

MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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

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- Physician/Provider
- Office manager
- Billing/Vendor
- Nursing Staff
- Other _____



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

Questions concerning this publication or its contents may be faxed to 1-904-361-0723.

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THE FCSO MEDICARE B UPDATE!

About the FCSO Medicare B Update!

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

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

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

Who receives the Update?

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

Following the table of contents, an administrative information section, the *Update!* content information is categorized as follows.

- The **claims** section provides claim submission requirements and tips.
- The **coverage/reimbursement** section discusses specific CPT and HCPCS procedure codes. It is arranged by *categories* (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **electronic data interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **local coverage determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **general information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.

In addition to the above, other sections include:

- **Educational resources**, and
- **Addresses**, and **phone numbers**, and **Web sites** for Florida and the U.S. Virgin Islands.

The Medicare B Update! represents formal notice of coverage policies

Articles included in each *Update!* represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Quarterly provider update

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

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

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

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

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

Advance beneficiary notices

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

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

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

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131 form as part of the Beneficiary Notices Initiative (BNI). The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

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

Note: Beginning March 3, 2008, providers (including independent laboratories), physicians, practitioners, and suppliers may use the revised ABN (CMS-R-131 [03/08]) for all situations where Medicare payment is expected to be denied. The revised ABN replaces the existing ABN-G (CMS-R-131G), ABN-L (CMS-R-131L), and NEMB (CMS-20007). Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid. Additional information is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6136.pdf>.

ABN modifiers

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

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

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

GA modifier and appeals

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

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

Nonassigned claims containing the modifier **GA** in which the patient has been found liable **must** have the patient's **written consent** for an appeal. Refer to the Address, Phone Numbers, and Web sites section of this publication for the address in which to send written appeals requests.

Sign up to our eNews electronic mailing list

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

Correction to the June 2009 Medicare B Update!

Please disregard an article published in the June 2009 Medicare B Update! (page 18) titled "2009 ICD-9-CM changes." This article was published in error.

We apologize for any inconvenience this may have caused.

Ambulatory Surgical Center

Proposed 2010 changes for certain services in hospitals and ambulatory surgical centers

Hospitals would be able to bill Medicare for pulmonary and intensive cardiac rehabilitation services furnished in outpatient departments beginning January 1, 2010, under a proposed rule issued today by the Centers for Medicare & Medicaid Services (CMS). The proposed rule would also provide for payments to rural hospitals for kidney disease education services furnished in their outpatient departments for Medicare beneficiaries with stage IV chronic kidney disease.

The proposals, which would implement provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), were contained in a notice of proposed rulemaking (NPRM) that would revise payment policies and update the payment rates for services furnished to beneficiaries during calendar year (CY) 2010 in hospital outpatient departments under the outpatient prospective payment system (OPPS). Additional proposals to incorporate an adjustment for hospital pharmacy costs that would result in OPPS payment at the average sale price (ASP) plus four percent for most separately payable drugs and biologicals and to adapt current requirements for physician supervision of hospital outpatient services to the changing health care environment would help ensure beneficiary access to safe, cost-effective health care at all hospital outpatient sites.

The NPRM also includes proposals for policy changes and payment rates for services in ambulatory surgical centers (ASCs), which would continue the expansion of surgical procedures Medicare would cover when performed in ASCs. The proposed rule seeks to ensure that beneficiaries have access to outpatient services in all appropriate settings, while improving the quality and efficiency of service delivery.

In this proposed rule, CMS is continuing to strengthen the connection between Medicare payment and efficient, high quality care," said CMS Acting Administrator Charlene Frizzera. "The payment proposals are also designed to ensure that when services can be performed in a variety of settings, such as a physician's office, a hospital outpatient department, or an ambulatory surgical center, the choice of setting is based on the patient's needs, rather than payment incentives.

Medicare currently pays more than 4,000 hospitals -- including general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals -- for outpatient services under the OPPS, which also sets payment policies and payment rates for partial

hospitalization services furnished by community mental health centers. CMS is projecting a market basket update for CY 2010 of 2.1 percent for outpatient departments and estimates total payments of \$31.5 billion under the OPPS in CY 2010.

There are approximately 5,000 Medicare-participating ASCs. Since January 1, 2008, ASCs have been paid under a revised payment system that not only aligns ASC payment rates with the rates paid for similar services when furnished in hospital outpatient departments but also greatly expands the number and types of surgical services that are covered by Medicare when performed in ASCs. CY 2010 is the third year of a four-year phase-in of the ASC payment rates calculated under the standard rate-setting methodology and the first year for which CMS is authorized to apply an update to the conversion factor. CMS is projecting the percentage increase in the consumer price index for all urban consumers that would update the ASC conversion factor to be 0.6 percent. Total CY 2010 payments to ASCs are estimated to be \$3.4 billion.

The proposed rule affects Medicare payments to hospitals and ASCs for the resources -- such as equipment, supplies, and hospital or ASC staff -- they use to furnish ambulatory health care services to beneficiaries. CMS pays separately for the services of physicians and nonphysician practitioners under the Medicare physician fee schedule (MPFS).

Under the hospital outpatient department quality reporting program (HOP QDRP), hospitals that did not participate in the program or did not successfully report the quality measures will receive an update in CY 2010 equal to the annual payment update factor minus 2.0 percentage points, or 0.1 percent. Hospitals that are exempt from the inpatient prospective payment system -- such as long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, cancer hospitals, and children's hospitals -- as well as hospitals in Puerto Rico are not subject to the HOP QDRP payment reduction.

CMS is proposing to continue to require HOP QDRP participating hospitals to report the existing seven emergency department and perioperative care measures, as well as the four existing claims-based imaging efficiency measures for the CY 2011 payment determination. Although it is not proposing to adopt any new measures for the CY 2011 update, CMS is seeking public comment on potential additional quality measures for consideration for future OPPS updates. The potential measures relate to a number of areas including cancer care, emergency department

Proposed 2010 changes for certain services in hospitals and ambulatory surgical centers (continued)

throughput, diabetes, stroke and rehabilitation, osteoporosis, medication reconciliation, respiratory, immunization, health information technology, cataract surgery, overuse/appropriate use, imaging efficiency, and surgical care.

CMS is also proposing to phase in a new HOP QDRP validation requirement to ensure that hospitals are accurately reporting measures for chart-abstracted data, but the validation results will not have any impact on outpatient department payments in CY 2011. In addition, CMS is proposing to establish procedures to make quality data collected under the HOP QDRP for quarters beginning with the third quarter of CY 2008 publicly available.

CMS will accept comments on the proposed rule until August 31, 2009, and will respond to comments in a final rule to be issued by November 1, 2009.

The proposed rule is available at:

<http://frwebgate2.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=RVzqZ6/13/2/0&WAIAction=retrieve>.

The supporting information on the CY 2010 proposals for the OPPI and ASC payment system will be posted on the CMS Web site at:

OPPI: <http://www.cms.hhs.gov/HospitalOutpatientPPS/>

ASC payment system: <http://www.cms.hhs.gov/ASCPayment/>

Source: PERL 200907-03

Correct Coding Initiative

Revised National Correct Coding Initiative edits

This is an important notice regarding the National Correct Coding Initiative (NCCI) edits for physicians (version number 15.2, effective 7/1/09 – 9/30/09) posted on the Centers for Medicare & Medicaid Services (CMS) Web site.

The Column 1 /Column 2 edits file for the CPT* code range 34000-39999 posted on July 2, 2009, was not updated with the July 2009 changes. The file has been corrected and is now available on the NCCI Edits Web page at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp>. This was the only file that was not updated. The direct link to the corrected file is

<http://www.cms.hhs.gov/apps/ama/license.asp?file=/NationalCorrectCodInitEd/downloads/ccigrp5b.zip>.

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Source: PERL 200907-07 & 200907-37

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Drugs and Biologicals

2009 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations

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

Provider types affected

This article has information for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for influenza and pneumococcal vaccinations provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6539 to remind the Medicare physician community of the requirements to correctly enroll in order to conduct mass immunization roster billing and centralized billing for influenza and pneumococcal immunizations. Remember that centralized billers participation is limited to one year and such billers must reapply each year they wish to be a centralized biller. The yearly reapplication process is not required for mass immunizer roster billers.

Note: A vaccine is being developed for the H1N1 virus and the development of the H1N1 vaccine could result in beneficiaries being eligible to receive more than one influenza vaccine during the upcoming influenza season. CMS will release more information regarding the development of the H1N1 vaccine and any coding updates in future CRs as necessary.

2009 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations (continued)**Background**

CMS is issuing CR 6539 as a reminder for mass immunization roster billing and centralized billing for influenza and pneumococcal vaccinations. Mass immunizers are providers and suppliers who enroll in the Medicare program to offer the influenza and/or pneumococcal vaccinations to a large number of individuals, and they must be properly licensed in the states in which they plan to operate influenza (flu) clinics. Enrollment for mass immunizers is ongoing and must be completed through the local A/B MAC or carrier. Mass immunizers submit their claims to the local Medicare contractor.

Centralized billers are mass immunizers who have applied to become centralized billers when they operate in at least three payment localities for which there are three different Medicare contractors or A/B MACs processing claims. Individuals and entities must be properly licensed in the States in which they plan to operate influenza (flu) and/or pneumococcal clinics.

All providers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, already enrolled in the Medicare program may render and bill for providing influenza and/or pneumococcal vaccinations. DMEPOS suppliers must enroll as a mass immunization roster biller (specialty provider type 73) with a carrier or A/B MAC to render influenza vaccination services to Medicare beneficiaries.

Providers/suppliers who will only render influenza and/or pneumococcal vaccination services must enroll as one of two types of providers including a mass immunization roster biller (specialty provider type 73), or a centralized biller.

They must:

- Accept assignment on both the vaccine and its administration;
- Bill only for influenza and/or pneumococcal vaccinations; and
- Submit claims using the roster billing process.

Participation as a centralized biller is limited to one year and must be renewed annually by contacting the CMS central office by June 1 to request participation for the upcoming year. Claims for centralized billers are processed by one Medicare specialty contractor regardless of the locality where the service was rendered. Centralized billers submit their claims to the designated specialty contractor.

Providers and suppliers must enroll using the appropriate CMS 855 provider enrollment form. Information on provider enrollment forms may be found at http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp on the CMS Web site. Refer to the *Medicare Claims Processing Manual* Chapter 18, Sections 10-10.5 for more information on billing requirements. This manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS Web site.

CMS offers a number of free educational products on its *Medicare Learning Network (MLN)*. These products are available on the *MLN Preventive Services Educational Products Web page* located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS Web site.

Note: Medicare Part B pays 100 percent for pneumococcal vaccines, influenza virus vaccines, and their administration. The Part B deductible and coinsurance do not apply for influenza virus and pneumococcal vaccine.

Remember the following regarding the influenza vaccine:

- Medicare allows one influenza (flu) vaccination per year
- Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the influenza vaccine and its administration, and
- The beneficiary may receive the influenza vaccine upon request without a physician's order and without physician supervision.

Remember the following with regard to the pneumococcal vaccine, effective for services furnished on or after July 1, 2000:

- Medicare does not require for coverage purposes, that a doctor of medicine or osteopathy order the pneumococcal vaccine and its administration, and
- The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Typically, the pneumococcal vaccine is administered once in a lifetime. Claims for pneumococcal vaccines are paid for beneficiaries who:

- Are at high risk of pneumococcal disease, and
- Have not received a pneumococcal vaccine within the last five years, or
- Are revaccinated because they are unsure of their vaccination status.

Additional information

CMS offers a number of free educational products on its *Medicare Learning Network (MLN)*. These products are available on the *MLN Preventive Services Educational Products Web page* located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS Web site.

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

The official instruction, CR 6539, issued to your Medicare FI, carrier or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R515OTN.pdf> on the CMS Web site.

MLN Matters® Number: MM6539

Related Change Request (CR) #: 6539

Related CR Release Date: July 10, 2009

Effective Date: August 10, 2009

Related CR Transmittal #: R515OTN

Implementation Date: August 10, 2009

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Durable Medical Equipment

2009 DMEPOS HCPCS codes jurisdiction list

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

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (durable medical equipment Medicare administrative contractors [DME MACs], Part B carriers, and Medicare administrative contractors [A/B MAC]) for durable medical equipment prosthetics orthotics and supplies (DMEPOS) provided to Medicare beneficiaries.

Impact on providers

This article is informational and is based on change request (CR) 6522 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2009 jurisdiction list is an Excel® spreadsheet and is available at <http://www.cms.hhs.gov/center/dme.asp> on the Centers for Medicare & Medicaid Services (CMS) Web site.

Additional information

To see the official instruction (CR 6522) issued to your Medicare DME MAC, carrier, or A/B MAC, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1765CP.pdf> on the CMS Web site. The 2009 jurisdiction list is attached to CR 6522.

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

MLN Matters® Number: MM6522

Related Change Request (CR) #: 6522

Related CR Release Date: July 10, 2009

Effective Date: August 10, 2009

Related CR Transmittal #: R1765CP

Implementation Date: August 10, 2009

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2009 jurisdiction list for DMEPOS HCPCS codes

This article is informational and is based on change request (CR) 6522 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for durable medical equipment Medicare administrative contractor (DME MAC) and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2009 jurisdiction list is attached to CR 6522 at <http://www.cms.hhs.gov/transmittals/downloads/R1765CP.pdf> on the CMS Web site.

Note: Deleted codes are valid for dates of service on or before the date of deletion.

HCPCS	Description	Jurisdiction
A0021-A0999	Ambulance services	Local carrier
A4206-A4209	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC
A4210	Needle free injection device	DME MAC
A4211	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC
A4212	Non coring needle or stylet with or without catheter	Local carrier

2009 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
A4213-A4215	Medical , surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC
A4216-A4218	Saline	Local carrier if incident to a physician's service (not separately payable). If other DME MAC
A4220	Refill kit for implantable pump	Local carrier
A4221-A4250	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC
A4252-A4259	Diabetic supplies	DME MAC
A4261	Cervical cap for contraceptive use	Local carrier
A4262-A4263	Lacrimal duct implants	Local carrier
A4265	Paraffin	Local carrier if incident to a physician's service (not separately payable). If other DME MAC
A4266-A4269	Contraceptives	Local carrier
A4270	Endoscope sheath	Local carrier
A4280	Accessory for breast prosthesis	DME MAC
A4281-A4286	Accessory for breast pump	DME MAC
A4290	Sacral nerve stimulation test lead	Local carrier
A4300-A4301	Implantable catheter	Local carrier
A4305-A4306	Disposable drug delivery system	Local carrier if incident to a physician's service (not separately payable). If other DME MAC
A4310-A4358	Incontinence supplies/urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4361-A4434	Urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4450-A4455	Tape;adhesive remover	Local carrier if incident to a physician's service (not separately payable). If other DME MAC
A4458	Enema bag	DME MAC
A4461-A4463	Surgical dressing holders	Local carrier if incident to a physician's service (not separately payable). If other DME MAC
A4465	Non-elastic binder for extremity	DME MAC
A4470	Gravlee jet washer	Local carrier
A4480	Vabra aspirator	Local carrier
A4481	Tracheostomy supply	Local carrier if incident to a physician's service (not separately payable). If other DME MAC
A4483	Moisture exchanger	DME MAC
A4490-A4510	Surgical stockings	DME MAC

COVERAGE/REIMBURSEMENT

2009 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
A4520	Diapers	DME MAC
A4550	Surgical trays	Local carrier
A4554	Disposable underpads	DME MAC
A4556-A4558	Electrodes; lead wires; conductive paste	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4559	Coupling gel	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4561-A4562	Pessary	Local carrier
A4565	Sling	Local carrier
A4570	Splint	Local carrier
A4575	Topical hyperbaric oxygen chamber, disposable	DME MAC
A4580-A4590	Casting supplies & material	Local Carrier
A4595	TENS supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4600	Sleeve for intermittent limb compression device	DME MAC
A4601	Lithium ion battery for non-prosthetic use	DME MAC
A4604	Tubing for positive airway pressure device	DME MAC
A4605	Tracheal suction catheter	DME MAC
A4606	Oxygen probe for oximeter	DME MAC
A4608	Transtracheal oxygen catheter	DME MAC
A4611-A4613	Oxygen equipment batteries and supplies	DME MAC
A4614	Peak flow rate meter	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4615-A4629	Oxygen and tracheostomy supplies	Local Carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4630-A4640	DME supplies	DME MAC
A4641-A4642	Imaging agent; contrast material	Local carrier
A4648	Tissue marker, implanted	Local carrier
A4649	Miscellaneous surgical supplies	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A4650	Implantable radiation dosimeter	Local carrier
A4651-A4932	Supplies for ESRD	DME MAC
A5051-A5093	Additional ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.

2009 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
A5102-A5200	Additional incontinence and ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5500-A5513	Therapeutic shoes	DME MAC
A6000	Non-contact wound warming cover	DME MAC
A6010-A6024	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6025	Silicone gel sheet	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6154-A6411	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6412	Eye patch	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6413	Adhesive bandage	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6441-A6512	Surgical dressings	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6513	Compression burn mask	DME MAC
A6530-A6549	Compression gradient stockings	DME MAC
A6550	Supplies for negative pressure wound therapy electrical pump	DME MAC
A7000-A7002	Accessories for suction pumps	DME MAC
A7003-A7039	Accessories for nebulizers, aspirators and ventilators	DME MAC
A7040-A7041	Chest drainage supplies	Local carrier
A7042-A7043	Pleural catheter	Local carrier
A7044-A7046	Respiratory accessories	DME MAC
A7501-A7527	Tracheostomy supplies	DME MAC
A8000-A8004	Protective helmets	DME MAC
A9150	Non-prescription drugs	Local carrier
A9152-A9153	Vitamins	Local carrier
A9155	Artificial saliva	Local carrier
A9180	Lice infestation treatment	Local carrier
A9270	Noncovered items or services	DME MAC
A9274-A9278	Glucose monitoring	DME MAC
A9279	Monitoring feature/device	DME MAC
A9280	Alarm device	DME MAC
A9281	Reaching/grabbing device	DME MAC

COVERAGE/REIMBURSEMENT

2009 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
A9282	Wig	DME MAC
A9283	Foot off loading device	DME MAC
A9284	Non-electric spirometer	DME MAC
A9300	Exercise equipment	DME MAC
A9500-A9700	Supplies for radiology procedures	Local carrier
A9900	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
B4034-B9999	Enteral and parenteral therapy	DME MAC
D0120-D9999	Dental procedures	Local carrier
E0100-E0105	Canes	DME MAC
E0110-E0118	Crutches	DME MAC
E0130-E0159	Walkers	DME MAC
E0160-E0175	Commodes	DME MAC
E0181-E0199	Decubitus care equipment	DME MAC
E0200-E0239	Heat/cold applications	DME MAC
E0240-E0248	Bath and toilet aids	DME MAC
E0249	Pad for heating unit	DME MAC
E0250-E0304	Hospital beds	DME MAC
E0305-E0326	Hospital bed accessories	DME MAC
E0328-E0329	Pediatric hospital beds	DME MAC
E0350-E0352	Electronic bowel irrigation system	DME MAC
E0370	Heel pad	DME MAC
E0371-E0373	Decubitus care equipment	DME MAC
E0424-E0484	Oxygen and related respiratory equipment	DME MAC
E0485-E0486	Oral device to reduce airway collapsibility	DME MAC
E0487	Electric spirometer	DME MAC
E0500	IPPB machine	DME MAC
E0550-E0585	Compressors/nebulizers	DME MAC
E0600	Suction pump	DME MAC
E0601	CPAP Device	DME MAC
E0602-E0604	Breast pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage board	DME MAC
E0607	Home blood glucose monitor	DME MAC
E0610-E0615	Pacemaker monitor	DME MAC
E0616	Implantable cardiac event recorder	Local carrier
E0617	External defibrillator	DME MAC
E0618-E0619	Apnea monitor	DME MAC
E0620	Skin piercing device	DME MAC
E0621-E0636	Patient lifts	DME MAC
E0637-E0642	Standing devices/lifts	DME MAC
E0650-E0676	Pneumatic compressor and appliances	DME MAC
E0691-E0694	Ultraviolet light therapy systems	DME MAC
E0700	Safety equipment	DME MAC
E0705	Transfer board	DME MAC
E0710	Restraints	DME MAC

2009 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
E0720-E0745	Electrical nerve stimulators	DME MAC
E0746	EMG device	Local carrier
E0747-E0748	Osteogenic stimulators	DME MAC
E0749	Implantable osteogenic stimulators	Local carrier
E0755	Reflex stimulator	DME MAC
E0760	Ultrasonic osteogenic stimulator	DME MAC
E0761	Electromagnetic treatment device	DME MAC
E0762	Electrical joint stimulation device	DME MAC
E0764	Functional neuromuscular stimulator	DME MAC
E0765	Nerve stimulator	DME MAC
E0769	Electrical wound treatment device	DME MAC
E0770	Functional electrical stimulator	DME MAC
E0776	IV pole	DME MAC
E0779-E0780	External Infusion Pumps	DME MAC
E0781	Ambulatory infusion pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782-E0783	Infusion pumps, implantable	Local carrier
E0784	Infusion pumps, insulin	DME MAC
E0785-E0786	Implantable infusion pump catheter	Local carrier
E0791	Parenteral infusion pump	DME MAC
E0830	Ambulatory traction device	DME MAC
E0840-E0900	Traction equipment	DME MAC
E0910-E0930	Trapeze/fracture frame	DME MAC
E0935-E0936	Passive motion exercise device	DME MAC
E0940	Trapeze equipment	DME MAC
E0941	Traction equipment	DME MAC
E0942-E0945	Orthopedic devices	DME MAC
E0946-E0948	Fracture frame	DME MAC
E0950-E1298	Wheelchairs	DME MAC
E1300-E1310	Whirlpool equipment	DME MAC
E1353-E1392	Additional oxygen related equipment	DME MAC
E1399	Miscellaneous DME	Local carrier if implanted DME. If other, DME MAC.
E1340	Repair or non-routine service for DME (deactivated as of 4/1/09)	
E1405-E1406	Additional oxygen equipment	DME MAC
E1500-E1699	Artificial kidney machines and accessories	DME MAC
E1700-E1702	TMJ device and supplies	DME MAC
E1800-E1841	Dynamic flexion devices	DME MAC
E1902	Communication board	DME MAC
E2000	Gastric suction pump	DME MAC
E2100-E2101	Blood glucose monitors with special features	DME MAC
E2120	Pulse generator for tympanic treatment of inner ear	DME MAC
E2201-E2399	Wheelchair accessories	DME MAC
E2402	Negative pressure wound therapy pump	DME MAC
E2500-E2599	Speech generating device	DME MAC

COVERAGE/REIMBURSEMENT

2009 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
E2601-E2621	Wheelchair cushions	DME MAC
E8000-E8002	Gait trainers	DME MAC
G0008-G0329	Misc. Professional services	Local carrier
G0333	Dispensing fee	DME MAC
G0337-G0365	Misc. Professional services	Local carrier
G0372	Misc. Professional services	Local carrier
G0378-G9140	Misc. Professional services	Local carrier
J0120-J3570	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified biologicals	Local carrier
J7030-J7130	Miscellaneous drugs and solutions	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7186-J7195	Antihemophilic factor	Local carrier
J7197	Antithrombin iii	Local carrier
J7198	Anti-inhibitor; per i.U.	Local carrier
J7199	Other hemophilia clotting factors	Local carrier
J7300-J7307	Intrauterine copper contraceptive	Local carrier
J7308	Aminolevulinic acid HCL	Local carrier
J7310	Ganciclovir, Long-Acting Implant	Local carrier
J7311	Fluocinolone acetonide, intravitreal implant	Local carrier
J7321-J7324	Hyaluronan	Local carrier
J7330	Autologous cultured chondrocytes, implant	Local carrier
J7500-J7599	Immunosuppressive drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7604-J7699	Inhalation solutions	Local carrier if incident to a physician's service. If other, DME MAC.
J7799	NOC, other than inhalation drugs through DME	Local carrier if incident to a physician's service. If other, DME MAC.
J8498	Anti-emetic drug	DME MAC
J8499	Prescription drug, oral, non chemotherapeutic	Local carrier if incident to a physician's service. If other, DME MAC.
J8501-J8999	Oral anti-cancer drugs	DME MAC
J9000-J9999	Chemotherapy drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001-K0108	Wheelchairs	DME MAC
K0195	Elevating leg rests	DME MAC
K0455	Infusion pump used for uninterrupted administration of epoprostenal	DME MAC
K0462	Loaner equipment	DME MAC
K0552	External infusion pump supplies	DME MAC
K0601-K0605	External infusion pump batteries	DME MAC
K0606-K0609	Defibrillator accessories	DME MAC
K0669	Wheelchair cushion	DME MAC
K0672	Soft interface for orthosis	DME MAC
K0730	Inhalation drug delivery system	DME MAC
K0733	Power wheelchair accessory	DME MAC

2009 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
K0734-K0737	Power wheelchair seat cushions	DME MAC
K0738	Oxygen equipment	DME MAC
K0739	Repair or nonroutine service for DME	Local carrier if implanted DME. If other, DME MAC.
K0740	Repair or nonroutine service for oxygen equipment	DME MAC
K0800-K0899	Power mobility devices	DME MAC
L0112-L2090	Orthotics	DME MAC
L2106-L2116	Orthotics	DME MAC
L2126-L4398	Orthotics	DME MAC
L5000-L5999	Lower limb prosthetics	DME MAC
L6000-L7499	Upper limb prosthetics	DME MAC
L7500-L7520	Repair of prosthetic device	Local carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic donning sleeve	DME MAC
L7900	Vacuum erection system	DME MAC
L8000-L8485	Prosthetics	DME MAC
L8499	Unlisted procedure for miscellaneous prosthetic services	Local carrier if implanted prosthetic device. If other, DME MAC.
L8500-L8501	Artificial larynx; tracheostomy speaking valve	DME MAC
L8505	Artificial larynx accessory	DME MAC
L8507-L8515	Voice prosthesis	DME MAC
L8600-L8699	Prosthetic implants	Local carrier
L9900	Miscellaneous orthotic or prosthetic component or accessory	Local carrier if used with implanted prosthetic device. If other, DME MAC.
M0064-M0301	Medical services	Local carrier
P2028-P9615	Laboratory tests	Local carrier
Q0035	Influenza vaccine; cardiokymography	Local carrier
Q0081	Infusion therapy	Local carrier
Q0083-Q0085	Chemotherapy administration	Local carrier
Q0091	Smear preparation	Local carrier
Q0092	Portable x-ray setup	Local carrier
Q0111-Q0115	Miscellaneous lab services	Local carrier
Q0144	Azithromycin dihydrate	Local carrier if incident to a physician's service. If other, DME MAC.
Q0163-Q0181	Anti-emetic	DME MAC
Q0480-Q0505	Ventricular assist devices	Local carrier
Q0510-Q0514	Drug dispensing fees	DME MAC
Q0515	Sermorelin acetate	Local carrier
Q1003-Q1005	New yechnology IOL	Local carrier
Q2004	Irrigation solution	Local carrier
Q2009	Fosphenytoin	Local carrier
Q2017	Teniposide	Local carrier
Q2023	Antihemophilic factor	Local carrier
Q3001	Radio elements for brachytherapy	Local carrier
Q3014	Telehealth originating site facility fee	Local carrier
Q3025-Q3026	Vaccines	Local carrier
Q3031	Collagen skin test	Local carrier
Q4001-Q4051	Splints and casts	Local carrier

2009 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
Q4080	Inhalation drug	Local carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	DME MAC for method II home dialysis. If other, local carrier.
Q4082	Drug subject to competitive acquisition program	Local carrier
Q4100-Q4116	Skin substitutes	Local carrier
Q5001-Q5009	Hospice services	Local carrier
Q9951-Q9954	Imaging agents	Local carrier
Q9955-Q9957	Microspheres	Local carrier
Q9958-Q9967	Imaging agents	Local carrier
R0070-R0076	Diagnostic radiology services	Local carrier
V2020-V2025	Frames	DME MAC
V2100-V2513	Lenses	DME MAC
V2520-V2523	Hydrophilic contact lenses	Local carrier if incident to a physician's service. If other, DME MAC.
V2530-V2531	Contact lenses, scleral	DME MAC
V2599	Contact lens, other type	Local carrier if incident to a physician's service. If other, DME MAC.
V2600-V2615	Low vision aids	DME MAC
V2623-V2629	Prosthetic eyes	DME MAC
V2630-V2632	Intraocular lenses	Local carrier
V2700-V2780	Miscellaneous vision service	DME MAC
V2781	Progressive lens	DME MAC
V2782-V2784	Lenses	DME MAC
V2785	Processing--corneal tissue	Local carrier
V2786	Lens	DME MAC
V2787-V2788	Intraocular lenses	Local carrier

DMEPOS accreditation and surety bond requirement deadlines coming in October

Suppliers may choose to voluntarily terminate enrollment if they do not plan to comply. Medicare suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), unless exempt, must be accredited and obtain a surety bond by October 1, 2009, and October 2, 2009, respectively.

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. You can voluntarily terminate your enrollment with the Medicare program by completing the sections associated with voluntary termination on page four of the Medicare enrollment application (CMS-855S). Once complete, you should sign, date and send the completed application to the national supplier clearinghouse (NSC). By voluntarily terminating your Medicare enrollment, you will preserve your right to re-enroll in Medicare once you meet the requirements to participate in the Medicare program.

If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.

For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to <http://www.cms.hhs.gov/MedicareProviderSupEnroll>. Frequently asked questions (FAQs) on the surety bond requirement may be found on the NSC's FAQ page at <http://www.palmettogba.com/nsc>.

Source: PERL 200907-04

Proposed DMEPOS regulatory updates

The Centers for Medicare & Medicaid Services (CMS) has announced limited proposed regulatory provisions for the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. These proposals include a proposed administrative process for contract suppliers whose contracts were terminated by the Medicare Improvements for Patients and Providers Act of 2008 to submit claims for any applicable damages and proposed grandfathering provision updates. These proposed provisions are found in Section O of the Physician Fee Schedule and Other Revisions to Part B regulation (CMS-1413-P), which is now on display at the Office of the *Federal Register*. Visit the CMS Web site at <http://www.cms.hhs.gov/center/dme.asp> to view the rule and obtain additional information.

Source: PERL 200907-02

Get ready for DMEPOS competitive bidding

The Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round 1 rebid is coming soon.

Summer 2009

- CMS announces bidding schedule/schedule of education events
- CMS begins bidder education campaign
- Bidder registration period to obtain user ID and passwords begins

Fall 2009

- Bidding begins

If you are a supplier interested in bidding, prepare now -- don't wait.

Update your national supplier clearinghouse (NSC) files: DMEPOS supplier standard # 2 requires all suppliers to notify the NSC of any change to the information provided on the Medicare enrollment application (CMS-855S) within 30 days of the change. DMEPOS suppliers should use the 3/09 version of the CMS-855S and should review and update:

- The list of products and services found in Section 2.D
- The authorized official(s) information in Sections 6A and 15
- The correspondence address in Section 2A2 of the CMS-855S.

This is especially important for suppliers who will be involved in the Medicare DMEPOS competitive bidding program. These suppliers must ensure the information listed on their supplier files is accurate to enable participation in this program. Information and instructions on how to submit a change of information may be found on the NSC Web site, <http://www.palmettogba.com/nsc>, by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

Get licensed: Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all DMEPOS state licensure requirements and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Prior to submitting a bid for a CBA and product category, the supplier must have a copy of the applicable state licenses on file with the NSC. As part of the bid evaluation we will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).

Get accredited: CMS would like to remind DMEPOS suppliers that time is running out to obtain accreditation by the September 30, 2009, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. Accreditation takes an average of 6 months to complete.

DMEPOS suppliers should contact a CMS-deemed accreditation organization to obtain information about the accreditation process and the application process. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at the CMS Web site http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp.

Get bonded: CMS would like to remind DMEPOS suppliers that certain suppliers will need to obtain and submit a surety bond by the October 2, 2009, deadline or risk having their Medicare Part B billing privileges revoked. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of sureties from which a bond can be secured is found at the Department of the Treasury's "List of Certified (Surety Bond) Companies;" the Web site is located at http://www.fms.treas.gov/c570/c570_a-z.html.

Visit the CMS Web site at <http://www.cms.hhs.gov/DMEPOSCompetitiveBid/> for the latest information on the DMEPOS competitive bidding program.

Source: PERL 200907-12

End-Stage Renal Disease

List of ESRD-related diagnostic tests added to the *Medicare Claims Processing Manual*

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

Provider types affected

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

Provider action needed

This article is informational in nature and conveys that the purpose of change request (CR) 6515 is to place a listing of diagnostic tests that are considered end-stage renal disease (ESRD)-related as Exhibit 1 (new) at the end of Chapter 16 of the *Medicare Claims Processing Manual*.

Background

CR 6515 places the listing of diagnostic tests that are considered ESRD-related as Exhibit 1 (formerly Attachment 1 in CR 2906) at the end of Chapter 16 of the *Medicare Claims Processing Manual*. This listing was inadvertently omitted from the manual during the implementation of CR 2906 (Transmittal 69, January 25, 2004; see on the Centers for Medicare & Medicaid Services [CMS] Web site <http://www.cms.hhs.gov/transmittals/downloads/R69CP.pdf>).

The purpose of CR 2906 was to address specific areas of concerns regarding Medicare system edits for skilled nursing facilities (SNF) consolidated billing (CB) to permit payment for certain diagnostic services furnished to beneficiaries receiving treatment for ESRD at an independent provider-based dialysis facility. One of the areas of concern was that providers and suppliers needed a listing of diagnostic tests that are considered ESRD-related that would require modifier CB. Consequently, a list defining specific diagnostic tests as ESRD-related was included in CR 2906. This list applies only to SNF CB. According to CR 2906, any diagnostic services related to the beneficiary's ESRD treatment/care must be submitted using modifier CB, however, if these services are not on the list labeled as Attachment 1 in CR 2906 or the list being added to the *Medicare Claims Processing Manual* by CR 6515, your Medicare contractor may require supporting medical documentation.

To view the list being added to the end of Chapter 16 of the *Medicare Claims Processing Manual*, see CR 6515, which is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1769CP.pdf>.

Additional Information

The official instruction, CR 6515, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1769CP.pdf>.

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

MLN Matters® Number: MM6515

Related Change Request (CR) Number: 6515

Related CR Release Date: July 10, 2009

Related CR Transmittal Number: R1769CP

Effective Date: July 31, 2009

Implementation Date: July 31, 2009

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Laboratory/Pathology

October 2009 changes to the laboratory national coverage determination edit software

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6548 which announces the changes that will be included in the October 2009 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in July 2009. Be sure billing staff are aware of the changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001.

Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2 (see <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf> on the Centers for Medicare & Medicaid Services [CMS] Web site), the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 6548 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2009. These changes become effective for services furnished on or after October 1, 2009. The changes that are effective for dates of service on and after October 1, 2009, are as follows:

For the urine culture, bacterial:

- Add ICD-9-CM codes 670.10, 670.12, 670.14, 670.20, 670.22, 670.24, 670.30, 670.32, 670.34, 670.80, 670.82, 670.84, and 789.7 to the list of ICD-9-CM codes that are covered by Medicare for the urine culture, bacterial (190.12) NCD.

For blood counts:

- Add ICD-9-CM codes V26.42, V26.82, V53.50-V53.51, V53.59, V61.07-V61.08, V61.23-V61.25, V61.42, V72.60-V72.63, and V72.69 to the list of ICD-9-CM codes that do not support medical necessity for the blood counts (190.15) NCD.
- Delete ICD-9-CM codes V53.5 and V72.6 from that list.

For partial thromboplastin time (PTT):

- Add ICD-9-CM codes 453.50-453.52, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 789.7, and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the PTT (190.16) NCD.

- Delete ICD-9-CM code 453.8 from that list.

For prothrombin time (PT):

- Add ICD-9-CM codes 209.70-209.75, 209.79, 453.50-453.52, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 789.7, and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the PT (190.17) NCD.
- Delete ICD-9-CM code 453.8 from that list.
- Replace the duplicate ICD-9-CM code 868.19 with 868.09 within that list.

For serum iron studies:

- Add ICD-9-CM codes 209.31-209.36, 209.70-209.75, 209.79, 239.81, 239.89, 285.3, 453.50-453.52 and 569.87 to the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.
- Delete ICD-9-CM code 239.8 from the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.

For thyroid testing:

- Add ICD-9-CM codes 279.41, 279.49, 784.42-784.44, 784.51, 784.59, 799.21-799.25, 799.29, and V10.91 to the list of ICD-9-CM codes that are covered by Medicare for the thyroid testing (190.22) NCD.
- Delete ICD-9-CM codes 279.4, 784.5, and 799.2 from that list.

For lipids testing:

- Add ICD-9-CM codes 438.13-438.14 to the list of ICD-9-CM codes that are covered by Medicare for the lipids testing (190.23) NCD.

For digoxin therapeutic drug assay:

- Add ICD-9-CM codes 787.04, 799.21-799.25, 799.29 and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the digoxin therapeutic drug assay (190.24) NCD.
- Delete ICD-9-CM code 799.2 from that list.

For alphafetoprotein:

- Add ICD-9-CM codes 209.70-209.75 and 209.79 to the list of ICD-9-CM codes that are covered by Medicare for the alphafetoprotein (190.25) NCD.

For carcinoembryonic antigen:

- Add ICD-9-CM codes 209.70-209.75 and 209.79 to the list of ICD-9-CM codes that are covered by Medicare for the carcinoembryonic antigen (190.26) NCD.

For gamma glutamyl transferase:

- Add ICD-9-CM codes 209.70-209.75, 209.79, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 569.87, 969.00-969.05, 969.09, 969.70-969.73 and 969.79 to the list of ICD-9-CM codes that are covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

October 2009 changes to the laboratory national coverage determination edit software (continued)

- Delete ICD-9-CM codes 453.8, 969.0 and 969.7 from that list.

For the hepatitis panel/acute hepatitis panel:

- Add ICD-9-CM codes 787.04 and 789.7 to the list of ICD-9-CM codes that are covered by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.

For fecal occult blood test

- Add ICD-9-CM codes 209.70-209.75, 209.79, 285.3, 569.87, 787.04, 789.7 and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the fecal occult blood test (190.34) NCD.
- Delete CPT® code G0394 from the list of CPT® codes covered by Medicare for the fecal occult blood test (190.34) NCD.

For all 23 lab NCDs:

- ICD-9-CM codes V20.31-V20.32, V60.81, V60.89, V80.01, and V80.09 will be denied for all 23 NCDs.
- ICD-9-CM codes V60.8 and V80.0 will be deleted from the noncovered by Medicare lists for all 23 NCDs.

Additional information

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

The official instruction (CR 6548) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1766CP.pdf> on the CMS Web site.

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Implementation Date: October 5, 2009

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Medicare Physician Fee Schedule Database

Medicare physician fee schedule payment policy indicators

The information that follows provides definitions of national policy indicators for each procedure code (and modifier, where applicable) described by specific fields on the Centers for Medicare & Medicaid Services' (CMS) Medicare physician fee schedule database (MPFSDB).

HCPC

This is the *Current Procedural Terminology (CPT)* code assigned by the American Medical Association (AMA) or the Healthcare Common Procedure Coding System (HCPCS) code assigned by CMS for the procedure.

Modifier

For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:

- 26** Professional component
- TC** Technical component

For services other than those with a professional and/or technical component, this field is blank with one exception: the presence of *CPT* modifier 53 which indicates that separate relative value units (RVUs) and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier 53 are subject to carrier medical review and priced by individual consideration.

Modifier 53 – Discontinued procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Code status

This field provides the fee schedule status of each code.

- A** Active code. These codes are separately paid under the physician fee schedule if covered. There are RVUs and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
- B** Payment for covered services is always bundled into payment for other services not specified. There are no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).
- C** Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
- D*** Deleted/discontinued codes.
- E** Excluded from physician fee schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.
- F** Deleted/discontinued codes. (Code not subject to a 90 day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective with the 2005 fee schedule as of January 1, 2005.
- G** Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90-day grace period.) This indicator is no longer effective with the 2005 fee schedule as of January 1, 2005.
- H*** Deleted modifier. For 2000 and later years, either the technical component (TC) or professional component (PC) shown for the code has been deleted and the deleted component is shown in the data base with the H status.
- I** Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code not subject to a 90-day grace period.)
- J** Anesthesia services (no relative value units or payment amounts for anesthesia codes on the database, only used to facilitate the identification of anesthesia services.)
- L** Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.
- M** Measurement codes, used for reporting purposes only.
- N** Noncovered service. These codes are carried on HCPCS as noncovered services.
- P** Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service).

Medicare physician fee schedule payment policy indicators (continued)

If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Social Security Act.

- R** Restricted coverage. Special coverage instructions apply.
- T** There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.
- X** Statutory exclusion. These codes represent an item or service that is not in the statutory definition of “physician services” for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

* Codes with these indicators had a 90 day grace period before January 1, 2005.

Global surgery

This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

- 000** Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.
- 010** Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.
- 090** Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.
- MMM** Maternity codes; usual global period does not apply.
- XXX** Global concept does not apply
- YYY** Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.
- ZZZ** Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post-service time.)

Preoperative, Intraoperative, and Postoperative percentages

- Preoperative percentage (**pre op**) – modifier 56
This field contains the percentage for the preoperative portion of the global package.
- Intraoperative percentage (**intra op**) – modifier 54
This field contains the percentage for the intraoperative portion of the global package including postoperative work in the hospital.
- Postoperative percentage (**post op**) – modifier 55
This field contains the percentage for the postoperative portion of the global package that is provided in the office after discharge from the hospital.

The total of preoperative, intraoperative, and postoperative percentages will usually equal one. Any variance is slight and results from rounding.

Professional component/technical component indicator (PC/TC)

- 0 Physician service codes:** This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The total RVUs include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.
- 1 Diagnostic tests or radiology services:** This indicator identifies codes that describe diagnostic tests (e.g., pulmonary function tests), or therapeutic radiology procedures (e.g., radiation therapy). These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes.

The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.

The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.

- 2 Professional component only codes:** This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

Medicare physician fee schedule payment policy indicators (continued)

- 3 Technical component only codes:** This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only.

An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes.

The total RVUs for technical component only codes include values for practice expense and malpractice expense only.
- 4 Global test only codes:** This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.
- 5 Incident to codes:** This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision.

Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.
- 6 Laboratory physician interpretation codes:** This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.
- 7 Physical therapy service:** Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist.
- 8 Physician interpretation codes:** This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.

No payment is recognized for code 85060 furnished to hospital outpatients or non- hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

- 9** Concept of a professional/technical component does not apply.

Multiple procedure - modifier 51

This field indicates which payment adjustment rule for multiple procedures applies to the service.

- 0** No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.
- 1** Standard payment adjustment rules in effect before January 1, 1996, or multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.
- 2** Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.
- 3** Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure).

Multiple endoscopy rules are applied to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure).

If an endoscopic procedure is reported with only its base procedure, carriers do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.
- 4** Subject to 25 percent reduction of the TC diagnostic imaging (effective for services January 1, 2006, and after).
- 9** Concept does not apply.

Medicare physician fee schedule payment policy indicators (continued)

Bilateral surgery – modifier 50

This field provides an indicator for services subject to a payment adjustment.

- 0 150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code XXXXX is \$125. The physician reports code XXXXX-LT with an actual charge of \$100 and XXXXX-RT with an actual charge of \$100. Payment would be based on the fee schedule amount (\$125) since it is lower than the total actual charges for the left and right sides (\$200).

The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

- 1 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), contractors base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code.

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.

- 2 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), contractors base payment for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code YYYYY is \$125. The physician reports code YYYYY-LT with an actual charge of \$100 and YYYYY-RT with an actual charge of \$100. Payment would be based on the fee schedule amount (\$125) since it is lower than the total actual charges for the left and right sides (\$200).

The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

- 3 The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier 50 or is reported for both sides on the same day by any

other means (e.g., with RT and LT modifiers or with a 2 in the units field), contractors base payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, contractors determine the fee schedule amount for a bilateral procedure before applying any applicable multiple procedure rules.

Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.

- 9 Concept does not apply.

Assistant at surgery

This field provides an indicator for services where an assistant at surgery is never paid for per the CMS Internet-only manual.

- 0 Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.
- 1 Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.
- 2 Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.
- 9 Concept does not apply.

Co-surgeons – modifier 62

This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid.

- 0 Co-surgeons not permitted for this procedure.
- 1 Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.
- 2 Co-surgeons permitted; no documentation required if two specialty requirements are met.
- 9 Concept does not apply.

Team surgeons – modifier 66

This field provides an indicator for services for which team surgeons may be paid.

- 0 Team surgeons not permitted for this procedure.
- 1 Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report.
- 2 Team surgeons permitted; pay by report.
- 9 Concept does not apply.

Physician supervision of diagnostic procedures

This field provides levels of physician supervision required for diagnostic tests payable under the physician fee schedule.

General supervision means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. Under general supervision, the training of the

Medicare physician fee schedule payment policy indicators (continued)

nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

- 01** Procedure must be performed under the general supervision of a physician.
- 02** Procedure must be performed under the direct supervision of a physician.
- 03** Procedure must be performed under the personal supervision of a physician.
- 04** Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.
- 05** Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the direct supervision of a physician.
- 06** Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under state law.
- 21** Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.
- 22** May be performed by a technician with on-line real-time contact with physician.
- 66** May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure.
- 6A** Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.
- 77** Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.
- 7A** Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.
- 09** Concept does not apply.

Facility pricing

Facility fees are calculated at a national level with a reduced practice expense, because of reduced physician overhead associated with services provided in a facility. Place of service (POS) codes to be used to identify facilities are:

- 21** Inpatient hospital
- 22** Outpatient hospital
- 23** Emergency room
- 24** Ambulatory surgical center - In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures **not** on the ASC list of approved procedures, contractors will also pay the lower facility fee to physicians.
- 26** Military treatment facility
- 31** Skilled nursing facility
- 34** Hospice
- 41** Ambulance - land
- 42** Ambulance air or water
- 51** Inpatient psychiatric facility
- 52** Psychiatric facility partial hospitalization
- 53** Community mental health center
- 56** Psychiatric residential treatment facility
- 61** Comprehensive inpatient rehabilitation facility

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Therapeutic Services

Sleep testing for obstructive sleep apnea

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6534 which announces that Medicare will allow for coverage of specified sleep tests for adult beneficiaries based upon clinical evaluation and a suspicion of obstructive sleep apnea (OSA) as contained in section 240.4.1 of the *National Coverage Determination (NCD) Manual*. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) has addressed the coverage of continuous positive airway pressure (CPAP) in three separate decisions in October 2001, April 2005, and March 2008. In each of those decisions, CMS limited coverage of CPAP in patients with OSA to those patients whose diagnosis was based on specific testing modalities. Initially, it limited coverage to OSA diagnosed with polysomnography (PSG). In the latest decision, it expanded coverage to OSA diagnosed with several types of home sleep tests. However, CMS has not, at a national level, specifically addressed coverage of the tests themselves. In other words, CPAP is nationally covered for beneficiaries with OSA if diagnosed with these specific tests; yet, coverage of the specific tests has previously been left to local contractor discretion.

After careful consideration, Medicare will allow for coverage of specified sleep tests for adult beneficiaries based upon clinical evaluation and a suspicion of OSA as contained in section 240.4.1 of the *NCD Manual*.

Effective for claims with dates of service on and after March 3, 2009, Medicare will allow for coverage of the following:

1. Type I PSG when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.
2. Type II or Type III sleep testing device when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
3. Type IV sleep testing device measuring three or more channels, one of which is airflow, when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
4. Sleep testing device measuring three or more channels that include actigraphy, oximetry, and peripheral arterial tone when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

Nationally noncovered indications

Effective for claims with dates of services on and after March 3, 2009, other diagnostic sleep tests for the diagnosis of OSA, other than those noted above for prescribing CPAP, are not sufficient for the coverage of CPAP and are not covered.

Note: All current claims processing and associated coding remain unchanged. Consult CR 6048, dated October 15, 2008, for detailed claims processing information. The *MLN Matters*[®] article related to CR 6048 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6048.pdf> on the CMS Web site.

Additional information

Note that Medicare contractors will not search their files to adjust claims processed prior to the implementation date of CR 6534. However, they will adjust such claims that you bring to their attention.

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

The official instruction (CR 6534) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R103NCD.pdf> on the CMS Web site.

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 Related CR Transmittal #: R103NCD
 Implementation Date: August 10, 2009

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General Coverage

Correct coding can avoid fragmented billing issues

When submitting Medicare claims, it is essential for providers to ensure that they are not only using current and valid codes but also that they are using the appropriate modifier when necessary. In addition, it is also critical – to ensure prompt and accurate payment – for providers to bill for services and procedures furnished on the same date of service in the same claim.

This is especially important to remember when billing Medicare for evaluation and management (E/M) services that were performed by a physician on the same day as a distinctly separate procedure, such as the administration of chemotherapy to a patient. If the service and related procedure are performed on the same day but are billed separately, the claim will be fragmented, and the provider may be paid inaccurately.

Note: If a fragmented claim results in an overpayment, the previously processed claim must be adjusted and overpaid funds recovered.

In order to receive appropriate payment, the submitted claim must meet these criteria:

- A valid consultation (E/M) code must be used.
- Modifier 25 should be billed with the E/M code only if significant, separately identifiable, evaluation and management service was performed on the same day of another service/procedure.
- The service and procedure must be billed together and submitted in the same claim.

Note: Global surgery is another example of the type of services that should be billed on the same claim when rendered by the same provider on the same day. Since the Medicare physician fee schedule amount for surgical procedures includes all services that are part of the global surgery package, Medicare administrative contractors do not pay more than that amount when a bill is fragmented. To view Medicare physician fee schedule payment policy indicators including information pertaining to global surgery, visit http://medicare.fcso.com/Fee_resources/137945.asp.

In the event a separate distinct service (different session, site, etc.) is performed on the same day as other services, the appropriate modifier must be billed on the lesser/minor procedure in order for the services to be paid correctly.

First Coast Service Options Inc. (FCSO) offers several resources to help providers avoid billing issues:

- Evaluation and management (E/M) FAQs – <http://medicare.fcso.com/FAQs/140855.asp>
- Modifier FAQs – <http://medicare.fcso.com/FAQs/138438.asp>
- Billing issue FAQs – <http://medicare.fcso.com/FAQs/138013.asp>
- National Correct Coding Initiative (NCCI) page – <http://medicare.fcso.com/NCCI/>

You will also find additional resources on the Centers for Medicare & Medicaid Services (CMS) Web site including a procedure/diagnosis lookup tool, which may be accessed at http://www.cms.hhs.gov/mcd/serviceindication_criteria.asp. To further assist providers, FCSO also offers online training as well as Medicare educational webcasts focusing on E/M and other Medicare billing issues.

- Preview online courses available on www.fcsoedicaretraining.com at http://medicare.fcso.com/Online_learning/140737.asp.
- For a listing of upcoming Medicare educational events, visit http://medicare.fcso.com/Education_resources/139814.asp.
- Review Chapter 12, Section 40.5, of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf#search=%2240.5%22>.

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

Expiration of Medicare processing of certain Indian Health Service Part B claims

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

Provider types affected

Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based) facilities submitting claims to Medicare contractors (carrier or DME Medicare administrative contractors [DME MACs]).

Provider action needed

This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected IHS physicians, IHS providers, and IHS suppliers that beginning January 1, 2010, IHS facilities can no longer bill Medicare for ‘other’ Part B services, including durable medical equipment (DME), prosthetics, orthotics, therapeutic shoes, clinical laboratory services, surgical dressing, splints and casts, drugs (those processed by the DME/MACs and those processed by the A/B MACs and the Part B carrier) and ambulance services. As a result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, coverage of these “other” Part B items and services started January 1, 2005, for a five-year period which ends January 1, 2010. This article alerts affected providers that the five-year period expires as of January 1, 2010.

Background

The Social Security Act, Section 1880 (http://www.ssa.gov/OP_Home/ssact/title18/1880.htm on the Internet) provides for payment to Indian Health Service (IHS) facilities for services paid under the physician fee schedule.

Additionally, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 630) expanded the scope of items and services for which payment could be made to IHS facilities to include all “other” Part B covered items and services for a five year period beginning January 1, 2005, and ending January 1, 2010. See change request (CR) 3288 at <http://www.cms.hhs.gov/transmittals/downloads/R241CP.pdf> on the Centers for

Medicare & Medicaid Services (CMS) Web site. An *MLN Matters*® article related to that transmittal is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3288.pdf> on the CMS Web site.

This special edition article is being provided by CMS to notify affected IHS physicians, IHS providers, and IHS suppliers that beginning January 1, 2010, IHS facilities can no longer bill Medicare for the following Part B services:

- Durable medical equipment (DME)
- Prosthetics and orthotics
- Surgical dressings, splints and casts
- Therapeutic shoes
- Drugs (those processed by the DME/MACs and those processed by the A/B MACs and the Part B carrier)
- Clinical laboratory services, and
- Ambulance services.

Additional information

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

MLN Matters® Number: SE0912
 Related Change Request (CR) #: 3288
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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Wrong surgical/other invasive procedure performed on a patient and/or body part

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

Provider types affected

Physicians, other practitioners, and providers billing Medicare contractors (carriers, fiscal intermediaries [FIs] or Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Effective January 15, 2009, the Centers for Medicare & Medicaid Services (CMS) does not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these noncovered procedures as defined in the *Medicare Benefit Policy Manual* (BPM) Chapter 1, Sections 10 and [120] and Chapter 16, Section [180]. This is pursuant to the national coverage determinations (NCDs) made as part of change request (CR) 6405.

Caution – what you need to know

For inpatient claims, hospitals are required to bill two claims when the erroneous surgery related to the NCD is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the noncovered services/procedures as a no-pay claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery/procedure.

Wrong surgical/other invasive procedure performed on a patient and/or body part (continued)**GO – what you need to do**

Make sure that your billing staff is aware of these new billing and claim requirements.

Background

In 2002, the National Quality Forum (NQF) published *Serious Reportable Events in Healthcare: A Consensus Report*, which listed 27 adverse events that were “serious, largely preventable and of concern to both the public and health care providers.” (That report is available at <http://www.qualityforum.org/pdf/reports/sre.pdf> on the Internet.) These events and subsequent revisions to the list became known as “never events.” This concept and need for the proposed reporting led to NQF’s “Consensus Standards Maintenance Committee on Serious Reportable Events,” which maintains and updates the list that currently contains 28 items.

In order to address and reduce the occurrence of these surgeries, CR 6405 establishes three new NCDs that nationally non-cover the three surgical errors and sets billing policy to implement appropriate claims processing.

Effective January 15, 2009, CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs:

- 1) a different procedure altogether;
- 2) the correct procedure but on the wrong body part; or
- 3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these noncovered procedures as defined in the *Medicare Benefit Policy Manual* (BPM) Chapter 1, Sections 10 and [120], and Chapter 16, Section [180]. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

Note: Related services do not include performance of the correct procedure.

Definitions

- Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the *Current Procedural Terminology (CPT)* and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.
- A surgical or other invasive procedure is considered to

be the wrong procedure if it is not consistent with the correctly documented informed consent for that patient.

- A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

Note: Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).

- A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient.

Beneficiary Liability

Generally, a beneficiary liability notice such as an advance beneficiary notice of noncoverage (ABN) or a hospital issued notice of noncoverage (HINN) is appropriate when a provider is furnishing an item/service that the provider reasonably believes Medicare will not cover on the basis of Section 1862(a)(1) of the Social Security Act.

- An ABN must include all of the elements described in the *Medicare Claims Processing Manual*, Chapter 30, Section 50.6.3, in order to be considered valid. For example, the ABN must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include a cost estimate for the noncovered item/service. (The *Medicare Claims Processing Manual* is available on the CMS Web site at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.)
- Similarly, HINNs must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include all of the elements described in the instructions found in the *Medicare Claims Processing Manual*, Chapter 30, Section 200.

Thus, a provider cannot shift financial liability for the noncovered services to the beneficiary, unless the ABN or the HINN satisfies all of the applicable requirements in Chapter 30, Sections 50.6.3 and 200, respectively, of the *Medicare Claims Processing Manual*.

Given these requirements, CMS cannot envision a scenario in which HINNs or ABNs could be validly delivered in these NCD cases. However, an ABN or a HINN could be validly delivered prior to furnishing follow-up care for the noncovered surgical error that would not be considered a related service to the noncovered surgical error (see Chapter 1, Sections 10 and 120, and Chapter 16, Section 180, of the *Benefit Policy Manual*).

Wrong surgical/other invasive procedure performed on a patient and/or body part (continued)**Implementation****Inpatient claims**

Effective for inpatient discharges on or after January 15, 2009, hospitals are required to bill two claims when the erroneous surgery(s) related to the NCD is reported:

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a type of bill (TOB) 11x (with the exception of 110), and
- The other claim with the noncovered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim).
- Both the covered and noncovered claim must have a matching statement covers period.

The noncovered TOB 110 will be required to be submitted via the UB-04 (hard copy) claim form, clearly indicating in form locator (FL) 80 (remarks), or the 837I (electronic) claim form, loop 2300, one of the applicable two-digit surgical error codes as follows:

- MX – for a wrong surgery on patient
- MY – for surgery on the wrong body part, or
- MZ – for surgery on the wrong patient.

The claim for the noncovered services will be denied using:

- Claim adjustment reason code (CARC) 50 – These are noncovered services because this is not deemed a ‘medical necessity’ by the payer.
- Group code CO – contractual obligation.

Outpatient, ambulatory surgical centers (ASCs), other appropriate bill types and practitioner claims

Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate TOBs are required to append one of the following applicable NCD modifiers to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009:

- PA: Surgery wrong body part
- PB: Surgery wrong patient
- PC: Wrong surgery on patient

Contractors shall suspend claims with dates of service on and after January 15, 2009, with surgical errors identified by one of the above HCPCS modifiers.

Contractors shall create/maintain a list that includes the beneficiary health information code and the surgical error date of service. Each new surgical error occurrence shall be added to the list, and an MPP event or a system

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control facility (SCF) rule shall be implemented so that all claims for that beneficiary for that date of service will be suspended. Contractors shall then continue to process the claim.

Claim lines submitted with one of the above HCPCS modifiers will be line-item denied using the following:

- CARC 50 – These are noncovered services because this is not deemed a “medical necessity” by the payer.
- Group code – CO – contractual obligation

Related claims

Within five days of receiving a claim for a surgical error, contractors shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, contractors shall review any claims applied to SCF rules and MPP events to identify incoming claims that have the potential to be related. When Medicare identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, contractors shall continue to review beneficiary history for related claims and take appropriate action as necessary.

Additional information

For complete details regarding this CR please see the official instruction (CR 6405) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction was issued in two transmittals. The first transmittal presents the national coverage determination related to this issue and that transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R102NCD.pdf> on the CMS Web site. The other transmittal presents the *Medicare Claims Processing Manual* revision and instructions. That transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R1778CP.pdf> on the CMS Web site.

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

MLN Matters® Number: MM6405

Related Change Request (CR) #: 6405

Related CR Release Date: July 24, 2009

Effective Date: January 15, 2009

Related CR Transmittal #: R1778CP and R102NCD

Implementation Date: July 6, 2009, for those billing carriers and Part B MACs; October 5, 2009, for FIs and Part A MACs

Annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification

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

Provider types affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare administrative contractors (MACs), durable medical equipment Medicare administrative contractors, and fiscal intermediaries (FIs) including regional home health intermediaries).

Provider action needed

This article is based on change request (CR) 6520 and reminds the Medicare contractors and providers that the annual International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) update will be effective for dates of service on and after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009). You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) Web site at <http://www.cdc.gov/nchs/icd9.htm> in June of each year.

Background

The ICD-9-CM codes are updated annually as stated in the Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 6520 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, nonphysician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers), and for all institutional claims; but is not required for ambulance supplier claims.

Additional information

If you have questions, please contact your Medicare MAC and/or FI/carrier at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the Centers for Medicare & Medicaid Services (CMS) Web site.

The official instruction (CR 6520) issued to your Medicare MAC and/or FI/carrier is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1770CP.pdf> on the CMS Web site.

MLN Matters® Number: MM6520
 Related Change Request (CR) #: 6520
 Related CR Release Date: July 10, 2009
 Effective Date: October 1, 2009
 Related CR Transmittal #: R1770CP
 Implementation Date: October 5, 2009

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Expansion of the current scope of editing for ordering/referring providers

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

Note: This article was revised on June 29, 2009, to reflect revisions that the Centers for Medicare & Medicaid Services (CMS) made to change request (CR) 6417 on June 26. In the revised CR 6417, CMS clarified the way claims will be processed in phases 1 and 2 and the article was revised accordingly. The article also reflects the remittance advice message that will be supplied on certain claims during phase 1. The CR release date, transmittal number and the CR Web address were also changed. All other information is the same. This information was previously published in the June 2009 *Medicare B Update!* pages 17-18.

Provider types affected

Physicians and nonphysician practitioners who order and/or refer services that are billed to Medicare carriers or Part B Medicare administrative contractors (MAC) for Medicare beneficiaries.

What you need to know

CR 6417, on which this article is based, announces that in order to comply with Social Security Act requirements, the Centers for Medicare & Medicaid Services (CMS) is expanding claim editing to verify that the ordering/referring provider on a claim is enrolled in Medicare and is eligible to order or refer Medicare services.

Please note: The changes being implemented with CR 6417 does not alter any existing regulatory restrictions that may exist with respect to the types of items or services for which some of the provider types listed above can order or refer or any claims edits that may be in place with respect to those restrictions. Please refer to the Background section, below, for more details.

Background

Only physicians and nonphysician practitioners (who meet the definitions at section 1861(r) and 1842(b)(18)(C) of the Social Security Act (the Act)) are eligible to order or refer services for Medicare beneficiaries. In addition, Section 1833(q) of the Act requires that all physicians and nonphysician practitioners who meet these definitions must be uniquely identified on all claims for services that they order or refer. More specifically, effective January 1, 1992, a physician or supplier who bills Medicare for a service or item that was the result of an order or referral must show the name and unique identifier of the ordering/referring provider on the claim. As of May 23, 2008, this unique identifier must be the national provider identifier (NPI).

Expansion of the current scope of editing for ordering/referring providers (continued)

CR 6417, from which this article is taken, announces that, effective October 5, 2009, CMS is expanding claim editing to meet these Social Security Act requirements to verify that the ordering/referring provider on a claim is enrolled in Medicare and is eligible to order or refer.

CR 6417 provides that only the following provider specialties can order or refer beneficiary services:

- Doctor of medicine or osteopathy
- Dental medicine
- Dental surgery
- Podiatric medicine
- Optometrist
- Chiropractic medicine
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife, or
- Clinical social worker.

During phase 1 implementation (beginning October 5, 2009), if the claim does not pass the edits described above, Medicare will continue to process the claim and will include a remark message (M68 – missing/incomplete/invalid attending, ordering, rendering, supervising, or referring physician identification) on the remittance advice.

In phase 2, if the billed service requires an ordering/referring provider and none is present, the claim will not be paid.

If the ordering/referring provider is on the claim, Medicare will verify the ordering/referring provider's NPI and name reported on the claim against Medicare's provider enrollment records to ensure the ordering/referring provider is enrolled in Medicare and is a specialty eligible to order or refer.

Notes:

If multiple provider identification numbers (PINs) are associated to the NPI in MCS, Medicare contractors will use the first active PIN with an eligible specialty to order and refer.

Therefore, upon phase 2 implementation and thereafter, the claim that does not pass the edits described above the claim will not be paid.

All physician and nonphysician practitioners who order and refer items or services for Medicare beneficiaries should verify their Medicare enrollment. They may do so by going to http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage on the CMS Web site.

Additional information

You may find the official instruction, CR 6417, issued to your carrier or B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R5100TN.pdf> on the CMS Web site.

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

MLN Matters® Number: MM6417 *Revised*

Related Change Request (CR) #: 6417

Related CR Release Date: June 26, 2009

Effective Date: October 1, 2009

Related CR Transmittal #: R5100TN

Implementation Date: October 5, 2009

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Billing routine costs of clinical trials

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

Note: This article was revised on June 29, 2009, to reflect a revised change request (CR) 6431, issued by the Centers for Medicare & Medicaid Services (CMS) on June 26, 2009. The transmittal number, CR release date, and the Web address for accessing CR 6431 have changed. In addition, the implementation date was changed to September 28, 2009. All other information is the same. This information was previously published in the May 2009 *Medicare B Update!* pages 18-19.

Provider types affected

Physicians and nonphysician practitioners submitting claims to Medicare administrative contractors (MACs) and carriers for clinical trials.

Provider action needed

This article is based on CR 6431 that alerts providers that they should continue to report the International Classification of Diseases diagnosis code V70.7 (Examination of participant in clinical trial) on clinical trial claims. It is no longer necessary to make a distinction between a diagnostic and therapeutic clinical trial service on the claim.

Background

CR 6431 revises the *Medicare Claims Processing Manual*, Chapter 32, Section 69.6 (Requirements for Billing Routine Costs of Clinical Trials). The revised manual section is attached to CR 6431. The Centers for Medicare & Medicaid Services (CMS) is clarifying that there no longer remains a need to make a distinction between a diagnostic versus therapeutic clinical trial service on the claim.

If the QV or Q1 modifier is billed and diagnosis code V70.7 is submitted by practitioners as a secondary rather than the primary diagnosis, your Medicare contractor will not consider the service as having been furnished to a diagnostic trial volunteer. Instead, they will process the service as a therapeutic clinical trial service.

- Effective for claims processed after September 28, 2009, with dates of service on or after January 1, 2008, claims submitted with either the modifier QV or the modifier Q1 will be returned as unprocessable if the diagnosis code V70.7 is not submitted on the claim.
- Providers will see the following messages from their Medicare contractor with the returned claim:
 - Claims adjustment reason code 16 -- Claim/service lacks information which is needed for adjudication, and
 - As least one remark code, which may be comprised of either:
 - The remittance advice code (M76, Missing/incomplete/invalid diagnosis or condition) or
 - National Council for Prescription Drug Programs Reject Reason Code.

Note: Healthcare Common Procedure Coding System (HCPCS) codes are not reported on inpatient claims. Therefore, the HCPCS modifier requirements (i.e., QV or Q1) as outlined in the outpatient clinical trial section immediately below, are not applicable to inpatient clinical trial claims.

On all outpatient clinical trial claims, providers need to do the following:

- Report condition code 30
- Report a secondary diagnosis code of V70.7, and
- Identify all lines that contain an investigational item/service with a HCPCS modifier of:
 - QA/QR for dates of service before January 1, 2008, or
 - Q0 for dates of service on or after January 1, 2008.
- Identify all lines that contain a routine service with a HCPCS modifier of:
 - QV for dates of service before January 1, 2008, or
 - Q1 for dates of service on or after January 1, 2008.

Additional information

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

The official instruction (CR 6431) issued to your Medicare MAC, or carrier is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1761CP.pdf> on the CMS Web site.

MLN Matters® Number: MM6431 *Revised*

Related Change Request (CR) #: 6431

Related CR Release Date: June 26, 2009

Effective Date: For claims with dates of service on or after January 1, 2008 and processed after September 28, 2009

Related CR Transmittal #: R1761CP

Implementation Date: September 28, 2009

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Smoking and tobacco use cessation counseling billing code update to Medicare

Note: This article was revised on July 22, 2009, to add a reference to change request (CR) 6163 (<http://www.cms.hhs.gov/Transmittals/downloads/R1593CP.pdf>), which removes the outpatient physical therapy provider (OPT) bill type 74x and comprehensive outpatient rehabilitation facility (CORF) bill type 75x from the list of applicable bill types for smoking and tobacco cessation counseling (effective July 1, 2008). The related *MLN Matters*® article may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6163.pdf> on the CMS Web site. All other information is unchanged. This information was previously published in the March 2008 *Medicare B Update!* page 34.

Provider types affected

Physicians and providers who bill Medicare contractors (fiscal intermediaries [FI], carriers, or Medicare administrative contractors [A/B MAC]) for smoking and tobacco use cessation counseling.

Provider action needed

Stop – impact to you

Effective for services on or after January 1, 2008, you must bill for smoking and tobacco use cessation counseling services with new *CPT* codes (99406 or 99407). If you bill using the former HCPCS codes (G0375 and G0376) for services provided after December 31, 2007, your claims will not be paid.

Caution – what you need to know

CR 5878, from which this article is taken, announces that the 2008 Medicare physician fee schedule database (MPFSDB) includes two new *CPT* codes for smoking and tobacco use cessation counseling services; replacing the temporary HCPCS G codes (G0375 and G0376) currently in use for billing these services. These new codes (effective on and after January 1, 2008) are:

- 99406 - *Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*
- 99407 - *Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes*

Go – what you need to do

Make sure that your billing staffs are aware of these newly required *CPT* codes for smoking and tobacco use cessation counseling services.

Background

CR 5878, from which this article is taken announces that the temporary HCPCS G codes G0375 and G0376, which are currently used to bill for smoking and tobacco use cessation counseling services, are effective only through December 31, 2007.

They are being replaced by two new *CPT* codes (99406 – *Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*; and 99407 – *Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes*).

These new *CPT* codes, which are included in the 2008 MPFSDB, become effective for claims with dates of service January 1, 2008, and later.

FIs, carriers, and A/B MACs will pay for counseling services billed with HCPCS codes G0375 and G0376 for dates of service performed on and after March 22, 2005, through Dec. 31, 2007 and with *CPT* codes 99406 and 99407 for dates of service on or after January 1, 2008.

Additional information

You may find CR 5878 at <http://www.cms.hhs.gov/Transmittals/downloads/R1433CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site. You will find the updated *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 12.1 (HCPCS and Diagnosis Coding), 12.2 (Carrier Billing Requirements), and 12.3 (FI Billing Requirements) as an attachment to that CR.

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

MLN Matters® Number: MM5878 *Revised*

Related Change Request (CR) #: 5878

Related CR Release Date: February 1, 2008

Effective Date: January 1, 2008

Related CR Transmittal #: R1433CP

Implementation Date: July 7, 2008

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.

Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. *CPT* codes, descriptions and other data only are copyrighted 2008 American Medical Association (or other such date of publication of *CPT*). All rights reserved. Applicable FARS/DFARS apply.

Electronic Data Interchange

Claim status category code and claim status code update

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

Provider types affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], carriers, A/B Medicare administrative contractors [MAC] and durable medical equipment MACs or DME MACs) for Medicare beneficiaries are affected.

Provider action needed

This article, based on change request (CR) 6525, explains that the claim status codes and claim status category codes for use by Medicare contractors with the health claim status request and response ASC X12N 276/277 were updated during the January 2009 meeting of the national code maintenance committee and code changes approved at that meeting were posted at <http://www.wpc-edi.com/content/view/180/223/> on the Internet on March 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the national code maintenance committee in the X12 276/277 health care claim status request and response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in

the X12 276/277 to report claim status. All code changes approved during the January 2009 committee meeting were posted at <http://www.wpc-edi.com/content/view/180/223/> on March 1, 2009. Medicare will implement those changes on July 6, 2009, as a result of CR 6525.

Additional information

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the Centers for Medicare & Medicaid Services (CMS) Web site.

The official instruction issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1756CP.pdf> on the CMS Web site.

MLN Matters® Number: MM6525
 Related Change Request (CR) #: 6525
 Related CR Release Date: June 12, 2009
 Effective Date: July 1, 2009
 Related CR Transmittal #: R1756CP
 Implementation Date: July 6, 2009

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CMS' dedicated section for information on versions 5010, D.0, and 3.0 available

This section of the Centers for Medicare & Medicaid Services (CMS) Web site contains information and educational resources pertaining to:

- **Version 5010** -- the new version of the X12 standards for Health Insurance Portability and Accountability Act (HIPAA) transactions
- **Version D.0** -- the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions
- **Version 3.0** -- a new NCPDP standard for Medicaid pharmacy subrogation

This section includes background information on the new standards, regulatory information, the latest

outreach messages from CMS, educational resources, resources specific to D.0 and 3.0, as well as implementation information for the Medicare fee-for-service systems. CMS plans to add additional information as it becomes available, so bookmark the section today. You may access this section at <http://www.cms.hhs.gov/Versions5010andD0>.

You may also view the presentation, transcript and listen to the audio file from the June 9 national provider conference call regarding versions 5010 and D.0, available on the *Educational Resources* page or at <http://www.cms.hhs.gov/Versions5010> and [D0/Downloads/6-9-2009_National_Provider_Call.pdf](http://www.cms.hhs.gov/Downloads/6-9-2009_National_Provider_Call.pdf) on the CMS Web site.

Source: PERL 200907-26

Medicare remit easy print software codes update

The Centers for Medicare & Medicaid Services (CMS) is not providing an updated "codes.ini" file with the implementation of the July 2009 release (change request 6453). Due to the timing of when the codes committee meets, the list of updated claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) will not be available until after the implementation of the July 2009 release. Therefore, CMS will provide an updated list of CARCs and RARCs via the "codes.ini" file with the implementation of the October 2009 release.

Source: PERL 200907-21

General Information

FDA consumer alert: Warning consumers of a tainted skin sanitizer

Following an announcement by the U. S. Food and Drug Administration (FDA) warning consumers of a tainted skin sanitizer, the Centers for Medicare & Medicaid Services (CMS) is advising health care providers and consumers not to use skin products made by Clarcon Biological Chemistry Laboratory. Clarcon is voluntarily recalling some skin sanitizers and skin protectants marketed under several different brand names because of high levels of disease-causing bacteria found in the product during a recent inspection.

Consumers and providers are being warned to not use any Clarcon products and to throw these products away in household refuse.

FDA analyses of several samples of Clarcon products revealed high levels of various bacteria, including some associated with unsanitary conditions. Some of these bacteria can cause opportunistic infections of the skin and underlying tissues. Such infections may need medical or surgical attention, and may result in permanent damage. Examples of products that should be discarded include:

- Citrusshield lotion
- Dermasentials dermabarrier
- Dermasentials by Clarcon antimicrobial hand sanitizer
- Iron fist barrier hand treatment

- Skin shield restaurant
- Skin shield industrial
- Skin shield beauty salon lotion
- Total skin care beauty
- Total skin care work

Health care professionals and consumers may report serious adverse events (side effects) or product quality problems with the use of this product to the FDA's MedWatch Adverse Event Reporting program either online, by regular mail, fax, or phone.

- Online
- Regular mail: use postage-paid FDA form 3500 and mail to
MedWatch
5600 Fishers Lane
Rockville, MD 20852-9787
- Fax: 800-FDA-0178
- Telephone: 800-FDA-1088

More information is available at <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm164845.htm>.

Source: PERL 200906-24

Coding and reporting principles for the PQRI and the e-Prescribing incentive programs

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

Provider types affected

Physicians and practitioners (referred to as eligible professionals [EPs]) who wish to participate in the Medicare Physician Quality Reporting Initiative (PQRI) and/or the electronic prescribing (e-Prescribing) incentive programs in 2009.

What you need to know

Change request (CR) 6514, from which this article is taken, provides a high-level overview of the coding and reporting principles for the claims-based reporting of quality measures data for the 2009 PQRI, and for the claims-based reporting of the e-prescribing measure for the 2009 e-Prescribing incentive program. Because the information in CR 6514 is quite detailed and important for these two programs, this article will mirror virtually all of that detail.

Background

The 2006 Tax Relief and Health Care Act (TRHCA) required the establishment of a physician quality reporting system, including an incentive payment for EPs who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007. The Centers for Medicare & Medicaid Services (CMS) named this program the PQRI.

For the 2009 PQRI, the Medicare, Medicaid, and State

Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) required the Secretary of Health and Human Services (HHS) to select measures for 2009 through rulemaking, and to establish alternative reporting criteria and alternative reporting periods for reporting on a group of measures, or measures groups, and for registry-based reporting. In addition, the Medicare Improvements for Patients and Providers Act (MIPPA), which was enacted on July 15, 2008, includes many provisions that impact the 2009 PQRI. Thus, for 2009, PQRI submission of quality data may be performed via claims or via a qualified registry; and multiple reporting options are available for each method of submission, including the option of reporting on individual quality measures or on measures groups.

Section 132 of the MIPPA also authorizes a new and separate incentive program for EPs who are successful e-prescribers as defined by MIPPA. This new incentive is separate from, and in addition to, the PQRI. To be considered a successful e-prescriber for 2009, an EP must report an e-prescribing measure in at least 50 percent of reportable cases. For 2009, the e-prescribing measure may be reported via claims only. To be considered a successful e-prescriber for 2009, an EP must report an e-prescribing measure on at least 50 percent of reportable cases and at least 10 percent of an EP's total allowed Medicare Part

Coding and reporting principles for the PQRI and the e-Prescribing incentive programs (continued)

B charges must come from the services delineated in the measure's denominator. For 2009, the e-prescribing measure may be reported via claims only.

CR 6514, from which this article is taken, provides a high-level overview of the coding and reporting principles for the claims-based reporting of quality measures data for the 2009 PQRI, and for the claims-based reporting of the e-prescribing measure for the 2009 e-Prescribing incentive program.

Coding and reporting principles for the claims-based reporting of PQRI measures

To implement 2009 PQRI claims-based reporting of measures or measures groups, eligible professionals (EPs), using your individual national provider identifier (NPI) and submitting billable services on Part B claims for allowable Medicare physician fee schedule (MPFS) charges, may report the quality action for selected PQRI quality measure(s) or measures groups, which are comprised of four or more PQRI quality measures. In general, the PQRI quality measures consist of a unique denominator (eligible case) and numerator (quality action) that permit the calculation of the percentage of a defined patient population: 1) who receive a particular process of care or achieve a particular outcome, or 2) for whom care was delivered using a particular structural element. It is important that you review and understand each measure specification, which provides definitions and specific instructions for reporting a measure.

Notes:

- 1) You should review the following documents if you choose to report individual PQRI quality measures:
 - "2009 PQRI Measure Specifications Manual for Claims and Registry".
 - "2009 PQRI Implementation Guide," which describes important reporting principles underlying claims-based reporting of measures and includes a sample claim in Centers for Medicare & Medicaid Services (CMS) 1500 format.
- 2) You should review the following documents if you choose to report PQRI measures groups:
 - **2009 PQRI Measures Groups Specifications Manual** – note that the specifications for a measures group are different from those for individual measures because measures groups require a common denominator. Be sure you use the correct specifications.
 - **Getting Started with 2009 PQRI Reporting of Measures Groups** – this is the implementation guide for reporting measures groups.
 - **2009 PQRI Tip Sheet: PQRI Made Simple – Reporting the Preventive Care Measures Group** – this tip sheet provides a useful worksheet to keep track of each patient reported when using the 30-consecutive patient sample method for a measures group.

You may find the first four documents on the *Measures/Codes* section of the CMS PQRI Web site at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage on the CMS Web site, and the fifth on the *Educational Resources* section of the CMS PQRI Web site at http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage on the CMS Web site.

As mentioned above PQRI measures consist of two major components: 1) A denominator that describes the eligible cases for a measure (the eligible patient population associated with a measure's numerator); and 2) A numerator that describes the quality action required by the measure for reporting and performance. Each component is defined by specific codes described in each measure specification along with reporting instructions and use of modifiers.

Current Procedural Terminology (CPT) category I modifiers

The PQRI measure specifications include specific instructions regarding inclusion of *CPT* category I modifiers. Unless otherwise specified, *CPT* category I codes may be reported with or without *CPT* modifiers. You should refer to each individual measure specification for detailed instructions to identify *CPT* category I modifiers that qualify or do not qualify a claim for denominator inclusion.

Please note that PQRI-eligible *CPT* category I procedure codes, billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population for applicable PQRI measure(s). Both surgeons participating in PQRI will be fully accountable for the quality action(s) described in the PQRI measure(s).

However, surgical procedures billed by an assistant surgeon(s) will be excluded from the denominator population so their performance rates will not be negatively impacted for PQRI. PQRI analyses will exclude otherwise PQRI-eligible *CPT* category I codes, when submitted with assistant surgeon modifiers 80, 81, or 82. The primary surgeon, not the assistant surgeon, is responsible for performing and reporting the quality action(s) in applicable PQRI measures.

Quality-data codes (QDCs)

QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified *CPT* category II codes and/or G-codes that describe the quality action required by a measure's numerator. Quality actions can apply to more than one condition, and therefore can also apply to more than one measure. Where necessary, to avoid shared *CPT* category II codes, G-codes are used to distinguish quality actions across measures. Some measures require more than one quality action and therefore have more than one *CPT* category II code, G-code, or a combination associated with them. You should review numerator reporting instructions carefully.

CPT category II codes

CPT category II or *CPT* II codes, developed through the *CPT* editorial panel for use in performance measurement, serve to encode the quality action(s) described in a measure's numerator. *CPT* II codes consist of five alphanumeric characters in a string ending with the letter "F." *CPT* II codes are not modified or updated during the reporting period and remain valid for the entire program year as published in the measure specifications manuals and related documents for PQRI.

Use of CPT II modifiers

CPT II modifiers are unique to *CPT* II codes and may be used to report PQRI measures by appending the appropriate modifier to a *CPT* II code as specified for a

Coding and reporting principles for the PQRI and the e-Prescribing incentive programs (continued)

given measure. The modifiers for a code are mutually exclusive and their use is guided by the measure's coding instructions, which are included in the numerator coding section of the measure specifications. Use of the modifiers is unique to *CPT* II codes and may not be used with other types of *CPT* codes. Only *CPT* II modifiers may be appended to *CPT* II codes. Descriptions of each modifier are provided below to help identify circumstances when the use of an exclusion modifier may be appropriate. Note that in a pay-for-reporting model, accurate reporting on all selected applicable measures counts the same, whether reporting that the quality action was performed or not.

CPT II code modifiers fall into two categories, exclusion modifiers and the 8P reporting modifier.

- 1) Exclusion modifiers may be appended to a *CPT* II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Some measures do not allow performance exclusions. Reasons for appending a performance measure exclusion modifier fall into one of three categories:
 - 1P exclusion modifier due to medical reasons
Examples include: not indicated (absence of organ/limb, already received/performed, other); contraindicated (patient allergic history, potential adverse drug interaction, other); other medical reasons.
 - 2P exclusion modifier due to patient reasons
Examples include: patient declined; economic, social, or religious reasons; other patient reasons.
 - 3P exclusion modifier due to system reasons
Examples include: resources to perform the services not available (e.g., equipment, supplies); insurance coverage or payer-related limitations; other reasons attributable to health care delivery system.
- 2) The 8P reporting modifier is available for use only with *CPT* II codes to facilitate reporting a denominator eligible case when an action described in a measure is not performed and the reason is not specified. Instructions for appending this reporting modifier to *CPT* category II codes are included in applicable measures. Use of the 8P reporting modifier indicates that the patient is eligible for the measure; however, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers.
 - 8P reporting modifier - action not performed, reason not otherwise specified.

The 8P reporting modifier facilitates reporting an eligible case on a given measure when the quality action does not apply to a specific encounter. EPs can use the 8P modifier to receive credit for satisfactory reporting but will not receive credit for performance.

For example, a clinician who has selected and submitted QDCs during the reporting period for 2009 PQRI Measure #6, oral antiplatelet therapy, sees a patient during an encounter and the claim for services for that encounter contains ICD-9-CM and *CPT* codes that will draw the patient into the measures' denominator during analysis. The 8P modifier serves to include the patient in the numerator when reporting rates are calculated for PQRI.

Claims-based reporting principles for PQRI

The following principles apply to the reporting of QDCs for PQRI measures:

- The *CPT* category II code(s) and/or G-code(s), which supply the numerator, must be reported:
 - on the same claim as the denominator billing code(s)
 - for the same beneficiary
 - for the same date of service (DOS)
 - by the same EP (individual NPI) who performed the covered service as the payment codes, usually ICD-9-CM, *CPT* category I or HCPCS codes, which supply the denominator.
- All diagnoses reported on the base claim, regardless of the order listed, will be included in PQRI analysis, as some PQRI measures require reporting more than one diagnosis on a claim. To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in PQRI analysis.
- Up to four diagnoses can be reported in the header on the CMS-1500 and up to eight diagnoses can be reported in the header on the electronic claim. However, only one diagnosis may be linked to each line item, whether billing on paper or electronically.
- If your billing software limits the number of line items available on a claim, you may add a nominal amount such as a penny, to one of the line items on that second claim for a total charge of one penny. PQRI analysis will subsequently join both claims based on the same beneficiary for the same date-of-service, for the same TIN/NPI and analyze as one claim. You should work with your billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses or QDCs are not dropped.
- QDCs must be submitted with a line-item charge of zero dollars (\$0.00) at the time the associated covered service is performed.
 - The submitted charge field cannot be blank.
 - The line item charge should be \$0.00.
 - If a system does not allow a \$0.00 line-item charge, a nominal amount can be substituted – the beneficiary is not liable for this nominal amount.

Coding and reporting principles for the PQRI and the e-Prescribing incentive programs (continued)

- Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be \$0.00.)
- Whether a \$0.00 charge or a nominal amount is submitted to the carrier/contractor, the PQRI QDC line is denied and tracked.
- QDC line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. EPs will receive a remittance advice (RA) associated with the claim which will contain the PQRI QDC line-item and will include a standard remark code (N365) and a message that confirms that the QDC(s) passed into the national claims history (NCH) file. N365 reads: “This procedure code is not payable. It is for reporting/information purposes only.” The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the EP is attempting to report.
- Multiple EPs’ QDCs may be reported on the same claim using their individual NPI. Therefore, when a group is billing, you should follow their normal billing practice of placing the NPI of the individual EP who rendered the service on each line item on the claim including the QDC line(s).
- Some measures require the submission of more than one QDC in order to properly report the measure. Report each QDC as a separate line item, referencing one diagnosis and including the rendering provider NPI.
- Solo practitioners should follow your normal billing practice of placing your individual NPI in the billing provider field, (#33a on the CMS-1500 or the electronic equivalent).
- EPs may submit multiple codes for more than one measure on a single claim.
- Multiple CPT category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim.
- If a denied claim is subsequently corrected through the appeals process to the carrier/AB MAC, with accurate codes that also correspond to the measure’s denominator, then QDCs that correspond to the numerator should also be included on the resubmitted claim as instructed in the measure specifications.
- Claims may **not** be resubmitted for the sole purpose of adding or correcting QDCs.

You may submit QDCs to your carriers/MACs either through electronic or paper based submission.

When using electronic submission, which is accomplished using the ASC X 12N Health Care Claim Transaction (Version 4010A1), you should submit CPT category II and/or temporary G-codes in the SV101-2 “Product/Service ID” Data Element on the SV1 “Professional Service” Segment of the 2400 “Service Line” loop.

You must also identify in this segment that a HCPCS code is being supplied by submitting the HC in data element

SV101-1 within the SV1 “Professional Service” Segment. Further, you should submit diagnosis codes at the claim level, loop 2300, in data element HI01, and if there are multiple diagnosis codes, in HI02 through HI08 as needed with a single reference number in the diagnosis pointer. In general for group billing, you should report the NPI for the rendering provider in loop 2310B (Rendering Provider Name, claim level) or 2420A (Rendering Provider Name, line level), using data element NM109 (with NM108=XX).

For paper-based submissions, use the CMS-1500 (08-05). Enter the relevant ICD-9-CM diagnosis codes in field 21 and enter service codes (including CPT, HCPCS, CPT category II and/or G-codes) with any associated modifiers in field 24D with a single reference number in the diagnosis pointer field 24E that corresponds with the diagnosis number in field 21.

For group billing, you should enter the national provider identifier (NPI) of the rendering in field 24J, and the tax identification number (TIN) of the employer is entered in field 25.

Group and solo NPI submission

When a group bills, the group’s NPI is submitted at the claim level, therefore, the individual rendering physician’s NPI must be placed on each line item, including all allowed charges and quality-data line items.

Solo practitioners must include your individual NPI on the claim line as is the normal billing process for submitting Medicare claims. For PQRI, the QDC must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in PQRI analysis.

Timeliness of quality data submission

You should be aware that claims processed by the carrier/MAC must reach the national Medicare claims system data warehouse (national claims history file) by February 28, 2010, to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

Analysis of PQRI data: reporting frequency and performance timeframes

Instructions for some measures limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically. Some measures, due to their complexity, are reportable as registry only or measures group only.

Each measure specification includes a reporting frequency for each denominator-eligible patient seen during the reporting period. The reporting frequency described in the instructions applies to each individual EP participating in PQRI. PQRI uses the reporting frequency to analyze each measure for determination of satisfactory reporting:

- **Patient-process:** Report a minimum of once per reporting period per individual EP (NPI).
- **Patient-intermediate:** Report a minimum of once per reporting period per individual EP (NPI).
- **Patient-periodic:** Report once per timeframe specified in the measure for each individual EP (NPI) during the reporting period.

Coding and reporting principles for the PQRI and the e-Prescribing incentive programs (continued)

- **Episode:** Report once for each occurrence of a particular illness/condition by each individual EP (NPI) during the reporting period.
- **Procedure:** Report each time a procedure is performed by the individual EP (NPI) during the reporting period.
- **Visit:** Report each time the patient is seen by the individual EP (NPI) during the reporting period.

A measure's performance timeframe is defined in the measure's description and is distinct from the reporting frequency requirement. The performance timeframe, unique to each measure, delineates the timeframe in which the quality action described in the numerator may be accomplished.

Coding and reporting principles for claims-based reporting of the e-Prescribing measure

Similar to the PQRI, the e-Prescribing measure consists of a unique denominator (eligible case) and numerator (quality action) that permit the calculation of the percentage of a defined patient population for whom care was delivered using a particular structural element. Also, similar to PQRI, claims-based reporting of the e-Prescribing measure requires EPs, using their individual NPI and submitting billable services on Part B claims for allowable physician fee schedule charges, to report the quality action for the e-Prescribing measure. You should review and understand the e-Prescribing measure specification, which provides definitions and specific instructions for reporting the measure.

Note: You should review the following documents if you choose to participate in the e-Prescribing incentive program:

- E-Prescribing Measure Specifications
- Claims-based Reporting Principles for E-Prescribing – this provides guidance about how to report the e-prescribing measure on claims
- Sample E-Prescribing Claim – this provides a detailed sample of an individual NPI reporting the e-prescribing measure on a CMS-1500.

These documents are all available on the *e-Prescribing Measure* section of the *e-Prescribing Incentive* Web site at <http://www.cms.hhs.gov/ERXIncentive> on the CMS Web site. In addition, educational resources to assist you in successfully participating in the e-Prescribing incentive program are also available on the *Educational Resources* section of the e-Prescribing Incentive Web site at http://www.cms.hhs.gov/ERXIncentive/09_Educational_Resources.asp#TopOfPage on the CMS Web site.

The following principles apply for claims-based reporting of the e-Prescribing measure:

- 1) You should report one of the three e-Prescribing codes listed below as the claim numerator:
 - G8443 - All prescriptions created during the encounter were generated using a qualified e-prescribing system.
 - G8445 - No prescriptions were generated during the encounter.

- G8446 - Provider does not have access to a qualified e-Prescribing system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by the state or federal law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances.
- 2) You must report the e-Prescribing code (which supplies the numerator):
 - on the same claim as the denominator billing code
 - for the same beneficiary
 - for the same date of service (DOS)
 - by the same EP (individual NPI) who performed the covered service
 - 3) You must submit the e-prescribing code with a line-item charge of zero dollars (\$0.00) at the time the associated covered service is performed.
 - The submitted charge field cannot be blank.
 - The line item charge should be \$0.00.
 - If a system does not allow a \$0.00 line-item charge, a nominal amount can be substituted - the beneficiary is not liable for this nominal amount.
 - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be \$0.00.)
 - Whether a \$0.00 charge or a nominal amount is submitted to the carrier/MAC, the e-Prescribing code line is denied and tracked.
 - e-Prescribing line items will be denied for payment, but are passed through the claims processing system to Medicare's National Claims History database (NCH), used for e-Prescribing claims analysis. EPs will receive a remittance advice (RA) which includes a standard remark code (N365). N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does NOT indicate whether the e-prescribing code is accurate for that claim or for the measure the EP is attempting to report. N365 only indicates that the e-prescribing code passed into NCH.
 - 4) When a group bills, the group NPI is submitted at the claim level, therefore, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items. Solo practitioners should follow your normal billing practice of placing your individual NPI in the billing provider field, (#33a on the CMS-1500 or the electronic equivalent).
 - 5) Claims may NOT be resubmitted for the sole purpose of adding or correcting an e-Prescribing code.

Submission through carriers/MACs

You may submit e-Prescribing codes to carriers/MACs either through electronic submission using the ASC X 12N Health Care Claim Transaction (Version 4010A1), or paper-based submission using the CMS-1500.

When using electronic submission you should submit the e-Prescribing codes in the SV101-2 "Product/Service ID" Data Element on the SV1 "Professional Service"

Coding and reporting principles for the PQRI and the e-Prescribing incentive programs (continued)

Segment of the 2400 “Service Line” loop. You will need to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 “Professional Service” segment.

You should submit diagnosis codes at the claim level, loop 2300, in data element HI01, and if there are multiple diagnosis codes, in HI02 through HI08 as needed with a single reference number in the diagnosis pointer.

In general for group billing, report the NPI for the rendering provider in loop 2310B (Rendering Provider Name, claim level) or 2420A (Rendering Provider Name, line level), using data elements NM108 and NM109.

For paper-based submissions, use the CMS-1500 (08-05) and enter relevant ICD-9-CM diagnosis codes in field 21. Enter service codes (including CPT, HCPCS, CPT category II and/or G-codes) with any associated modifiers in field 24D with a single reference number in the diagnosis pointer field 24E that corresponds with the diagnosis number in field 21.

For group billing, the NPI of the rendering/performing provider is entered in field 24J and the TIN of the employer is entered in field 25.

Timeliness of quality data submission

As mentioned above, claims processed by the carrier/MAC must reach the Medicare NCH file by February 28, 2010, to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis

Additional information

The official instruction, CR 6514, issued to your carrier/MAC is available at <http://www.cms.hhs.gov/Transmittals/downloads/R513OTN.pdf> on the CMS Web site. You may find additional information about PQRI at <http://www.cms.hhs.gov/PQRI> on the CMS Web site. Additional information on the e-Prescribing incentive program is available at <http://www.cms.hhs.gov/ERXIncentive> on the CMS Web site. If you have any questions, please contact your carrier or MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Web site.

MLN Matters® Number: MM6514

Related Change Request (CR) #: 6514

Related CR Release Date: July 2, 2009

Effective Date: June 1, 2009

Related CR Transmittal #: R513OTN

Implementation Date: September 2, 2009

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Reminder -- 2009 Physician Quality Reporting Initiative program

It is not too late to start participating in the 2009 Physician Quality Reporting Initiative (PQRI) and potentially qualify to receive incentive payments. A new half-year reporting period began on July 1. If you have not yet started, you can begin by reporting either:

- Three individual 2009 PQRI measures for at least 80 percent of applicable Medicare Part B fee-for-service (FFS) patients seen between July 1, 2009, and December 31, 2009, through a qualified 2009 PQRI registry. To qualify for a half-year incentive (some registries may allow an eligible professional to submit data to them from the start of 2009 thus being able to report for the entire year).
- A measures group through claims or a qualified 2009 PQRI registry; depending on the sample method selected for a measures group, you could qualify for:
- A half-year incentive by reporting the measures group on 80 percent of applicable Medicare Part B FFS patients seen between July 1, 2009, and December 31, 2009, or
- A full-year incentive by reporting the measures group on 30-consecutive patients.

A list of qualified registries for the 2009 PQRI may be found on the CMS PQRI “Reporting” section at <http://www.cms.hhs.gov/PQRI> on the CMS Web site.

Eligible professionals do not need to sign-up or pre-register to participate in the 2009 PQRI.

Submission of quality data codes for individual PQRI measures to the Centers for Medicare & Medicaid Services (CMS) through a qualified registry or for a measures group through claims or a qualified registry will indicate intent to participate.

Although there is no requirement to register prior to submitting the data, there are some preparatory steps that professionals should take prior to undertaking PQRI reporting. CMS has created a tip sheet titled, “Satisfactorily Reporting 2009 PQRI Measures,” that provides information about how to get started with PQRI reporting. To access this tip sheet and all available educational resources on the 2009 PQRI please visit, <http://www.cms.hhs.gov/PQRI/> on the CMS Web site. Eligible professionals are encouraged to visit the PQRI Web page often for the latest information and downloads on PQRI.

Source: PERL 200906-35

Prompt payment interest rate revision

The Centers for Medicare & Medicaid Services (CMS) has revised Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 80.2.2 (Interest Payment on Clean Non-PIP Claims Not Paid Timely) to replace the Internet address (URL) with the latest URL for accessing the Department of Treasury Web site current and past prompt payment interest rates payable when clean Medicare claims are not paid in a timely manner by Medicare contractors.

The prompt payment interest rate is determined by the Department of the Treasury on a six-month basis, effective every January and July 1. Providers may access the prompt payment interest rate history on the Financial Management Service Web page at <http://fms.treas.gov/prompt/rates.html>.

The new rate of 4.875 percent is in effect through December 31, 2009. This revision is addressed under change request (CR) 6542, which may be accessed at <http://www.cms.hhs.gov/Transmittals/downloads/R1771CP.pdf>.

Source: Pub 100-04, Transmittal 1771, CR 6542

Now available -- Recovery Act and health information technology section

A new Web site section is now available from the Centers for Medicare & Medicaid Services (CMS) concerning health information technology as provided for in the American Recovery and Reinvestment Act of 2009. On this Web site, you can find information pertaining to the Medicare and Medicaid incentives for electronic health records adoption and important links to related Web sites at the Department of Health & Human Services.

Posted now are:

- A CMS fact sheet and questions/answers pertaining to the incentive programs
- Link to press release pertaining to the process of defining meaningful use (Comments are due June 26, 2009.)
- Resources on health IT and privacy & security (Health Insurance Portability and Accountability Act of 1996 [HIPAA])

Bookmark http://www.cms.hhs.gov/Recovery/11_HealthIT.asp#TopOfPage today to find the latest on health information technology.

Source: PERL 200906-33

Healthcare common procedure coding system quarterly update

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the healthcare common procedure coding system (HCPCS) code set. These changes have been posted to the HCPCS Web site at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp.

Changes are effective on the date indicated on the update.

Source: PERL 200907-06

Health care costing: Data, methods, future directions report now available

The National Cancer Institute (NCI), the Agency for Healthcare Research and Quality (AHRQ), and the Department of Veterans Affairs (VA) are pleased to announce the publication of *Health Care Costing: Data, Methods, Future Directions*, published July 2009, Volume 47, Issue 7, Supplement 1 in *Medical Care*. Accurate measurement of health care costs is critical for developing health care budgets, setting priorities for allocating funds, and making health care policy decisions. Estimates of these costs are key inputs to cost-effectiveness analyses and other economic evaluations. The supplement takes a careful look at diverse methodological issues related to this timely and important topic.

Written by experts in health economics, epidemiology, health services research, and biostatistics, the papers discuss ways to improve and apply health care cost estimation methods and promote research in this area. The supplement was developed by scientists at the NCI, the AHRQ, the VA, and Emory University. It was based on a 2007 workshop sponsored by the NCI and the AHRQ. For more information about the supplement and the workshop, visit <http://healthservices.cancer.gov/publications/costing.html>.

Requests for one free copy of the supplement may be made to the AHRQ publications clearinghouse. Please order by specifying AHRQ publication number OM 09-0079: Medical Care supplement on health care costing. If more than one copy is needed, please describe the reason in your request.

In the United States, call the toll-free number 800-358-9295, 24 hours a day, 7 days a week.

Hearing impaired persons may call 888-586-6340 for the TDD service.

Callers from outside of the United States only should use the telephone number 703-437-2078.

Written requests may be sent to:

AHRQ Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907-8547

Electronic requests may be made to:
AHRQPubs@ahrq.hhs.gov.

Source: PERL 200907-20

Manual revision related to deactivation of Medicare billing privileges

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

Provider types affected

Physicians, suppliers and other providers who bill Medicare carriers or Medicare administrative contractors (MACs).

Provider action needed

This article, based on change request (CR) 6491, clarifies manual instructions found in the Centers for Medicare & Medicaid Services' (CMS) CR 6310.

Background

The *Medicare Program Integrity Manual*, Chapter 10, Section 13, available at <http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf> on the CMS Web site, contains information about deactivations, reactivations and revocations of Medicare billing privileges and their respective effective dates. Portions of this manual chapter are being revised by CR 6491 and those changes are summarized as follows:

- Medicare contractors will ensure that a supplier that has had its Medicare billing privileges reactivated does not become subject to a second deactivation for non-billing within 30 days of the reactivation.
- For physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, or organizations (e.g., group practices) consisting of any of the aforementioned categories of individuals, Medicare contractors will establish the reactivation effective date as the later of: (a) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or (b) the date the supplier first started furnishing services at a new practice location, unless the supplier has at least one other enrolled practice location (under the same TIN) for which it is actively billing Medicare, the contractor shall establish and enter the reactivation effective date as either: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS, whichever is later.

- If the individual (physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals or organizations (e.g., group practices) consisting of any of the aforementioned categories of individuals) or organizational supplier reports a change in practice location more than 30 days after the effective date of the change, the supplier's billing privileges are not revoked on this basis.

However, if the Medicare contractor independently determines, through an on-site inspection under 42 CFR Section 424.535(a)(5)(ii) or via another verification process, that the individual's or organization's address has changed and the supplier has not notified the contractor of this within the aforementioned 30-day timeframe, the supplier's billing privileges may be revoked.

Additional information

If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Web site. The official instruction, CR 6491, issued to your Medicare carrier and/or MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R295PI.pdf> on the CMS Web site. Attached to the CR are the revised portions of the *Program Integrity Manual*.

MLN Matters® Number: MM6491
 Related Change Request (CR) #: 6491
 Related CR Release Date: June 26, 2009
 Effective Date: July 27, 2009
 Related CR Transmittal #: R295PI
 Implementation Date: July 27, 2009

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Revised Clinical Laboratory Improvement Amendments brochure

The Clinical Laboratory Improvement Amendment (CLIA) established quality standards for laboratories to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed. The CLIA brochure contains information and links to a variety of CLIA resources including: CLIA regulations, CLIA enrollment, CLIA certificates, CLIA fee schedules, CLIA-approved accrediting organizations, and CLIA state and regional offices. To view the brochure, go to: <http://www.cms.hhs.gov/MLNProducts/downloads/CLIABrochure.pdf>.

Source: PERL 200907-11

New and revised Medicare Learning Network fact sheets

ICD-10-CM/PCS Myths & Facts (June 2009) -- presents correct information in response to some myths regarding the ICD-10-Clinical Modification/Procedure Coding System, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10-CM_PCS_Myths&Facts.pdf.

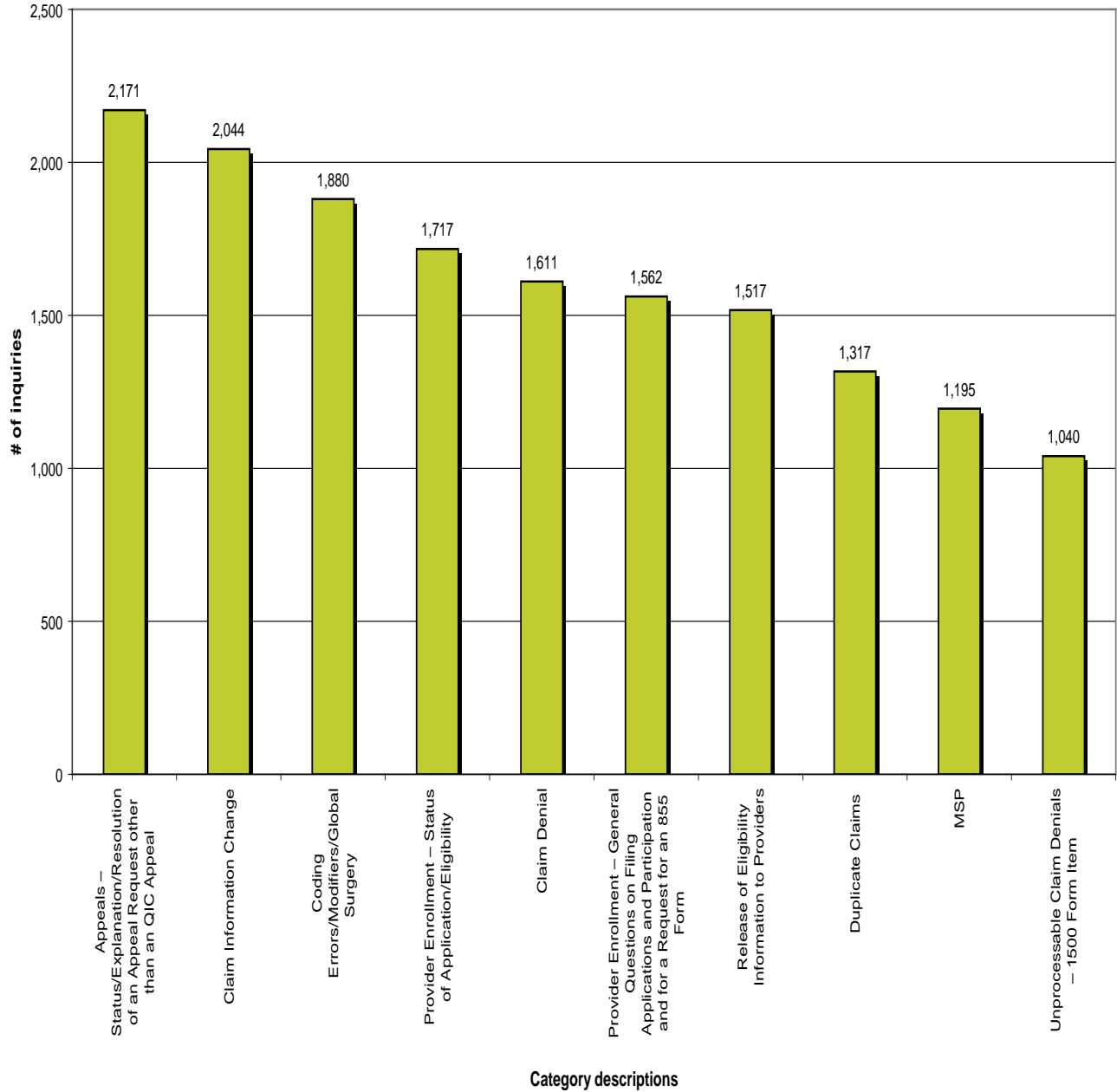
Second in Series: General Equivalence Mappings -- ICD-9-CM to and from ICD-10-CM and ICD-10-PCS Fact Sheet (May 2009) -- provides basic information about the general equivalence mappings (GEM) including possible users of the GEMs, why the GEMs are needed, and how the GEMs files are formatted as well as reimbursement mappings information, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at <http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10Mappingfctshst.pdf>.

Source: PERL 200907-10

Top inquiries, denials, and returned as unprocessable claims for June 2009

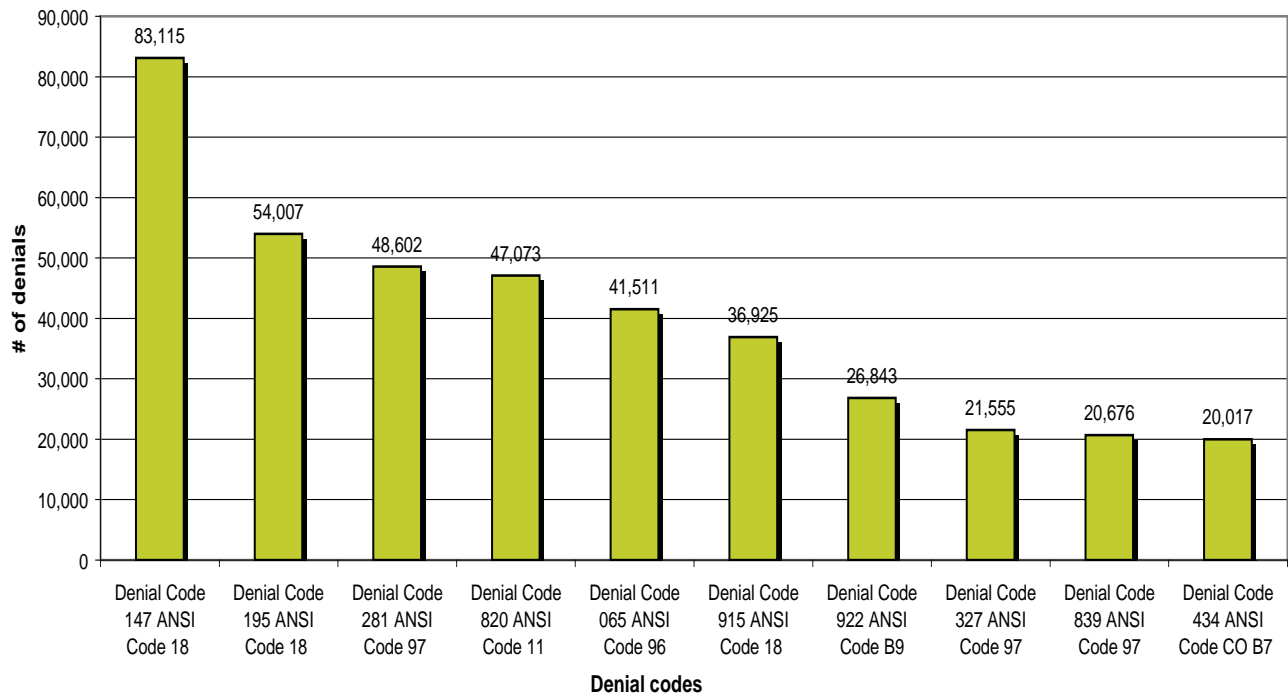
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Island providers during June 2009. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our Web site at http://medicare.fcso.com/Inquiries_and_denials/index.asp.

Florida Part B top inquiries for June 2009

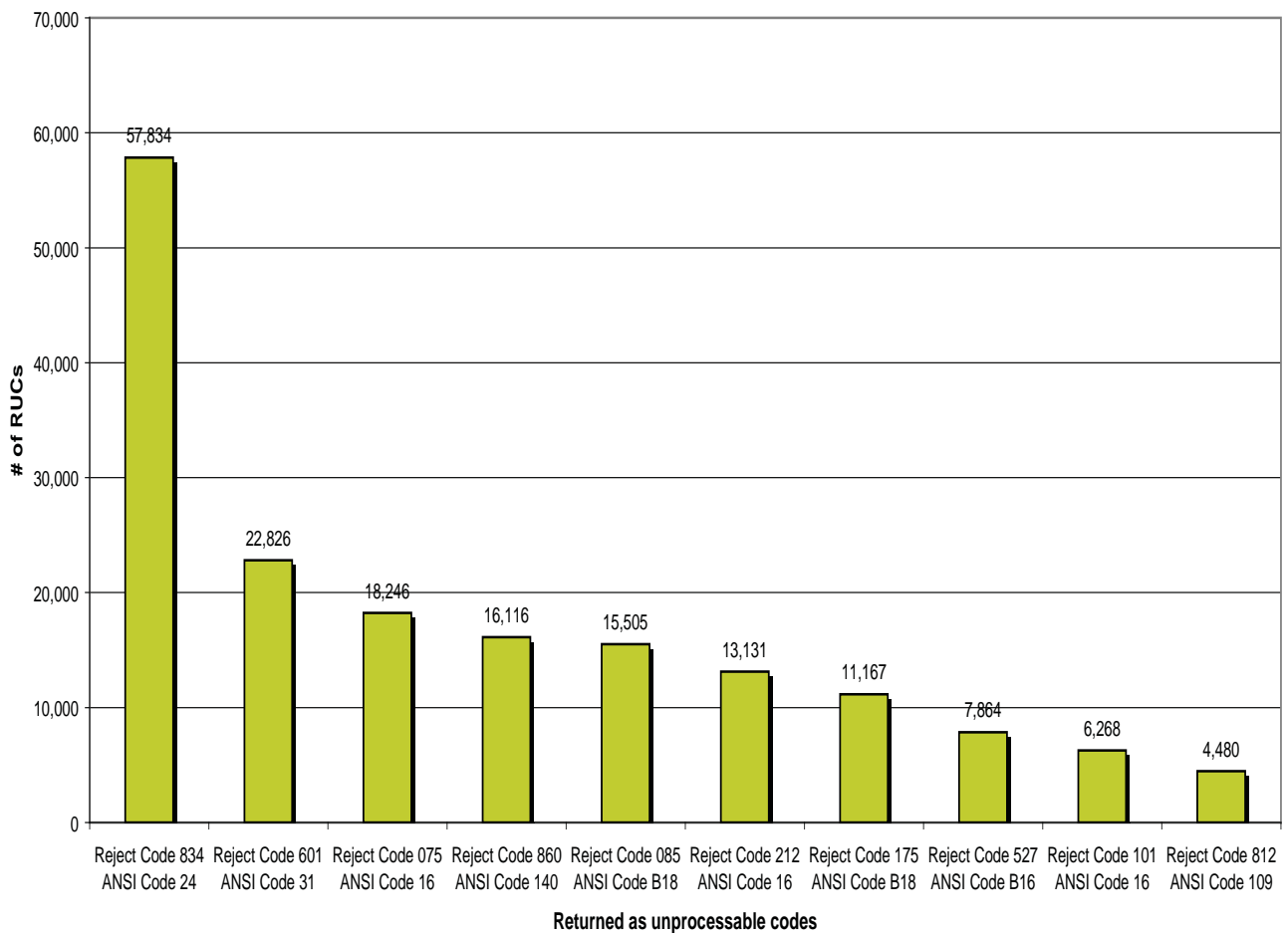


Top inquiries, denials, and return unprocessable claims for June 2009 (continued)

Florida Part B top denials for June 2009

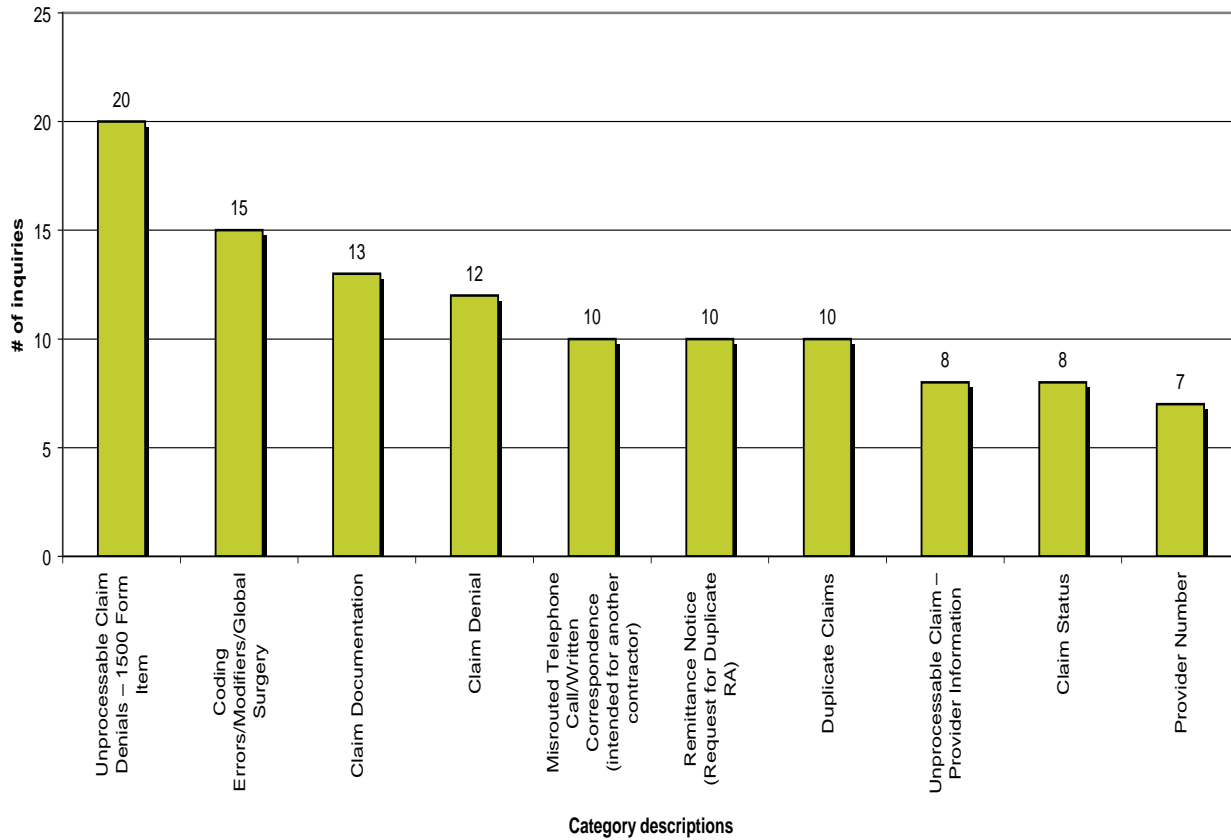


Florida Part B top returned as unprocessable claims (RUC) June 2009

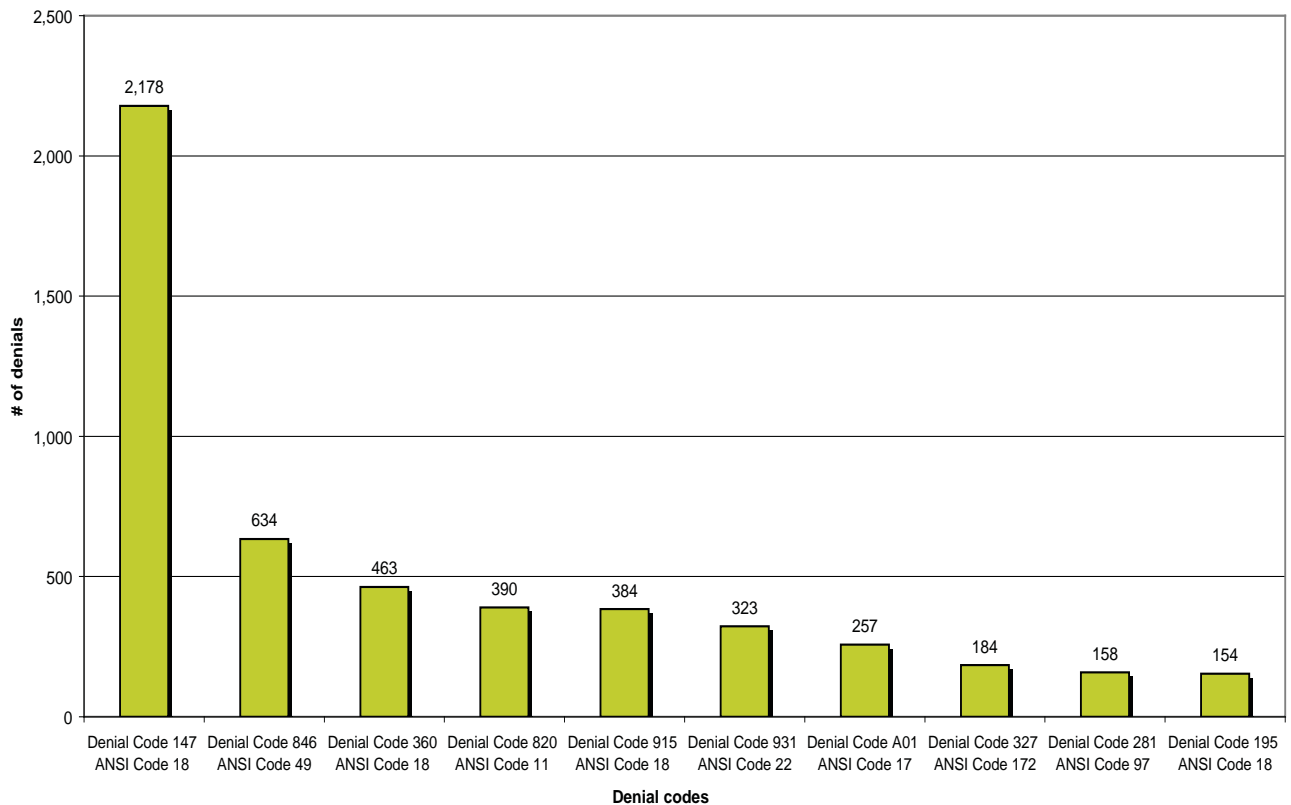


Top inquiries, denials, and return unprocessable claims for June 2009 (continued)

U.S. Virgin Islands Part B top inquiries for June 2009

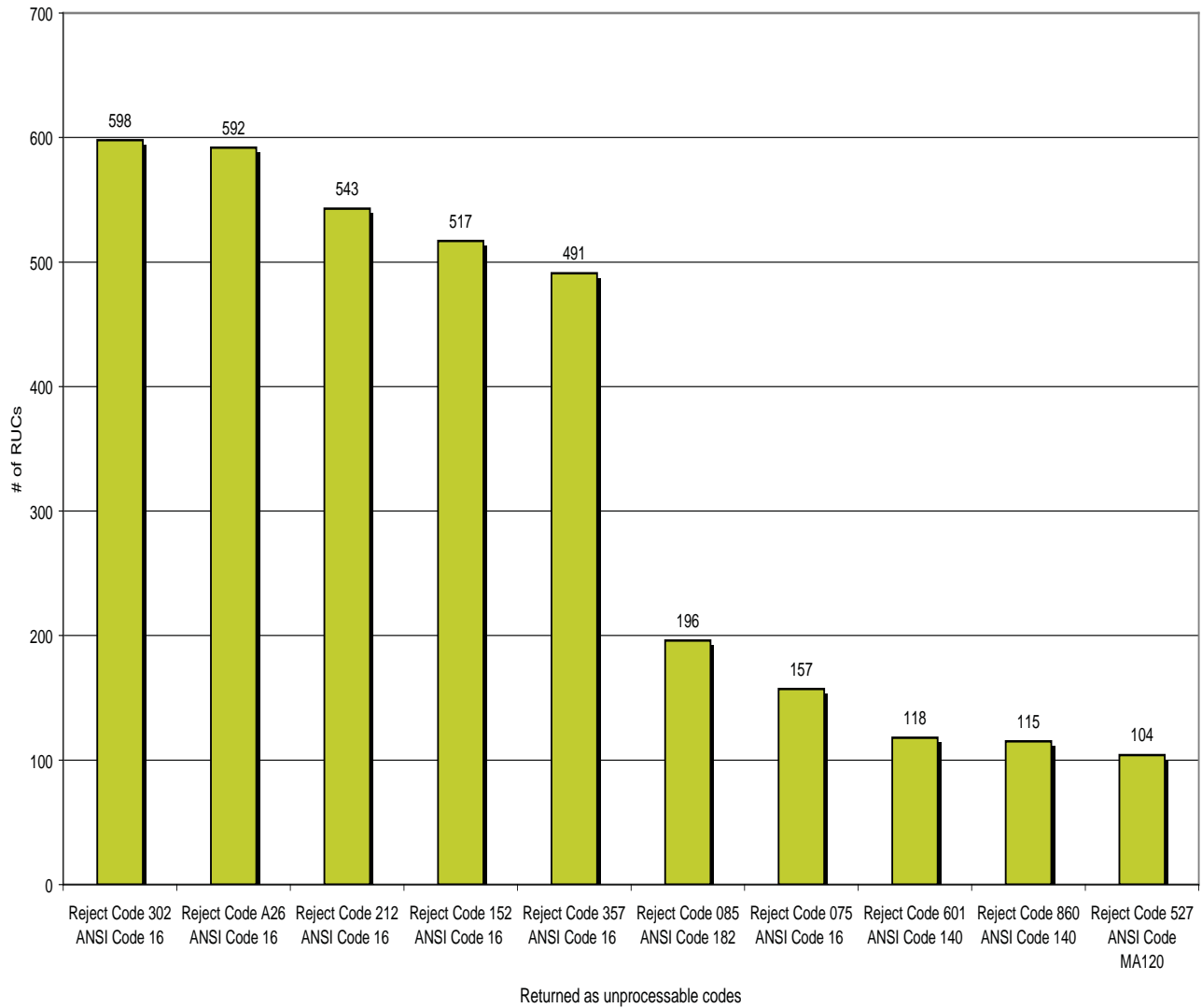


U.S. Virgin Islands Part B top denials for June 2009



Top inquiries, denials, and return unprocessable claims for June 2009 (continued)

U.S. Virgin Islands Part B top returned as unprocessable (RUC) claims June 2009



Sign up to our eNews electronic mailing list

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

Local Coverage Determinations

This section of the *Medicare B Update!* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier’s LCDs and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), contractors no longer include full-text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text of final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries through the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/overview.asp>.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date of service (unless otherwise noted in the LCD). Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the Web site is considered the notice date.

Electronic notification

To receive quick, automatic notification when new LCDs are posted to the Web site, subscribe to our *FCSO eNews* mailing list. It’s very easy to do. Simply go to our Web site <http://medicare.fcsso.com>, click on the “Join eNews” link located on the upper-right-hand corner of the page and follow the instructions.

More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
 PO Box 2078
 Jacksonville, FL 32231-0048

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Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Revisions to LCDs

SKINSUB: Skin substitutes -- revision to the LCD

LCD ID number: L29279 (Florida)

LCD ID number: L29393 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for skin substitutes was last revised on June 30, 2009. Since that time, a revision was made to the LCD based on change request (CR) 6471 (July 2009 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing to Prior Quarterly pricing Files), CR 6484 (July Update to the 2009 Medicare Physician Fee Schedule Database [MPFSDB]), and CR 6496 (July 2009 Update to the ASC Payment System; Summary of Payment Policy Changes) issued by the Centers for Medicare & Medicaid Services (CMS).

A review of HCPCS codes C9363, J3590 (when used for Integra meshed bilayer wound matrix) and Q4115 determined that these skin substitute codes should be added to the “Non-Covered Products” section of the “CPT/HCPCS Codes” section of the LCD.

- C9363 -- Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter (ASC only)
- J3590 -- Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter (Provider only)
- Q4115 -- Skin substitute, alloskin, per square centimeter

In addition, references under the “Sources of Information and Basis for Decision” section of the LCD were updated.

Effective date

This revision to the LCD is effective for claims processed on or after July 6, 2009, for services rendered on or after July 1, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section,” drop-down menu at the top of the LCD page.

VISCO: Viscosupplementation therapy for knee -- revision to the LCD

LCD ID number: L29307 (Florida)

LCD ID number: L29408 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised on April 17, 2009. Since that time, the LCD was revised to add HCPCS code C9399 to the “CPT/HCPCS Codes” section of the LCD for billing synvisc-one in an ambulatory surgical center (ASC). The “Utilization Guidelines” section of the LCD was updated with the dosage, total dosage and duration of treatment for synvisc-one. Additionally, the “coding guideline” attachment was revised to instruct providers to use HCPCS code C9399 when billing synvisc-one in an ASC.

Effective date

This LCD revision is effective for claims processed on or after July 16, 2009, for services rendered on or after February 26, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section,” drop-down menu at the top of the LCD page.

93000: Electrocardiography -- revision to the LCD

LCD ID number: L29163 (Florida)

LCD ID number: L29337 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for electrocardiography was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised. The “Documentation Requirements” section of the LCD has been revised to clarify that the physician must document that he/she has reviewed, interpreted and agrees with the results of the test and document how the findings are being used to manage the patient’s condition. First Coast Service Options Inc. (FCSO) expects that this information will be documented in the medical record and be made available upon request for medical review.

Effective date

This LCD revision is effective for services rendered on or after July 14, 2009. FCSO LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section,” drop-down menu at the top of the LCD page.

95805: Polysomnography and sleep testing -- revision to the LCD**LCD ID number: L29949 (Florida)****LCD ID number: L29951 (Puerto Rico/U.S. Virgin Islands)**

The new local coverage determination (LCD) for polysomnography and sleep testing that includes home sleep testing (HST) was effective for services rendered on or after June 30, 2009, for Florida, Puerto Rico, and the U.S. Virgin Islands. Since that time, a revision to the LCD was made to update CMS language for Type I devices, and to add verbiage for clarification of accreditation and physician training/certification requirements, including the extended date for accreditation of sleep testing facilities.

The following sections of the LCD were updated:

- Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD for Type I devices, added the following CMS language: “*Type I PSG is covered when used to aid the diagnosis of obstructive sleep apnea (OSA) in beneficiaries who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.*” This revision is effective for claims processed on or after August 10, 2009, for services rendered on or after March 3, 2009, based on CMS change request 6534.
- Under the “Indication of Coverage” portion of the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, added language for clarification for “Accreditation” and “Physician Training/Certification.”
- Under the “Documentation/Credentialing Requirements” section of the LCD, added language for clarification of accreditation requirements including the extended date of accreditation for sleep testing facilities, and sub-headings of Accreditation, Physician Training/Certification, and Technician Credentials/Training. In addition, added sub-heading and information on “Home Sleep Testing” under this section.
- Updated the “Sources of Information and Basis for Decision” section of the LCD.

Effective date

The revisions to the LCD for bullets 2, 3, and 4 above are effective for services rendered on or after July 21, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section,” drop-down menu at the top of the LCD page.

*Additional Information***J2778: Ranibizumab (Lucentis®) -- article clarification****LCD ID number: L29266 (Florida)****LCD ID number: L29383 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for ranibizumab (Lucentis®) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. First Coast Service Options Inc. (FCSO) Medicare will consider ranibizumab (Lucentis®) medically reasonable and necessary for patients with established exudative senile macular degeneration for services rendered on or after the U.S. Food and Drug Administration (FDA) approval date of June 30, 2006.

Ranibizumab (Lucentis®) is supplied as a preservative-free, sterile solution in a single-use, glass vial designed to deliver a single 0.5 mg dose (0.05 mL of a 10 mg/mL solution). The vial contains overfill to account for loss of product when the dose is being prepared and administered appropriately, and according to the FDA-approved labeling. The vial is designed to contain enough liquid so that a single 0.5 mg (0.05 mL) dose can be administered.

Each Lucentis® carton also contains one filter needle, one injection needle and one package insert. To prepare Lucentis® for administration, using aseptic technique, all of the Lucentis® vial contents are withdrawn through the filter needle. The filter needle should be discarded after withdrawal of the vial contents and should not be used for intravitreal injection. The filter needle should be replaced with a sterile 30-gauge, 1/2-inch needle for the intravitreal injection.

If the contralateral eye requires treatment, a new vial should be used and the sterile field, syringe, gloves, drapes, eyelid speculum, filter needle and injection needle should be changed before Lucentis® is administered.

The FDA-approved prescribing information does not support the use of Lucentis® vials as multi-dose vials, nor does it support the practice of administering the contents of one vial of Lucentis® to more than one eye or more than one patient. As stated in the prescribing information, each vial of Lucentis® should only be used for the treatment of a single eye.

Please refer to the full prescribing information for complete product, and safety information.

Drugs or biologicals approved for marketing by the FDA are considered safe and effective when used as specified on the labeling. The labeling lists the safe and effective delivery method, dosage and frequency. Drugs and biologicals provided off-label may be considered not medically reasonable and necessary.

J2778: Ranibizumab (Lucentis®) -- article clarification (continued)

FCSO has become aware of multiple patients (up to three) receiving injections from a single use vial of Lucentis®. Medicare allows for use of a single use vial in multiple patients for certain drugs, unless the FDA label specifically precludes such use. In the case of Lucentis®, the FDA-approved label specifically states, “Vials are for single eye use only”, and goes on to provide explicit preparation and administration information.

The Medicare allowance for Lucentis® is based on the average sales price (ASP) as required by current regulations. As discussed above, the vial is designed to deliver a single 0.5 mg dose (0.05 mL of a 10 mg/mL solution) and contains overfill to account for loss of product when the dose is being prepared and administered appropriately. The descriptor for HCPCS code J2778 represents “Injection, ranibizumab, 0.1 mg”. The current ASP PAR allowance is \$407.79 per 0.1 mg (\$2038.95 per 0.5mg. treatment dose/single use vial). This amount represents payment for the entire single use vial of Lucentis®. Per the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 50.3, “The charge, if any, for the drug or biological must be included in the physician’s bill, and the cost of the drug or biological must represent an expense to the physician.” Therefore, when a single use vial is used and billed for three patients at 0.5 mg per patient, a physician would receive payment as if three single use vials were utilized. When in fact, one vial was purchased and the two additional doses represented no additional cost to the physician. The physician is then overstating his/her expense for the drug when billing in this manner and is, therefore, overpaid. If a provider chooses to provide “off-label” services in this manner, they would code the dose provided (0.5 mg. or 5 units in the unit billed field) however, the provider’s charges to Medicare should be reduced to reflect the actual cost incurred (based on current ASP, approximately \$679.65 per patient).

Providers may be selected for medical review when atypical billing patterns are identified, or when a particular kind of problem (e.g., errors in billing a specific type of service) is identified. Medical review is the collection of information and review of medical records by Medicare contractors to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements. The goal of the medical review program is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers. Providers may also conduct self audits to identify coverage and coding errors using the Office of Inspector General (OIG) Compliance Program Guidelines at <http://www.os.dhhs.gov/oig/modcomp/index.htm>.

In situations where providers have given multi doses of Lucentis® from single use vials, it would be expected that a voluntary reimbursement of the overpayment be sent to the FCSO Medicare program in order to proactively take action and/or address the identified error. Providers can access a voluntary refund form on FCSO’s Medicare Web site at <http://medicare.fcsso.com/Forms/138379.pdf>.

FCSO LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section,” drop-down menu at the top of the LCD page.

Sign up to our eNews electronic mailing list

Join our *eNews* mailing list and receive urgent and other critical information issued by First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It’s very easy to do. Simply go to our Web site <http://medicare.fcsso.com>, click on the “Join eNews” link located on the upper-right-hand corner of the page and follow the instructions.

Educational Resources

Upcoming provider outreach and education events – September 2009

Medifest 2009 (classes full)

When: September 1-2

All classes are now full; no additional registrations will be accepted.

Hot Topics Series: 2009 Part B updates and changes

When: September 15

Time: 11:30 a.m. – 12:30 p.m.

Focus: Florida and the U.S. Virgin Islands

Two easy ways to register

Note: Unless otherwise indicated, all FCSO educational offerings are considered to be “ask-the-contractor” events, “webcast” type of event, and designated times are stated as ET.

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

FAX: Providers without Internet access can leave a message on our Registration Hotline at 904-791-8103 requesting a fax registration form. Class materials will be faxed to you the day of the event.

Tips for using the FCSO provider training Web site

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

- “Course Catalog” from top navigation bar
- “Catalog” in the middle of the page
- “Browse Catalog” on the right of the search box
- Select your location (Florida, Puerto Rico, or the U.S. Virgin Islands)

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

If you need assistance, please contact our FCSO Medicare training help desk by calling 1-866-756-9160 or sending an e-mail to fcsohelp@geolearning.com.

If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to 1-904-361-0407. Keep listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and new scheduled events!

Please note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to event advertisement.

Registrant’s Name: _____

Registrant’s Title: _____

Provider’s Name: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

**Mail directory
Claims submissions**

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

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

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare secondary payer
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

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

Communication
Redetermination requests
Medicare Part B claims review
P.O. Box 2360
Jacksonville, FL 32231-0018

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of Information Act
Freedom of Information Act requests
Post office box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

**Durable medical
equipment (DME)
DME, orthotic or prosthetic claims**
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

**Electronic media claims (EMC)
Claims, agreements and inquiries**
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development
Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

**Over 40 days of initial request:
Submit the charge(s) in question,
including information requested, as you
would a new claim, to:**
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous
Provider participation and group
membership issues; written requests for
UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education
**Educational purposes and review of
customary/prevaling charges or fee
schedule:**
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

**Limiting charge issues:
Processing errors:**
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

Refund verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare claims for Railroad retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse
First Coast Service Options, Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

**Phone numbers
Providers**

Toll-Free
Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992
E-mail Address: AskFloridaB@fcsso.com
FAX: 1-904-361-0696

Beneficiary
Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

**Education event
registration (not toll-free):**
1-904-791-8103

**Electronic data
interchange (EDI)**
1-888-670-0940

- Option 1** -Transaction support
- Option 2** - PC-ACE support
- Option 4** - Enrollment support
- Option 5** - Electronic funds (check return assistance only)
- Option 6** - Automated response line

**DME, orthotic or prosthetic
claims**
Cigna Government Services
1-866-270-4909

Medicare Part A
Toll-Free:
1-866-270-4909

**Medicare Web sites
Provider**

First Coast Service Options Inc.
(FCSO), your CMS-contracted Medicare
administrative contractor
<http://medicare.fcsso.com>

**Centers for Medicare & Medicaid
Services**
www.cms.hhs.gov

Beneficiaries
**Centers for Medicare & Medicaid
Services**
www.medicare.gov

**Mail directory
Claims, additional
development, general
correspondence**

First Coast Service Options Inc.
P. O. Box 45098
Jacksonville, FL 32232-5098

Flu rosters

First Coast Service Options Inc.
P. O. Box 45031
Jacksonville, FL 32232-5031

**Electronic data
interchange (EDI)**

First Coast Service Options Inc.
P. O. Box 44071
Jacksonville, FL 32231-4071

**Part B debt recovery,
MSP inquiries and
overpayments, and cash
management**

First Coast Service Options Inc.
P.O. Box 45013
Jacksonville, FL 32232-5013

Provider enrollment

**Where to mail provider/supplier
applications**
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Redeterminations

First Coast Service Options Inc.
P. O. Box 45024
Jacksonville, FL 32232-5091

**Redetermination
overpayment**

First Coast Service Options Inc.
P. O. Box 45091
Jacksonville, FL 32232-5091

**Freedom of Information
Act requests (FOIA)**

First Coast Service Options Inc.
P. O. Box 45073
Jacksonville, FL 32232-5073

Congressional inquiries

First Coast Service Options Inc.
Attn: Carla-Lolita Murphy
P. O. Box 2078
Jacksonville, FL 32231-0048

Provider education

**Educational purposes and review of
customary/prevaling charges or fee
schedule:**

Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:

Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

**Medicare claims for
railroad retirees**

Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse

First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

**Local coverage
determinations**

First Coast Service Options Inc.
P. O. Box 2078
Jacksonville, FL 32231-0048

Post pay medical review

First Coast Service Options Inc.
P. O. Box 44288
Jacksonville, FL 32231-4288

**Overnight mail and/or
other special courier
services**

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Medicare Web sites

Provider

First Coast Service Options Inc.
(FCSO), your CMS-contracted Medicare
administrative contractor
<http://medicare.fcso.com>

**Centers for Medicare &
Medicaid Services**

www.cms.hhs.gov

Beneficiaries

Centers for Medicare & Medicaid
Services
www.medicare.gov

**Phone numbers
Provider customer service**

1-866-454-9007

**Interactive voice response
(IVR)**

1-877-847-4992

E-mail Address: AskFloridaB@fcso.com

FAX: 1-904-361-0696

**Beneficiary customer
service**

1-800-MEDICARE

Hearing Impaired:

1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

**Education event
registration**

1-904-791-8103

**Electronic data
interchange (EDI)**

1-888-670-0940

Option 1 - Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

**DME, orthotic or prosthetic
claims**

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:

1-866-270-4909

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO Account # (use appropriate account number). Do not fax your order; it must be mailed.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at http://medicare.fcso.com/Publications_B/ (English) or http://medicareespanol.fcso.com/Publicaciones/ (Español). Non-provider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2008 through September 2009.	40300260	Hardcopy \$33		
		CD-ROM \$55		
2009 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2009, through December 31, 2009 is available free of charge online at http://medicare.fcso.com/Data_files/ (English) or http://medicareespanol.fcso.com/Fichero_de_datos/ (Español). Additional copies or a CD-ROM are available for purchase. The fee schedule contains calendar year 2009 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note: Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications.	40300270	Hardcopy \$12		
		CD-ROM \$6		
Language preference: English [] Español []				
<i>Please write legibly</i>			Subtotal	\$
			Tax (add % for your area)	\$
			Total	\$

Mail this form with payment to:

**First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443**

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

*First Coast Service Options Inc.
P.O. Box 2078 Jacksonville, FL. 32231-0048*

◆ ATTENTION BILLING MANAGER ◆