

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.fcsom.com/>.

Routing Suggestions:

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



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Medicare B Update!

Vol. 7, No. 11
November 2009

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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.

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CLAIMS

Processing anti-markup services – missing or incomplete information in item 20

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

Provider types affected

This article is for physicians and other providers submitting claims to Medicare contractors (carriers and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop -- impact to you

This article is based on change request (CR) 6670 which provides your Medicare contractor with instructions for processing claims for diagnostic services that are subject to the “anti-markup payment limitation” and that are billed with missing or incomplete information in item 20 of the CMS-1500 or the electronic equivalent.

Caution -- what you need to know

Prior to the implementation of the anti-markup payment limitation, contractors were instructed to assume none of the services presented on a claim were purchased if item 20 was either not completed or was missing information. CR 6670 gives specific criteria for processing claims with partial information completed in item 20.

Go -- what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

The *Medicare Claims Processing Manual* (Chapter 1, Section 80.3.2.1.2) establishes guidelines for processing of claims for diagnostic services when:

- There is no entry for the “Yes/No” indicator in item 20 of the CMS-1500, or
- The ANSI X12 837P electronic claim is missing a claim or line level PS1 segment to indicate whether the diagnostic services were purchased.

Your Medicare contractor is instructed to assume that a diagnostic service was not purchased when there is no “Yes/No” indicator marked in item 20 of the paper claim form or the electronic equivalent. Additionally, the instructions referred to anti-markup as it was formerly known as “purchased diagnostic tests” and applied only to the technical component (TC) of a diagnostic test. (See CR 6122 [Transmittal 1589, Sep. 8, 2008] at <http://www.cms.hhs.gov/transmittals/downloads/R1589CP.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/MM6122.pdf> on the CMS Web site.)

CR 6670 provides instructions for processing claims for diagnostic services that are subject to what is now known as the “anti-markup payment limitation” and that are billed with missing or incomplete information in item 20 of the CMS-1500 or the electronic equivalent.

Medicare contractors will use the following guidelines for determining whether a claim contains a diagnostic service that is subject to the “anti-markup payment limitation”: **Note:** These guidelines apply to both the CMS-1500 and the electronic equivalent.

- If a “Yes” or “No” is not indicated in item 20 and the associated dollar amount is missing, contractors shall assume the service is not subject to the anti-markup payment limitation and shall process the claim accordingly
- If a “Yes” or “No” is not indicated in item 20 and the associated dollar amount is present, contractors shall return the claim to you as unprocessable
- If the “Yes” box is marked in item 20 and the associated dollar amount is missing, contractors shall return the claim as unprocessable
- If the “No” box is marked in item 20 and the associated dollar amount is present, contractors shall return the claim as unprocessable

Note: In accordance with the requirements of the “anti-markup payment limitation,” Medicare contractors will apply the above logic to both the technical and professional component of diagnostic tests.

Additional information

The official instruction, CR 6670, issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1842CP.pdf> on the CMS Web site.

If you have any questions, please contact your 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: MM6670

Related Change Request (CR) #: 6670

Related CR Release Date: October 30, 2009

Effective Date: April 1, 2010

Related CR Transmittal #: R1842CP

Implementation Date: April 5, 2010

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Ambulance

Medicare coverage of non-emergency ground ambulance services

First Coast Service Options (FCSO) became the Centers for Medicare & Medicaid Services' (CMS) Medicare administrative contractor (MAC) for Puerto Rico and the U.S. Virgin Islands on March 1, 2009. In preparation for this new responsibility, FCSO evaluated paid claims data to identify potential Medicare program vulnerabilities in Puerto Rico and the U.S. Virgin Islands. An extreme data anomaly was quickly identified regarding reimbursement for non-emergency ambulance services. This article provides an overview of the coverage requirements for the Medicare program's ambulance benefit, FCSO's analysis of ambulance data in Puerto Rico and the U.S. Virgin Islands, and corrective actions that have been or will be taken by FCSO as a result of that analysis.

Coverage requirements for Medicare's ambulance benefit

The Medicare ambulance benefit is contained in the Social Security Act and further defined in the *Code of Federal Regulations* and CMS administrative manuals that may be found at <http://www.cms.hhs.gov/Manuals/>. Under existing laws and regulations, the Medicare ambulance benefit is limited to situations where the patient's medical condition requires transportation by ambulance, as further discussed below:

"Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services." (Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 10, Section 10.2.1.)

As outlined in CMS' administrative manuals and FCSO's local coverage determination (LCD) for ambulance transportation, the presence or absence of a physician's order and/or certificate of medical necessity for transport by ambulance does not necessarily prove or disprove the medical necessity of the transport. In addition to meeting the coverage requirements quoted above, ambulance services must meet all other Medicare program coverage criteria including vehicle and crew requirements and covered origins/destinations. Ambulance services denied on the basis of coverage requirements are not subject to a waiver of liability provisions. As a result, in such situations, the patient is liable for the service.

FCSO's LCD for ambulance transportation includes the following medical indications that could support the medical necessity for non-emergency ground ambulance services:

- The beneficiary is bed confined before and after the ambulance trip and meets all other criteria (see note below).
- There is a risk of physical injury to the patient or others requiring observation during transport.

- The patient requires ongoing IV meds/fluids during transportation and a heparin/saline lock is contraindicated.
- Medical treatment and/or observation during transport are required to prevent endangering the beneficiary's health.

Note: "Bed confined" is defined as the inability to get up from bed without assistance, the inability to ambulate, and the inability to sit in a chair (including a wheelchair). All three conditions must be met in order for the patient to be considered "bed confined." "Bed confined" is not synonymous with bed rest or non-ambulatory. Additionally, bed confinement, by itself, is neither sufficient nor necessary to determine coverage for Medicare ambulance benefits.

As outlined in the "Limitations" section of FCSO's LCD, non-emergency ground ambulance services are not covered in the following situations:

- Transportation to a funeral home
- Transfer from one residence to another
- Transfer from a hospital, which has appropriate facilities and staff for treatment, to another hospital
- Transportation via ambi-buses, ambulettes, stretcher vans, wheelchair vans, mobility assistance vehicle (MAV), mediacabs, vans, privately owned vehicles and taxicabs
- Transportation to a dialysis facility for maintenance dialysis, unless the patient's condition justifies the medical necessity of the transport
- Patient refuses to be transported.

In all cases, appropriate patient, medical, and other relevant documentation must be kept on file and presented to FCSO upon request. As per CMS Pub 100-08, Chapter 3, Section 3.5.1.1, contractors, like FCSO, have the authority to implement prepayment edits designed to prevent payment for noncovered and/or incorrectly coded services and to select targeted claims for review prior to payment.

Analysis of payment data for ambulance services in Puerto Rico and the U.S. Virgin Islands

As noted earlier, FCSO quickly identified an extreme data anomaly related to non-emergency ambulance services provided in Puerto Rico and the U.S. Virgin Islands. More specifically, our analysis of paid claims data for procedure code A0428 -- ambulance service, basic life support, non-emergency transport (BLS), revealed that utilization in Puerto Rico for this procedure code was over 1,000 percent higher than the rest of the United States. For the second half of 2008, Medicare spent \$236,789 per 1,000 Puerto Rico beneficiaries for procedure code A0428, as compared to only \$20,140 per 1,000 beneficiaries in the rest of the United States. Furthermore, FCSO found that approximately

Medicare coverage of non-emergency ground ambulance services (continued)

25 percent of all Medicare Part B payments in Puerto Rico were for non-emergency ambulance services, as compared to less than 5 percent in the rest of the United States.

Data analysis also revealed that 95 percent of non-emergency ambulance utilization in Puerto Rico involved repetitive transportation of dialysis patients to/from their dialysis facilities as compared to less than 5 percent in Florida. Although dialysis patients may have multiple health issues, the vast majority can safely and routinely travel by means other than an ambulance.

A similar utilization problem was identified in the U.S. Virgin Islands, although to a much lesser extent. In the first half of 2007, for example, utilization of procedure code A0428 was 155 percent higher than the rest of the United States. At that time, the U.S. Virgin Islands ranked third in the United States in utilization of procedure code A0428; however, more recent data shows a significant drop in utilization beginning in early 2008.

Further findings and required corrective actions

Medicare does not have a “transportation” benefit but rather an “ambulance” benefit for patients whose physical conditions are such that they require one-on-one medical monitoring and treatment while being transported to/from a Medicare-covered destination to obtain necessary diagnostic or therapeutic treatment. FCSO’s LCD references CMS Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 10, which outlines ambulance vehicle requirements, ambulance crew requirements, and other coverage requirements. As stated in section 10.1.2, “Basic Life Support ambulances must be staffed by at least two people, at least one of whom must be certified as an emergency medical technician (EMT) by the State or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.”

Furthermore, the condition of the patient must be such that they require the services of such medical personnel because without constant medical monitoring and/or treatment during transportation, the patient’s health could/would be endangered. The medical records FCSO has reviewed and claims history for the vast majority of the patients being transported by ambulance suppliers billing non-emergency transports in Puerto Rico, and previously in U.S. Virgin Islands, do not support that these patients meet these requirements.

Site visits to dialysis facilities have further validated that patients are being transported to/from dialysis treatments, up to three times per week, and that the majority of these patients do not meet Medicare’s ambulance benefit requirements. Patients have been observed, for example, arriving in ambulances and walking from the ambulance into the facility as well as riding as passengers in the front of the ambulance. Interviews with patients and dialysis facility staff, including the nephrologists managing dialysis treatments, indicate the majority of patients are capable of traveling safely to/from their dialysis appointments without monitoring or treatment provided by ambulance personnel. In fact, most certificates of medical necessity for these transports are not signed by the patient’s treating nephrologist but rather by a primary care physician who may, or may not, be involved with the patient’s care.

As the MAC for jurisdiction 9, FCSO is responsible for ensuring the appropriateness of all fee-for-service Medicare payments in Florida, Puerto Rico, and the U.S. Virgin Islands. Immediately after taking over as the MAC, FCSO became concerned about reimbursement for non-emergency ambulance transportation in the islands and developed and implemented an LCD to specifically address this issue. All ambulance suppliers billing non-emergency transports in Puerto Rico and the U.S. Virgin Islands were invited to attend education sessions on April 16, 2009, to discuss FCSO’s concerns, provide feedback, and review the proposed LCD. Additional education was provided via webcasts and teleconferences prior to the LCD becoming effective June 30, 2009.

Regrettably, claims data for services provided after these educational sessions and implementation of the LCD do not demonstrate the degree of expected changes in bills for non-emergency ambulance transportation in Puerto Rico. As mentioned earlier, there has been a change in billing patterns in the U.S. Virgin Islands, although FCSO believes some degree of program vulnerability continues.

Therefore, FCSO will implement a prepayment claim edit effective for claims processed on or after December 15, 2009, that will require the submission of medical records prior to payment for the majority of non-emergency ground ambulance BLS transports to/from dialysis facilities billed by ambulance suppliers in Puerto Rico and the U.S. Virgin Islands. In addition, FCSO will continue to support additional prepayment editing and other activities carried out by the zone program integrity contractor (ZPIC), SafeGuard Services LLC (SGS), which is responsible for fraud case investigation and development. Isolated ambulance billing issues also have been identified for specific ambulance suppliers in Florida. Specific review actions will be initiated for those providers.

Providers should respond to FCSO’s additional development requests by submitting the appropriate medical documentation to the address indicated on the additional development letter. The medical record should include:

- Documentation of dispatch instructions
- A detailed description of the patient’s condition at the time of transport in order for FCSO to determine whether other means of transportation were contraindicated
- A description of specific monitoring and/or treatments ordered and performed/ administered during transport
- Mileage transported
- A physician’s certification statement

Please refer to FCSO’s LCD for a more details regarding documentation requirements.

FCSO understands that there is a need for a public transportation infrastructure that meets the needs of beneficiaries in Puerto Rico and the U.S. Virgin Islands. However, given the limited nature of the program’s ambulance benefit, Medicare cannot pay for non-emergency ambulance services that are not medically necessary. We encourage health care providers to work with civic and community leaders to promote the use of alternative means of transportation, where it is available, and to identify other solutions where such alternatives do not exist.

Medicare coverage of non-emergency ground ambulance services (continued)

For additional information please refer to:

- Social Security Act 1861(s) (7)
- Social Security Act 1834(1)
- 42 CFR Section 410.40 and 410.41
- 42 CFR Part 414, Subpart H
- Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 10
- Pub 100-04, *Medicare Claims Processing Manual*, Chapter 15

Note: FCSO LCDs: Puerto Rico, L29955; U.S Virgin Islands, L29955 – may be accessed through the FCSO Medicare provider Web site at: http://medicare.fcso.com/Coverage_Find_LCDs_and_NCDs/.

Ambulance services rendered to beneficiaries in Part A SNF

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

Provider types affected

Skilled nursing facilities (SNFs) and ambulance suppliers submitting claims to Medicare contractors (carriers, Fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for ambulance services provided to Medicare beneficiaries should review this article.

Provider action needed

This article is based on change request (CR) 6700 which implements additional Medicare system checks to ensure that ambulance services that are subject to SNF consolidated billing (CB) rules (but that are billed separately as a Part B service) are denied when the date of service (DOS) on the ambulance claims overlap outpatient hospital claims that are rejected for SNF CB. SNF and ambulance billing staff should be aware of this issue.

Background

The Social Security Act (Section 1888(e); see http://www.ssa.gov/OP_Home/ssact/title18/1888.htm on the Internet) established a Medicare prospective payment system (PPS) for skilled nursing facilities (SNF). Under the SNF PPS, most of the services that outside suppliers provide to SNF residents are included in the SNF's Medicare Part A payments. Most ambulance services furnished to a beneficiary in a SNF Part A stay are subject to this rule as well (exceptions are discussed below). Accordingly, pursuant to the Social Security Act's consolidated billing (CB) requirements, SNFs are responsible for billing Medicare Part A for these services. The outside suppliers may not separately bill Medicare but must obtain payment from the SNFs.

A Department of Health and Human Services' Inspector General (IG) Report A-01-08-00505 dated August 25, 2009 (see <http://oig.hhs.gov/oas/reports/region1/10800505.asp>); found that, on occasion, ambulance services that were subject to the SNF CB rule were improperly billed separately by the supplier. The IG Report stated in part:

“Federal regulations (42 CFR § 409.27(c)) state that the SNF benefit includes medically necessary ambulance transportation provided to a SNF resident during a covered Part A stay. Accordingly, when an ambulance supplier erroneously bills Medicare Part B for ambulance services included in the SNF's Part A consolidated billing payment, Medicare pays for the same service twice, once to the SNF and once to the ambulance supplier.”

“The SNF consolidated billing requirement applies only to those services that are provided to a SNF resident. As a result, ambulance transportation that begins or ends beneficiaries' SNF stays is excluded from consolidated billing. Federal regulations (42 CFR Section 411.15(p)(3)(iii)) also state that receiving certain emergency or intensive outpatient hospital services that are beyond a SNF's scope of care ends a beneficiary's status as a SNF resident. Accordingly, because the beneficiary receiving those specific emergency or intensive outpatient hospital services is temporarily not a SNF resident, ambulance transportation associated with those services is excluded from consolidated billing and may be billed to Medicare Part B.”

You may review 42 CFR 409.27(c) and 42 CFR 411.15(p)(3)(iii) at <http://www.gpoaccess.gov/CFR/retrieve.html>.

As stated above, there are exceptions to the general rule that ambulance services furnished to a beneficiary in a SNF Part A stay are subject to SNF CB rules. In accordance with the *Medicare Claims Processing Manual* (Chapter 15, Section 30.2.2; see <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the Centers for Medicare & Medicaid Service Web site), ambulance payments associated with the following outpatient hospital service exclusions are paid under the ambulance fee schedule:

- Cardiac catheterization
- Computerized axial tomography (CT) scans
- Magnetic resonance imaging (MRIs)
- Ambulatory surgery involving the use of an operating room, including the insertion, removal, or replacement of a percutaneous esophageal gastrostomy (PEG) tube in the hospital's gastrointestinal (GI) or endoscopy suite
- Emergency services
- Angiography
- Lymphatic and venous procedures, and
- Radiation therapy.

The following ambulance transportation and related ambulance services for residents in a Part A stay are included in the SNF PPS rate and may not be billed as Part B services by the supplier. In these scenarios, the services provided are subject to SNF CB:

Ambulance services rendered to beneficiaries in Part A SNF (continued)

- A beneficiary's transfer from one SNF to another before midnight of the same day, for which the first SNF is responsible for billing the services to the Part A Medicare administrative contractor (MAC)
- Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility.

CR 6700 implements additional Medicare system checks to ensure that ambulance services that are subject to SNF CB rules (but that are billed separately as a Part B service) are denied when the date of service (DOS) on the ambulance claims overlap outpatient hospital claims that are rejected for SNF CB. The Medicare claims processing system will enforce SNF CB rules by subjecting claims for ambulance services to the following if-then logic:

- If a claim for a hospital outpatient service is rejected because it should have been billed and paid for according to SNF CB rules, then Medicare contractors will deny any ambulance service associated with the denied hospital outpatient service as the ambulance transportation is also subject to SNF CB rules, and conversely
- If payment for a hospital outpatient service is not bundled into the SNF CB rate and is separately payable under Part B, then the ambulance service associated with that service is also separately payable under Part B.

Where claims are denied as a result of CR 6700, Medicare will use remittance advice reason code 190 (Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.), remark code N106 (Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made

to the SNF. You must request payment from the SNF rather than the patient for this service.), and group code CO (Contractual obligation).

Note also that if Medicare processes an ambulance claim first and later discovers that the ambulance service was provided during a SNF stay and the ambulance service should have been bundled under the SNF stay payment, Medicare will consider the separate ambulance claim payment as an overpayment and will initiate overpayment recovery procedures.

Additional information

The official instruction, CR 6700, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R595OTN.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site.

If you have any questions, please contact your carrier, FI, 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: MM6700

Related Change Request (CR) #: 6700

Related CR Release Date: November 6, 2009

Effective Date: April 1, 2010

Related CR Transmittal #: R595OTN

Implementation Date: April 5, 2010

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Ambulance services

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

Provider types affected

Ambulance providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FI] and Medicare administrative contractors [MAC]) for ambulance services provided to Medicare beneficiaries.

Provider action needed

This article, based on CR 6707, advises you that the *Medicare Benefit Policy Manual* Chapter 10 – Ambulance Service section 10.3 has been revised to incorporate consistent manual language to the definition of “The Destination.” There is no change to policy. Please make sure your billing staffs are aware of this update.

Background

The *Medicare Benefit Policy Manual* Chapter 10 – Ambulance Service section 10.3 has been updated to incorporate consistent manual language. The change states that “an ambulance transport is covered to the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) as well as the return transport. In addition to all other coverage requirements, this transport situation is covered only to the extent of the payment that would be made for bringing the service to the patient.” The word “appropriate” has been added to that statement.

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, CR 6707, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R115BP.pdf> on the CMS Web site.

MLN Matters® Number: MM6707

Related Change Request (CR) #: 6707

Related CR Release Date: November 13, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R115BP

Implementation Date: January 4, 2010

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Ambulatory Surgical Center

Payment rate changes for services in hospital outpatient departments and ambulatory surgical centers

The Centers for Medicare & Medicaid Services (CMS) announced that most hospitals will receive an inflation update of 2.1 percent in their payment rates for services furnished to Medicare beneficiaries in outpatient departments. As required by Medicare law, CMS will reduce the update by 2.0 percentage points for hospitals that did not participate in quality data reporting for outpatient services or did not report the quality data successfully, resulting in a 0.1 percent update for those hospitals.

CMS also announced that ambulatory surgical centers (ASCs) will receive a 1.2 percent inflation update beginning January 1, 2010. CMS projects that the aggregate Medicare payments to more than 4,000 hospitals and community mental health centers in calendar year (CY) 2010 will be approximately \$32.2 billion, while aggregate Medicare payments to approximately 5,000 ASCs will total \$3.4 billion.

The payment updates are included in a final rule with comment period that revises payment policies and updates the payment rates for services furnished to beneficiaries during CY 2010 in hospital outpatient departments under the outpatient prospective payment system (OPPS) and in ASCs under a revised rate-setting methodology that was implemented January 1, 2008.

“The payment rates we are announcing for 2010 are intended to ensure that Medicare beneficiaries continue to receive high quality and efficient care in the most appropriate setting,” said Jonathan Blum, director of the CMS Center for Medicare Management.

The final rule with comment period implements provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) that extend Medicare coverage to important rehabilitative and educational services intended to improve the health of patients diagnosed with certain respiratory, cardiac, and renal diseases. Beginning January 1, 2010, hospitals will be able to bill Medicare for new pulmonary and intensive cardiac rehabilitation services furnished in hospital outpatient departments to Medicare beneficiaries.

The final rule with comment period also provides payments to rural hospitals for kidney disease education services furnished in outpatient departments to Medicare beneficiaries with stage IV chronic kidney disease.

The final rule with comment period incorporates a payment adjustment for the hospital pharmacy overhead costs of separately payable drugs and biologicals. This adjustment better recognizes the overhead costs for these drugs and biologicals relative to those for drugs and biologicals that

are packaged into Medicare’s payment for the associated ambulatory payment classification (APC). As a result, CMS will pay hospitals for most separately payable drugs and biologicals administered in hospital outpatient departments at the manufacturer’s average sales price (ASP) plus four percent. In order to maintain beneficiary access to safe, cost-effective health care, the final rule with comment period also modifies CMS’s requirements for physician supervision to ensure that hospital outpatient services are appropriately supervised by physicians or other qualified practitioners.

In addition to hospital outpatient departments, the final rule with comment period includes policy changes and payment rates for services in ASCs and continues to expand the list of surgical procedures that Medicare will cover when performed in ASCs. The final rule with comment period seeks to ensure that beneficiaries have access to outpatient services in all appropriate settings, while improving the quality and efficiency of service delivery.

Under the Hospital Outpatient Department Quality Data 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 inflation update factor minus 2.0 percentage points for a net update of 0.1 percent. CMS will continue to require HOP QDRP participating hospitals to report the existing seven emergency department and peri-operative care measures, as well as the four existing claims-based imaging efficiency measures for the CY 2011 payment determination. CMS also will phase in a new HOP QDRP validation requirement to ensure that hospitals are accurately reporting measures for chart-abstracted data. In addition, CMS established procedures to make quality data collected under the HOP QDRP publicly available beginning with the third quarter of CY 2008.

The CY 2010 OPPS/ASC final rule with comment period will appear in the November 20 *Federal Register*. Comments on designated provisions are due by 5:00 p.m. (ET) on December 29, 2009. CMS will respond to comments in the CY 2011 OPPS/ASC final rule.

More information on the final CY 2010 policies for the OPPS and ASC payment system is available at:

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

Source: CMS PERL 200911-02

Anesthesia

Teaching anesthesiologists – implementation of MIPPA Section 139

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

Provider types affected

Anesthesiologists and certified registered nurse anesthetists (CRNA) need to know about this issue if they bill Medicare carriers and/or Medicare administrative contractors (A/B MAC) for providing teaching anesthesia services for anesthesia residents and student nurse anesthetists.

What you need to know

Change request (CR) 6706, from which this article is taken, implements Section 139 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). This section of MIPPA: 1) Establishes a special payment rule for teaching anesthesiologists (effective for services furnished on or after January 1, 2010); 2) Specifies the periods during which the teaching anesthesiologist must be present during the procedure in order to receive payment based on the regular anesthesia fee schedule amount; and 3) Provides the Secretary of Health and Human Services (HHS) a directive that addresses payments for the anesthesia services of teaching certified registered nurse anesthetists (CRNA).

Please see the *Background* section for details.

Background

Teaching anesthesiologist payment

For anesthesia services furnished prior to January 1, 2010, payment for the services of a teaching anesthesiologist involved in cases with anesthesia residents was determined in the following manner:

- If the teaching anesthesiologist was involved in a single case with an anesthesia resident, and satisfied the criteria in the *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Non-physician Practitioners), section 100.1 (Payment for Physician Services in Teaching Settings Under the MPFS), payment could be made based on the anesthesia fee schedule amount, which would be the same as if the anesthesiologist performed the anesthesia case alone.
- If the anesthesiologist medically directed the provision of anesthesia services in two, three or four concurrent cases and any of which involved residents, then payment was made for the physician's involvement in the resident case(s) under the medical direction payment policy. Under this policy, payment for the anesthesiologist service would be based on 50 percent of the anesthesia fee schedule that would apply if the anesthesiologist performed the cases alone.

CR 6706, from which this article is taken, announces a change to this payment policy for teaching anesthesiologists, through the implementation of Section 139 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Effective for anesthesia services furnished on or after January 1, 2010, payment may be made to a teaching

anesthesiologist under the Medicare physician fee schedule at the regular fee schedule level, if he or she is involved in the training of residents in a single anesthesia case, two concurrent cases, or in a single case that is concurrent to another case paid under the medical direction rules.

Note: The medical direction payment policy would apply to the concurrent case if it involves a CRNA, anesthesia assistant (AA), or student nurse anesthetist.

In order for this special payment rule to apply: 1) The teaching anesthesiologist (or different anesthesiologists in the same physician group) must be present during all critical or key portions of the anesthesia service; 2) If different teaching anesthesiologists in the anesthesia group are present during the key or critical periods, the performing physician (for purposes of claims reporting) is the teaching anesthesiologist who started the case; and 3) The teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure.

Note: If more than one teaching anesthesiologist in the anesthesia group is present during the key or critical periods, the national provider identifier (NPI) of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the claim. A teaching anesthesiologist in a group practice would put his/her NPI in field #24 (as the rendering physician) and the NPI of the group would go in field #33.

Finally, the patient's medical record documentation must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist as necessary. The teaching anesthesiologist should use the modifier AA (Anesthesia services performed personally by anesthesiologist) and the certification modifier GC (The teaching physician was present during the key portion of the service and was immediately available during other parts of the service) to report such cases.

Anesthesia services and teaching CRNAs

CR 6706 also provides a new section in the *Medicare Claims Processing Manual* that addresses payment for teaching CRNAs. This section -- Section 140.5 (Payment for Anesthesia Services Furnished by a Teaching CRNA) in Chapter 12 (Physicians/Non-physician Practitioners) is attached to CR 6706.

This new section reiterates that a teaching CRNA (not under the medical direction of a physician) can be paid under Medicare Part B when continuously present and supervising a single case involving a student nurse anesthetist. In this single-case scenario, if the teaching CRNA is supervising a case performed by a student nurse

Teaching anesthesiologists – implementation of MIPPA Section 139 (continued)

anesthetist and is present with the student throughout the case, payment was made at the regular fee schedule rate. The CRNA should report the service using the usual modifier QZ, which designates that he or she is not medically directed by an anesthesiologist.

Further, the American Association of Nurse Anesthetists (AANA) indicates that their standards for approved nurse anesthetist training programs allow a teaching CRNA to supervise two concurrent cases involving student nurse anesthetists. For services furnished on or after August 1, 2002, a teaching CRNA (not under the medical direction of a physician can also be paid under Medicare Part B when supervising two student nurse anesthetists.

In this scenario, the CRNA has historically been paid in the following manner:

- By recognizing the full base units (assigned to the anesthesia code) when the teaching CRNA is present with the student nurse anesthetist throughout pre and post anesthesia care, and
- By recognizing the actual time the teaching CRNA is personally present with the student nurse anesthetist.

CR 6706 provides that the payment policy for the teaching CRNA in the single student nurse anesthetist case remains unchanged for services furnished on or after January 1, 2010; however, under MIPPA Section 139, when involved with two concurrent cases with student nurse anesthetists (on or after this date), he or she can be paid at the regular fee schedule rate for each case.

To bill the base units for each of the two cases, the teaching CRNA must be present with the student during the pre and post anesthesia care for each case and bill the time for each based on the actual amount of time present with the student nurse anesthetist.

In addition, while he or she can decide how to allocate time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health status and other factors; the CRNA must continue to devote all of his or her time to the two concurrent student nurse anesthetist cases and not be involved in other anesthesia cases.

For services furnished on or after January 1, 2010, the teaching CRNA should report these cases with the modifier

QZ as described above. You should also remember that the teaching CRNA's medical record documentation in these cases must be sufficient to support the payment of the fee and be available for review upon request. Additionally, be aware that no payment is made under Part B for the service provided by a student nurse anesthetist.

Note: No new payment modifiers are being created to describe the services of teaching anesthesiologists or teaching CRNAs. Both teaching anesthesiologists and teaching CRNAs should continue to report their anesthesia services using the existing anesthesia payment modifiers.

Additional information

You may find more information about payment for teaching anesthesiologists and CRNAs by going to CR 6706, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1859CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site. You will find updated *Medicare Claims Processing Manual* Chapter 12 (Physicians/Non-physician Practitioners), Sections 50 (Payment for Anesthesiology Services), 100.1.4 (Anesthesia), and 140.5 (Payment for Anesthesia Services Furnished by a Teaching CRNA) as an attachment to that CR.

If you have any questions, please contact your 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: MM6706
 Related Change Request (CR) #: 6706
 Related CR Release Date: November 20, 2009
 Effective Date: Effective for services on or after January 1, 2010
 Related CR Transmittal #: R1859CP
 Implementation Date: January 4, 2010

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Drugs and Biologicals

January 2010 quarterly average sales price update and revision to prior files

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 who submit claims to Medicare contractors (Medicare administrative contractors [MACs], fiscal intermediaries [FIs], carriers, durable medical equipment Medicare administrative contractors [DME MACs] or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6708, which instructs Medicare contractors to download and implement the January 2010 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2009, July 2009, April 2009, and January 2009 files. Medicare will use the January 2010 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 4, 2010, with dates of service January 1, 2010, through March 31, 2010. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

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

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. Note that payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) under a separate CR.

The following table shows how the quarterly payment files will be applied (for those files that are released):

Files	Effective dates of service
January 2010 ASP and NOC files	January 1, 2010, through March 31, 2010
October 2009 ASP and NOC files	October 1, 2009, through December 31, 2009
July 2009 ASP and NOC files	July 1, 2009, through September 30, 2009
April 2009 ASP and NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC files	January 1, 2009, through March 31, 2009

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 6708) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1854CP.pdf> on the CMS Web site.

MLN Matters® Number: MM6708

Related CR Release Date: November 13, 2009

Related CR Transmittal #: R1854CP

Related Change Request (CR) #: 6708

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

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Educational Resources

First Coast Service Options (FCSO) provides the training and information you need when it best fits into your busy schedule. If you or your colleagues were unable to attend one of FCSO's past Medicare educational webcasts, or if you would like to review the topics discussed, you may download a recording and listen to the webcast whenever it is *most convenient for you*. It's the next best thing to being there.

Durable Medical Equipment

2010 update of the durable medical equipment, prosthetics, orthotics and supplies fee schedule

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 (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) for items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider action needed

This article, based on CR 6720, advises you of the CY 2010 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule.

Key points about these changes are summarized in the *Background* section below. Please note that the fee schedule for Code E2227 (Manual wheelchair accessory, gear reduction drive wheel, each) is being revised, effective January 1, 2010, to remove pricing information for one product that was used in calculating payment for E2227. That product was erroneously classified as a gear reduction drive wheel when the code was established. Providers should be aware that your Medicare contractor will not adjust previously processed claims for the code E2227 with dates of service on or after January 1, 2009, through December 31, 2009, if they are submitted for adjustments. These changes are effective for DMEPOS provided on or after January 1, 2010. Be sure your billing staffs are aware of these changes.

Background

CR 6720 provides instructions regarding the 2010 annual update for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by sections 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 *Code of Federal Regulations* (CFR) section 414.102 for parenteral and enteral nutrition (PEN).

Key points of CR 6720

The DMEPOS fee schedule file will be available on or after November 17, 2009, for state Medicaid agencies, managed care organizations, and other interested parties at <http://www.cms.hhs.gov/DMEPOSFeeSched/> on the CMS Web site.

2010 fees for HCPCS labor payment codes K0739, L4205, L7520 are effective January 1, 2010, and those rates are as follows:

State	K0739	L4205	L7520	State	K0739	L4205	L7520
AK	25.27	28.79	33.88	NC	13.41	19.99	27.14
AL	13.41	19.99	27.14	ND	16.72	28.73	33.88
AR	13.41	19.99	27.14	NE	13.41	19.97	37.84
AZ	16.59	19.97	33.39	NH	14.40	19.97	27.14
CA	20.58	32.83	38.26	NJ	18.10	19.97	27.14
CO	13.41	19.99	27.14	NM	13.41	19.99	27.14
CT	22.40	20.45	27.14	NV	21.37	19.97	36.99
DC	13.41	19.97	27.14	NY	24.71	19.99	27.14
DE	24.71	19.97	27.14	OH	13.41	19.97	27.14
FL	13.41	19.99	27.14	OK	13.41	19.99	27.14
GA	13.41	19.99	27.14	OR	13.41	19.97	39.03
HI	16.59	28.79	33.88	PA	14.40	20.56	27.14
IA	13.41	19.97	32.49	PR	13.41	19.99	27.14
ID	13.41	19.97	27.14	RI	15.99	20.58	27.14
IL	13.41	19.97	27.14	SC	13.41	19.99	27.14
IN	13.41	19.97	27.14	SD	14.99	19.97	36.28
KS	13.41	19.97	33.88	TN	13.41	19.99	27.14

2010 update of the DMEPOS fee schedule (continued)

State	K0739	L4205	L7520	State	K0739	L4205	L7520
KY	13.41	25.60	34.71	TX	13.41	19.99	27.14
LA	13.41	19.99	27.14	UT	13.45	19.97	42.27
MA	22.40	19.97	27.14	VA	13.41	19.97	27.14
MD	13.41	19.97	27.14	VI	13.41	19.99	27.14
ME	22.40	19.97	27.14	VT	14.40	19.97	27.14
MI	13.41	19.97	27.14	WA	21.37	29.30	34.80
MN	13.41	19.97	27.14	WI	13.41	19.97	27.14
MO	13.41	19.97	27.14	WV	13.41	19.97	27.14
MS	13.41	19.99	27.14	WY	18.70	26.65	37.84
MT	13.41	19.97	33.88				

The following new codes are effective as of January 1, 2010:

- A4264, A4466, L2861, L3891, L8692, K0739, and K0740, all of which have no assigned payment category
- A4336, A4360, and A4456, which are in the ostomy, traheostomy, and urological supplies payment category
- E0433 in the oxygen and oxygen equipment category
- E0136 in the capped rental category, and
- L5973, L8031, L8032, L8627, L8628, L8629, and Q0506, all of which are in the prosthetics and orthotics category.

The fee schedule amounts for the above new codes will be established as part of the July 2010 DMEPOS fee schedule update, when applicable. The DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2010, through June 30, 2010. The new codes are not to be used for billing purposes until they are effective on January 1, 2010.

The following codes are being deleted from the HCPCS effective January 1, 2010, and are therefore being removed from the DMEPOS fee schedule files:

A4365	L1825	L3701	E2223	L1901	L3909	E2393	L2770
L3911	L0210	L3651	L6639	L1800	L3652	L1815	L3700

For gap-filling purposes, the 2009 deflation factors by payment category are listed as follows:

Factor	Category
0.508	Oxygen
0.511	Capped rental
0.512	Prosthetics and orthotics
0.650	Surgical dressings
0.707	Parenteral and enteral nutrition

Code E2227 Manual Wheelchair Accessory, Gear Reduction Drive Wheel, Each was added to the HCPCS effective January 1, 2008. The fee schedule for code E2227 was calculated using pricing information for two products; however, the fee schedule is being revised effective January 1, 2010, to remove pricing information for one product that was erroneously classified as a gear reduction drive wheel when the code was established. Contractors will not adjust previously processed claims for the code E2227 with dates of service on or after January 1, 2009 through December 31, 2009, if they are submitted for adjustments.

CY 2010 fee schedule update factor

Under the Act, the DMEPOS fee schedule amounts are being updated for 2010 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2009. Since the percentage change in the CPI-U for the 12-month period ending with June of 2009, is negative (-1.41 percent), the percentage increase in the CPI-U used to update the DMEPOS fee schedule amounts for 2010 is 0 percent.

2010 update to the labor payment rates

Since the percentage increase in the consumer price index (CPI) for the 12 month period ending with June of the previous year is negative for 2010, a 0 percent change is applied to the labor payment amounts for 2010 for codes K0739, L4205, and L7520.

2010 national monthly payment amounts for stationary oxygen equipment

CMS will also implement the 2010 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2010.

2010 update of the DMEPOS fee schedule (continued)

The fee schedule file is being revised to include the new national 2010 monthly payment rate of \$173.17 for stationary oxygen equipment. The payment rates are being adjusted for the new oxygen generating portable equipment (OGPE) class. The revised 2010 monthly payment rate of \$173.17 includes the 0 percent update due to the -1.41 percent CPI-U change. The budget neutrality adjustment for 2010 caused the 2010 rate to decrease from \$175.79 to \$173.17.

When updating the oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS code E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

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 CMS Web site.

The official instruction, CR 6720, issued to your Medicare contractor regarding this change, may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1853CP.pdf> on the CMS Web site. CR 6720 includes the revisions that will be made to the *Medicare Claims Processing Manual*, Chapter 23 – Fee Schedule Administration and Coding Requirements.

More information on durable medical equipment prosthetics, orthotics, and supplies is available at <http://www.cms.hhs.gov/center/dme.asp> on the CMS Web site.

MLN Matters® Number: MM6720

Related Change Request (CR) #: 6720

Related CR Release Date: November 13, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R1853CP

Implementation Date: January 4, 2010

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2010 update—splints, casts, dialysis supplies and equipment, and certain IOLs

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

Provider types affected

Physicians, providers, and suppliers, billing Medicare contractors (carriers, fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses, should be aware of this article.

Provider action needed

The payment on a reasonable charge basis is required for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses by regulations contained in 42 CFR 405.501.

CR 6691, from which this article is taken, instructs your carriers, FIs, MACs, and DME MACs how to calculate reasonable charges for the payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2010. Make sure your billing staff are aware of these changes.

Background

CR 6691 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2010.

The inflation indexed charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the consumer price index for all urban consumers (CPI-U)(United States city average) for the 12-month period ending with June of 2009.

Since the percentage change in the CPI-U for the 12-month period ending with June 2009 is negative (-1.41 percent), the IIC update factor for 2010 is 0 percent. The 2010 payment limits for splints and casts will be based on the 2009 limits that were announced in CR 6221 last year. Those limits are repeated in Attachment A at the end of this article. In addition, please note that: 1) Payment for intraocular lenses is only made on a reasonable charge basis for lenses implanted in a physician’s office; and 2) The Q-codes should be used for splints and casts when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast. An attachment to CR 6691 lists the 2010 payment limits for splints and casts.

CR 6691 instructs your carrier or MAC to: 1) Compute 2010 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician’s Office) using actual charge data from July 1, 2008, through June 30, 2009; and 2) Compute 2010 IIC amounts for these codes that were not paid using gap-filled payment amounts in 2009.

For codes identified in the following four tables, CR 6691 instructs DME MACs to compute 2010 customary and prevailing charges using actual charge data from July 1, 2008, through June 30, 2009; and to compute 2010 IIC amounts for these codes that were not paid using gap-filled amounts in 2009.

Dialysis supplies billed with modifier AX

A4215	A4216	A4217	A4244	A4245	A4246	A4247	A4248
A4450	A4452	A4651	A4652	A4657	A4660	A4663	A4670
A4927	A4928	A4930	A4931	A6216	A6250	A6260	A6402

2010 update—splints, casts, dialysis supplies and equipment, and certain IOLs (continued)

Dialysis supplies billed without modifier AX

A4653	A4671	A4672	A4673	A4674	A4680	A4690	A4706
A4707	A4708	A4709	A4714	A4719	A4720	A4721	A4722
A4723	A4724	A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766	A4770	A4771
A4772	A4773	A4774	A4802	A4860	A4870	A4890	A4911
A4918	A4929	E1634					

Dialysis equipment billed with modifier AX

E0210NU	E1632	E1637	E1639
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Dialysis equipment billed without modifier AX

E1500	E1510	E1520	E1530	E1540	E1550	E1560
E1570	E1575	E1580	E1590	E1592	E1594	E1600
E1610	E1615	E1620	E1625	E1630	E1635	E1636

Additional information

Detailed instructions for calculating:

- Reasonable charges are located in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments)
- Customary and prevailing charges are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge), and
- The IIC are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge [IIC] for Nonphysician Services).

The *Medicare Claims Processing Manual* is available at <http://www.cms.hhs.gov/manuals/IOM/list.asp>.

For complete details regarding this CR please see the official instruction (CR 6691) issued to your Medicare FI, carrier, MAC, or DME MAC. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1834CP.pdf>.

If you have any questions, please contact your FI, carrier, MAC, 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.

Attachment A

Code	Payment Limit	Code	Payment Limit
A4565	\$7.75	Q4025	\$34.07
Q4001	\$44.11	Q4026	\$106.37
Q4002	\$166.75	Q4027	\$17.04
Q4003	\$31.69	Q4028	\$53.19
Q4004	\$109.71	Q4029	\$26.05
Q4005	\$11.68	Q4030	\$68.58
Q4006	\$26.33	Q4031	\$13.03
Q4007	\$5.86	Q4032	\$34.28
Q4008	\$13.17	Q4033	\$24.30
Q4009	\$7.80	Q4034	\$60.44
Q4010	\$17.56	Q4035	\$12.15
Q4011	\$3.90	Q4036	\$30.23
Q4012	\$8.78	Q4037	\$14.83

Code	Payment Limit	Code	Payment Limit
Q4013	\$14.20	Q4038	\$37.14
Q4014	\$23.95	Q4039	\$7.43
Q4015	\$7.10	Q4040	\$18.56
Q4016	\$11.97	Q4041	\$18.02
Q4017	\$8.21	Q4042	\$30.77
Q4018	\$13.09	Q4043	\$9.02
Q4019	\$4.11	Q4044	\$15.39
Q4020	\$6.55	Q4045	\$10.46
Q4021	\$6.07	Q4046	\$16.83
Q4022	\$10.96	Q4047	\$5.22
Q4023	\$3.06	Q4048	\$8.42
Q4024	\$5.48	Q4049	\$1.91

MLN Matters® Number: MM6691
 Related CR Release Date: October 23, 2009
 Related CR Transmittal #: R1834CP

Related Change Request (CR) #: 6691
 Effective Date: January 1, 2010
 Implementation Date: January 4, 2010

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End-Stage Renal Disease

Validating the billing of end-stage renal disease 50/50 rule modifier

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

Provider types affected

This article is for physicians, laboratories, and providers billing Medicare contractors (carriers or Medicare administrative contractors [MACs]) for automated multi-channel chemistry (AMCC) ESRD-related tests provided to Medicare beneficiaries.

Provider action needed

You should be aware that change request (CR) 6683 creates the functionality in the Medicare systems to check that claims for AMCC ESRD-related tests for an ESRD beneficiary ordered by a physician from the dialysis facility use the ESRD 50/50 rule modifiers properly. Claims validation will begin with claims processed on or after April 5, 2010.

The *Background* section sets out the billing instructions to be validated. These instructions were discussed in MM3890, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3890.pdf> and added to the *Medicare Benefit Policy Manual*, Chapter 11, Section 30.2.2 and the *Medicare Claims Processing Manual*, Chapter 16, Section 40.6.1, both available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the Centers for Medicare & Medicaid Services (CMS) Web site. Make sure that your staff is aware of this validation process.

Background

Effective with claims processed on or after April 5, 2010, Medicare will validate claims for AMCC ESRD-related tests provided to a beneficiary who is ESRD eligible to ensure your compliance with billing instructions regarding the use of the ESRD 50/50 rule modifiers CD, CE, and CF.

The payment of certain ESRD laboratory services performed by an independent laboratory is included in the composite rate calculation for ESRD facilities. When billing Medicare for AMCC ESRD-related tests, laboratories must indicate which tests are or are not included within the ESRD facility composite rate to ensure proper reimbursement.

The ESRD 50/50 rule classifies AMCC ESRD-related tests according to the following categories:

1. AMCC test ordered by an ESRD facility (or a physician included in the monthly capitation payment (MCP), i.e., an MCP physician) that is part of the composite rate and is not separately billable
2. AMCC test ordered by an ESRD facility (or MCP physician) that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity, and
3. AMCC test ordered by an ESRD facility (or MCP physician) that is not part of the composite rate and is separately billable.

When billing for AMCC ESRD-related tests, the laboratory must include the appropriate modifier for each test, as follows:

Modifier CD – AMCC test has been ordered by an ESRD facility (or MCP physician) that is part of the composite rate and is not separately billable

Modifier CE – AMCC test has been ordered by an ESRD facility (or MCP physician) that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity, or

Modifier CF – AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.

The proportion (or percentage) of composite tests to non-composite tests billed is used to determine whether separate payment may be made for all tests performed on the same day for the same beneficiary. The chart attached to CR 6683 identifies the AMCC ESRD-related tests and the Web address for accessing CR 6683 is provided in the *Additional information* section of this article.

Physicians, providers, and suppliers billing AMCC ESRD-related tests to Medicare must report modifier CD, CE, or CF for each test. If at least one of the three modifiers is not shown for one of the AMCC ESRD-related test codes, all AMCC ESRD-related tests on the claim will be returned as unprocessable.

When an organ disease panel (i.e., 80076, 80047, 80048, 80053, 80069, 80061, or 80051 in the chart attached to CR 6683) is billed on a claim regardless of whether modifier CD, CE, or CF is used, the claim will be returned as unprocessable.

If the beneficiary is not ESRD eligible or if the ordering physician is not an MCP physician, then the Medicare contractor will process the claim as acceptable and payable as a non-ESRD claim.

Additional information

If you have questions, please contact your Medicare 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 6683) issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R586OTN.pdf> on the CMS Web site.

The *Outpatient Maintenance Dialysis End-Stage Renal Disease* fact sheet provides general information about outpatient maintenance dialysis for ESRD, the composite payment rate system, and separately billable items and services. The fact sheet is available at <http://www.cms.hhs.gov/MLNProducts/downloads/ESRDpaymfctsh08-508.pdf> on the CMS Web site.

Validating the billing of end-stage renal disease 50/50 rule modifier (continued)

MLN Matters® Number: MM6683
 Related Change Request (CR) #: 6683
 Related CR Release Date: October 30, 2009
 Effective Date: Claims processed on or after April 5, 2010
 Related CR Transmittal #: R586OTN
 Implementation Date: April 5, 2010

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Laboratory/Pathology

Changes to the laboratory national coverage determination edit software for January 2010

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], 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) 6717 which announces the changes that will be included in the January 2010 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 October 2009. Be sure billing staff are aware of the changes in this article.

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 6717 announces changes to the laboratory edit module for changes in laboratory NCD code lists for January 2010. These changes become effective for services furnished on or after January 1, 2010. The changes that are effective for dates of service on and after January 1, 2010, are as follows:

For serum iron studies:

- Delete ICD-9-CM codes 453.50-453.52 from the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.

For gamma glutamyl transferase:

- Add ICD-9-CM codes 453.50-453.52 to the list of ICD-9-CM codes that are covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

Note: Effective dates for the following codes were inadvertently changed to July 1, 2009, with the July 1, 2009 quarterly release. The correct actual effective dates were October 1, 2007, and those dates will be reinstated with the January 2010 release of Medicare's edit module.

For prothrombin time (PT):

- Revise the effective date from July 1, 2009, to October 1, 2007 for ICD-9-CM codes 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, and 202.78 that are listed for the prothrombin time (PT) (190.17) NCD.

For serum iron studies:

- Revise the effective date from July 1, 2009, to October 1, 2007, for ICD-9-CM codes 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, and 202.78 that are listed for the serum iron studies (190.18) NCD.

*Changes to the laboratory national coverage determination edit software for January 2010 (continued)***For gamma glutamyl transferase:**

- Revise the effective date from July 1, 2009, to October 1, 2007 for ICD-9-CM codes 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, and 202.78 that are listed for the gamma glutamyl transferase (190.32) NCD.

Note that Medicare contractors will adjust claims affected by the above three categories if you bring such claims to their attention.

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Psychiatric Services

New physician specialty code for geriatric psychiatry

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

Provider types affected

This article is for physicians and nonphysician practitioners who bill Medicare carriers and Medicare administrative contractors (A/B MAC) for providing psychiatric care to geriatric Medicare beneficiaries.

What you need to know

Effective April 1, 2010, the Centers for Medicare & Medicaid Services (CMS) will establish a new physician specialty code (code 27) for geriatric psychiatry. In addition, the codes 32, 74, and 75 are being removed from the physician specialty section of the *Medicare Claims Processing Manual*, because they are nonphysician specialty codes. You should ensure that your billing staffs are aware of this new specialty code.

Background

When enrolling in Medicare, physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I) or Internet-based Provider Enrollment, Chain and Ownership System; and nonphysician practitioners are assigned a Medicare specialty code. This specialty code becomes associated with the claims that the physician or nonphysician practitioner submits, and describes the specific/unique types of medicine that physicians and nonphysician practitioners (and certain other suppliers) practice. Moreover, CMS uses these specialty codes for programmatic and claims processing purposes.

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 6717) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1847CP.pdf> on the CMS Web site.

MLN Matters® Number: MM6717

Related Change Request (CR) #: 6717

Related CR Release Date: November 6, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R1847CP

Implementation Date: January 4, 2010

Change request (CR) 6533, from which this article is taken, announces that effective April 1, 2010, CMS will establish a new physician specialty code for geriatric psychiatry. For care you provide on or after that effective date, your carrier or A/B MAC will recognize and use specialty code 27 as a valid primary and/or secondary specialty code for geriatric psychiatry services provided by both individuals and organizations.

Additional information

You may find more information about the new physician specialty code for geriatric psychiatry services by going to CR 6533, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1836CP.pdf> on the CMS Web site. If you have any questions, please contact your 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: MM6533

Related Change Request (CR) #: 6533

Related CR Release Date: October 27, 2009

Effective Date: April 1, 2010

Related CR Transmittal #: R1836CP

Implementation Date: April 5, 2010

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Outpatient mental health treatment limitation

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

Provider types affected

This article is of special interest to physicians, clinical psychologists (CPs), clinical social workers (CSWs), nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and comprehensive outpatient rehabilitation facilities (CORFs) who submit claims to Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), or carriers, for mental health services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 6686 alerts providers that the Centers for Medicare & Medicaid Services (CMS) is phasing out the outpatient mental health treatment limitation (the limitation) over a five year period, from 2010-2014. Effective January 1, 2014, Medicare will pay outpatient mental health services at the same rate as other Part B services, that is, at 80 percent of the physician fee schedule.

Background

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends section 1833(c) of the Social Security Act (the Act) to phase out the outpatient mental health treatment limitation over a five year period, from 2010-2014. The limitation has resulted in Medicare paying only 50 percent of the approved amount under the physician fee schedule for outpatient mental health treatment rather than 80 percent that is paid for most other services.

Key points of CR 6686

Section 102 of MIPPA requires that the current 62.5 percent outpatient mental health treatment limitation (effective since the inception of the Medicare program until December 31, 2009) will be reduced as follows:

January 1, 2010-December 31, 2011 – the limitation percentage is 68.75 percent (of which Medicare pays 55 percent and the patient pays 45 percent)

January 1, 2012-December 31, 2012 – the limitation percentage is 75 percent (of which Medicare pays 60 percent and the patient pays 40 percent)

January 1, 2013-December 31, 2013 – the limitation percentage is 81.25 percent (of which Medicare pays 65 percent and the patient pays 35 percent), and

January 1, 2014-onward – the limitation percentage is 100 percent, at which time Medicare pays 80 percent and the patient pays 20 percent.

Note: For RHCs and FQHCs, the amount the patient pays may differ from the percentages shown above if the charges are not equal to the encounter rate for the clinic.

Services not subject to the limitation

- **Medicare will not apply the limitation on type of bill (TOB) 75x:** Since CORFs do not provide mental health therapeutic services; the limitation does not apply to CORF services. Note that *CPT* code 96152 is the only *CPT* code allowed for behavioral health services provided in a CORF, and this service is not subject to the limitation.
- **Diagnosis of Alzheimer’s disease or Related Disorder:** When the primary diagnosis reported for a particular service is Alzheimer’s disease or as an Alzheimer’s related disorder, your Medicare contractor will look to the nature of the service that has been rendered in determining whether it is subject to the limitation.
 - Alzheimer’s disease is coded 331.0 in the “International Classification of Diseases, 9th Revision”, which is outside the diagnosis code range 290-319 that represents mental, psychoneurotic and personality disorders that are potentially subject to the limitation.
 - Additionally, Alzheimer’s related disorders are identified by Medicare contractors under ICD-9 codes that are outside the 290-319 diagnosis code range. Typically, treatment provided to a patient with a diagnosis of Alzheimer’s disease or a related disorder represents medical management of the patient’s condition (such as described under *CPT* code 90862 or any successor code) and is not subject to the limitation. *CPT* code 90862 describes pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.
 - However, when the primary treatment rendered to a patient with a diagnosis of Alzheimer’s disease or a related disorder is solely psychotherapy, it is subject to the limitation.

Additional information

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.

Outpatient mental health treatment limitation (continued)

The official instruction, CR 6686, was issued via three transmittals to your Medicare FI, carrier, or A/B MAC regarding this change. The first transmittal, available at <http://www.cms.hhs.gov/Transmittals/downloads/R60GI.pdf>, revises the *Medicare General Information, Eligibility and Entitlement Manual*. The second transmittal, available at <http://www.cms.hhs.gov/Transmittals/downloads/R114BP.pdf>, revises the *Medicare Benefit Policy Manual*. The third transmittal, available at <http://www.cms.hhs.gov/Transmittals/downloads/R1843CP.pdf>, revises the *Medicare Claims Processing Manual*.

MLN Matters® Number: MM6686

Related Change Request (CR) #: 6686

Related CR Release Date: October 30, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R51GI, R114BP, and R1843CP

Implementation Date: January 4, 2010

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Therapy Services

Therapy cap values for calendar year 2010

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

Provider types affected

This article is for providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or DME Medicare administrative contractors [DME MACs]) for physical therapy, speech-language pathology, and/or occupational therapy services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6660 which describes the policy for outpatient therapy caps for calendar year (CY) 2010 and announces that therapy caps for CY 2010 will be \$1860. Billing staff should be aware of these revised caps.

Background

The Balanced Budget Act 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare patients. These limits change annually. The Deficit Reduction Act of 2005 (signed Feb. 8, 2006) directed that a process for exceptions to therapy caps for medically necessary services be implemented. Subsequently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008, and Section 141 extended the effective date of the exceptions process to the therapy caps to December 31, 2009. The exceptions process will continue unchanged for the time frame directed by Congress.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1860 for CY 2010. For occupational therapy services, the limit is \$1860 for CY 2010. The limit is based on incurred expenses and includes applicable deductible and coinsurance.

CR 6660 revises the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 10 (Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General), and Section 20 (HCPCS Coding Requirement) to include the CY 2010 therapy caps, and this revision is included as an attachment to CR 6660.

Additional Information

You may find out more about Medicare therapy services and resources at <http://www.cms.hhs.gov/therapyservices/> on the Centers for Medicare and Medicaid Services (CMS) Web site.

The official instruction, CR 6660, issued to your FI, A/B MAC, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1851CP.pdf> on the CMS Web site.

If you have any questions, please contact your FI, A/B MAC, 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: MM6660

Related Change Request (CR) #: 6660

Related CR Release Date: November 13, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R1851CP

Implementation Date: January 4, 2010

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General Coverage

2010 payment and policy changes for physician services

The Centers for Medicare & Medicaid Services (CMS) announced final changes to policies and payment rates for services to be furnished during calendar year (CY 2010) by over one million physicians and nonphysician practitioners who are paid under the Medicare physician fee schedule (MPFS). The MPFS sets payment rates for more than 7,000 types of services in physician offices, hospitals, and other settings. This action complies with federal law, which requires these policies and payment rates to be announced by November 1.

Current law requires CMS to adjust the MPFS payment rates annually based on an update formula which requires application of the sustainable growth rate (SGR) that was adopted in the Balanced Budget Act of 1997. This formula has yielded negative updates every year beginning in CY 2002, although CMS was able to take administrative steps to avert a reduction in CY 2003, and Congress has taken a series of legislative actions to prevent reductions in CYs 2004-2009. In the absence of congressional action for the CY 2010 physician update, the final rule with comment period will reduce the conversion factor for services on or after January 1, 2010, by 21.2 percent rather than the -21.5 percent projected in the proposed rule. The difference is due to the use of the most recently available data on CMS spending for physicians' services.

"The Administration tried to avert the pending fee schedule cut in the FY 2010 budget proposal that it submitted to Congress, and remains committed to repealing the SGR," said Jonathan Blum, director of the CMS Center for Medicare Management. "In the meantime, CMS is finalizing its proposal to remove physician-administered drugs from the definition of "physicians' services" for purposes of computing the physician fee schedule update. While this decision will not affect payments for services during CY 2010, CMS projects it will have a positive effect on future payment updates."

In the final rule with comment period, CMS is also adopting several refinements to Medicare payments to physicians which will improve payment rates for primary care services relative to other services. For 2010, for purposes of establishing the practice expense (PE) relative value units (RVUs), CMS had proposed to include data about physicians' practice costs from a new survey, the physician practice information survey (PPIS), designed and conducted by the American Medical Association. CMS is finalizing the proposal, but will phase it in over a four year period. In addition, CMS will not use the PPIS data to determine the practice expenses for medical oncology, but instead will continue to use specialty supplemental survey data, as indicated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

CMS is also finalizing its proposal to stop making payment for consultation codes other than the G codes

that are used to bill for telehealth consultations, and to redistribute the resulting savings to increase payments for the existing evaluation and management (E/M) services. CMS will adjust the payment for the surgical global period to reflect the higher value of the office visits furnished during the global period.

In the final rule with comment period, CMS is adopting two significant modifications to its proposal to increase the equipment utilization percentage that is assumed for purposes of setting PE RVUs. CMS will increase the equipment utilization rate assumption used to determine the practice expense for expensive equipment priced over one million dollars from 50 to 90 percent but will phase in this change over a four year period. CMS also will not apply this change to expensive therapeutic equipment.

CMS is increasing payment for the initial preventive physical exam (IPPE), also called the "Welcome to Medicare" visit to be more in line with payment rates for higher complexity services. Originally established in the MMA, the IPPE benefit now pays for an initial assessment of key elements of a beneficiary's health within one year of the beneficiary's enrollment in Medicare Part B.

Taking all changes in the final rule with comment period into account, CMS projects that payments to general practitioners, family physicians, internists, and geriatric specialists will increase by between five and eight percent, prior to application of the negative update required by the SGR.

The final rule with comment period also implements a number of provisions in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) including:

- Adding new Medicare benefit categories for cardiac and pulmonary rehabilitation services and for chronic kidney disease (CKD) education beginning Jan. 1, 2010. The final rule with comment period outlines what these programs will entail, how they will be paid under the MPFS and the criteria for covering these services.
- Increasing the Medicare share of payments for outpatient mental health services to 55 percent from 50 percent, beginning a gradual transition to bring payment parity for mental health and medical services furnished to Medicare beneficiaries.
- Implementing a requirement that suppliers of the technical component of advanced imaging services be accredited beginning Jan. 1, 2012. The accreditation requirement will apply to mobile units, physicians' offices, and independent diagnostic testing facilities that create the images, but will not apply to the physician who interprets them. CMS will address suppliers' accountability, business integrity, physician and technician training, service quality, and performance management through additional guidance.

2010 payment and policy changes for physician services (continued)

The final rule with comment period contains a number of provisions to promote improvement in quality of care and patient outcomes through revisions to the electronic prescribing incentive program (e-Prescribing) and the Physician Quality Reporting Initiative (PQRI). Specifically, the final rule simplifies the reporting requirements for the electronic prescribing measure, provides eligible professionals with more reporting options, and establishes a new process for group practices to be considered successful electronic prescribers. Eligible professionals or group practices that meet the requirements of each program in CY 2010 will be eligible for incentive payments for each program equal to 2.0 percent of their total estimated allowed charges for the reporting periods.

In addition, CMS is adding measures for eligible professionals to report under the PQRI, providing a mechanism for participants to submit quality measure data from a qualified electronic health record and creating a process for group practices to use for reporting the quality measures.

The final rule with comment will appear in the November 25, 2009, *Federal Register*. CMS will accept comments on designated provisions of the final rule with comment period until December 29, 2009, and will respond to all comments at a later date. Unless otherwise specified, the new payment rates and policies will apply to services furnished to Medicare beneficiaries on or after January 1, 2010.

To view a copy of the final rule with comment period and supporting documentation, please see:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1230135&intNumPerPage=10>.

A fact sheet providing more information about the e-Prescribing program and PQRI provisions may be found at:

http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

Source: CMS PERL 200911-03

Processing claims rejecting for gender/procedure conflict

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

Provider types affected

This article is for physicians, nonphysician practitioners, and providers 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**Stop -- impact to you**

This article is based on change request (CR) 6638 which provides instructions for completing Part A and Part B claims for gender specific services for beneficiaries who are transgender, hermaphrodites, or have ambiguous genitalia.

Caution -- what you need to know

Claims for some beneficiaries are being rejected by Medicare systems due to gender specific edits, and this is resulting in inappropriate denials for Part A and Part B claims. CR 6638 instructs that for Part A claims processing, institutional providers should report condition code 45 (ambiguous gender category) on inpatient or outpatient services that can be subjected to gender specific editing (i.e., services that are considered female or male only) for the above defined beneficiaries. CR 6638 instructs physicians and nonphysician practitioners that for Part B professional claims the modifier KX (requirements specified in the medical policy have been met) should be billed on the detail line with any procedure code(s) that are gender specific for the affected beneficiaries.

Go -- what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Claims for some services for beneficiaries described above may be inadvertently denied due to sex related edits unless these services are billed properly.

As a result of the number of subject claims received that are being denied due to sex/diagnosis and sex/procedure edits, the National Uniform Billing Committee (NUBC) approved condition code 45 (ambiguous gender category) to identify these unique claims and to allow the sex related edits to be processed correctly.

CR 6638 instructs institutional providers submitting Part A claims to report condition code 45 (ambiguous gender category) on inpatient or outpatient services for affected beneficiaries where the service performed is gender specific (i.e., services that are considered female or male only). This claim level condition code should be used by providers to identify these unique claims and to allow the sex related edits to be processed correctly by Medicare systems and allow the service to continue normal processing. Payment will be made if the coverage and reporting criteria have been met for the service.

The modifier KX, which is defined as "Requirements specified in the medical policy have been met", is a multipurpose informational modifier for Part B professional claims. In addition to its other existing uses, the modifier KX should also be used to identify services that are gender specific (i.e., services that are considered female or male only) for affected beneficiaries on claims submitted by physicians and nonphysician practitioners to Medicare carriers and MACs. Use of the modifier KX will alert the carrier/MAC that the physician/practitioner is performing a service on a patient for whom gender specific editing may apply, and that the service should be allowed to continue with normal processing. Payment will be made if the coverage and reporting criteria have been met for the service.

*Processing claims rejecting for gender/procedure conflict (continued)***Additional information**

The official instruction, CR 6638, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1839CP.pdf> on the CMS Web site.

If you have any questions, please contact your carrier, FI, 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: MM6638

Related Change Request (CR) #: 6638

Related CR Release Date: October 28, 2009

Effective Date: April 1, 2010

Related CR Transmittal #: R1839CP

Implementation Date: April 5, 2010

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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 CR 6723, 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 September 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 November 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 codes and claim status category 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 September 2009 committee meeting were posted at <http://www.wpc-edi.com/content/view/180/223/> on November 1, 2009. Medicare will implement those changes on January 4, 2010, as a result of CR 6723.

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/R1852CP.pdf> on the CMS Web site.

MLN Matters® Number: MM6723

Related Change Request (CR) #: 6723

Related CR Release Date: November 13, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R1852CP

Implementation Date: January 4, 2010

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Timely claim filing guidelines

All Medicare claims must be submitted to the contractor within the established timeliness parameters. The time parameters are:

Dates of Service

Last Filing Date

October 1, 2007 – September 30, 2008 by December 31, 2009

October 1, 2008 – September 30, 2009 by December 31, 2010

October 1, 2009 – September 30, 2010 by December 31, 2011

General Information

2010 annual participation enrollment program extension

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

Provider types affected

This article is for physicians currently participating in Medicare or considering participation during 2010.

What you need to know

Due to recent revisions that were made to the 2010 Medicare physician fee schedule (MPFS), the Centers for Medicare & Medicaid Services (CMS) has extended the 2010 annual participation enrollment program end date from December 31, 2009, to January 31, 2010 – therefore, the enrollment period now runs from November 13, 2009, through January 31, 2010. The effective date for any participation status change during the extension, however, remains January 1, 2010; and will be in force for the entire year.

Medicare contractors (carriers and Medicare administrative contractors [MACs]) will accept and process any participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before January 31, 2010.

Background

This is an extension of the annual participation enrollment period dates in CR 6637 (Transmittal 1832 -- Calendar Year [CY] 2010 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory [MEDPARD] Procedures), dated October 16, 2009. CR 6637 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1832CP.pdf> on the CMS Web site.

The participation agreement (CMS-460) is available on the CD-ROM that is sent out annually by your Medicare contractor during the annual participation enrollment period. Your contractor will also make the participation agreement available to you by placing it on their Web sites with participation enrollment (and termination) instructions.

Additional information

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. The addresses of Medicare contractors' Web sites are available at this location as well.

MLN Matters® Number: SE0929
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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Medicare deductible, coinsurance, and premium rates for 2010

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

Provider types affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC], durable medical equipment Medicare administrative contractors [DME MAC] and carriers) for services provided to Medicare beneficiaries.

Impact on providers

This article is based on change request (CR) 6690, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for calendar year (CY) 2010.

2010 Part A hospital insurance (HI)

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

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

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during an illness episode. The 2010 deductible and coinsurance amounts are in the following table.

Table 1

2010 Part A hospital insurance (HI)			
Deductible	\$1,100.00		
Coinsurance	Hospital		Skilled Nursing Facility
	Days 61-90	Days 91-150 (lifetime reserve days)	Days 21-100
	\$275.00	\$550.00	\$137.50

Medicare deductible, coinsurance, and premium rates for 2010 (continued)

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

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a two year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2010 Part A premiums are listed in the following table.

Table 2

Voluntary enrollees Part A premium schedule for 2010	
Base premium (BP)	\$461.00 per month
Base premium with 10 percent surcharge	\$507.10 per month
Base premium with 45 percent reduction	\$254.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45 percent reduction and 10 percent surcharge	\$279.40 per month

2010 Part B supplementary medical insurance SMI

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

For 2010, the standard premium for SMI services is \$110.50 a month; the deductible is \$155.00 a year; and the coinsurance is 20 percent. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 6690, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R61GI.pdf> on the CMS Web site.

Additional information

If you have questions, please contact your Medicare FI, A/B MAC, DME MAC, carriers or RHHI 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: MM6690

Related Change Request (CR) #: 6690

Related CR Release Date: November 13, 2009

Effective Date: January 1, 2010

Related CR Transmittal #: R61GI

Implementation Date: January 4, 2010

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Fraud prevention message for Florida Medicare summary notice

Beginning no later than November 6, 2009, through September 30, 2012, First Coast Service Options Inc. will print the general message number 24.15 on all Medicare summary notices (MSNs) issued to beneficiaries in Florida. This message will be placed on the first page in the fraud section:

English

Report items and services that you did not receive to Medicare's Fraud Hotline at 1-866-417-2078.

Spanish

Reporte los servicios y artículos que no recibió a la línea gratuita para Fraude de Medicare al 1-866-417-2078.

Source: CMS JSM 10035

Educational Resources

First Coast Service Options (FCSO) provides the training and information you need when it best fits into your busy schedule. If you or your colleagues were unable to attend one of FCSO's past Medicare educational webcasts, or if you would like to review the topics discussed, you may download a recording and listen to the webcast whenever it is *most convenient for you*. It's the next best thing to being there.

New tougher standards in calculation of improper Medicare payment rates for 2009

Part of administration-wide strategy to eliminate errors and prevent waste and fraud

As part of the Obama administration's goal of reducing waste, fraud, and abuse in Medicare, the Department of Health & Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) significantly revised and improved its calculations of Medicare fee-for-service (FFS) error rates in 2009, reflecting a more complete accounting of Medicare's improper payments than in past years. These improvements will provide CMS with more complete information about errors so that the agency can better target improper payments.

"The Obama administration is committed to strengthening and improving the Medicare and Medicaid systems and doing everything we can to be responsible and vigilant stewards of these programs that millions of Americans rely upon," said HHS Secretary Kathleen Sebelius. "From the very start of the Administration, the President has directed all the agencies across government to use honest budgeting and to take the hardest, most detailed look possible at what was happening with taxpayer dollars inside our agencies and inside critical programs. This year, we made the call to stop calculating our error rate in fee-for-service Medicare the way that the previous administration did and to start using a more rigorous method in calculating this rate in keeping with our mandate to root out errors and fraud."

The Medicare, Medicaid and Children's Health Insurance Program (CHIP) improper payment rates are issued annually as part of the HHS agency financial report.

While improper payment rates are not necessarily an indicator of fraud in Medicare or any other federal health care program, they do provide HHS, CMS, and its partners who are responsible for the oversight of Medicare and Medicaid funds a more complete assessment of how many errors need to be fixed.

"If we aren't honest about the problem, there is no way we can get to a solution. Through a more stringent review of Medicare claims, we've been able to establish a more complete accounting of errors, enabling CMS to take more actionable steps to further reduce the error rate and identify abusive or potentially fraudulent actions before they become problems," said Sebelius. "This change in calculating the error rate is just one part of our larger Administration-wide effort to reduce waste, fraud and abuse in health care. In addition to the establishment of HEAT, the joint task force that was established earlier this year with the Department of Justice, we've taken aggressive steps at HHS and CMS to improve our oversight of the Medicare trust funds and the taxpayer dollars that pay for the health care of millions of older and vulnerable Americans."

"As we move forward in our review of the Medicare and Medicaid error rate data, we expect to be able to determine if there are specific trends that can better help us identify weaknesses in our programs or systems," said Acting CMS Administrator Charlene Frizzera. "We hope to be able to use data available through the use of new electronic health record reporting that can help in the design of new and innovative approaches to finding emerging trends and vulnerabilities in high risk areas such as durable medical equipment and home health."

Sebelius and Frizzera also pointed out the HHS and the CMS would invest more time and resources into working with providers to eliminate errors through increased and improved training and education outreach.

"It's important that we continue to work closely with doctors, hospitals and other health care providers to make sure they understand and follow the more comprehensive fee-for-service requirements," said Frizzera. "We are committed to working closely with them to reduce the rate of improper payments."

The entire press release is available at: https://www.cms.hhs.gov/apps/media/press_releases.asp.

Source: CMS PERL 200911-31

H1N1 flu prompts HHS secretary to lift certain program requirements

Secretary of Health & Human Services Kathleen Sebelius has invoked her waiver authority under Section 1135 of the Social Security Act. This allows for the waiver or modification of certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and for the time periods covered by the 1135 authority.

Requests by providers to operate under the flexibilities afforded by the waiver should be sent to the state survey agency or CMS regional office. Please visit the Centers for Medicare & Medicaid Services' Web site for details on what's required to submit a waiver request: <http://www.cms.hhs.gov/H1N1/Downloads/RequestingAWaiver101.pdf>.

Further information on the 1135 waiver process may be found at: <http://www.cms.hhs.gov/H1N1/>.

Source: CMS PERL 200910-44

Submitting suggestions for 2011 PQRI quality measures and/or measures groups

The Centers for Medicare & Medicaid Services (CMS) is now accepting quality measure suggestions for consideration for possible inclusion in the proposed set of quality measures for use in the 2011 Physician Quality Reporting Initiative.

Interested parties have an additional opportunity to submit measure suggestions for the 2011 PQRI program beyond the request for 2011 measure suggestions included in the calendar year (CY) 2010 Medicare physician fee schedule (PFS) proposed rule published in the *Federal Register* (74 FR 33587) on July 13, 2009. Interested parties who have already submitted measure suggestions in response to the request for 2011 PQRI measures included in the CY 2010 PFS proposed rule do not need to re-submit their measure suggestions.

To learn more about the 2011 PQRI call for measures, visit the CMS Quality Measures Management Information System (QMIS) Web site at <http://www.cms.hhs.gov/apps/QMIS/CallforMeasures.asp>.

All suggestions must be received by CMS no later than 5:00 p.m. (ET) December 16, 2009.

Please note: Suggesting individual measures or measures for a new or existing measures group does not guarantee that the measure(s) will be included in the proposed or final sets of measures of any proposed or final rules that address the 2011 PQRI. CMS will determine what individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the 2011 PQRI.

Source: CMS PERL 200911-32

Medicare paid over \$92 million in incentives under the 2008 PQRI

More than 85,000 physicians and other eligible professionals who successfully reported quality-related data to Medicare under the 2008 Physician Quality Reporting Initiative (PQRI) received incentive payments totaling more than \$92 million, the Centers for Medicare & Medicaid Services (CMS) announced November 13, well above the \$36 million paid in 2007.

The number of eligible professionals who earned an incentive payment increased by one third from 2007, when 56,700 eligible professionals earned an incentive payment. In 2007, eligible professionals could only participate in the program during a 6-month reporting period. In 2008, the program expanded to allow reporting for either a 6-month or a 12-month period.

“We are very pleased with the results for 2008,” said Charlene Frizzera, acting CMS administrator. “More health professionals have successfully reported data, and the substantial growth in the national total for PQRI incentive payments demonstrates that Medicare can align payment with quality incentives.”

Read the entire press release and CMS fact sheet issued November 13 at:

Press release: http://www.cms.hhs.gov/apps/media/press_releases.asp.

CMS fact sheet: http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

CMS recently announced its plan for the 2010 PQRI program as part of the Medicare physician fee schedule final rule. A fact sheet on the 2010 PQRI program is available online at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3541&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&src>.

More information about the PQRI program, including participation guidance and the criteria to qualify for an incentive payment is available at <http://www.cms.hhs.gov/PQRI>.

Source: CMS PERL 200911-22

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Physician Quality Reporting Initiative program updates

How to access 2007 re-run and 2008 PQRI feedback reports

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that Physician Quality Reporting Initiative (PQRI) feedback reports are now available for the 2007 re-run and 2008 PQRI programs. Incentive payments for 2008 PQRI were distributed in October 2009. Incentive payments for the 2007 PQRI re-run will be distributed to eligible professionals (EPs) that are newly incentive-eligible in November 2009.

CMS has posted two educational guides on understanding the PQRI incentive payments for the 2007 re-run and for 2008. To access “A Guide for Understanding the 2007 Re-Run PQRI Incentive Payment,” visit <http://www.cms.hhs.gov/PQRI> on the CMS Web site and click on the 2007 PQRI Program from the menu at the left. To access “A Guide for Understanding the 2008 PQRI Incentive Payment,” visit <http://www.cms.hhs.gov/PQRI> on the CMS Web site and click on the 2008 PQRI Program from the menu at the left.

How to request feedback reports based on individual national provider identifiers

CMS has created an alternative feedback report request process for EPs requesting PQRI feedback reports based on their individual national provider identifiers (NPI). It is not necessary for EPs requesting a feedback report based on their individual NPI to register in the Individuals Authorized Access to CMS Computer Services (IACS) system to use the alternative feedback report request process.

Individual eligible professionals can simply call their respective carrier or A/B MAC provider contact center to request confidential 2007 PQRI re-run and 2008 PQRI feedback reports that will contain information based on their individual NPI. To get a list of provider contact centers, visit <http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip> on the CMS Web site. In addition to PQRI information, these reports will provide individual EPs with information on their Medicare Part B physician fee schedule allowed charges for the 2007 or 2008 PQRI reporting period, upon which an incentive payment is based.

Additional information about the alternative feedback report request process may be found by accessing special edition *Medicare Learning Network (MLN)* article (SE0922) “Alternative Process for Individual Eligible Professionals to Request Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (E-Prescribing) Feedback Reports”: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0922.pdf>.

How to request feedback reports based on tax identification numbers

EPs requesting feedback reports based on tax identification numbers (TINs) or by groups will be required to access their PQRI feedback reports through the secure

PQRI portal on QualityNet at <http://www.qualitynet.org/portal/server.pt>. The “Verify TIN Report Portlet” on the home page of the PQRI portal can be utilized to verify if a feedback report exists for your organization’s TIN or individual NPI. A user login must be established before reports can be accessed. If you do not have an IACS account, you must apply for an account to gain access to the PQRI portal and retrieve the feedback reports. Information on establishing an IACS account is available in Section 3 of the PQRI Portal User Guide. To access the PQRI user guide go to <http://www.qualitynet.org/portal/server.pt>.

If you have established an IACS account and have received a user name and password, but have forgotten your password, you can retrieve it through the home page of the PQRI portal by clicking on “Forgot Your Password?” This will route you to the CMS Account Management page at <https://applications.cms.hhs.gov/category.html?name=acctmngmt> on the CMS Web site. Please contact the EUS Help Desk at 1-866-484-8049 or TTY: 1-866-523-4759 if you are having difficulty accessing your IACS account or to obtain a new one.

Once your user login is established, click on “Sign In” on the home page of the PQRI portal, which will route you to the sign-in screen. (Note that the sign-in page requires your IACS credentials, not any Quality Net credentials you may possess.) Enter your user name and password in the fields provided and click “Sign In.” You will then be asked to read and accept the terms and conditions.

After accepting the terms and conditions, you will be routed to the PQRI Report Delivery System (RDS) Reports Portlet where confidential feedback reports may be retrieved. Available reports will be listed in the main body of the page. Only reports that are relevant to your TIN organization or individual practice will display.

To view a report, click on the report name. The selected report will display on the screen. To keep a copy of the report, you will need to save the report to your computer. Detailed information on available reports may be found in the “User Guide: 2007 Re-Run and 2008 PQRI Feedback Reports” available at <http://www.cms.hhs.gov/PQRI/Downloads/UserGuide2007Re-Runand2008PQRIFeedbackReports.pdf> on the CMS Web site.

To log off of the PQRI portal, click “Log Off” in the upper left hand corner of the page.

Help desk resources

For more information on the 2007 re-run and 2008 PQRI feedback reports or incentive payments, see the “PQRI and eRx Quick-Reference Support Guide for Eligible Professionals” at http://www.cms.hhs.gov/PQRI/Downloads/PQRI-eRxEPQuickRefGuideDiagram_100209.pdf on the CMS Web site.

Additional information about PQRI may be found at <http://www.cms.hhs.gov/PQRI> on the CMS Web site.

Source: CMS PERL 200911-15

Flu season is upon us

The Centers for Medicare & Medicaid Services (CMS) encourages providers to begin taking advantage of each office visit to encourage your patients with Medicare to get seasonal flu shots. Flu shots are their best defense against combating flu this season. And don't forget – health care workers also need to protect themselves.

Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient as a part B benefit. No deductible or copayment/coinsurance applies. Note that influenza vaccine is not a Part D covered drug.

For more information about Medicare coverage of the seasonal influenza vaccine and its administration, as well as related educational resources for health care professionals, please go to http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS Web site.

For information on Medicare policies related to H1N1 influenza, please go to <http://www.cms.hhs.gov/H1N1> on the CMS Web site.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 200910-42

November is American Diabetes Month

Twenty four million adults and children in the United States suffer from diabetes. Complications from diabetes can include increased risk of heart disease, blindness, glaucoma, nerve damage, and kidney damage. However, detection and treatment of diabetes may prevent or delay many of these complications.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your patients by educating them about their risk factors and encouraging them to take advantage of Medicare-covered diabetes detection and treatment services.

For more information

The Centers for Medicare & Medicaid Services (CMS) has developed several educational products related to Medicare-covered diabetes-related services, including:

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – this recently revised comprehensive resource provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including diabetes and glaucoma screening tests, diabetes self-management training, medical nutritional therapy, and supplies and other services for Medicare beneficiaries with diabetes.
http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

Diabetes-Related Services brochure – this recently updated brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes.
<http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf>

Quick Reference Information: Medicare Preventive Services – this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including diabetes and glaucoma screening tests, diabetes self-management training, medical nutritional therapy, and supplies and other services for Medicare beneficiaries with diabetes.
http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for Medicare Learning Network (MLN) preventive services educational products and resources for health care professionals and their staff.
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

Glaucoma Screening brochure – this recently updated brochure provides information on coverage for Medicare-covered glaucoma screenings, including the dilated eye examination.
<http://www.cms.hhs.gov/MLNProducts/downloads/Glaucoma.pdf>

Information for your use and materials for consumers and health professionals developed by the National Diabetes Education Program are available at <http://ndep.nih.gov/>.

For more information about American Diabetes Month, please visit the American Diabetes Association Web site at <http://www.diabetes.org/community-events/programs/american-diabetes-month/>.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

Source: CMS PERL 200911-06

November 19 is the Great American Smokeout

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep Medicare beneficiaries healthy by encouraging them to take advantage of Medicare-covered smoking and tobacco-use cessation counseling benefits.

Tobacco use contributed to more than 438,000 premature deaths in the United States annually between 1997 and 2001[1]. Additionally, tobacco continues to be the leading cause of preventable disease and death in the United States. Smoking can attribute to and exacerbate heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysm, and cataracts.

Medicare provides coverage of smoking and tobacco-use cessation counseling for beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use, or who take certain therapeutic agents whose metabolism or dosage is affected by tobacco use.

What you can do

As a health care professional who provides care to patients with Medicare, you can help protect the health of your patients by educating them about their risk factors and encourage them to take advantage of Medicare-covered smoking and tobacco-use cessation counseling benefits.

For more information

CMS has developed several educational products related to Medicare-covered smoking and tobacco-use cessation counseling:

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including smoking and tobacco-use cessation counseling.

http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for Medicare Learning Network (MLN) preventive services educational products, including products related to Medicare-covered smoking and tobacco-use cessation counseling.

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

Quick Reference Information: Medicare Preventive Services – this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including smoking and tobacco-use cessation counseling.

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

Smoking and Tobacco-Use Cessation Counseling brochure – this brochure provides information on coverage for Medicare-covered smoking and tobacco-use cessation counseling.

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

Please visit the MLN for more information on these and other Medicare fee-for-service educational products. For more information about the Great American Smokeout, please visit the American Cancer Society's Web site at <http://acsf2f.com/gaso/index.html>.

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate eligible beneficiaries about the importance of taking advantage of smoking and tobacco-use cessation counseling services and other preventive services covered by Medicare.

[1] The American Cancer Society. 2009. Great American Smokeout: Tobacco-Related Cancer Statistics 2007 [online]. [cited 5 November 2009]. Available from the World Wide Web: (<http://acsf2f.com/gaso/statistics.html>).

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Source: CMS PERL 200911-25

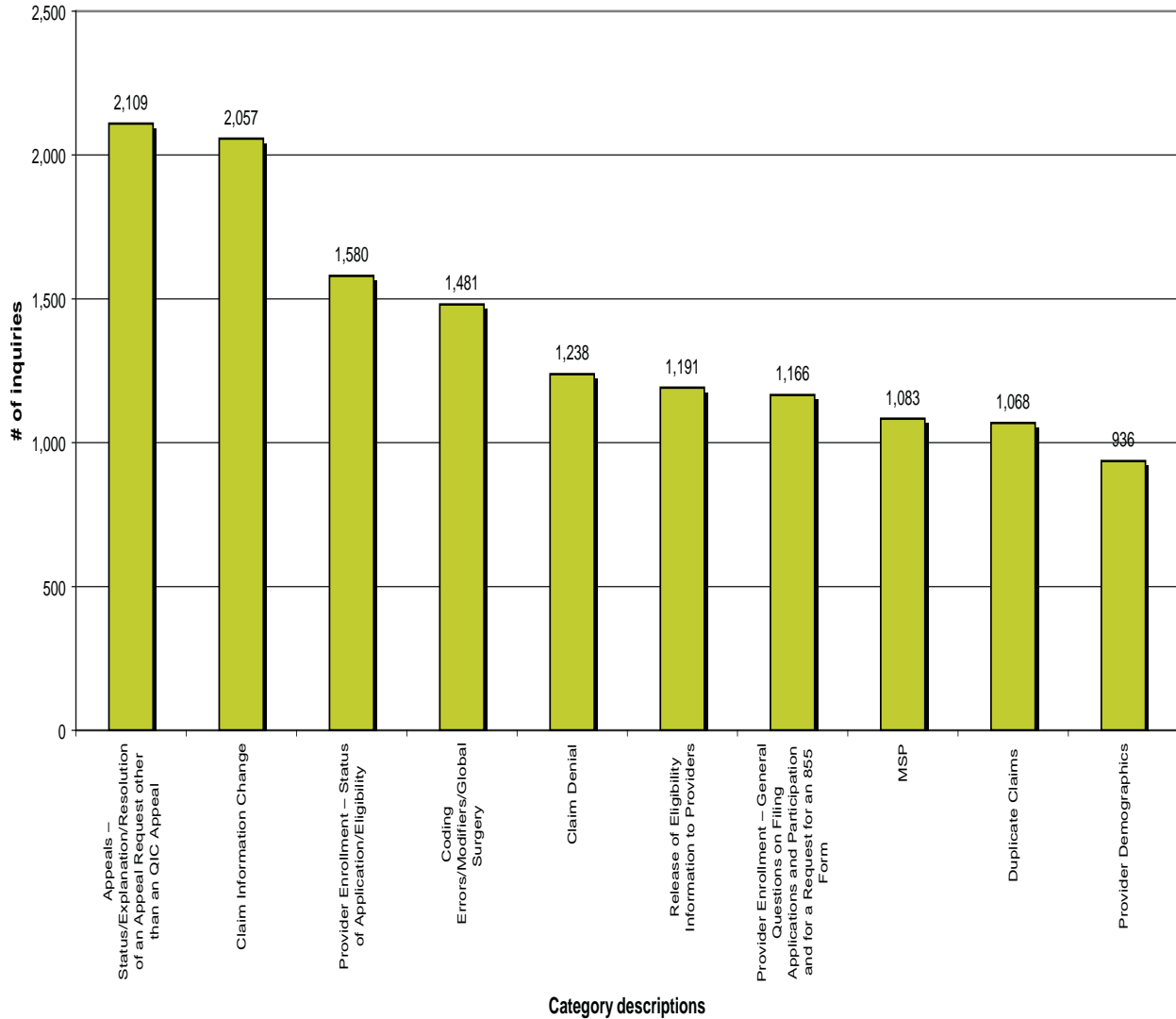
Sign up to our eNews electronic mailing list

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.

Top inquiries, denials, and return unprocessable claims for October 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 Islands providers during October 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 October 2009

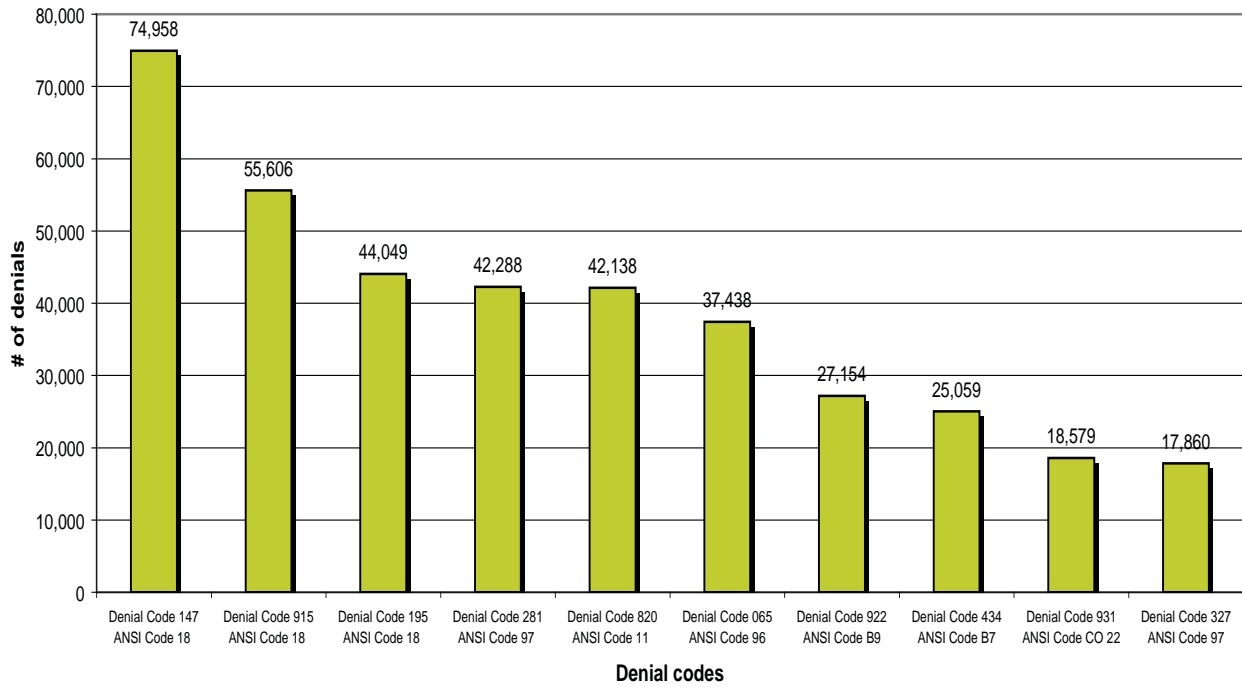


Find LCDs faster on our new medical coverage page

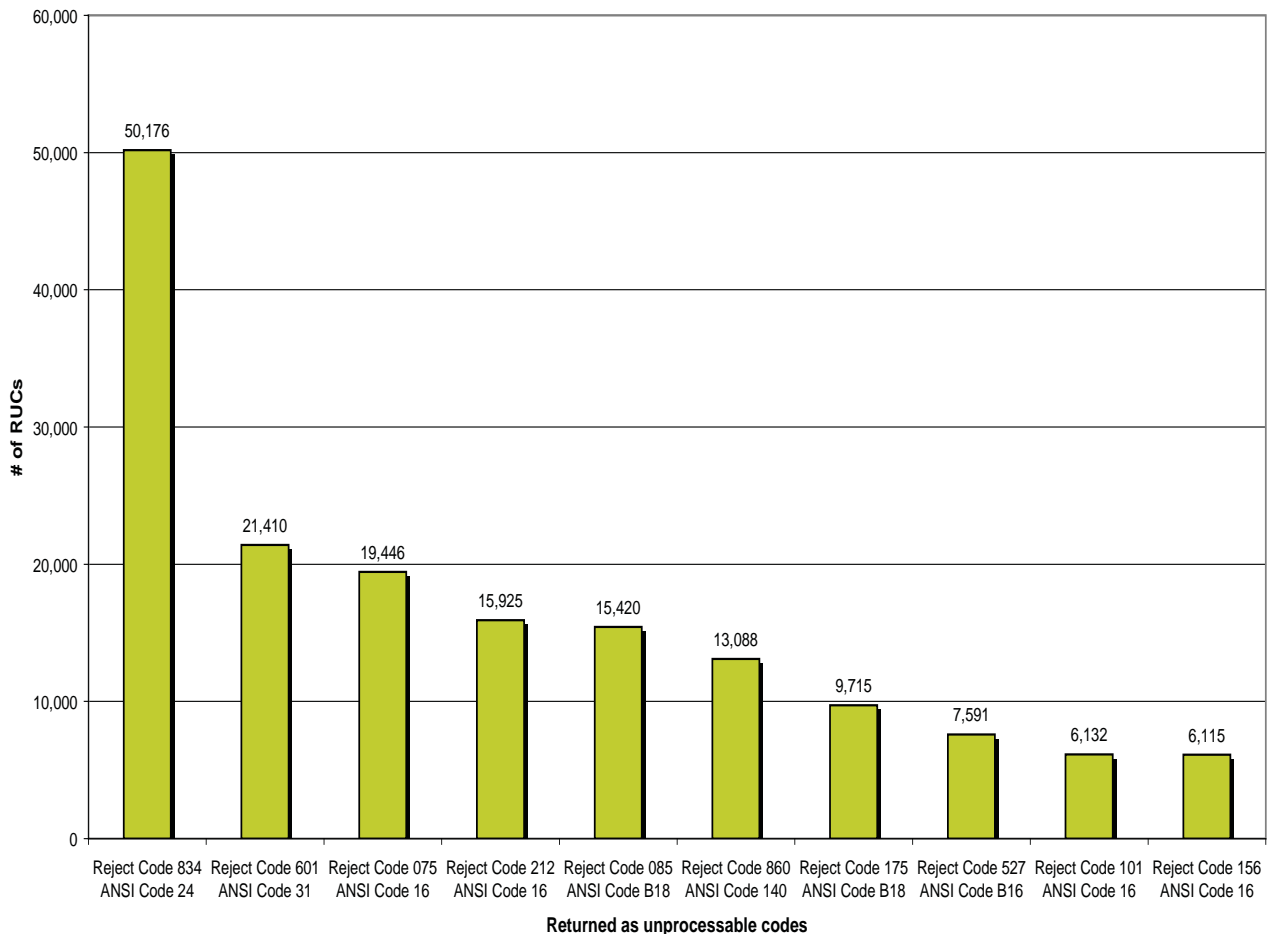
Looking for an LCD? Try the new integrated-search features on our redesigned medical coverage page. You may now search for local coverage determinations (LCDs) by procedure name or code as well as by L number. With its new features and user-friendly layout, you'll also find the medical coverage news and resources you need more quickly and easily than ever before -- try it today. <http://medicare.fcso.com/Landing/139800.asp>.

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

Florida Part B top denials for October 2009

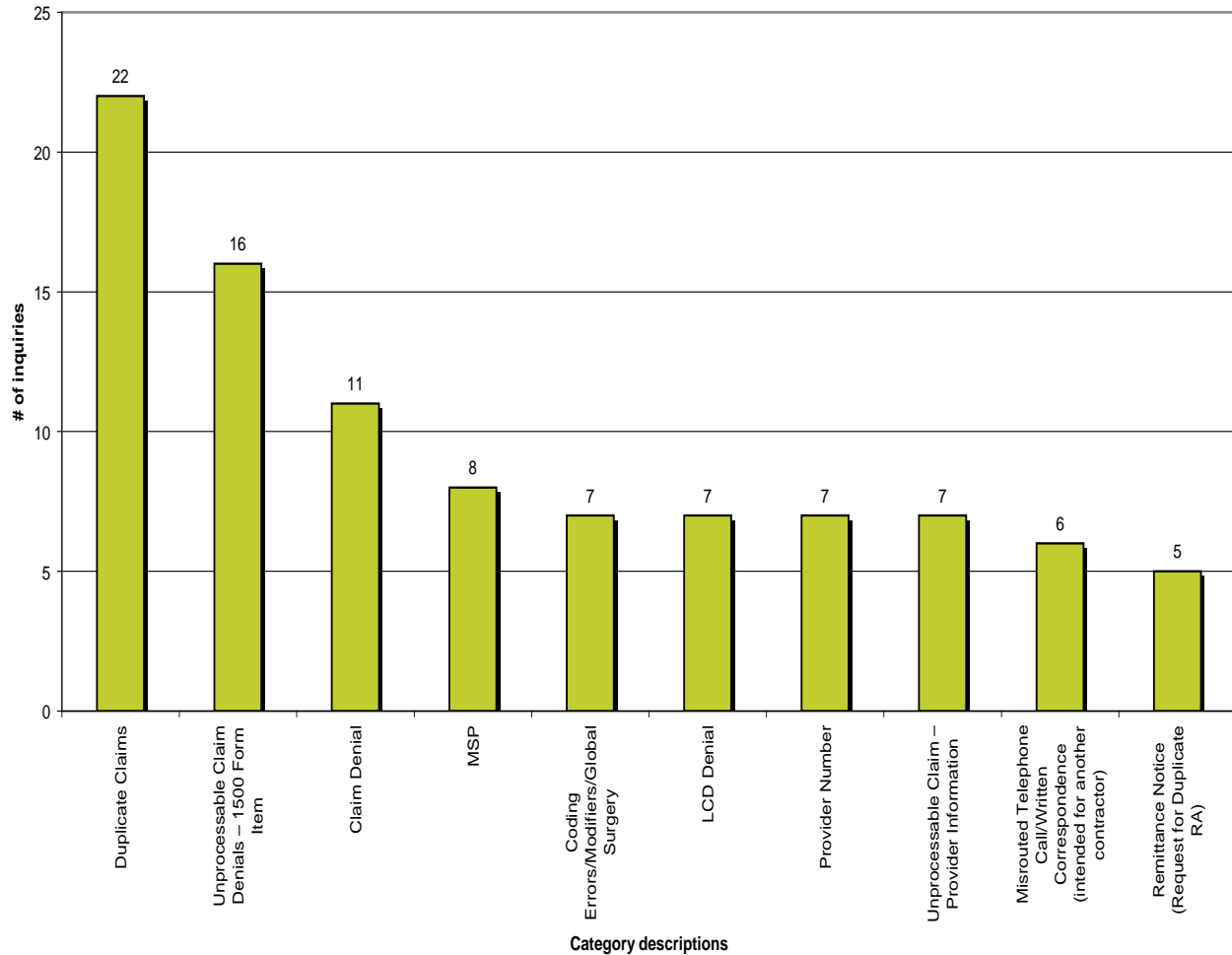


Florida Part B top return as unprocessable claims (RUC) for October 2009



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

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



Correcting minor errors or omissions outside the appeals process

A clerical error reopening may be initiated via the telephone or in writing; or, in many cases, the denied service(s) may simply be resubmitted. Resubmitting claims to correct minor clerical errors or omissions is the most efficient method for addressing certain denied services.

Note: Only resubmit the denied service(s) - resubmitting an entire claim will create a duplicate denial.

If these issues are received via written and telephone requests, it may take up to 60 days to process and finalize an adjustment, versus 14-30 days for a resubmitted claim. Ensure that you review the type of clerical error or omission you are attempting to correct and select the most efficient option available.

Note: Single-line clerical reopenings may now be requested through the Part B interactive voice response unit (IVR). Access the Part B interactive voice response (IVR) operating guide at <http://medicare.fcsso.com/IVR/138426.asp>.

Determine if the error can be corrected and resubmitted prior to writing in or calling to request a clerical error reopening.

The following are minor clerical errors or omissions that may be corrected and resubmitted:

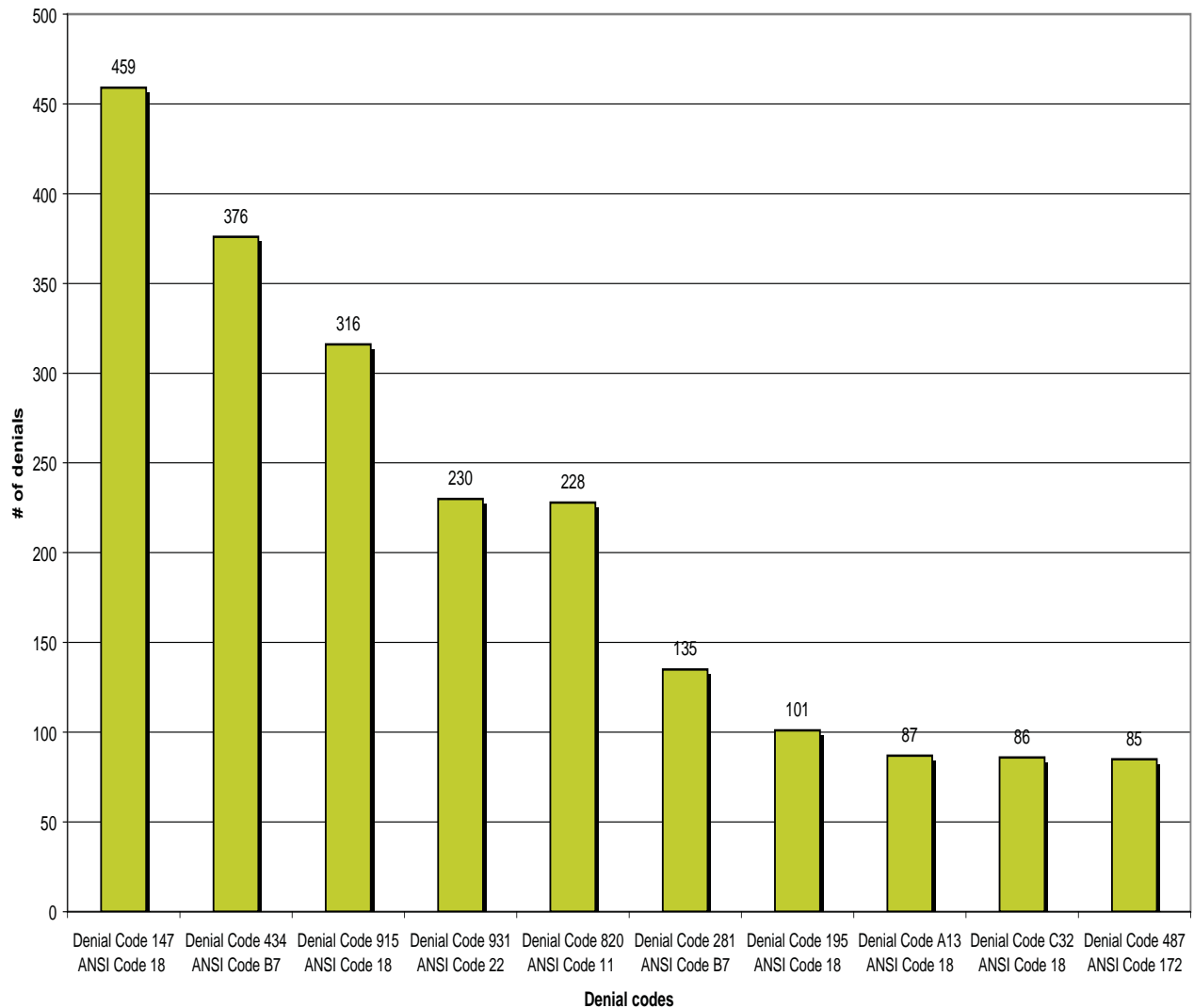
- Change of diagnosis codes
- Add, change, or delete modifiers (e.g., 24, 25, 50, 59, 78, 79, RT, LT)
- Incorrect place of service

Written or telephone clerical error reopenings are appropriate only for services that were processed and received an approved amount, and could include the following types of situations:

- Number of services (NB) billed
- Submitted charge amount
- Date of service (DOS)
- Add, change or delete certain modifiers
- Procedure code; excluding codes requiring documentation on the initial submission or codes being upcoded

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

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

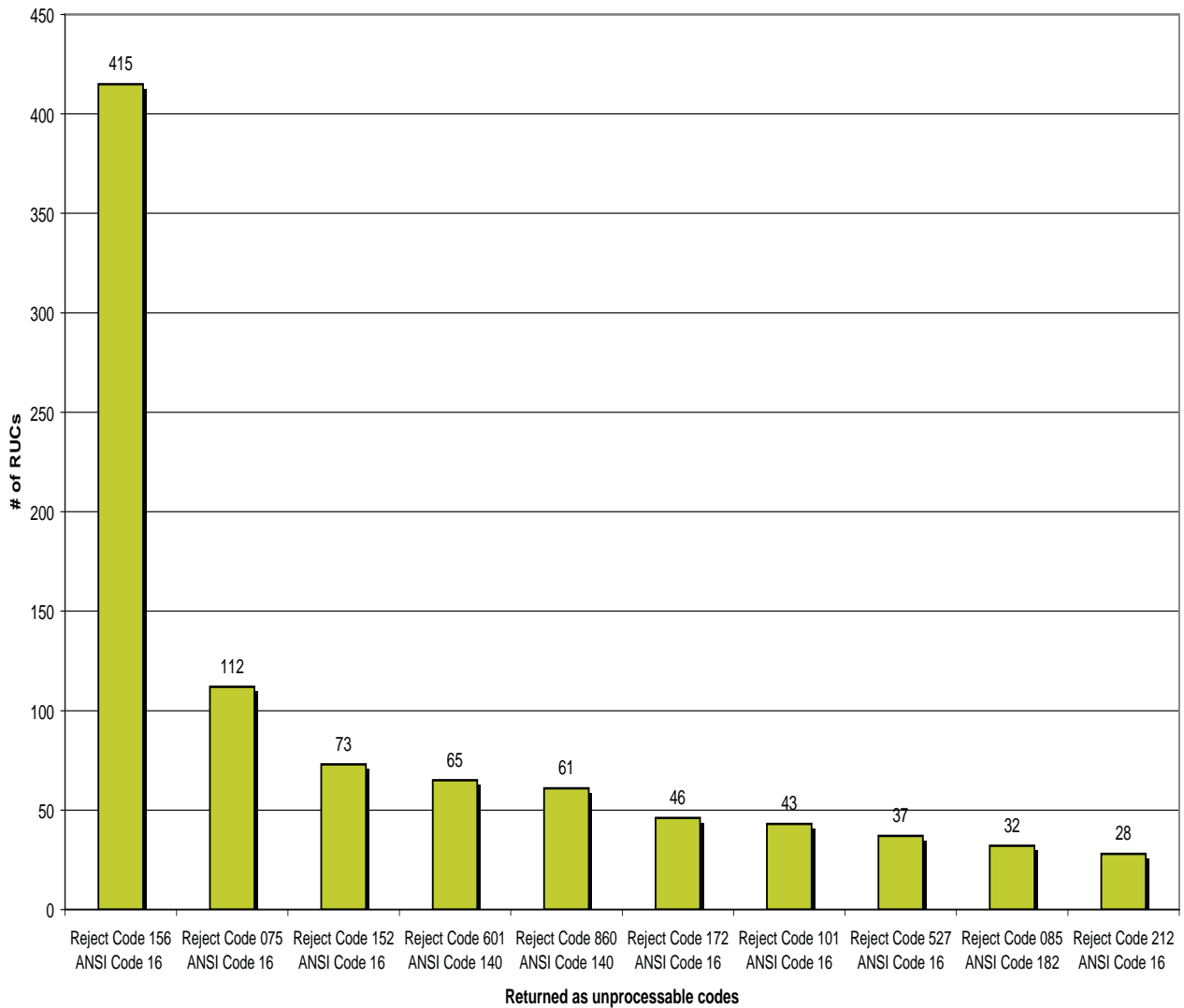


Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

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

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for October 2009



Reporting service facility location information on the CMS-1500

Report the name and complete address (including ZIP code) of the physical location where services were rendered in Item 32. This information needs to be completed for all paper claims submitted to Medicare, unless services were rendered in the patient’s home (POS 12). Report a nine-digit ZIP code (instead of five digits) if the physical location is in an affected locality.

Note: To verify if a nine-digit ZIP code is needed for the facility, visit http://www.cms.hhs.gov/prospmedicarefeesvcpmgen/01_overview.asp.

The service facility location ID (Item 32a of the paper claim form) is only used for the national provider identifier (NPI) of providers who render a purchased service. Refer to the frequently asked question (FAQ) titled “Reporting service facility location information,” available at <http://medicare.fcso.com/Wrapped/157141.asp>.

Additional information

CR 5208 – Use of Nine-Digit ZIP Codes for Determining Correct Payment Locality for Services <http://www.cms.hhs.gov/transmittals/downloads/R1193CP.pdf>

CR 5730 – Update to the Nine-Digit ZIP Code List for Establishing Payment Based on Locality <http://www.cms.hhs.gov/transmittals/downloads/R1337CP.pdf>

Note: No information should be entered in Item 32b of the paper claim, as it is no longer used. Claims will be returned as unprocessable if any information appears in Item 32b.

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.fcso.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.

Article Correction

THERSVCS: Therapy and rehabilitation services – article correction

LCD ID number: L29289 (Florida)

LCD ID number: L29399 (Puerto Rico/U.S. Virgin Islands)

Note: This information is a correction to an article previously published in the August 2009 *Medicare B Update!* (Page 41)

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on April 6, 2009. Since that time, the “CPT/HCPCS Codes” section of the LCD has been revised to add CPT code 97755 (*Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility)*), direct one-on-one contact by provider, with written report, each 15 minutes). The “Indications and Limitations of Coverage and/or Medical Necessity” and “Documentation Requirements” sections of the LCD have also been revised to add a new section, “Assistive Technology Assessment (CPT code 97755).”

Correction

The effective date in the original article indicated “for services rendered on or after April 11, 2009.” **It should have indicated “for services rendered on or after August 11, 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. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

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.

Revisions to LCDs

J9055: Cetuximab (Erbix[®]) – revision to the LCD

LCD ID number: L29097 (Florida)

LCD ID number: L29112 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cetuximab (Erbix[®]) 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, a revision was made to the LCD based on new prescribing information for indications and usage of Erbix[®] for colorectal cancer by the Food and Drug Administration (FDA).

Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, language was added regarding analysis of K-ras mutation in codon 12 or 13, and that the use of Erbix[®] is not recommended for the treatment of colorectal cancer in patients with these mutations. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated.

Effective date

This LCD revision is effective for services **rendered on or after July 22, 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. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

Find LCDs faster on our new medical coverage page

Looking for an LCD? Try the new integrated-search features on our redesigned medical coverage page. You may now search for local coverage determinations (LCDs) by procedure name or code as well as by L number. With its new features and user-friendly layout, you’ll also find the medical coverage news and resources you need more quickly and easily than ever before -- try it today. <http://medicare.fcso.com/Landing/139800.asp>.

PULMDIAGSVCS: Pulmonary diagnostic services – revision to the LCD**LCD ID number: L29265 (Florida)****LCD ID number: L29382 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for pulmonary diagnostic services was last updated October 1, 2009. Since that time, First Coast Service Options Inc (FCSO) has become aware that there are clinicians within the Medicare administrative contractor (MAC) J9 rendering services that do not have access to the credentialing and licensing bodies as outlined in the LCD. Therefore, verbiage has been added to assure that clinicians rendering services to Medicare beneficiaries within the MAC J9 have received appropriate training in lieu of the credentialing and licensing requirements as outlined in the LCD.

Effective date

This LCD revision is effective for services **rendered on or after November 3, 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. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

92081: Visual field examination – revision to the LCD**LCD ID number: L29308 (Florida)****LCD ID number: L29487 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for visual field examination 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, a revision was made to the LCD to provide clarification when it is medically reasonable and necessary for providers to perform repeat visual field examinations.

Repeat visual field examinations for patients undergoing surgery of the upper eyelid(s) and brow are considered reasonable and medically necessary. The initial (taped) and repeat (untaped) visual field examination should be performed on the same date of service.

Effective date

This LCD revision is effective for claims **processed on or after November 3, 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. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

*Retired LCDs***J9213: Interferon, alfa-2a (Roferon®-A) – retired LCD****LCD ID number: L29203 (Florida)****LCD ID number: L29355 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for interferon, alfa-2a (Roferon®-A) 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. The manufacturer announced on November 29, 2007, the discontinuation of the production of Roferon®-A for the United States market. It was estimated that the existing supply available for sale would be depleted in early to mid-2008. Therefore, First Coast Service Options Inc. (FCSO) has retired the LCD for interferon, alfa-2a (Roferon®-A).

Effective date

This LCD retirement is effective for services **rendered on or after November 12, 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. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

OOS: Outpatient observation services – retired LCD

LCD ID number: L29247 (Florida)

LCD ID number: L29377 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for outpatient observation services 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 was reviewed for accuracy of coverage and billing guidelines. It was determined that updating the LCD would be a reflection of national guidelines provided in the *Medicare Benefit Policy Manual*, Pub 100-02, Chapter 6, Section 20.6 and the *Medicare Claims Processing Manual*, Pub 100-04, Chapter 4, Section 290. Therefore, the LCD and “Coding Guidelines” attachment for outpatient observation services were retired.

Effective date

This LCD retirement is effective for services rendered on or after **November 3, 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. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

*Additional Information***Administration of Synvisc and Synvisc-one**

Providers are using both Synvisc and Synvisc-one within a single course of treatment. The FDA labeling in regards to the frequency of injections during a course of treatment for Synvisc vs. Synvisc-one are not the same. Synvisc is administered once per week for three weeks per course of treatment. Synvisc-one is administered as a one time dose per course of treatment. Providers should not switch or combine the use of Synvisc and Synvisc-one within the same course of treatment. The switching or combination within the same course of treatment is considered not medically reasonable and necessary.

Billing and coding information for prostate biopsies

In the United States, prostate cancer is the most common cancer and the second leading cause of cancer deaths in men. If an abnormality is found on the digital rectal exam (DRE) or the prostate-specific antigen (PSA) test, a biopsy of the prostate is typically ordered. This involves taking a very small sample of tissue from the prostate. A tiny amount of tissue is trapped in the needle while it is in the prostate and then the needle is pulled out. This is repeated in a number of locations through the prostate so as to minimize the chance of missing an area where cancer may be present.

Needle biopsies are commonly performed using ultrasonic guidance. After localizing the region, a physician uses ultrasound to guide the needle into a mass or region to obtain a specimen. The specimen is then sent to a pathology lab for appropriate analysis.

CPT code 55700 (Biopsy, prostate; needle or punch, single or multiple, any approach) is used for a biopsy of the prostate from any approach.

- If imaging guidance is performed, *CPT code 76942 (Ultrasonic guidance for needle placement (eg. biopsy, aspiration, injection, localization device), imaging supervision and interpretation)* is billed in addition to *CPT code 55700*.
- The surgical pathology code that is billed with *CPT code 55700* is *CPT code 88305 (Level IV – Surgical pathology, gross and microscopic examination)*.

CPT code 55706 (Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance) was established to report prostate saturation biopsies (PSB). This service was previously reported with category III *CPT code 0137T (Biopsy, prostate, needle, saturation sampling for prostate mapping)*, which was deleted January 1, 2009, and replaced with *CPT code 55706*. PSB is typically performed after an initial diagnosis of prostate cancer when (1) initial biopsies obtained through the traditional method (*CPT code 55700*) are equivocal or nondiagnostic and more extensive biopsying is needed to rule out prostate cancer (e.g., A patient with a rising prostate specific antigen (PSA) with traditional biopsy revealing tissue suspicious but not diagnostic for prostate cancer); and (2) traditional biopsies reveal localized prostate cancer and the patient has elected focal tissue cryoablation. Since prostate saturation biopsy is performed under general anesthesia, it is not appropriate in the office setting.

Effective January 1, 2009, the Centers for Medicare & Medicaid Services (CMS) implemented the following four new HCPCS codes to be used to report PSBs (*CPT code 55706*) when submitted for evaluation:

Billing and coding information for prostate biopsies (continued)

- G0416 Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens
- G0417 Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens
- G0418 Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens
- G0419 Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens

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Complete blood count with or without automated differential WBC count

Medicare pays for clinical laboratory services that are medically reasonable and necessary, ordered by a physician, and used by the physician in the treatment of the patient. When a physician documents an order for a complete blood count (CBC) in a patient's medical record, Medicare will not pay for a CBC with automated differential (*CPT* code 85025).

In order to receive payment for a CBC with automated differential, the physician's order must state CBC "with differential." Even if a laboratory has a policy in place to always perform an automated differential with a CBC, regardless of what is included in the request/order, the physician may bill only for what is ordered in the patient's medical record.

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.

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.

Educational Resources

Upcoming provider outreach and education event January 2010

Hot Topics: Medicare Part B (ACT)

When: January 20

Time: 11:30 a.m.-1:00 p.m.

Focus: Florida, Puerto Rico, 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 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.

Message for providers on H1N1 outreach

The Department of Health and Human Services thanks you for your work in communities across the country. As this year's flu season continues, we want to provide you with up-to-date information about the new 2009 H1N1 virus, and also give you some easy-to-read information with the hope that it will reach people who need it the most.

We've also included an example of an e-mail that will allow you to share important resources with members of your community and help protect them from the H1N1 virus. Participation in this outreach effort is voluntary.

2009 H1N1 updates

Flu activity is already higher than what is seen during the peak of many regular flu seasons. Almost all of the flu viruses identified this season so far have been 2009 H1N1.

All states have placed orders for the 2009 H1N1 vaccine, and more orders are expected daily. Vaccine is arriving in thousands of places across the country. Because the vaccine distribution system varies by state, the vaccine situation on the ground may differ from community to community.

The 2009 H1N1 vaccine is taking longer to produce than manufacturers initially expected. Scientists, doctors, and manufacturers are working around the clock to produce this vaccine safely, effectively, and as quickly as the science allows. The U.S. Department of Health and Human Services, through state and local health departments, will continue to make the vaccine available as soon as it comes off the production line.

Clinical trials conducted by the National Institutes of Health and the vaccine manufacturers have shown that the new H1N1 vaccine is both safe and effective.

In the past, flu pandemics have been characterized by multiple waves. Scientists and doctors recommend H1N1 vaccination even if flu activity slows, as it could resume later in the season.

Please feel free to share any general feedback you receive for additional information and materials. Again, dissemination of this information is voluntary.

Outreach e-mail

Please copy and paste the information below:

Dear friend,

You've probably been hearing a lot this year about the H1N1 flu. And you may have questions. You may have even had the flu, or know a friend or neighbor who has been sick. This e-mail features some tools suggested by the U.S. Department of Health and Human Services to help you prevent the flu, know what to do if you get sick, and find a place to get vaccinated.

People recommended by the Centers for Disease Control and Prevention (CDC) to receive the vaccine as soon as possible include:

- Health care workers
- Pregnant women
- People ages 25 through 64 with chronic medical conditions, such as asthma, heart disease, or diabetes
- Anyone from six months through 24 years of age, and
- People living with or caring for infants under six months old.

A one-stop resource with the latest updates on the H1N1 flu is <http://www.flu.gov/>. On this site, you may find information on how to prevent and treat the flu, flu essentials, and why the H1N1 vaccine is safe and recommended by health experts. To look up where to get vaccinated in your state, visit the vaccine locator. This information is updated regularly as more doses are shipped each week.

An additional resource is the CDC hotline, 1-800-CDC-INFO (1-800-232-4636), which offers services in English and Spanish, 24 hours a day, seven days a week.

Heard a rumor? Visit Myths and Facts to run a fact check.

Please forward this e-mail to your family, friends, co-workers and networks today. Let's work together to help keep our communities safe and healthy.

Third-party Web sites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

Source: CMS PERL 200911-28

**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 2009 through September 2010.	40300260	Hardcopy \$33		
		CD-ROM \$55		
2010 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2010, through December 31, 2010, 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 2010 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 ◆