

## **Provider Partnership Program (PPP) E-mail Notification Archives**

**June 1, 2006**

### **Medicare Prescription Drug Update**

Since December of 2005, CMS has been holding weekly Part D Providers conference calls to address issues physicians and other health care providers were having with Part D. The participation on those calls has gradually declined to the point where the May 30th call was the final one scheduled.

CMS continues to remain committed to fixing your Part D issues and we are confident that between your email access to us (PRIT@cms.hhs.gov) and our participation in the Open Door Forums (ODF) you will not feel abandoned. We are asking that physicians and other health care providers take their Part D issues to their respective ODF calls. If you do not currently participate in the ODFs, you are encouraged to sign up to receive the ODF announcements by going to: <http://www.cms.hhs.gov/apps/maillinglists/default.asp?audience=4> or <http://www.cms.hhs.gov/opendoorforums/>

Just a reminder that the next Skilled Nursing Facilities/Long-Term Care ODFs is June 6th (1-800-837-1935, Reference ID: 8266876) and the next Physician ODF is June 27th. Both will start at 2pm EST.

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### **New ! Reference Guide for Medicare Institutional Providers Who Submit Part B Claims**

Reference Guide for Medicare Institutional Providers Who Submit Part B Claims is now available on the Medicare Learning Network at [www.cms.hhs.gov/MLNGenInfo/](http://www.cms.hhs.gov/MLNGenInfo/).

The guide contains a variety of information to help institutional providers submit accurate and timely Medicare claims. While providing historical information on Medicare Part A, Medicare Advantage, and a brief introduction to the new Medicare Part D drug coverage benefits, this guide is focused on providing information and procedures for institutional entities that provide Part B services in addition to, or instead of, Part A services.

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## **June 2, 2006**

### ***Physician election period extended for Medicare Part B Drug CAP 2006***

On June 1, 2006, CMS announced an extension to the physician election period for the Medicare Part B Drug Competitive Acquisition Program (CAP). The CAP is a voluntary program that offers physicians an option to acquire many drugs they use in their practice from approved CAP vendors. Rather than purchasing these drugs from distributors and being reimbursed by Medicare, the physician would order the drug from an approved vendor and administer it to the beneficiary, but the vendor would be responsible for billing Medicare for the drug and collecting the coinsurance from the beneficiary.

The CAP physician election period's extension will begin on June 3, 2006 and continue through June 30, 2006. Physicians must return their completed election forms to their local carrier by mail. Physicians whose completed physician election forms are postmarked on or after June 3, but no later than June 30, 2006, will begin participation in the CAP starting on August 1, 2006.

Initial CAP implementation is still scheduled for July 1, 2006. Physicians whose completed CAP election forms are postmarked on or before June 2, 2006 will begin participation in the CAP starting on July 1, 2006.

Please see the Medicare Part B Drug CAP Website's Information for Physicians page ([http://www.cms.hhs.gov/CompetitiveAcquisforBios/02\\_infophys.asp#TopOfPage](http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage)) for additional information about CAP physician election. The physician election form may be downloaded from this page. Completed forms must be returned by mail to the physician's local carrier.

Please note that participation in the CAP is voluntary and that no action is required from physicians who do not wish to participate.

CMS anticipates holding another Ask the Contractor call for physicians before the conclusion of the extended physician election period. We will post details on the CAP Information for Physicians page ([http://www.cms.hhs.gov/CompetitiveAcquisforBios/02\\_infophys.asp#TopOfPage](http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopOfPage)) as they become available.

*Mary K. Loane (for Valerie A. Hart)*  
*Provider Communications Group*  
*Division of Provider Information Planning and Development*

June 3, 2006

*Good morning everyone. Attached are several news items that I thought you might be interested in, including information on ~*

- **Hospital Payment Data on Common Elective Procedures and Other Hospital Admissions**
- **New HCPCS codes for Power Mobility Devices (PMDs)**
- **New Technology Intraocular Lenses (NTIOLs) Payment for Ambulatory Surgical Centers (ASCs)**
- **Home Health Advance Beneficiary Notices**

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**MEDICARE POSTS HOSPITAL PAYMENT INFORMATION ~**  
Important Step Toward Transparency in Health Care Costs and Quality

To help consumers, providers, and payers make more informed health care decisions, the Department of Health and Human Services, through its Centers for Medicare & Medicaid Services (CMS), posted information on what Medicare pays for 30 common elective procedures and other hospital admissions. President Bush directed the data be made publicly available to all Americans as part of the Administration's commitment to make health care more affordable and accessible.

The new information posted by CMS at [http://www.cms.hhs.gov/HealthCareConInit/01\\_Overview.asp](http://www.cms.hhs.gov/HealthCareConInit/01_Overview.asp) shows the range of payments by county and the number of cases treated at each hospital for a variety of treatments provided to seniors and people with disabilities in fiscal year 2005. These include 30 common elective procedures including heart operations and implanting cardiac defibrillators, hip and knee replacements, kidney and urinary tract operations, gallbladder operations and back and neck operations, and for common non-surgical admissions.

Please click the following link to read more from the HHS Press Release  
<http://www.hhs.gov/news/press/2006pres/20060601a.html>

Click on the CMS Fact Sheet at  
<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1872>  
Also, you can read more helpful information on the CMS webpage for Health Care Consumer Initiatives located at [http://www.cms.hhs.gov/HealthCareConInit/01\\_Overview.asp](http://www.cms.hhs.gov/HealthCareConInit/01_Overview.asp)

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**New HCPCS codes for Power Mobility Devices (PMDs)**

The Centers for Medicare & Medicaid Services (CMS) recently released new HCPCS codes for Power Mobility Devices (PMDs). These new codes more accurately reflect the range of PMDs currently on the market and will allow CMS to make more reliable payments and, ultimately, more easily detect fraud and abuse.

The revised codes are the product of extensive discussions with industry and other experts in the field and closely mirror the recommendations of a technical expert panel (TEP) that was

convened in February 2006. The 14-member TEP was comprised of suppliers, manufacturers, testing facilities, rehabilitation engineers, and clinicians.

Through the ongoing close collaboration with the industry, CMS continues to make significant progress in the area of PMDs in order to ensure that Medicare beneficiaries have access to the appropriate vehicles to meet their needs. The next step in CMS' PMD initiative is to implement these revised codes through pricing and local coverage policies for mobility assistive equipment. This will result in a more accurate description of these important technologies and support appropriate payments by Medicare.

The new codes may be viewed on the SADMERC website at:

<http://www.palmettogba.com/SADMERC> .

(Click on the heading "What's New" under the "Welcome to SADMERC" banner to reach the wheelchair code posting.)

Additional information about the new HCPCS codes for PMDs can be found on the CMS website at: [http://www.cms.hhs.gov/DMEPOSFeeSched/01a\\_Power\\_Mobility\\_Devices.asp](http://www.cms.hhs.gov/DMEPOSFeeSched/01a_Power_Mobility_Devices.asp) .

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### **New Technology Intraocular Lenses (NTIOLs) Payment for Ambulatory Surgical Centers (ASCs)**

*Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare will pay an additional \$50 to ambulatory surgical centers (ASCs) for new technology intraocular lenses (NTIOLs) that CMS recognizes as belonging to NTIOL Category 3(Reduced Spherical Aberration). Information regarding the lenses that are classified in NTIOL Category 3 is posted at [http://www.cms.hhs.gov/CoverageGenInfo/09\\_NTIOLs.asp](http://www.cms.hhs.gov/CoverageGenInfo/09_NTIOLs.asp).*

*Additional information about NTIOLs is posted at <http://www.cms.hhs.gov/center/coverage.asp>.*

*Or, refer to Publication # 100-04, Medicare Claims Processing, Chapter 14, Section 40.3, which can be accessed on the following web page:*

<http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

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### **Update on the Revised Home Health Advance Beneficiary Notice (HHABN)**

This note is to follow up on an announcement from CMS' **May 24 Home Health, Hospice and Durable Medical Equipment Open Door Forum**. As discussed, CMS received a significant number of comments on the revised HHABN form and instructions. The comment period under the Paperwork Reduction Act (PRA) ended on May 23, and we are now in the process of reviewing these comments. In order to enable CMS to give due consideration to these comments and make any appropriate changes, CMS is extending the phase-in period for use of the new form through at least September 1, 2006. **Thus, home health agencies may continue to use either the traditional HHABN or the revised version of the form until further notice.**

We will issue further guidance as soon as possible with respect to the deadline for final implementation of the new HHABN, and we sincerely appreciate your cooperation in this process.

Further inquiries on this matter may be directed to Elizabeth.Carmody@cms.hhs.gov.

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***I hope you all enjoy a wonderful weekend!***

***Valerie***

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**June 6, 2006**

***Note: Please share this information with your association members. Thank you!***

- **Medicare Part B Drug Competitive Acquisition Program (CAP)**

In order to provide physicians and their staff an opportunity to learn more about the Medicare Part B Drug Competitive Acquisition Program (CAP) and the CAP's extended physician election period, the Centers for Medicare & Medicaid Services (CMS), and Noridian Administrative Services, the designated carrier for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals, will host a second Ask the Contractor teleconference.

Call details:

**Date:** Monday, June 12, 2006, 2:00-3:30 p.m. Eastern Time  
**Title:** Ask the Contractor Teleconference for CAP  
**Call in Number:** 1-866-216-6835  
**Access Code:** 343677

Participation information:

- Please dial in 5 minutes prior to the teleconference start time.
- Enter your access code, followed by the pound (#) sign.
- Your line will be placed on hold with music until the teleconference begins.

Much of the call will follow a question and answer format. You may submit questions for the teleconference in advance to the following e-mail address:

MMA303DdrugBid@cms.hhs.gov. Questions must be submitted by Friday June 9, 2006.

PowerPoint slides for the Ask the Contractor Teleconference will be made available for download prior to the teleconference on the information for physicians page of the CMS CAP website ([www.cms.hhs.gov/CompetitiveAcquisforBios/02\\_infophys.asp](http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp)).

Additional information about CAP is available on this site as well.

On May 31, 2006, CMS announced an extension to the physician election period for the CAP. The extension began on June 3, 2006 and will continue through June 30, 2006. Physicians whose completed physician election forms are returned to their carrier bearing a postmark on or after June 3, but no later than June 30, 2006, will begin participation in the CAP starting on August 1, 2006.

CAP implementation is scheduled for July 1, 2006 and physicians whose completed election forms were received by their local carrier bearing a postmark on or before June 2, 2006 will begin participation in the CAP on July 1, 2006.

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### **Clinical Laboratory Improvement Amendments (CLIA) Brochure**

The Clinical Laboratory Improvement Amendments (CLIA) brochure has been updated and is now available in downloadable format on the Medicare Learning Network's (MLN) Products page located at

<http://www.cms.hhs.gov/MLNProducts/downloads/CLIABrochure.pdf>

The brochure includes an overview of CLIA, why it is important, how test methods are categorized, enrollment information, as well as information regarding the five types of laboratory certificates. A hard copy of the brochure will be available early this summer and will be available for ordering on the MLN Publications Page at

<http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp>

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**June 13, 2006**

**Subject:** June 12-18, 2006 is National Men's Health Week

In conjunction with National Men's Health Week and in commemoration of Father's Day (June 18), the Centers for Medicare & Medicaid Services (CMS) would like to invite you to join with us as we strive to heighten the awareness of prevention and encourage early detection and treatment of disease. Medicare now provides coverage for preventive screenings for heart disease, stroke, diabetes and cancer – four of the leading diseases that significantly impact the health of men. Medicare provides payment for a full range of preventive services specific for men's health that aim to prevent disease from developing or prevent serious complications of disease.

Although Medicare is now providing better benefits, many men with Medicare are not yet taking full advantage of them, leaving significant gaps in prevention. 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. With your help we can begin to close the prevention gap.

**How Can You Help?** As a trusted source, your recommendation is the most important factor in increasing the use of preventive and screening services. We need your help to ensure that men with Medicare are aware of these covered benefits and that they are encouraged to take advantage of the preventive services for which they may be eligible.

**For Patients New to Medicare** ~ When appropriate, provide the *Welcome to Medicare Visit*. This one time exam, which must be received within the first 6 months of the beneficiary's Medicare Part B effective date, is an excellent opportunity to orient new beneficiaries to Medicare, assess risk factors for disease, discuss lifestyle modifications that support a healthy lifestyle and may reduce the complication of disease, and encourage utilization of preventive screenings through referral for appropriate services. Remember to follow-up with patients on all screening results, even negative ones – every one likes to hear good news.

**Established Patients** ~ Remember to talk with your patients about their risk for disease and the importance and value of prevention, detection, early treatment, and lifestyle modifications. Encourage appropriate utilization of preventive services for which they may be eligible and provide follow-up on all screening results and continue to promote a prevention-oriented lifestyle.

**Working together we can begin to:**

- increase awareness of prevention, and early detection and treatment of disease affecting men's health,
- prevent and reduce serious complications of disease,
- reduce mortality for many diseases effecting men,
- improve the health and quality of life of men,
- ensure that men with Medicare take advantage of preventive benefits they may be eligible for, and
- ultimately, save health care dollars.

**Educational Products and Resources for Health Care Professionals**

CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with the coverage of and payment for the array of preventive and screening services covered by Medicare.

- The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The page is located at [http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) on the CMS website.
- The CMS website also has a prevention website which contains a section on each of the preventive services. Click on <http://www.cms.hhs.gov>, select “Medicare”, and scroll down to “Prevention”.
- For products to share with your Medicare patients go to [www.medicare.gov](http://www.medicare.gov) on the Web.

Men’s health conditions do not simply affect men. Wives, mothers, daughters, and sisters are all impacted, making men’s health a family matter. Encourage your patients to take advantage of Medicare-covered preventive services – it could save their life.

Thank you for joining with CMS to spread the message about prevention, early detection and treatment. For more information about National Men’s Health Week visit <http://www.menshealthweek.org/> on the Web.

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**June 23, 2006**

**CMS asks that you share this information with all of your association members and State and local chapters. Thanks!**

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*Happy Summer everyone and isn't it great that the weekend is almost here! There's a lot of information in this e-mail message, so here's a brief summary:*

1. **Announcement of Proposed Changes to Physician Fee Schedule Methodology**
2. **New Payment Rates for Part B Drugs (IVIG)**
3. **Submitting Home Health Requests for Anticipated Payment Under Revised OASIS Reporting Requirements**

4. **A Medicare Consumer Alert Regarding Telephone Scams Surrounding New Medicare Drug Benefit**
5. **Notice of a Laboratory Public Meeting Regarding Payment for New Clinical Laboratory Tests for 2007**

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**CMS ANNOUNCES PROPOSED CHANGES TO PHYSICIAN FEE SCHEDULE  
METHODOLOGY**

***SUBSTANTIAL INCREASES IN PAYMENTS FOR TIME SPENT WITH  
PATIENTS***

The Centers for Medicare & Medicaid Services (CMS) issued a notice proposing changes to the Medicare Physician Fee Schedule (MPFS) that will improve the accuracy of payments to physicians for the services they furnish to Medicare beneficiaries. The proposed notice includes substantial increases for “evaluation and management” services, that is, time and effort that physicians spend with patients in evaluating their condition, and advising and assisting them in managing their health. The changes reflect the recommendations of the Relative Value Update Committee (RUC) of the American Medical Association.

The proposed notice will appear in the June 29 *Federal Register*. Comments will be accepted until August 21, 2006. CMS responses to public comments on the proposals in this notice will be combined with those for the upcoming MPFS notice of proposed rulemaking in a final MPFS rule scheduled for publication this fall. If adopted, the RVU revisions in this proposed notice would be fully implemented for services to Medicare beneficiaries on or after January 1, 2007, while the practice expense revisions would be phased in over a four-year period.

To view the entire press release, go to

<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1887> .

To view the display copy of the proposed notice (CMS-1512-PN), go to

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS1183724> .

To view more MPFS information, go to <http://www.cms.hhs.gov/PhysicianFeeSched/> on the CMS website.

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**New Payment Rates for Part B Drugs (IVIG)**

The Centers for Medicare & Medicaid Services (CMS) has posted a file on its Website that contains the payment amounts that will be used to pay for Part B covered drugs for the third quarter of 2006.

Comparing the third quarter 2006 payment amounts with the previous quarter reveals that for the most part average drug prices in the market remain stable. Payment amounts across all drugs and across the top physician administered drugs increased on average (weighted by Medicare expenditures) by slightly over 0.5 percent. Preliminary 2005 data for the top physician administered drugs suggests that overall utilization of these drugs appears to have increased compared with 2004 levels.

For most of the higher volume drugs (28 out of the top 50), the payment amounts changed 2 percent or less, and for 24 of these drugs the change is about 1 percent. Overall, the payment amounts for 30 of the top 50 drugs increased, while 3 remained the same. For the top drugs with a decrease, in general, the changes appear to be a result of a number of competitive market factors -- multiple manufacturers, alternative therapies, new products, recent generic entrants, or market shifts to lower priced products.

Recent studies of Medicare payment rates for oncology drugs by the Department of Health and Human Services Office of Inspector General and the Medicare Payment Advisory Commission have found that physicians are generally able to acquire these drugs at prices below the Medicare reimbursement rate. CMS will continue to support groups representing Medicare Part B drug purchasers, especially small and rural purchasers, to help them identify the most favorable drug prices possible.

For the third quarter of 2006, the Medicare payment amount is increasing 11.9 percent for lyophilized intravenous immune globulin services (IVIG) (powdered form) and 3.5 percent for liquid IVIG.

CMS has noted the concerns of some advocacy groups and providers about patients' access to IVIG (HCPCS codes J1566 and J1567), and concerns that there may be problems with the adequacy of Medicare payment amounts and the supply of IVIG. CMS and other agencies within the Department of Health and Human Services are continuing to work with manufacturers, providers, patient groups, and stakeholders to better understand the present situation and to assess potential actions that will help to ensure an adequate supply of IVIG and patients receiving appropriate and high quality care. However, we view the payment increases for IVIG that will become effective July 1, as an important development. CMS will continue to monitor IVIG marketplace developments and beneficiary access to care closely.

The payment amounts are 106 percent of the Average Sales Price (ASP) calculated from data submitted by drug manufacturers, according to the methodology required by the Medicare Modernization Act of 2003. The quarter to quarter price changes are the result of updated data from the manufacturers of these drugs.

The payment amounts are posted on the CMS Website at:  
[http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02\\_aspfiles.asp#TopOfPage](http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#TopOfPage)

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## **Submitting Home Health Requests for Anticipated Payment Under Revised OASIS Reporting Requirements**

### Background

On December 23, 2005, CMS published new OASIS regulations that removed the locking requirement effective June 21, 2006. New HAVEN software (Version 7.0) based on new OASIS data specifications (Version 1.50) have been developed. This reporting regulation also informed HHAs that the lock date requirement would be removed from the OASIS data specifications and HAVEN software many agencies use to transmit to the States. This change in regulations does not alter Medicare's need to assure that data submitted for payment and quality are consistent. Believing that HHAs could no longer finalize OASIS data through locking it, CMS announced via an Open Door Forum that it

intended to require HHAs to transmit their OASIS data to the State prior to submitting RAPs.

CMS has learned recently that while the lock date requirement has been removed from the OASIS data specifications, the ability to lock an OASIS assessment has been retained in the new OASIS software – HAVEN 7.0 (OASIS data specifications version 1.50). Once data entry for an assessment is completed, the HAVEN Management Screen shows that the assessment is “Locked (Export Ready)” and a payment group code is available for use on the RAP. As a result, HHAs can still comply with the Claims Processing Manual requirement to lock assessments prior to submitting RAPs.

CMS recognizes that HHAs need guidance about how to respond to the new regulations effective June 21, 2006. HHAs have three options that are fully compliant with current billing instructions. These options, along with additional information, will be posted on the QTSO home page in the Alert box located on the top right hand side of the page. The URL is <https://www.qtso.com/> This information will also be posted on CMS’ Home Health Agency Provider Center website, at <http://www.cms.hhs.gov/center/hha.asp>, within the next several days.

Please note that these options pertain only to the locking of OASIS data and do not modify any other existing requirements for submission of RAPS.

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**MEDICARE CONSUMER ALERT: MEDICARE FIGHTS AGAINST NEW SCHEMES TO DEFRAUD BENEFICIARIES**

**Medicare Beneficiaries Warned To Be Aware of Telephone Scams Surrounding New Medicare Drug Benefit**

The “\$299 Ring” scheme to defraud seniors and people with disabilities has changed into a higher priced scam involving in some cases a new Medicare card, instead of a prescription drug plan.

The Centers for Medicare & Medicaid Services (CMS) recently said that the dollar amount now requested by phone callers is usually \$379, but cases have also occurred where the callers asked for \$350 or \$365. Medicare has already referred nearly 250 cases involving attempts to steal beneficiaries’ funds to federal law enforcement officials. These are pending further action.

The CMS Consumer Alert is attached.



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## **Laboratory Public Meeting: Payment for New Clinical Laboratory Tests for 2007**

**Date: Monday, July 17, 2006 10:00am - 3:00pm e.d.t.**  
**On-site check-in will begin at 9:30am**

**Place: Centers for Medicare & Medicaid Services  
Auditorium  
7500 Security Boulevard, Baltimore, MD 21244**

The meeting is open to the general public to make recommendations on the assignment of payment levels for new codes to be included in the 2007 Medicare Clinical Laboratory Fee Schedule. The meeting announcement was published in the Federal Register on Friday May 26, 2006, pages 30423 - 30424. As discussed in more detail in the Federal Register notice, the meeting is intended to provide expert input on the nature of the new test codes and receive recommendations to either crosswalk or gap fill for payment.

### **Registration**

Registration will begin June 19, 2006. To register for the meeting, individuals should complete the Internet registration form by July 12, 2006 at [www.cms.hhs.gov/ClinicalLabFeeSched](http://www.cms.hhs.gov/ClinicalLabFeeSched). A confirmation will be sent upon receipt of the registration by CMS. Individuals who wish to make a presentation to recommend assignment of payment for one or more of the new test codes should complete this information on the registration form, prepare a brief presentation (not to exceed 15 minutes), and provide three written copies at the time of presentation. Presenters may also make copies available for up to 50 meeting participants.

### **Security**

This meeting will be held in a Federal government building; therefore, Federal security measures are applicable. Photo identification and registration confirmation will be required to enter the building. Vehicles are inspected, at entrance to the grounds, and persons must pass through a metal detector when entering the building. Directions and other information for visitors to the building are available at [www.cms.hhs.gov/CMSHeadquarters](http://www.cms.hhs.gov/CMSHeadquarters)

### **Audio Listening**

Also, individuals may listen to the public meeting by dialing 410-786-3100, conference ID number 178976. Registration is not required for audio listening. Registration, in-person attendance, and 3 written copies of the presentation are necessary to make a presentation on the assignment of payment levels at this meeting. After the on-site presentations, a question and answer period will be opened to both the participants in the room and the audio listeners. The moderator of the meeting will monitor the question and answer period.

### **New Test Codes for 2007 Medicare Clinical Laboratory Fee Schedule**

The following is a list of the newly created codes that require recommendations on the assignment of payment levels in order to be included in the clinical laboratory fee schedule. The coding changes have been developed by the American Medical Association's Current Procedural Terminology (CPT) Editorial Panel and will not be further discussed at the CMS public meeting. Numbering of the codes has not yet been finalized. The identifying information should be sufficient for those knowledgeable in coding for clinical laboratory services.

Chemistry

Code 82105 Alpha-fetoprotein (AFP); serum

1) Code 8210x: AFP-L3 fraction isoform and total AFP (including ratio)

2) Code 8369x Lipoprotein-associated phospholipase A<sub>2</sub>, (Lp-PLA<sub>2</sub>)

Code 83890 Molecular diagnostics; molecular isolation or extraction

3) Code 8391x RNA stabilization Immunology

Code 86710 Antibody; influenza virus

4) Code 8678x West Nile virus, IgM

5) Code 8678x West Nile virus

#### Microbiology

Code 87301 Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; adenovirus enteric types 40/41

6) Code 8730x Aspergillus

Code 87470 Infectious agent detection by nucleic acid (DNA or RNA); Bartonella henselae and Bartonella quintana, direct probe technique

7) Code 8749x Enterovirus, amplified probe technique

8) Code 8764x Staphylococcus aureus, amplified probe technique

9) Code 8764x Staphylococcus aureus, methicillin resistant, amplified probe technique  
(For assays that detect methicillin resistance and identify Staphylococcus aureus using a single nucleic acid sequence, use 87641)

10) Code 8765x Streptococcus, group B, amplified probe technique

Code 87802 Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group B

11) Code 8780x Trichomonas vaginalis

#### **2007 Medicare Clinical Laboratory Fee Schedule**

The 2007 clinical laboratory fee schedule will be effective for services delivered January 1 to December 31, 2007. CMS will issue instructions and fees to Medicare carriers/intermediaries for implementation of the 2007 clinical laboratory fee schedule during or after the last week of October 2006. Internet access to the instructions should be available at [www.cms.hhs.gov/ClinicalLabFeeSched](http://www.cms.hhs.gov/ClinicalLabFeeSched) file should be available on or after the third week of November 2006 at [www.cms.hhs.gov/ClinicalLabFeeSched](http://www.cms.hhs.gov/ClinicalLabFeeSched) For questions, contact Anita Greenberg by phone 410-786-4601 or [anita.greenberg@cms.hhs.gov](mailto:anita.greenberg@cms.hhs.gov)

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*I hope you enjoy a terrific weekend ~ Valerie*

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**June 30, 2006**

**CMS asks that you share this important information with all of your association members and State and local chapters. Thanks!**

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The Centers for Medicare & Medicaid Services (CMS) has announced that its contingency plan for the HIPAA compliant transaction 835, or Electronic Remittance Advice, will expire on **October 1, 2006**. A Special Edition *MLN Matters* article has been developed to help the Medicare fee-for-service provider community prepare for this change. I have attached a copy of the article to this e-mail for your convenience. You can also access the article on the CMS Website at

<http://www.cms.hhs.gov/MLNMattersArticles/2006MMAN/itemdetail.asp?filterType=keyword&filterValue=Se0646&filterByDID=0&sortByDID=8&sortOrder=ascending&itemID=CMS1184013>

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