edit 71 to bill type 12x.
1/1/07	Modify the program to exclude bill type 12x from edit 77 (change effective date from 10/1 to 1/1/07).
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> Return “0” in the payment APC/ASC field.

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

**Related CR Transmittal #:** R1391CP

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

**Effective Date:** January 1, 2008

**Implementation Date:** January 7, 2008

## Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHIs), 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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## 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 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 OPPOS.

### **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 percent 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 OPPOS 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 percent 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 percent 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 percent 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 percent of the WAC (or invoice pricing if the WAC is not published) except under OPPS in which the payment allowance limit is 95 percent 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 Web page. 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 Web site 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**

Payment Allowance Limit Revision Date	Applicable Dates of Service
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 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.



## 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), regional home health intermediaries (RHHIs), 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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## 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>

**MLN Matters Number:** SE0752

**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**
- Cancer Screenings**
  - Breast (mammogram and clinical breast exam)
  - Cervical & Vaginal (Pap test & pelvic exam)
  - Colorectal
  - Prostate
- Cardiovascular Disease Screening**
- Diabetes Screening**
- Diabetes Self Management Training**
- Diabetes Self-Management Training**
- Diabetes Supplies**
- Medical Nutrition Therapy (beneficiaries diagnosed with diabetes or renal disease)**
- Glaucoma Screening**
- Initial Preventive Physical Exam (IPPE) (“Welcome to Medicare” Physical Exam)**
- Smoking and Tobacco-Use Cessation Counseling Services**
- Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)**

### Help in Spreading the Word

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

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

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

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

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

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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.

### Disclaimer

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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 CR Release Date:** December 21, 2007

**Related CR Transmittal #:** R79NCD

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

**Effective Date:** September 10, 2007

**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 MAC), 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.

## Disclaimer

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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 Change Request (CR) #:** 5834

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

**Effective Date:** September 25, 2007

**Related CR Transmittal #:** R78NCD

**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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## 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 Newsline*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at:

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

**MLN Matters Number:** 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), regional home health intermediaries (RHHIs), 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.

## Disclaimer

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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, *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:** 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), regional home health intermediaries (RHHIs), 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, or \$135 in 2008), and the beneficiary pays 20 percent of the total payment amount (after the annual Part B deductible of \$131 in 2007, or \$135 in 2008). 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.



## **Reporting of Additional Data to Describe Services on Hospice Claims—Revised**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) article entitled “Reporting of Additional Data to Describe Services on Hospice Claims,” which was published in the December 1, 2007, *Home Health & Hospice Medicare A Newsline*. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at:

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

**MLN Matters Number:** MM5567 Revised

**Related CR Release Date:** December 18, 2007

**Related CR Transmittal #:** R1397CP

**Related Change Request (CR) #:** 5567

**Effective Date:** January 1, 2008 (optional); July 1, 2008 (mandatory)

**Implementation Date:** January 7, 2008

**Note:** This article was revised on December 26, 2007, to reflect that CMS revised CR 5567. The CR transmittal date, transmittal number, and Web address for accessing CR 5567 were changed. Previously, this article was revised on November 2, 2007, to amend the effective date for mandatory reporting by hospices. The mandatory reporting date for these changes is July 1, 2008. As of January 1, 2008, hospices have the option to begin reporting the data. These changes were made as CMS re-issued CR 5567 on November 2. All other information remains the same.

### **Provider Types Affected**

Hospices billing Medicare regional home health intermediaries (RHHIs) for hospice services provided to Medicare beneficiaries.

### **Provider Action Needed**

#### **STOP – Impact to You**

This instruction, CR 5567, requires hospices to report an **expanded level of claims data** for Medicare payments that describe the services provided in the course of delivering **each hospice level of care billed**.

#### **CAUTION – What You Need to Know**

CR 5567 provides instructions for the expansion of required data on hospice claims.

#### **GO – What You Need to Do**

Make certain that your billing staffs are aware of these changes as listed in the Key Points below and in the revisions to the *Medicare Claims Processing Manual* (CMS Pub. 100-04) Chapter 11, §§30.1 and 30.3. The revised manual sections are attached to the official instruction in CR 5567. The Web address for accessing CR 5567 is in the “Additional Information” section of this article.

### **Background**

Historically, billings by institutional providers to Medicare fiscal intermediaries contained limited service line information. Claim lines on a typical institutional claim in the 1980s or early 90s may have reported only a revenue code, a number of units, and a total charge amount.

Over the last decade, legislated payment requirements have changed and Medicare has implemented increasingly complex payment methods. These changes have required more line item detail on claims for most institutional provider types, such as line item dated services, reporting HCPCS codes and modifiers, and submission of non-covered charges. This detail has supported the payment requirements of legislated payment systems and also improved the quality and richness of Medicare analytic data files.

Hospice claims have been an exception to this process. Since the inception of the hospice program in 1983, hospices have been required to submit on Medicare claims only a small number of service lines to report the number of days at each of the four hospice levels of care. HCPCS coding was required only to report procedures performed by the beneficiary's attending physician if that physician was employed by the hospice. CMS believes that this limited claims data has restricted Medicare's ability to ensure optimal payment accuracy in the hospice benefit, and to carefully analyze the services provided in this growing benefit.

### **Key Points**

Effective for service dates on or after January 1, 2008, hospice providers may begin to report data on their claims for Medicare payments that describe the services provided in the course of delivering each hospice level of care billed. As of July 1, 2008, such reporting is mandatory. Specifically:

For each week, beginning on Sunday and ending on Saturday, hospice providers are to indicate the number of services/visits provided by nurses (registered, licensed and/or nurse practitioner), home health aides, social workers, physicians, and nurse practitioners serving as the beneficiary's attending physician.

- Each line shall reflect the total number of direct patient care visits for each category and not as an aggregate total for all.
- A service/visit constitutes direct care to the beneficiary. An entry in a medical record without a visit does not constitute a visit and as such is not counted.
- Rounds in facilities do not constitute a visit and as such are not counted. Items and services provided within a visit are not counted as separate items.
- Only the number of direct patient care visits are counted and all items and services within that visit are not separately counted.
- If the site of service changes, a separate line will be required to reflect the site where the direct patient care visit was made.
- To be counted a service/visit must be medically reasonable and necessary and this applies in circumstances where separate billing for physician or nurse practitioner, serving as the attending physician.
- For the nurse, home health aide and social worker, the weekly total of services/visit by discipline are not for the purpose of separate payment but to provide transparency into the services that are being provided to beneficiaries who are electing the Medicare hospice benefit.

### **Codes**

Effective on claims with dates of service on or after January 1, 2008, hospices may report the services (effective July 1, 2008, reporting is mandatory) that were provided to the beneficiary in the course of delivering the hospice levels of care billed with the codes listed below.

- Medicare systems will allow revenue codes 055X, 056X and 057X on types of bill 81X and 82X.
- Medicare systems require 055X, 056X and 057X revenue code lines reported on types of bill 81X and 82X to contain units and charges.
- Medicare systems will accept one or more 055X, 056X or 057X revenue code lines associated with each hospice level of care revenue code (0651, 0652, 0655, 0656).
- Medicare systems will accept for each hospice level of care revenue code that there is one or more 055X, 056X or 057X revenue code lines with a date of service equal to or later than the date of that level of care revenue code and prior to the date of the next level of care revenue code. Medicare systems will not make payment on 055X, 056X or 057X revenue code lines.

- Medicare systems will reflect the charges associated with each 055X, 056X or 057X revenue code as paid under the all-inclusive payment for the associated level of care revenue code line and Medicare systems will change any charges and units associated with each 055X, 056X, or 057X revenue code to be noncovered.
- Medicare systems will reflect bundling of services into level of care revenue codes on the remittance advice with reason code 97. Reason code 97 is defined as “Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.”
- Medicare systems will not allow reporting of V-codes as the principal diagnosis on hospice claims and will return claims to the provider if a V-code is reported as the principal diagnosis.

**Special Reminder: The site of service code Q5003 is to be used for skilled nursing facility residents in a non Medicare covered stay, while Q5004 is to be used for skilled nursing facility residents in a Medicare covered stay.**

The revised manual section 30.3 also contains clarification for the entry of other fields on the claim as well and providers should review this revised section to assure accurate claims submission.

### **Additional Information**

For complete details regarding CR 5567, please see the official instruction, including the revised sections of the *Medicare Claims Processing Manual*, issued to your Medicare RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1397CP.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.

Transmittal 1011 (CR 5245) was implemented effective January 1, 2007, and that transmittal represented a first phase in the expansion of line level detail information requirements on hospice claims. It required codes describing the location where hospice levels of care were delivered and created line item dating requirements for continuous home care level of care. CR 5245 can be viewed at <http://www.cms.hhs.gov/MLNMArticles/downloads/MM5245.pdf> on the CMS Web site.

In addition, refer to the [Hospice Educational Materials](#) page on our Web site for more information.

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### **Updated Top Inquiries Frequently Asked Questions (FAQs)**

The FAQs for the top inquiries received in Cahaba 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.



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

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 Home Health Local Coverage Determination – Speech-Language Pathology**

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

- **Speech-Language Pathology – Home Health**

Revision # 6

Effective Date: February 1, 2008

#### **Narrative:**

- Removed additional outpatient-related information not previously removed.

- In the “Indications and Limitations of Coverage and/or Medical Necessity” section, information under the “Unskilled Procedures” and “Group Therapy” headings was removed.
- In the “CPT/HCPCS Codes” section, the following information was added: “As of July 1999, speech-language pathologists must report time spent with the patient in 15-minute increments. The following code should be used by speech-language pathology: G0153: Services of speech and language pathologist in home health setting, each 15 minutes,” and “The following CPT codes addressed in this policy are for informational and descriptive purposes only:”
- In the “Documentation Requirements” section, all the information was removed under the “Components of Documentation” headings, sections B(1) and (2) related to certification/recertification and physician recertification; and sections D, E, and F, related to treatment objectives, frequency of visits, and estimated duration of treatment.

Please update your records.

## *News from Cahaba GBA, LLC for Hospice Providers*



### **Hospice Certification/Recertification of Terminal Illness**

To be eligible to elect the Hospice Benefit under Medicare, an individual must be entitled to Medicare Part A benefits and be certified as being terminally ill. The patient must continue to be recertified as terminally ill at the start of each new benefit period. There are no standardized forms for this certification; however, the written certification must include:

1. A statement that the individual’s medical prognosis is that their life expectancy is six months or less if the terminal illness runs its normal course;
2. Specific clinical findings and other documentation supporting a life expectancy of six months or less; and
3. The signature(s) of the physician(s) (e.g., Medical Director and/or the patient’s attending physician).

The actual dates for the certification period for which the physician is signing must be clearly stated on the form. Simply having the statement “third benefit period” is not enough to be able to tell which certification period the physician is signing. Each certification period must have the exact certification dates listed. For example “recertification statement for the period 3/1/07-4/29/07” is acceptable; however, “Recertification statement, 3rd benefit period” is not acceptable.

If the date span for which the physician is certifying cannot be identified, your claim may be denied. Please take the time to review your agency’s certification and recertification forms and make sure there is a place on the form to document the exact certification period dates.

For more information on certification of terminal illness, see the [Medicare Benefit Policy Manual \(CMS Pub. 100-02\), Ch. 9](#), §20.

## 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 Hospice Claim Entry](#)" Webinar

**Date:** February 5, 2008

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

**Registration Deadline:** January 31, 2008

**Intended Audience:** This event is tailored for hospice providers and staff.

**Description:** This event will demonstrate how to use the eligibility screens ELGH/ELGA to determine Medicare eligibility for hospice services, and how to use the Fiscal Intermediary Standard System (FISS) to submit hospice billing transactions.

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➤ "[FISS 201: Exploring Eligibility and Mapping Home Health Claim Entry](#)" Webinar

**Date:** February 13, 2008

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

**Registration Deadline:** February 7, 2008

**Intended Audience:** This event is tailored for home health providers and staff.

**Description:** This event will demonstrate how to use the eligibility screens ELGH/ELGA to determine Medicare eligibility for home health services, and how to use the Fiscal Intermediary Standard System (FISS) to submit a Request for Anticipated Payment (RAP) and final claim to Medicare.

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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.

➤ **“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.



- Didn't find what you were looking for? [Visit our Web site](#)—it provides a variety of valuable information and is continuously updated. You may want to bookmark the [Medicare Part A](#) page for the most current Medicare A headlines or to subscribe to the Cahaba GBA, LLC [E-mail Notification Service](#). In addition, our [“Online Courses”](#) are computer-based and can be launched from the convenience of your own desk. All courses are free and open to anyone.

Course Title	Description
Adjusting and Canceling Claims	Learn how to adjust or cancel claims.
Advanced Hospice Billing	Learn about advanced hospice billing topics.
Appeals Process	Learn about the Medicare appeals process.
Beginner Home Health Billing <i>Updated</i>	Learn the basics of home health billing.
Beginner Hospice Bill <i>Updated</i>	Learn the basics of hospice billing.
CERT (Comprehensive Error Rate Test)	Learn about the CERT Program.
Checking Claims Status	Learn how to use the Fiscal Intermediary Standard System (FISS) to check the status of your claims.
Comprehending Medicare Claims Processing	Learn about Medicare claims processing.
Electronic Data Interchange	Learn about the Electronic Data Interchange (EDI) process.

## *Cahaba GBA, LLC Learning Corner*

<b>Course Title</b>	<b>Description</b>
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.
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](#).