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.fcso.com/*.

Routing Suggestions:

- ❑ Physician/Provider
- ❑ Office manager
- ❑ Billing/Vendor
- ❑ Nursing Staff
- ❑ Other _______________

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

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

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THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

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

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

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education Web site, *http://medicare.fcso.com*. 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-R131form 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** (wavier 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

Quarterly update to correct coding initiative edits

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6728, which provides a reminder for physicians to take note of the quarterly updates to correct coding initiative (CCI) edits. The last quarterly release of the edit module was issued in October 2009.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The coding policies developed are based on coding conventions defined in the following:

- American Medical Association's (AMA's) *Current Procedural Terminology (CPT) Manual*
- National and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice
- Review of current coding practice.

The latest package of CCI edits, version 16.0, is effective January 1, 2010, and includes all previous versions and updates from January 1, 1996, to the present.

Additional information

Additional information about CCI, including the current CCI and MEC edits, is available at *http://www.cms.hhs.gov/NationalCorrectCodInitEd*.

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which may be found at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*. The official instruction (CR 6728) issued to your carrier and A/B MAC, RHHI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1858CP.pdf*.

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*.

MLN Matters® Number: MM6728
Related Change Request (CR) #: 6728
Related CR Release Date: November 20, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1858CP
Implementation Date: January 4, 2010

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Ambulance

Ambulance inflation factor 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 of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

What you need to know

Change request (CR) 6631, from which this article is taken, provides the ambulance inflation factor (AIF) for calendar year (CY) 2010. The AIF for CY 2010 is zero (0).

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services.

Specifically, this section of the Act provides for a 2010 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the AIF.

The following table displays the AIF for CY 2010 and for the previous seven years.

Ambulance inflation factor by CY	
2010	0.0 percent
2009	5.0 percent
2008	2.7 percent
2007	4.3 percent
2006	2.5 percent
2005	3.3 percent
2004	2.1 percent
2003	1.1 percent

Additional information

The official instruction, CR 6631, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1861CP.pdf*.

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*

MLN Matters® Number: MM6631
Related Change Request (CR) #: 6631
Related CR Release Date: November 27, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1861CP
Implementation Date: January 4, 2010

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Ambulatory Surgical Center

January 2010 update of the ambulatory surgical center payment system

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

Provider types affected

This article has information for ambulatory surgical centers (ASC) that submit claims to Medicare administrative contractors (MACs) or carriers for services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 6746 and is a recurring update that describes changes to, and billing instructions for, various payment policies implemented in the January 2010 ASC update. It also includes updates to the Healthcare Common Procedure Coding System (HCPCS), and to the *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers). Make sure that your billing staff are aware of the changes.

Background

Included in CR 6746 are calendar year (CY) 2010 payment rates for separately payable drugs and biologicals, including short descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the CY 2010 ASC payment rates for covered surgical and ancillary services (ASCFS file). In addition, it includes the following updates to the *Medicare Claims Processing Manual* ASC Chapter (Chapter 14):

- Section 10.1 to reflect revised 42 CFR 416.30, which clarifies Centers for Medicare & Medicaid Services (CMS) policy related to the ability of ASCs that are operated by hospitals to become provider-based outpatient departments; and
- Section 40.9 to update ASC payment and billing policies for insertion of a new technology intraocular lens (NTIOL) that is also an approved astigmatism-correcting intraocular lens (A-C IOL) or presbyopia-correcting intraocular lens (P-C IOL), concurrent with cataract extraction.

Updated core-based statistical areas (CBSA)

Table 1 shows updates to eight CBSAs recognized by the CMS for ASC claims with dates of service on and after January 1, 2010.

Table 1
January 1, 2010 Core Based Statistical Area (CBSA) Changes

County/State	FIPS Code	2009 CBSA	2010 CBSA
Alexander, IL	17003	14	16020
Geary, KS	20061	17	31740
Pottawatomie, KS	20149	17	31740
Riley, KS	20161	17	31740
Blue Earth, MN	27013	24	31860
Nicollet, MN	27103	24	31860
Bollinger, MO	29017	26	16020
Cape Girardeau, MO	29031	26	16020

Drugs and biologicals with payment based on average sales price (ASP), effective January 1, 2010

In the CY 2010 OPPS/ASC final rule with comment period, it was stated that payments for separately payable drugs and biologicals based on the average sales prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2010, payment rates for many covered ancillary drugs and biologicals have changed from the values published in the CY 2010 outpatient prospective payment system (OPPS)/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2009. In cases where adjustments to payment rates are necessary, the updated payment rates will be incorporated in the January 2010 release of the ASC DRUG file.

You may find the updated payment rates effective January 1, 2010, for covered ancillary drugs and biologicals in the January 2010 update of the ASC Addendum BB at *http://www.cms.hhs.gov/ASCPayment/ASCRN/ItemDetail.asp?ItemID=CMS1216691*.

New HCPCS codes for drugs and biologicals separately payable under the ASC payment system as of January 1, 2010

For CY 2010, new Level II HCPCS codes have been created for reporting specific drugs and biologicals. Twenty-three of the new Level II HCPCS codes for reporting drugs and biologicals are separately payable to ASCs for dates of service on or after January 1, 2010. The new Level II HCPCS codes, their payment indicators, and short descriptors are displayed in Table 2 and included in the January 2010 ASC DRUG file.

January 2010 update of the ambulatory surgical center payment system (continued)

Table 2
New Level II HCPCS codes for drugs and biologicals separately payable under the ASC payment system for CY 2010

CY 2010 HCPCS Code	CY 2010 Payment Indicator	Short Descriptor
A9581	K2	Gadoxetate disodium inj
A9582	K2	Iodine I-123 iobenguane
A9583	K2	Gadofosveset trisodium inj
C9254	K2	Injection, lacosamide
C9255	K2	Paliperidone palmitate inj
C9256	K2	Dexamethasone intravitreal
C9257	K2	Bevacizumab injection
J0586	K2	AbobotulinumtoxintypeA
J0598	K2	C1 esterase inhibitor inj
J0718	K2	Certolizumab pegol inj
J0833	K2	Cosyntropin injection NOS
J0834	K2	Cosyntropin cortrosyn inj
J1680	K2	Human fibrinogen conc inj
J2562	K2	Plerixafor injection
J2793	K2	Rilonacept injection
J2796	K2	Romiplostim injection
J7185	K2	Xyntha inj
J7325	K2	Synvisc or Synvisc-One
J9155	K2	Degarelix injection
J9171	K2	Docetaxel injection
J9328	K2	Temozolomide injection
Q0138	K2	Ferumoxytol, non-esrd
Q9968	K2	Visualization adjunct

Updated payment rates for certain HCPCS codes effective April 1, 2009, through June 30, 2009

The payment rates for three HCPCS codes were incorrect in the April 2009 ASC DRUG file. The corrected payment rates are listed in Table 3 and have been included in the revised April 2009 ASC DRUG file effective for services furnished on April 1, 2009 through implementation of the July 2009 update. If you believe that have received an incorrect payment on claims processed between April 1, 2009, and June 30, 2009, you may request your carrier or MAC to adjust those claims.

Table 3
Updated payment rates for certain HCPCS codes effective April 1, 2009, through June 30, 2009

HCPCS Code	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9245	Injection, romiplostim	$44.81	$8.79
J1260	Dolasetron mesylate	$4.54	$0.91
J2778	Ranibizumab injection	$399.55	$79.91

Updated payment rates for certain HCPCS codes effective July 1, 2009, through September 30, 2009

The payment rates for three HCPCS codes were incorrect in the July 2009 ASC DRUG file. The corrected payment rates are listed in Table 4 and have been included in the revised July 2009 ASC DRUG file effective for services furnished on July 1, 2009 through implementation of the October 2009 update. If you believe that you may have received an incorrect payment on claims processed between July 1, 2009, and September 30, 2009, you may ask your carrier or MAC to adjust those claims.

Table 4
Updated payment rates for certain HCPCS codes effective July 1, 2009, through September 30, 2009

HCPCS Code	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9354	Veritas collagen matrix, cm2	$11.77	$2.31
C9364	Porcine implant, Permacol	$18.46	$3.62
J1520	Gamma globulin 7 CC inj	$102.15	$20.43

January 2010 update of the ambulatory surgical center payment system (continued)

Correct reporting of drugs and biologicals when used as implantable devices

When billing for a biological for which the HCPCS code describes a product that is solely surgically implanted or inserted (and that is separately payable under the ASC payment system) you should report the HCPCS code for the product. However, if the implanted biological is packaged (that is, not eligible for separate payment under the ASC payment system) you should not report the biological product HCPCS code.

When billing for a biological for which the HCPCS code describes a product that may be either surgically implanted or inserted or otherwise applied in the care of a patient, you should not report the HCPCS code for the product when the biological is used as an implantable device (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures.

Under the ASC payment system, ASCs are provided a packaged payment for surgical procedures that includes the cost of supportive items. When using biologicals during surgical procedures as implantable devices, you may include the charges for these items in your charge for the procedure.

***Medicare Claims Processing Manual* updates for ASC terms of agreement with CMS**

CR 6746 also provides updates to the *Medicare Claims Processing Manual*, Chapter 14 in the following sections:

Section 10.1 update information

This updated policy provides that a hospital-operated facility has the option of being considered by Medicare either to be an ASC or to be a provider-based department of the hospital as defined in 42 CFR 413.65.

It further provides that:

- A hospital-operated facility that decides to discontinue participation in Medicare as an ASC must terminate its ASC agreement with CMS, complying with guidance provided in 42 CFR 416.35 (either by sending written notice to CMS or by ceasing to furnish services to the community), and
- To participate in Medicare as a provider-based department of the hospital, the hospital must comply with CMS requirements to certify the hospital-operated facility as a provider-based department of the hospital as described in 42 CFR 413.65, including meeting all of the hospital conditions of participation specified in 42 CFR 482.

Section 40.9 update information

This update provides that (effective for services on and after January 1, 2010), you are to use three separate codes to bill for the insertion of a Category 3 new technology intraocular lens (NTIOL) (concurrent with cataract extraction), that is also an approved astigmatism-correcting (A-C) intraocular lens (IOL) or presbyopia-correcting (P-C) IOL.

- To report charges associated with the non-covered functionality of the A-C IOL or P-C IOL, you should use HCPCS code V2787 (Astigmatism-correcting function of intraocular lens) or V2788 (Presbyopia-correcting function of intraocular lens), as appropriate;
- To report the covered cataract extraction and insertion procedure, you should use the appropriate *Current Procedural Terminology (CPT)* code: 1) *66982* (*Extracapsular cataract removal with insertion of intraocular lens prosthesis [one stage procedure], manual or mechanical technique [eg, irrigation and aspiration or phacoemulsification], complex, requiring devices or techniques not generally used in routine cataract surgery [eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis] or performed on patients in the amblyogenic developmental stage*); 2) *66983 (Intracapsular cataract extraction with insertion of intraocular lens prosthesis [1 stage procedure]*); or 3) *66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis [1 stage procedure], manual or mechanical technique [eg, irrigation and aspiration or phacoemulsification])*, and
- To report the covered NTIOL aspect of the lens on claims for insertion of an A-C IOL or P-C IOL that is also designated as an NTIOL, you should use HCPCS code Q1003 (New technology, intraocular lens, category 3 (reduced spherical aberration) as defined in *Federal Register* notice, Vol. 65, dated May 3, 2000.

Note: A listing of the CMS-approved Category 3 NTIOLs, A-C IOLs, and P-C IOLs are available at *http://www.cms.hhs.gov/ASCPayment/*.

CR 6746 also provides updates for when a device is furnished with no cost, or with full or partial credit. For CY 2010, CMS updated the list of ASC-covered device intensive procedures and devices that are subject to the no cost/full credit and partial credit device adjustment policy. You should be aware that your carrier or MAC will reduce the payment for the device implantation procedures listed in Table 6 (CR 6746, Attachment B) by the full device offset amount for no cost/full credit cases.

Further, you must append the modifier FB to the HCPCS procedure code when the device that is furnished without cost or with full credit is listed in Table 7 (CR 6746, Attachment C) and the associated implantation procedure code is listed in Table 6.

Finally, your carrier or MAC will reduce the payment for implantation procedures listed in Table 6 by one half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost.

If you receive a partial credit of 50 percent or more of the cost of a device listed in Table 7, you must append the modifier “FC” to the associated implantation procedure code if the procedure is listed in Attachment B. You should not submit a single procedure code with both modifiers FB and FC.

You may find more information about billing for procedures involving no cost/full credit and partial credit devices in the *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Section 40.8 (Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008) at *http://www.cms.hhs.gov/manuals/downloads/clm104c14.pdf*.

January 2010 update of the ambulatory surgical center payment system (continued)

CR 6746, attachment A lists the surgical procedures and ancillary services that are newly payable in the ASC setting as of January 1, 2010. Those procedures are displayed in Table 5.

Table 5
ASC covered surgical procedures and ancillary services that are newly payable in ASCs effective CY 2010

HCPCS/*CPT*	Short Descriptor
0193T	Rf bladder neck microremodel
0213T	Us facet jt inj cerv/t 1 lev
0214T	Us facet jt inj cerv/t 2 lev
0215T	Us facet jt inj cerv/t 3 lev
0216T	Us facet jt inj ls 1 level
0217T	Us facet jt inj ls 2 level
0218T	Us facet jt inj ls 3 level
14301	Skin tissue rearrangement
14302	Skin tissue rearrange add-on
21011	Exc face les sc < 2 cm
21012	Exc face les sc = 2 cm
21013	Exc face tum deep < 2 cm
21014	Exc face tum deep = 2 cm
21016	Resect face tum = 2 cm
21552	Exc neck les sc = 3 cm
21554	Exc neck tum deep = 5 cm
21558	Resect neck tum = 5 cm
21931	Exc back les sc = 3 cm
21932	Exc back tum deep < 5 cm
21933	Exc back tum deep = 5 cm
21936	Resect back tum = 5 cm
22901	Exc back tum deep = 5 cm
22902	Exc abd les sc < 3 cm
22903	Exc abd les sc > 3 cm
22904	Resect abd tum < 5 cm
22905	Resect abd tum > 5 cm
23071	Exc shoulder les sc > 3 cm
23073	Exc shoulder tum deep > 5 cm
23078	Resect shoulder tum > 5 cm
24071	Exc arm/elbow les sc = 3 cm
24073	Ex arm/elbow tum deep > 5 cm
24079	Resect arm/elbow tum > 5 cm
25071	Exc forearm les sc > 3 cm
25073	Exc forearm tum deep = 3 cm
25078	Resect forearm/wrist tum=3cm
26037	Decompress fingers/hand
26111	Exc hand les sc > 1.5 cm
26113	Exc hand tum deep > 1.5 cm
26118	Exc hand tum ra > 3 cm
27043	Exc hip pelvis les sc > 3 cm
27045	Exc hip/pelv tum deep > 5 cm
27059	Resect hip/pelv tum > 5 cm
27337	Exc thigh/knee les sc > 3 cm
27339	Exc thigh/knee tum deep >5cm
27364	Resect thigh/knee tum >5 cm
27475	Surgery to stop leg growth
27479	Surgery to stop leg growth
27616	Resect leg/ankle tum > 5 cm
27632	Exc leg/ankle les sc > 3 cm
27634	Exc leg/ankle tum deep >5 cm
27720	Repair of tibia
28039	Exc foot/toe tum sc > 1.5 cm
28041	Exc foot/toe tum deep >1.5cm
28047	Resect foot/toe tumor > 3 cm
29581	Apply multlay comprs lwr leg
31626	Bronchoscopy w/markers
32552	Remove lung catheter
32553	Ins mark thor for rt perq
35460	Repair venous blockage
35475	Repair arterial blockage
36147	Access av dial grft for eval
37761	Ligate leg veins open
41512	Tongue suspension
42225	Reconstruct cleft palate
42227	Lengthening of palate
43130	Removal of esophagus pouch
43752	Nasal/orogastric w/stent
45171	Exc rect tum transanal part
45172	Exc rect tum transanal full
45541	Correct rectal prolapse
46707	Repair anorectal fist w/plug
49411	Ins mark abd/pel for rt perq
49435	Insert subq exten to ip cath
49436	Embedded ip cath exit-site
49442	Place cecostomy tube perc
50080	Removal of kidney stone
50081	Removal of kidney stone
50727	Revise ureter
51535	Repair of ureter lesion
51727	Cystometrogram w/up
51728	Cystometrogram w/vp
51729	Cystometrogram w/vp&up
53855	Insert prost urethral stent
57295	Revise vag graft via vagina
57426	Revise prosth vag graft lap
60210	Partial thyroid excision
60212	Partial thyroid excision
60220	Partial removal of thyroid
60225	Partial removal of thyroid
61770	Incise skull for treatment
63661	Remove spine eltrd perq aray
63662	Remove spine eltrd plate

January 2010 update of the ambulatory surgical center payment system (continued)

HCPCS/*CPT*	Short Descriptor
63663	Revise spine eltrd perq aray
63664	Revise spine eltrd plate
64490	Inj paravert f jnt c/t 1 lev
64491	Inj paravert f jnt c/t 2 lev
64492	Inj paravert f jnt c/t 3 lev
64493	Inj paravert f jnt l/s 1 lev
64494	Inj paravert f jnt l/s 2 lev
64495	Inj paravert f jnt l/s 3 lev
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
77338	Design mlc device for imrt
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
90476	Adenovirus vaccine, type 4
90680	Rotovirus vacc 3 dose, oral
90725	Cholera vaccine, injectable
90735	Encephalitis vaccine, sc
A9581	Gadoxetate disodium inj
A9582	Iodine I-123 iobenguane
A9583	Gadofosveset trisodium inj
C9254	Injection, lacosamide
C9255	Paliperidone palmitate inj

HCPCS/*CPT*	Short Descriptor
C9256	Dexamethasone intravitreal
C9257	Bevacizumab injection
J0586	AbobotulinumtoxintypeA
J0598	C1 esterase inhibitor inj
J0718	Certolizumab pegol inj
J0833	Cosyntropin injection NOS
J0834	Cosyntropin cortrosyn inj
J0945	Brompheniramine maleate inj
J1324	Enfuvirtide injection
J1680	Human fibrinogen conc inj
J1817	Insulin for insulin pump use
J2320	Nandrolone decanoate 50 MG
J2321	Nandrolone decanoate 100 MG
J2322	Nandrolone decanoate 200 MG
J2562	Plerixafor injection
J2793	Rilonacept injection
J2796	Romiplostim injection
J7185	Xyntha inj
J7197	Antithrombin iii injection
J7325	Synvisc or Synvisc-One
J7515	Cyclosporine oral 25 mg
J9155	Degarelix injection
J9171	Docetaxel injection
J9212	Interferon alfacon-1 inj
J9328	Temozolomide injection
Q0138	Ferumoxytol, non-esrd
Q2004	Bladder calculi irrig sol
Q9968	Visualization adjunct

Table 6
CY 2010 ASC-covered surgical procedures to which the no cost/full credit and partial credit device adjustment policy applies

CPT Code	Short Descriptor	CY2010 Device Offset Amount for No Cost/Full Credit Case	CY2010 Device Offset Amount for Partial Credit Case
24361	Reconstruct elbow joint	$4,607.23	$2,303.62
24363	Replace elbow joint	$4,607.23	$2,303.62
24366	Reconstruct head of radius	$4,607.23	$2,303.62
25441	Reconstruct wrist joint	$4,607.23	$2,303.62
25442	Reconstruct wrist joint	$4,607.23	$2,303.62
25446	Wrist replacement	$4,607.23	$2,303.62
27446	Revision of knee joint	$4,607.23	$2,303.62
33206	Insertion of heart pacemaker	$5,750.42	$2,875.21
33207	Insertion of heart pacemaker	$5,750.42	$2,875.21
33208	Insertion of heart pacemaker	$7,169.69	$3,584.85
33212	Insertion of pulse generator	$4,925.26	$2,462.63
33213	Insertion of pulse generator	$5,451.67	$2,725.84

January 2010 update of the ambulatory surgical center payment system (continued)

CPT Code	Short Descriptor	CY2010 Device Offset Amount for No Cost/Full Credit Case	CY2010 Device Offset Amount for Partial Credit Case
33214	Upgrade of pacemaker system	$7,169.69	$3,584.85
33224	Insert pacing lead & connect	$11,169.79	$5,584.90
33225	Lventric pacing lead add-on	$11,169.79	$5,584.90
33240	Insert pulse generator	$19,533.73	$9,766.87
33249	Eltrd/insert pace-defib	$24,535.85	$12,267.93
33282	Implant pat-active ht record	$3,833.98	$1,916.99
53440	Male sling procedure	$3,915.41	$1,957.71
53444	Insert tandem cuff	$3,915.41	$1,957.71
53445	Insert uro/ves nck sphincter	$7,812.01	$3,906.01
53447	Remove/replace ur sphincter	$7,812.01	$3,906.01
54400	Insert semi-rigid prosthesis	$3,915.41	$1,957.71
54401	Insert self-contd prosthesis	$7,812.01	$3,906.01
54405	Insert multi-comp penis pros	$7,812.01	$3,906.01
54410	Remove/replace penis prosth	$7,812.01	$3,906.01
54416	Remv/repl penis contain pros	$7,812.01	$3,906.01
61885	Insrt/redo neurostim 1 array	$11,868.32	$5,934.16
61886	Implant neurostim arrays	$16,331.99	$8,166.00
62361	Implant spine infusion pump	$11,071.42	$5,535.71
62362	Implant spine infusion pump	$11,071.42	$5,535.71
63650	Implant neuroelectrodes	$2,553.00	$1,276.50
63655	Implant neuroelectrodes	$3,707.26	$1,853.63
63685	Insrt/redo spine n generator	$11,868.32	$5,934.16
64553	Implant neuroelectrodes	$2,553.00	$1,276.50
64555	Implant neuroelectrodes	$2,553.00	$1,276.50
64560	Implant neuroelectrodes	$2,553.00	$1,276.50
64561	Implant neuroelectrodes	$2,553.00	$1,276.50
64565	Implant neuroelectrodes	$2,553.00	$1,276.50
64573	Implant neuroelectrodes	$7,779.06	$3,889.53
64575	Implant neuroelectrodes	$3,707.26	$1,853.63
64577	Implant neuroelectrodes	$3,707.26	$1,853.63
64580	Implant neuroelectrodes	$3,707.26	$1,853.63
64581	Implant neuroelectrodes	$3,707.26	$1,853.63
64590	Insrt/redo pn/gastr stimul	$11,868.32	$5,934.16
69714	Implant temple bone w/ stimul	$4,607.23	$2,303.62
69715	Temple bne implnt w/ stimulat	$4,607.23	$2,303.62

January 2010 update of the ambulatory surgical center payment system (continued)

CPT Code	Short Descriptor	CY2010 Device Offset Amount for No Cost/Full Credit Case	CY2010 Device Offset Amount for Partial Credit Case
69717	Temple bone implant revision	$4,607.23	$2,303.62
69718	Revise temple bone implant	$4,607.23	$2,303.62
69930	Implant cochlear device	$24,434.36	$12,217.18

Table 7
CY 2010 devices for which modifier FB or FC must be reported with the procedure code when furnished at no cost or with full or partial credit

HCPCS Code	Short Descriptor
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual, rate-resp
C1786	Pmkr, single, rate-resp
C1813	Prosthesis, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/dual

HCPCS Code	Short Descriptor
C1891	Infusion pump, non-prog, perm
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Prosthesis, penile, non-inf
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8614	Cochlear device/system
L8680	Implt neurostim elctr each
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

Additional information

You may find the official instruction, CR 6746, issued to your carrier or MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1865CP.pdf*.

You will find the updates to the *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.1 (Definition of Ambulatory Surgical Center (ASC)) and 40.9 (Payment and Coding for Presbyopia Correcting IOLs (P-C IOLs) and Astigmatism Correcting IOLs (A-C IOLs)) as an attachment to CR 6746.

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*.

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Anesthesia

Teaching anesthesiologists – implementation of MIPPA Section 139

Note: This article was revised on December 15 to clarify the language regarding teaching certified registered nurse anesthetists (CRNA's) billing two concurrent cases with student nurse anesthetists on or after January 1, 2010. All other information remains the same. This information was previously published in the November 2009 *Medicare B Update!* pages 11-12.

Provider types affected

Anesthesiologists and CRNAs 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 following *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 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).

Specifically, (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 modifier (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

Teaching anesthesiologists – implementation of MIPPA Section 139 (continued)

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 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 modifer QZ that 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. Thus (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.

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. The teaching CRNA may bill usual anesthesia time for each anesthesia case.

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 Medic*are 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.

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Consolidated Billing

Annual update of HCPCS codes used for home health consolidated billing

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, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries during an episode of home health care.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS). Make sure your billing staff is aware of these changes.

What you need to know

Change request (CR) 6662 provides the annual HH consolidated billing update effective January 1, 2010.

The following two HCPCS codes are added to the home health consolidated billing supply code list. Code A4456 is a new code that replaces code A4365 which is deleted below.

Added HCPCS code	Descriptor
A4360	Disposable external urethral clamp or compression device with pad and/or pouch
A4456	Ostomy adhesive remover wipe

The following HCPCS code is deleted from the home health consolidated billing supply code list.

Deleted HCPCS code	Descriptor
A4365	Ostomy adhesive remover wipe

Background

The CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the HH PPS. With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Additional information

If you have questions, please contact your Medicare carrier/FI/RHHI/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 6662) issued to your Medicare carrier/FI/RHHI/MAC is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1827CP.pdf* on the CMS Web site.

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Drugs and Biologicals

January 2010 average sales price file is available

The Centers for Medicare & Medicaid Services (CMS) has posted the January 2010 average sales price (ASP) and not otherwise classified (NOC) pricing files and crosswalks. The ASP pricing files for January 2009 and October 2009 have also been updated. All are available for download at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/* (see left menu for year-specific links).

Source: CMS PERL 200912-21

Revised January 2010 average sales price file is available

The Centers for Medicare and Medicaid Services (CMS) has posted the revised January 2010 average sales price (ASP) drug file and crosswalk. All are available for download at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a19_2010aspfiles.asp*.

Source: CMS PERL 200912-30

Durable Medical Equipment

Delay in implementing phase 2 on editing claims for ordering/referring providers

The Centers for Medicare & Medicaid Services (CMS) will delay, until April 5, 2010, the implementation of phase 2 of change request (CR) 6417 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)) and CR 6421 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)). CRs 6417 and 6421 are applicable to Part B claims only.

The delay in implementing phase 2 of these CRs will give physicians and nonphysician practitioners who order items or services for Medicare beneficiaries or who refer Medicare beneficiaries to other Medicare providers or suppliers sufficient time to enroll in Medicare or take the action necessary to establish a current enrollment record in Medicare prior to phase 2 implementation.

Although enrolled in Medicare, many physicians and nonphysician practitioners who are eligible to order items or services or refer Medicare beneficiaries to other Medicare providers or suppliers for services do not have current enrollment records in Medicare. A current enrollment record is one that is in the Medicare provider enrollment, chain and ownership system (PECOS) and also contains the physician/nonphysician practitioner's national provider identifier (NPI). Under phase 2 of the above referenced CRs, a physician or nonphysician practitioner who orders or refers and who does not have a current enrollment record that contains the NPI will cause the claim submitted by the Part B provider/supplier who furnished the ordered or referred item or service to be rejected.

CMS continues to urge physicians and nonphysician practitioners who are enrolled in Medicare but who have not updated their Medicare enrollment record since November 2003 to update their enrollment record now. If these physicians and nonphysician practitioners have no changes to their enrollment data, they need to submit an initial enrollment application, which will establish a current enrollment record in PECOS.

For physicians and nonphysician practitioners who order or refer

If you are not enrolled in the Medicare program, or if you enrolled more than six years ago and have not submitted any updates or changes to your enrollment information in more than six years, you do not have an enrollment record in PECOS. In order to continue to order or refer items or services for Medicare beneficiaries, you will have to submit an initial enrollment application using one of this to methods:

1. Using Internet-based PECOS (which transmits your enrollment application to the Medicare carrier or A/B MAC via the Internet -- be sure to mail the signed and dated certification statement to the carrier or A/B MAC immediately after submitting the application)
2. Filling out the appropriate paper Medicare-provider enrollment application(s) (CMS-855I and CMS-855R, if appropriate) and mailing the application, along with any required additional supplemental documentation, to the local Medicare carrier or A/B MAC, who will enter your information into PECOS and process your enrollment application. You may find the information on how to enroll in Medicare on the CMS provider/supplier enrollment Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/*.

Delay in implementing phase 2 on editing claims for ordering/referring providers (continued)

If you are already enrolled in Medicare, make sure you have a current enrollment record. You can find out if you have an enrollment record in PECOS by calling your designated carrier or A/B MAC or by going online, using Internet-based PECOS, to view your enrollment record. CMS will be posting information to the Medicare provider/supplier enrollment Web site that will guide you through this process. A link and information about Internet-based PECOS may be found on the CMS provider/supplier enrollment Web site. Before using Internet-based PECOS, CMS recommends that you read the posted information available in the downloadable document section.

If you are a dentist or a physician with a specialty such as a pediatrics who is eligible to order or refer items or services for Medicare beneficiaries but have not enrolled in Medicare because Medicare does not cover the services you provide or you treat few Medicare beneficiaries, you need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries.

If you are a physician who is employed by the Department of Veterans Affairs, the Public Health Service, or the Department of Defense Tricare program but have not enrolled in Medicare because Medicare does not pay for your services, you need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries.

If you are a resident who has a medical license but have not enrolled in Medicare because Medicare does not pay for your services, you do not need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. The teaching physician -- not the resident – must be identified in claims as the ordering/referring provider when a resident orders or refers items or services for Medicare beneficiaries.

CMS actions to mitigate the number of informational messages

Since many Part B providers and suppliers are receiving a high volume of informational messages in their remittances, CMS is taking the following actions to reduce the number of informational messages being generated prior to the implementation of phase 2:

- CMS will systematically add the NPIs to the PECOS enrollment records of all physicians and nonphysician practitioners whose enrollment records are in PECOS but do not contain their NPIs. Because the NPI is one of the matching criteria used in implementing the two new edits on the ordering/referring provider, it is essential that the NPI be in the PECOS enrollment record. Because the data file used to implement the two edits contains only the eligible physicians and nonphysician practitioners who are in PECOS with NPIs in their enrollment records, this action will add many more physicians and nonphysician practitioners to that data file.
- CMS will make publicly available on the Internet the names and NPIs of the Medicare physicians and nonphysician practitioners who are eligible to order or refer in the Medicare program. The name displayed will be that of the physician or nonphysician practitioner as it appears in his or her PECOS enrollment record. This will allow Part B providers and suppliers who furnish and bill for items or services based on orders or referrals to determine if the ordering/referring provider being identified in their claims will pass the two new edits prior to submitting the claims to Medicare.
- CMS will issue instructions to carriers and A/B MACs that will assist them in processing enrollment applications from physicians who are employed by the Department of Veterans Affairs, the Public Health Service, and the Department of Defense Tricare program. The instructions will also state that the teaching physician needs to be reported as the ordering/referring physician in situations where a resident orders or refers items or services for Medicare beneficiaries. The instructions will also note that dentists and pediatricians, who sometimes order or refer items or services for Medicare beneficiaries, may be enrolling in Medicare in order to continue to order and refer.

CMS will be preparing a special edition *Medicare Learning Network* (*MLN*) *Matters* article on the implementation of these two new edits. This *MLN Matters* article will expand upon the information currently available in *MLN Matters* articles MM6417 and MM6421.

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

Source: CMS PERL 200911-35

Accreditation deadline for pharmacies is January 1, 2010

Since the President signed Public Law 111-072 postponing the accreditation deadline for pharmacies until January 1, 2010, the Centers for Medicare & Medicaid Services is reminding pharmacies who have not been accredited to do so by January 1, 2010.

Pharmacies going through the accreditation process are encouraged to resolve any outstanding issues on their accreditation report so that the accrediting organization can make an accreditation determination in advance of the January 1, 2010, deadline. The durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) accrediting organization will notify the national supplier clearinghouse (NSC) when the organization is accredited.

Pharmacies that do not plan to remain enrolled in the DMEPOS Medicare program are strongly encouraged to notify their customers as soon as possible. This will give their customers an opportunity to find another DMEPOS supplier.

Source: CMS PERL 200912-04

Evaluation and Management

Revisions to consultation services payment policy

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 (NPPs) who perform the initial evaluation and management (E/M) consultation for Medicare beneficiaries and submit claims to Medicare carriers, fiscal intermediaries, and/or Medicare administrative contractors (MACs) for those services. It is also intended for Method II critical access hospitals, which bill for the services of those physician and nonphysician practitioners who have reassigned their billing rights. This article only applies to physicians billing the Medicare fee-for-service program. It does not apply to Medicare Advantage or non-Medicare insurers.

Provider action needed

This article pertains to change request (CR) 6740, which alerts providers that effective January 1, 2010, the *Current Procedural Terminology* (*CPT*) consultation codes (ranges *99241-99245* and *99251-99255*) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after January 1, 2010, providers should code a patient evaluation and management visit with E/M codes that represents WHERE the visit occurs and that identify the COMPLEXITY of the visit performed. See the *Key points* section of this article for details.

Background

In the calendar year 2010 Medicare physician fee schedule (MPFS) final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the use of all consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation G-codes. The change will not increase or decrease Medicare payments. In place of the consultation codes, CMS increased the work relative value units (RVUs) for new and established office visits, increased the work RVUs for initial hospital and initial nursing facility visits, and incorporated the increased use of these visits into the practice expense (PE) and malpractice calculations. CMS also increased the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes. All references (both text and code numbers) in the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6 that pertain to the use of the American Medical Association (AMA) *CPT* consultation codes (ranges *99241-99245* and *99251-99255*) are removed by CR 6740. (The Web address for viewing CR 6740 is in the *Additional information* section of this article.)

Key points of CR 6740

- Effective January 1, 2010, local Part B carriers and/or A/B MACs will no longer recognize AMA *CPT* consultation codes (ranges *99241-99245*, and *99251-99255*) for inpatient facility and office/outpatient settings where consultation codes were previously billed for services in various settings.
- Effective January 1, 2010, local FIs and/or A/B MACs will no longer recognize AMA *CPT* consultation codes (ranges *99241-99245*, and *99251-99255*) for Method II CAHs, when billing for the services of those physician and nonphysician practitioners who have reassigned their billing rights.
- Physicians may employ the 2009 consultation service codes, where appropriate, to bill for consultative services furnished up to and including December 31, 2009.
- Physicians who bill a consultation after January 1, 2010, will have the claim returned with a message indicating that Medicare uses another code for the service. The physician must bill another code for the service and may not bill the patient for a noncovered service.
- RHCs and FQHCs will discontinue use of AMA *CPT* consultation codes *99241-99245* and *99251-99255* and should instead use *99201-99215* and *99304-99306*.
- Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.
- In the inpatient hospital setting and nursing facility setting, any physicians and qualified NPPs who perform an initial evaluation may bill an initial hospital care visit code (*99221-99223*) or nursing facility care visit code (*99304-99306*), where appropriate.
- In all cases, physicians will bill the available code that most appropriately describes the level of the services provided.
- The principal physician of record will append modifier AI (Principal Physician of Record), to the E/M code when billed. This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation on this patient will bill only the E/M code for the complexity level performed.
- However, claims that include the modifier AI on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected and returned to the physician or provider.

Revisions to consultation services payment policy (continued)

- For patients receiving hospital outpatient observation services who are not subsequently admitted to the hospital as inpatients, physicians should report *CPT* codes *99217-99220*. In the event another physician evaluation is necessary, the physician who provides the additional evaluation bills the office or other outpatient visit codes when they provide services to the patient.
  - For example, if an internist orders observation services, furnishes the initial evaluation, and asks another physician to additionally evaluate the patient, only the internist may bill the initial observation care code. The other physician who evaluates the patient must bill the new or established patient office or other outpatient visit codes as appropriate.
- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients and who are discharged on the same date, the physician should report *CPT* codes *99234-99236* (e.g. code *99234*-Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date). If the patient is an inpatient and another physician evaluation is necessary, the physician would bill the initial hospital day code as appropriate (*99221-99223*). Otherwise, physician should use the new or established patient office or other outpatient visit codes for a necessary evaluation.
- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients on the same date, the physician should report only the initial hospital care services codes (codes *99221-99223*). Medicare will pay for an initial hospital care service if a physician sees a patient in the emergency room and decides to admit the person to the hospital. When a physician performs a visit that meets the definition of a Level 5 office visit several days prior to an admission and on the day of admission performs less than a comprehensive history and physical, he or she should report the office visit that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code *99221*) for the initial hospital admission. Medicare will pay the office visit as billed and the Level 1 initial hospital care code. The principal physician of record, as previously noted, must append the "-AI" modifier to the claim with the initial hospital care code.
- For patients receiving hospital outpatient observation services or inpatient care services (including admission and discharge services) for whom observation services are initiated or the hospital inpatient admission begins on the same date as the patient's discharge, the ordering physician should report CPT codes *99234-99236*.
- Emergency department visits (codes *99281-99288*) - physician billing for emergency department services provided to patient by both patient's personal physician and emergency department (ED) physician. If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only advises the ED physician by telephone, then the patient's personal physician may not bill.
- If the ED physician requests that another physician evaluate a given patient, the other physician should bill an emergency department visit code. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.
- Follow-up visits by the physician in the facility setting should be billed as subsequent hospital care visits for hospital inpatients and subsequent nursing facility care visits for patients in nursing facilities, as is the current policy.
- In the office or other outpatient setting where an evaluation is performed, physicians and qualified NPPs should report the *CPT* codes (*99201-99215*) depending on the complexity of the visit and whether the patient is a new or established patient to that physician.
- A new patient is a patient who has not received any professional services (E/M or other face-to-face service) within the previous three years. Examples of where a new patient office is not billable:
- If the consultant furnishes a pre-operative consultation at the request of a surgeon on a beneficiary, the consultant has provided a professional service to the patient within the past three years and would not meet the requirements to bill a new patient office visit.
- The consultant could not bill for a new patient office visit for a consultation furnished to a known beneficiary for a different diagnosis than he or she has previously treated if the patient was seen by the consultant in the prior three years.
- The consultant furnishes a consultation to a known beneficiary in an outpatient setting different than the office (e.g. emergency department, observation where the patient was seen in the past three years). As the patient has been seen by the consultant within the past three years, a new patient office visit cannot be billed.
- In order for physicians to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet *CPT's* definition of a comprehensive history).
- Medicare may pay for an inpatient hospital visit or an office or other outpatient visit if one physician or qualified NPP in a group practice requests an evaluation and management service from another physician in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting professional's knowledge.

Revisions to consultation services payment policy (continued)

- Medicare will also no longer recognize the consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, physicians and others must bill an appropriate E/M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:
  - Bill the primary payer an E/M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or
  - Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

Note: The first option may be easier from a billing and claims processing perspective.

- All physicians and qualified NPPs need to follow the E/M documentation guidelines, which are available at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*.
- Medicare contractors will use the following threshold times to determine if the prolonged services codes *99354* and/or *99355* can be billed with the office or other outpatient settings including domiciliary, rest home, or custodial care services and home services codes. Threshold time for prolonged visit codes *99354* and/or *99355* billed with office outpatient visit are as follows (all times in minutes):

Code	Typical Time for Code	Threshold Time to Bill Code *99354*	Threshold Time to Bill Codes *99354* and *99355*
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99324	20	50	95
99325	30	60	105
99326	45	75	120
99327	60	90	135
99328	75	105	150
99334	15	45	90
99335	25	55	100
99336	40	70	115
99337	60	90	135
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

- Threshold time for prolonged visit codes *99356* and/or *99357* billed with inpatient setting codes are as follows (all times in minutes):

Code	Typical Time for Code	Threshold Time to Bill Code *99356*	Threshold Time to Bill Codes *99356* and *99357*
99221	30	60	105
99222	50	80	125

Revisions to consultation services payment policy (continued)

Code	Typical Time for Code	Threshold Time to Bill Code *99356*	Threshold Time to Bill Codes *99356* and *99357*
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110
99304	25	55	100
99305	35	65	110
99306	45	75	120
99307	10	40	85
99308	15	45	90
99309	25	55	100
99310	35	65	110
99318	30	60	105

- Appropriate documentation is required to support the billing of the prolonged visit codes.
- The existing rules for counting time for purposes of meeting the prolonged care threshold times continue to apply. In particular, the *Medicare Claims Processing Manual*, Chapter 12, 30.6.15.1.C, provides that physicians may count only the duration of direct face-to-face contact between the physician and the patient for these purposes, and may not include time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient.

Additional Information

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

The official instruction, CR 6740, issued to Medicare MACs and carriers regarding this change may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf*.

The E/M documentation guidelines are available at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*.

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Laboratory/Pathology

New waived tests

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

Provider types affected

Clinical diagnostic laboratories billing Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for laboratory tests are impacted by this article.

Provider action needed

Stop – impact to you

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare carrier or A/B MAC for a *Current Procedural Terminology* (*CPT*) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Caution – what you need to know

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The CPT codes that the Centers for Medicare & Medicaid Services (CMS) considers to be laboratory tests under CLIA (and thus requiring certification) change periodically. Change request (CR) 6685, from which this article is taken, informs carriers and A/B MACs about the latest new *CPT* codes that are subject to CLIA edits.

Go – what you need to do

Make sure that your billing staff is aware of these CLIA-related changes and that you remain current with certification requirements.

Background

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. The tests are valid as soon as they are approved. The *CPT* codes for the following new tests **must** have the modifier QW to be recognized as a waived test.

CPT Code	Effective Date	Description
80101QW	March 10, 2009	Amedica Biotech Amedica Drug Screen Test Cup
80101QW	May 11, 2009	Twin Spirit, Inc. DrugSmart Cup
84443QW	June 3, 2009	CLIAwaived Inc. Thyroid Test Rapid TSH Cassette {whole blood}
86308QW	July 16, 2009	ProAdvantage by NDC Infectious Mononucleosis Test Device (whole blood only)
86318QW	August 7, 2009	Pro-Advantage by NDC H. pylori Device (whole blood)
87804QW	August 18, 2009	BinaxNOW Influenza A & B Test, K092223

Other key points

- Only tests with the following *CPT* codes **do not** require a modifier QW to be recognized as a waived test: *81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013*, and *85651*.
- For 2009, the description for the *CPT* code *84155* was modified from “Protein, total, except by refractometry; serum” to “Protein, total, except by refractometry; serum, plasma or whole blood.”

Therefore, the *CPT* codes assigned for the total protein test performed on the following test systems have been changed from *84157QW* to *84155QW*:

- Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 13 Panel){whole blood}
- Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 13 Panel){whole blood}
- Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}
- Abaxis Piccolo xpress Chemistry Analyzer {Liver Panel Plus} (whole blood), and
- Arkay SPOTCHEM EZ Chemistry Analyzer (Spotchem II Basicpanel 2){whole blood}.

- As a result, Medicare will permit the use of *84155QW* for claims submitted by facilities with a valid and current CLIA certificate of waiver with dates of service on or after January 1, 2009, but Medicare will deny the use of code *84157QW* from such facilities with the dates of service on or after January 1, 2010.
- Medicare carriers and A/B MACs will not search their files to adjust claims affected by this change, but processed prior to the implementation of CR 6685. They will, however, adjust such claims that you bring to their attention.

New waived tests (continued)

Additional information

The official instruction (CR 6685) issued to your Medicare carrier and/or A/B MAC is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1857CP.pdf* on the CMS Web site.

If you have questions, please contact your Medicare carrier and/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.

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Medicare Physician Fee Schedule

Holding of claims for services paid under the 2010 Medicare physician fee schedule – update

The Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, non-physician practitioners, and other providers of services paid under the Medicare physician fee schedule, beginning January 1, 2010. In this regard, CMS has instructed its contractors to hold claims for services paid under the Medicare physician fee schedule (MPFS) for up to the first 10 business days of January (January 1 through January 15) for 2010 dates of service. This should have minimum impact on provider cash flow because, by law, clean electronic claims are not paid any sooner than 14 calendar days (29 days for paper claims) after the date of receipt. Meanwhile, all claims for services delivered on or before December 31, 2009, will be processed and paid under normal procedures.

The holding of claims allows Medicare contractors time to receive the new, updated payment files and perform necessary testing before paying claims at the new rates. CMS has instructed contractors to begin processing claims at the new rates no later than January 19, 2010. Please note that most contractors are closed on the January 18 Martin Luther King Day holiday. Therefore, even absent a new update, most claims likely would not have been paid any sooner than January 19, 2010, given the aforementioned statutory 14-day payment floor.

CMS has extended the 2010 annual participation enrollment program end date from January 31, 2010, to March 17, 2010; therefore, the enrollment period now runs from November 13, 2009, through March 17, 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.

Contractors will accept and process any participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before March 17, 2010.

In addition, be on the alert for more information about other legislative provisions that may affect you.

Source: CMS PERL 200912-31

Radiology

FDG positron emission tomography imaging for cervical cancer

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

Provider types affected

Physicians, hospitals, and other providers who provide F-18 flouro-D-glucose (FDG) positron emission tomography (PET) imaging services should be aware of this article if they bill Medicare carriers, fiscal intermediaries (FIs) or Medicare administrative contractors (MACs) for those services provided to Medicare beneficiaries with cervical cancer.

What you need to know

Change request (CR) 6753, from which this article is taken, announces a national coverage determination (NCD) regarding FDG PET imaging for cervical cancer.

Specifically, (effective for claims with dates of service on and after November 10, 2009) the Centers for Medicare & Medicaid Services (CMS) ends the coverage with evidence development (CED) requirements for FDG PET for cervical cancer; and will cover only one FDG PET for cervical cancer for staging in beneficiaries with biopsy-proven tumors when the treating physician determines that the study is needed to determine the location and/or extent of the tumor for specific therapeutic purposes related to initial treatment strategy (as outlined in the *Medicare National Coverage Determination Manual*, Section 220.6.17 (FDG PET for Oncologic Conditions (Various Effective Dates).

Background

CR 6753 announces an NCD regarding FDG PET imaging for cervical cancer (including FDG PET/CT). It provides that, effective November 10, 2009 (as the result of a reconsideration request), CMS:

- Ended CED prospective data collection requirements for the use of FDG PET imaging in the initial staging of cervical cancer related to initial treatment strategy
- Determined that there is no credible evidence that the results of FDG PET imaging are useful in making the initial diagnoses of cervical cancer; or in improving health outcomes, and
- Announced that FDG PET is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act (the Act) and, therefore, CMS noncovers FDG PET imaging for initial diagnosis of cervical cancer related to initial treatment strategy.

As a result, CR 6753 provides that (effective for claims with dates of service on and after November 10, 2009), CMS will cover only one initial FDG PET study for staging in beneficiaries who have biopsy-proven cervical cancer when the treating physician determines that the FDG PET study is needed to determine the location and/or extent of the tumor for the following therapeutic purposes related to initial treatment strategy:

- To determine whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure, or
- To determine the optimal anatomic location for an invasive procedure, or
- To determine the anatomic extent of the tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.

Note the exception to this policy: CMS continues to noncover FDG PET for the initial diagnosis of cervical cancer related to initial treatment strategy.

Billing changes

Effective for claims with dates of service on or after November 10, 2009, your carrier, FI, or MAC will accept FDG PET oncologic claims that you bill to inform initial treatment strategy; specifically for staging in beneficiaries who have biopsy-proven cervical cancer when the beneficiary's treating physician determines the FDG PET study is needed to determine the location and/or extent of the tumor as specified above. **Please note that for these claims, the modifier Q0 (investigational clinical service provided in a clinical research study that is in an approved clinical research study) is no longer necessary for FDG PET services for cervical cancer.**

In addition, your carrier, FI, or MAC will "return as unprocessable/return to provider" your claims for FDG PET for cervical cancer billed to inform initial treatment if all the following are not present:

- PET or PET/CT *Current Procedural Terminology* (*CPT*) code (*78608, 78811, 78812, 78813, 78814, 78815*, or *78816*)
- Modifier PI (PET Tumor initial treatment strategy)
- ICD-9 cervical cancer diagnosis code.

Failure to use the correct codes will result in the following messages:

- **Claim Adjustment Reason Code 4**: The procedure code is inconsistent with the modifier used or a required modifier is missing.
- **Remittance Advice Remark Code (RARC) MA130**: Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.
- **RARC M16: Alert**: See our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

FDG positron emission tomography imaging for cervical cancer (continued)

You should be aware that while your carrier, FI, or MAC will not search their files for FDG PET oncologic cervical cancer claims for initial treatment strategy, for dates of service November 10, 2009, through January 3, 2010, they will adjust such claims that you bring to their attention.

Additional information

The official CR 6753 was issued in two transmittals, one announcing the NCD as added to the *Medicare NCD Manual* and the other transmittal providing the revised *Medicare Claims Processing Manual* instructions. You may find these transmittals at *http://www.cms.hhs.gov/Transmittals/downloads/R110NCD.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1888CP.pdf*, respectively.

If you have any questions, please contact your carrier, FI, or MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6753
Related CR Release Date: January 6, 2010
Related CR Transmittal #: R1888CP and R110NCD
Related Change Request (CR) #: 6753
Effective Date: November 10, 2009
Implementation Date: January 4, 2010

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Surgery

Payment for implantable tissue markers

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 who bill Medicare carriers and A/B Medicare administrative contractors (A/B MAC) for implantable tissue markers provided Medicare beneficiaries.

What you need to know

Change request (CR) 6579, from which this article is taken, clarifies guidance regarding payment for implantable tissue markers (HCPCS code A4648 -- Tissue marker, implantable, any type, each). When billed on a physician claim and used in conjunction with *Current Procedural Terminology (CPT)* code *55876 (Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, prostate, single or multiple)*, the use of implantable tissue markers (HCPCS code A4648) is separately billable and payable by Medicare. Make sure that your billing staffs are aware of this policy.

Background

CR 6579 announces that HCPCS code A4648 is separately billable and payable when billed on a physician claim and when used in conjunction with *CPT* code *55876*. Therefore, in these instances, your carrier or A/B MAC will make a separate payment for HCPCS code A4648. If you bill A4648 on a physician claim and code *55876* is not also billed for that same date of service, Medicare will deny payment for A4648 with a claim adjustment reason code of B15 indicating “This service /procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.”

Note that there are no changes in CR 6579 to current payment policy for A4648 with regard to payment to hospitals for inpatient or outpatient hospital services or with regard to payment to ambulatory surgery centers.

Additional information

You may find the official instruction, CR 6579, issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R604OTN.pdf* on the Centers for Medicare & Medicaid (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: MM6579
Related Change Request (CR) #: 6579
Related CR Release Date: November 27, 2009
Effective Date: February 26, 2010
Related CR Transmittal #: R604OTN
Implementation Date: February 26, 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.

Note: This article was revised on November 24, 2009, to reflect a revised change request (CR) 6660 that the Centers for Medicare & Medicaid Services issued on November 23, 2009. As a result of the revised CR, the article was revised to include regional home health intermediaries as an additional contractor type involved with this issue. The CR release date, transmittal number, and Web address for accessing CR 6660 were also changed. Also, carriers were added as a contractor type involved as they were inadvertently not included in the original article. All other information remains the same. This information was previously published in the November 2009 *Medicare B Update!* page 22.

Provider types affected

This article is for providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), RHHIs, A/B Medicare administrative contractors (A/B MACs), and/or 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 2010 and announces that therapy caps for 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 calendar year (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 carrier, FI, RHHI, A/B MAC, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1860CP.pdf* on the CMS Web site.

If you have any questions, please contact your carrier, FI, RHHI, 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 *Revised*
Related Change Request (CR) #: 6660
Related CR Release Date: November 23, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1860CP
Implementation Date: January 4, 2010

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2010 annual update to the therapy code list

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

Provider types affected

Physicians, therapists, and providers of therapy services billing Medicare carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs) for outpatient rehabilitation therapy services should take note of this article.

Provider action needed

This article is based on change request (CR) 6719, which updates the therapy code list for calendar year (CY) 2010 with one “sometimes therapy” code *92520* (*laryngeal function studies [ie, aerodynamic testing and acoustic testing*]). Note that this code always represents therapy services when performed by therapists and requires the use of a therapy modifier.

2010 annual update to the therapy code list (continued)

Background

The Social Security Act (Section 1834(k)(5); see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/*Current Procedural Terminology 2010 Edition* (HCPCS/*CPT-4*) is the coding system used for the reporting of these services. The additions, changes, and deletions to the therapy code list reflect those made in the CYs 2009 and 2010 Healthcare Common Procedure Coding System and *Current Procedural Terminology*, Fourth Edition (HCPCS/*CPT-4*).

CR 6719 updates the therapy code list by adding one "sometimes therapy" code for CY 2010 shown in the table. Note that this code always represents therapy services when performed by therapists and requires the use of a therapy modifier.

Therapy Code	Descriptor
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)

In addition, CR 6719 announces that *95992* (*Standard Canalith repositioning procedure(s), (e.g., Epley maneuver, Semont maneuver), per day*) is being removed from the therapy code list effective January 1, 2010.

Therapy services, including "always therapy" services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, Chapter 5 which is available at *http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf*.

Additional information

You may also find more information about the therapy code List at *http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage*.

The official instruction, CR 6719, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1850CP.pdf*.

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

MLN Matters® Number: MM6719
Related Change Request (CR) #: 6719
Related CR Release Date: November 13, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1850CP
Implementation Date: January 4, 2010

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General Coverage

Preventing the misuse of modifiers PA, PB, and PC on incoming claims

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

Provider types affected

Physicians, nonphysician practitioners, and hospitals submitting claims to Medicare contractors (fiscal intermediaries [FIs], carriers, and Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article, based on CR 6718, advises you that modifiers PA, PB and PC are often being submitted incorrectly on claims. This can cause incorrect denials. The Centers for Medicare & Medicaid Services (CMS) issued CR 6718 to direct contractors on handling incorrect claims in order to alleviate the issue. These detailed instructions are explained in the background section of this article. Your billing staffs need to be aware of the proper uses of the modifiers PA, PB, and PC. The instructions are in MM6405, available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6405.pdf*.

Background

This article is based on CR 6718, which clarifies billing instructions and claims processing for information provided in a previous article MM6405. CR 6718 does not change the policy for the coverage or noncoverage of the adverse events described in MM6405.

CR 6405, "Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient," a revised version of which was issued on September 25, 2009, implemented billing procedures for these adverse events.

CMS has learned that the modifiers described in the CR 6405 are, in many cases, being submitted incorrectly by the providers. In particular, some providers are using the modifier PC to represent the professional component of a service. This is incorrect. The modifier PC is defined as "Wrong Surgery on a Patient." The incorrect use of this modifier results in claims being incorrectly denied. Medicare contractors will follow the requirements in CR 6718 to help prevent claims from being processed with modifiers incorrectly submitted on them.

Preventing the misuse of modifiers PA, PB, and PC on incoming claims (continued)

Medicare contractors will:

- Suspend, review, and develop all claim lines that are submitted with modifiers PA, PB, or PC, and
- Contact the provider to determine whether the claims are related to one of the adverse events as described by the modifiers PA, PB, or PC.

If the contractor determines that the modifiers PA, PB, or PC have been incorrectly submitted, they will:

- Reject (return to provider) Part A outpatient claims
- Return Part B claims as unprocessable with:
  - Claim adjustment reason code 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing.), and
  - Remittance advice remark code MA130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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*.

The official instruction, CR 6718, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1867CP.pdf*.

MLN Matters® Number: MM6718
Related Change Request (CR) #: 6718
Related CR Release Date: December 4, 2009
Effective Date: January 15, 2009
Related CR Transmittal #: R1867CP
Implementation Date: No later than January 4, 2010

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

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

Note: This article was revised on December 11, 2009, to reflect an extension of phase 1 and a delay in implementing phase 2 of change request (CR) 6417. All other information remains the same. This information was previously published in the October 2009 *Medicare B Update!* pages 21-22.

Provider types affected

Physicians, nonphysician practitioners, and other Part B providers and suppliers submitting claims to carriers or Part B Medicare administrative contractors (MACs) for items or services that were ordered or referred. (A separate article (MM6421) discusses similar edits affecting claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for items or services that were ordered or referred, and relates to CR 6421. That article is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6421.pdf* on the CMS Web site.)

Provider action needed

This article is based on change request (CR) 6417, which requires Medicare implementation of system edits to assure that Part B providers and suppliers bill for ordered or referred items or services only when those items or services are ordered or referred by physician and nonphysician practitioners who are eligible to order/refer such services. Physician and nonphysician practitioners who order or refer must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and must be of the type/specialty who are eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact Part B provider and supplier claims for ordered or referred items or services that are received and processed on or after October 5, 2009.

Background

CMS is expanding claim editing to meet the Social Security Act requirements for ordering and referring providers. Section 1833(q) of the Social Security Act requires that all ordering and referring physicians and nonphysician practitioners meet the definitions at section 1861(r) and 1842(b)(18)(C) and be uniquely identified in all claims for items and services that are the results of orders or referrals. Effective January 1, 1992, a provider or supplier who bills Medicare for an item or service that was ordered or referred must show the name and unique identifier of the ordering/referring provider on the claim.

The providers who can order/refer are:

- Doctor of medicine or osteopathy
- Dental medicine

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

- Dental surgery
- Podiatric medicine
- Optometry
- Chiropractic medicine
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife, and
- Clinical social worker.

Claims that are the result of an order or a referral must contain the national provider identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system with one of the above types/specialties.

Key points

- During Phase 1 (October 5, 2009-April 4, 2010): If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. If the ordering/referring provider is not in PECOS the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will continue to process and the Part B provider or supplier will receive a warning message on the remittance advice. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will continue to process and the Part B provider or supplier will receive a warning message on the remittance advice.
- During Phase 2, (April 5, 2010, and thereafter): If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. If the ordering/referring provider is not in PECOS, the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will not be paid. It will be rejected. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.
- In both phases, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.
- Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at *https://pecos.cms.hhs.gov/pecos/login.do* on the CMS Web site. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp* on the CMS Web site. Once at that site, scroll to the *Downloads* section of that page and click on the materials that apply to you and your practice.

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

Additional information

You may find the official instruction, CR 6417, issued to your carrier or B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R572OTN.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6417 *Revised*
Related Change Request (CR) #: 6417
Related CR Release Date: October 2, 2009
Effective Dates: Phase 1: October 5, 2009, Phase 2: April 1, 2010
Related CR Transmittal #: R572OTN
Implementation Dates: Phase 1: October 5, 2009, Phase 2: April 5, 2010

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Electronic Data Interchange

Update of remittance advice remark codes and claim adjustment reason codes

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

Provider action needed

CR 6742, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs). The CR is effective January 1, 2010. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated three times a year – in early March, July, and November although the Committee meets every month. A national code maintenance committee maintains the CARCs. That Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. Both code lists are posted at *http://www.wpc-edi.com/Codes*. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 6742.

CMS has also developed a tool to help search for a specific category of code and that tool is available at http://www.cmsremarkcodes.info. Note that this Web site does not replace the Washington Publishing Company (WPC) site. That site is *http://www.wpc-edi.com/Codes* and, should there be any discrepancies in what is posted at the CMS site and the WPC site, consider the WPC site to be correct.

Additional information

To see the official instruction (CR 6742) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1862CP.pdf*. If you have questions, please contact your Medicare carrier, RHHI, DME/MAC, FI and/or MAC at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

New codes - CARC

Code	Current narrative	Effective date per WPC posting
232	Institutional transfer amount. Note: Applies to Institutional claims only and explains the DRG amount differences when patients care crosses multiple institutions.	11/1/2009
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	11/1/2009

Modified codes - CARC

Code	Current modified narrative	Effective date per WPC posting
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

Update of remittance advice remark codes and claim adjustment reason codes (continued)

Code	Current modified narrative	Effective date per WPC posting
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
49	These are noncovered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
51	These are noncovered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
96	Noncovered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
107	Related or qualifying claim/service was not identified on the claim. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present	7/1/2010
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
152	Payer deems the information submitted does not support this length of service.	7/1/2010
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

Update of remittance advice remark codes and claim adjustment reason codes (continued)

Code	Current modified narrative	Effective date per WPC posting
179	Patient has Not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is Not an "Alert".)	7/1/2010
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
148	Information from another provider was not provided or was insufficient/ incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided ((may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 07/01/2010: Charges do Not meet qualifications for emergent/urgent care. Note: Refer to the 835 REF Segment: Healthcare Policy Identification, if present.	7/1/2010

Update of remittance advice remark codes and claim adjustment reason codes (continued)

Deactivated codes - CARC

Code	Current narrative	Effective date
87	Transfer Amount	1/1/2012
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	1/1/2012

New codes - RARC

Code	Current narrative	Medicare initiated
N521	Mismatch between the submitted provider information and the provider information stored in our system.	No
N522	Duplicate of a claim processed as a crossover claim.	No

Modified codes - RARC

Code	Modified narrative	Medicare initiated
M39	The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.	No
M118	Letter to follow containing further information.	No
N59	Please refer to your provider manual for additional program and provider information.	No
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	No
N202	Additional information/explanation will be sent separately.	No

Deactivated codes - RARC
None

MLN Matters® Number: MM6742
Related Change Request (CR) #: 6742
Related CR Release Date: November 27, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1862CP
Implementation Date: January 4, 2010

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

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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

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.

Note: This article was revised on December 15 to reflect revisions to change request (CR) 6723 that was issued on December 14. The CR release date, transmittal number, and the Web address for accessing CR 6723 were revised. All other information remains the same. This information was previously published in the November 2009 *Medicare B Update!* page 26.

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 that is 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 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 category codes and claim status codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the 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*.

MLN Matters® Number: MM6723 *Revised*
Related Change Request (CR) #: 6723
Related CR Release Date: December 14, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1874CP
Implementation Date: January 4, 2010

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New Feedback page

One of the trends identified in the 2009 Medicare Contractor Provider Satisfaction Survey (MCPSS) was our providers' preference to have more ways to communicate with us. Our new Feedback page offers our customers the convenience of a central "hub" for communication and includes three interactive feedback, available at *http://medicare.fcso.com/feedback/*.

General Information

Extension of the 2010 Annual Participation Enrollment Program

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

Note: This article was revised on December 22 to show that the 2010 Annual Participation Enrollment Program has been extended through March 17, 2010. This information was previously published in the November 2009 *Medicare B Update!* page 27.

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 March 17, 2010. Therefore, the enrollment period now runs from November 13, 2009, through March 17, 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 March 17, 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*.

The Participation Agreement (CMS-Form 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*. The addresses of Medicare contractors' Web sites are available at this location as well.

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

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Provider participation essential to success of 2010 MCPSS

The Centers for Medicare & Medicaid Services (CMS) has announced that data collection for the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS) will begin in January 2010 and conclude in April 2010. The primary goal of the annual MCPSS is to objectively measure provider satisfaction levels with regard to the performance of the fee-for-service (FFS) contractors responsible for the processing and payment of more than $280 billion in Medicare claims each year.

SciMetrika, LLC, a public health consulting firm, will be responsible for all aspects of the 2010 survey administration including printing and mailing survey materials, processing all completed surveys, analyzing the data, and reporting the results. All fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, Medicare administrative contractors (MACs), and durable medical equipment (DME) MACs will be included in the national administration of this important survey.

Goals of the MCPSS

- Provide feedback from providers to FFS Medicare contractors so they may implement process improvement initiatives
- Establish a uniform measurement of provider satisfaction with contractor performance
- Satisfy the requirements of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) to measure provider satisfaction levels

Contractor performance rated on seven key business functions

Of the 1.2 million Medicare providers (physicians, health care practitioners, and facilities) who provide service for Medicare beneficiaries, approximately 30,000 will be invited to participate in the 2010 MCPSS; the goal is to obtain approximately 400 completed surveys per contractor sample. Those surveyed will be asked to rate their FFS contractor(s) using a scale of 1 to 5 on each of the business functions listed below, with "1" representing "not at all satisfied" and "5" representing "completely satisfied."

Provider participation essential to success of 2010 MCPSS (continued)

The MCPSS offers randomly selected providers and suppliers the opportunity to rate their contractor(s) on the following seven key business functions of the provider-contractor relationship:

1. Provider outreach and education
2. Provider inquiries
3. Claim processing
4. Appeals
5. Medical review
6. Provider enrollment
7. Provider audit and reimbursement.

Annual survey helps improve contractor performance and program efficiency

CMS uses the findings of the annual MCPSS as a benchmark for monitoring future trends and to improve the oversight of contractor performance as well as the efficiency of Medicare program administration. In addition, the survey provides contractors with greater insight into their provider communities and allows them to initiate process improvements based on provider feedback.

Providers chosen to participate in the MCPSS also represent other organizations similar in size, practice type, and geographical location; therefore, the views of every respondent are critical to the success of this important study.

Medicare providers are strongly encouraged to complete and return their surveys promptly. Responses may be submitted via a secure Internet site, a telephone interview, or via mail or fax (if a paper copy of the survey instrument is requested) and will be kept strictly confidential.

How to obtain additional information and MCPSS updates

Data collection reports and study updates will be available, beginning January 2010, at: *https://www.mcpsstudy.org/*, and the final results of the 2010 MCPSS will be accessible via an online reporting system in August 2010. For further information about the 2010 survey, please visit the MCPSS Web page at *http://www.cms.hhs.gov/MCPSS/*.

Source: JSM 10062

Fifth annual Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) is listening and wants to hear from you about the services provided by your Medicare fee-for-service (FFS) contractor that processes and pays your Medicare claims. CMS is preparing to conduct the fifth annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions: provider inquiries, provider outreach & education, claims processing, appeals, provider enrollment, medical review, and provider audit & reimbursement.

The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate in the 2010 MCPSS will be notified starting in January. If you are selected to participate, please take a few minutes to complete this important survey. Providers and suppliers may complete the survey on the Internet via a secure Web site or by mail, fax, or telephone. To learn more about the MCPSS, please visit *http://www.cms.hhs.gov/MCPSS* on the CMS Web site.

Source: CMS PERL 200912-10

Claim crossover process

The Centers for Medicare & Medicaid Services (CMS) reminds all providers, physicians, and suppliers to allow sufficient time for the Medicare crossover process to work before attempting to balance bill their patients' supplemental insurers. As stated in *MLN Matters* article SE0909, available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0909.pdf*, this process takes approximately 15 work days after Medicare's reimbursement is made. Do not balance bill until you have received written confirmation from Medicare that your patients' claims will not be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over. Remittance advice remark codes MA18 or N89 on your Medicare remittance advice (MRA) represent Medicare's intention to cross your patients' claims over. Medicare will continue to issue supplemental notifications to all participating providers, physicians, and suppliers informing them if claims targeted for crossover, as evidenced by MA18 or N89 on the MRA, do not actually result in successful crossover transmissions.

Members of the supplemental payer/Medigap market are noting higher than average receipts of Medicare Part A paper claims that are preceding the arrival of Medicare's 837 institutional COB crossover claims. The arrival of paper claims in advance of Medicare crossover claims is resulting in supplemental payer receipt of duplicate claims. This trend is particularly pronounced among hospital providers within the states of Iowa, Missouri, and Wisconsin.

Current trending suggests that approximately 99 percent of all claims that Medicare identifies for crossover, as cited on your MRA, actually are crossed over by CMS' Coordination of Benefits Contractor (COBC). The remaining percentage error out at the COBC due to HIPAA compliance issues or related data errors, resulting in the provider, physician, or supplier's receipt of a Medicare-generated special notification letter specifying the reason for the claim's failure to cross over. This trending demonstrates that the crossover process is becoming more reliable all the time. CMS requests that providers, physicians, and suppliers ensure that the trend continues.

Source: CMS PERL 200911-08

Special open door forum on 2010 PQRI and eRx Initiative programs

The Centers for Medicare & Medicaid Services (CMS) will host a special open door forum (ODF) on the 2010 PQRI and eRx Incentive programs. This special ODF will focus on a new reporting option, available for the 2010 Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (eRx) Incentive programs, known as the Group Practice Reporting Option (GPRO). Group practices that are interested in participating in the GPRO for PQRI and/or the eRx Incentive program must submit a self-nomination letter to CMS by no later than January 31, 2010. Once a group practice (tax identification number or TIN) is selected to participate in the GPRO for PQRI or eRx, this is the only method of PQRI or eRx reporting available to the group and all individual eligible professionals (national provider identifier or NPI) who bill Medicare under the group's TIN for 2010.

Conference call details

Title: 2010 Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (eRx) Incentive Programs: Group Practice Reporting Option (GPRO)
When: Thursday, January 14, 2010, 3:30-5:00 p.m. (ET)
Dial: 1-800-837-1935
Conference ID: 45243499
Conference call only

Note: TTY Communications Relay Services are available for the hearing impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A relay communications assistant will help.

During this call, CMS will:

- Provide information on the eligibility requirements for participating in the 2010 PQRI GPRO and/or the 2010 eRx Incentive Program GPRO
- Provide instructions for self-nominating to participate in the 2010 PQRI GPRO and/or 2010 eRx Incentive Program GPRO
- Provide an overview of the data submission process for PQRI and the eRx Incentive Program
- Describe the measures for the 2010 PQRI GPRO
- Discuss the criteria for satisfactory reporting of PQRI quality measures under GPRO, and
- Discuss the criteria for successful reporting of the eRx measure under GPRO.

Following the presentation, the telephone lines will be opened to allow participants to ask questions of the CMS subject matter experts as well as of individuals who have experience with the data submission process that will be used for quality reporting under the PQRI GPRO.

The 2010 GPRO for the PQRI and eRx Incentive programs was finalized in the 2010 physician fee schedule final rule with comment period. The final regulation was published in the *Federal Register* on November 25, 2009. To view the entire 2010 PFS final rule with comment period, go to the CMS PQRI Web site *http://www.cms.hhs.gov/PQRI* and click on the "Statute/Regulations/Program Instructions" section. PQRI GPRO information is also available by clicking on the "Group Practice Reporting Option" section of the CMS PQRI Web site. eRx Incentive GPRO information is available by clicking on the "Group Practice Reporting Option" section of the CMS eRx Incentive Program Web site located at *http://www.cms.hhs.gov/erxincentive*.

CMS looks forward to your participation.

Audio-recording

An audio-recording and transcript of this special forum will be posted to the Special Open Door Forum Web site at *http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp* and will be accessible for downloading beginning on or around January 27, 2010.

Additional information

For automatic e-mails of open door forum schedule updates (e-mailing list subscriptions) and to view frequently asked questions, please visit *http://www.cms.hhs.gov/opendoorforums/*.

Thank you for your interest in CMS open door forums.

Source: CMS PERL 200912-20

Accessing 2007 re-run and 2008 PQRI feedback reports

The Centers for Medicare & Medicaid Services (CMS) would like to remind Physician Quality Reporting Initiative (PQRI) participants that there is a "Verify Report Portlet" look-up tool available on the PQRI portal for eligible professionals (EPs) to verify if a 2007 re-run and/or 2008 PQRI feedback report exists for your organization's tax identification number (TIN) or national provider identifier (NPI). The TIN or NPI must be the one used by the EP to submit Medicare claims and valid PQRI quality data codes. This tool is available at *https://www.qualitynet.org/portal/server.pt*.

If a report is available for your organization's TIN or NPI, there are two ways to access 2007 re-run and/or 2008 PQRI feedback reports. You may either call your carrier or A/B Medicare administrative contractor (MAC) provider contact center (MAC) or access via the Individuals Authorized Access to CMS Computer Services (IACS) system. Further instructions are as follows.

Provider contact center

An individual EP may simply call their respective carrier or A/B MAC provider contact center to request confidential 2007 PQRI re-run and/or 2008 PQRI feedback reports that will contain information based on their individual NPI. If an EP is part of a group practice, each EP in the group practice must individually call their respective carrier or A/B MAC provider contact center to request a feedback report based on the individual NPI. To obtain 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 this alternative feedback report request process may be found by accessing special edition *Medicare Learning Network* (*MLN*) article (SE0922)

Accessing 2007 re-run and 2008 PQRI feedback reports (continued)

"Alternative Process for Individual Eligible Professionals to Access Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (E-Prescribing) Feedback Reports." Visit *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0922.pdf* on the CMS Web site.

Individuals Authorized Access to CMS Computer Services (IACS) system

EPs may logon to the secure PQRI portal on QualityNet at *http://www.qualitynet.org/portal/server.pt* to access their feedback report(s) based their TIN, or for a group. Access to the PQRI portal requires registration in the IACS system to obtain a user ID and password.

Important information on updating IACS user accounts and passwords

CMS would like to remind users that the CMS security policy requires IACS passwords to be changed every 60 days. An IACS user who has not changed his or her password in over 60 days will be prompted to do so at the next login attempt.

An IACS user who has not changed his or her password in over 120 days will first be prompted to answer the security questions established at registration. After successfully answering security questions, the user will then be prompted for a password change.

Updating IACS user accounts and passwords is essential to maintaining this access and functionality.

Resources

The IACS account management page is at *https://applications.cms.hhs.gov/category.html?name=acctmngmt*. Click on "My Profile" to login, change your password, or use the "Forgot Password?" option.

If you are having difficulty with IACS registration or disabled accounts, follow the self-service instructions below on how to retrieve your IACS user ID, password, and/or change your IACS password.

Instructions for retrieving your IACS user ID

1. Go to the CMS Applications portal at *https://applications.cms.hhs.gov*.
2. Enter the portal and select the "Forgot Your User ID?" link under the "Account Management" tab. Follow the online instructions.
3. You will receive an e-mail at the e-mail address on record.

Instructions for retrieving your IACS password

1. Go to the CMS Applications Portal at *https://applications.cms.hhs.gov/warning.html*.
2. Enter the portal and select the "My Profile" link under the "Account Management" tab.
3. Enter your user ID.
4. Click on "Forgot Your Password?" button on the login page and follow the online instructions.
5. You will receive a one-time password in an e-mail that will be sent to your e-mail address on record.

Instructions to login and change your IACS password

1. Go to the CMS Applications portal at *https://applications.cms.hhs.gov*.
2. Enter the portal and select the "Account Management" tab.
3. Select the "My Profile" link.
4. Login using your user ID and one-time temporary password.
5. The system will prompt you to change your password.
6. Enter your new password in both the "New Password" and "Confirm New Password" fields and then select the "Change Password" button.
7. The system will take you back to the "My Profile" screen.
8. Log out.

Once you have successfully changed your password, you may login and access your PQRI feedback report(s) on the PQRI portal at *https://www.qualitynet.org/portal/server.pt*.

Additional information

If you are still having difficulty with IACS registration or disabled accounts, please contact the External Users Services (EUS) Help Desk at 1-866-484-8049, TTY/TDD at 1-866-523-4759 (Monday-Friday 7:00 a.m.-7:00 p.m., ET) or via e-mail at *EUSSupport@cgi.com*.

The IACS homepage for the provider/supplier user community, which includes PQRI, is at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site. Provider community users should direct questions or concerns to the External User Services (EUS) Help Desk at 1-866-484-8049, TTY/TDD at 1-866-523-4759 (Monday-Friday 7:00 a.m.-7:00 p.m., ET) or via e-mail at *EUSSupport@cgi.com*.

The PQRI portal is available at *https://www.qualitynet.org/portal/server.pt*. Although the "Forgot Password" link on the PQRI portal sends users to the IACS Web site, IACS and the PQRI portal are two separate Web sites.

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

Users who still have questions or need assistance should contact the QualityNet Help Desk at 1-866-288-8912 (Monday-Friday 7:00 a.m.-7:00 p.m., CT) or *qnetsupport@sdps.org*.

Source: CMS PERL 200911-07

2010 holiday schedule

First Coast Service Options Inc. will observe the following holiday schedule in 2010:

Holiday closures: Florida and U.S. Virgin Islands

Date	Holiday
January 1 (Friday)	New Year's Day
January 18 (Monday)	Martin Luther King Jr. Day
April 2 (Friday)	Good Friday
May 31 (Monday)	Memorial Day
July 5 (Monday)	Independence Day (observed)
September 6 (Monday)	Labor Day
November 25 (Thursday)	Thanksgiving Holiday
November 26 (Friday)	Thanksgiving Holiday
December 23 (Thursday)	Christmas Holiday (observed)
December 24 (Friday)	Christmas Holiday

Holiday closures: Puerto Rico

Date	Holiday
January 1 (Friday)	New Year's Day
January 5 (Tuesday)	Day before Three Kings
January 6 (Wednesday)	Three Kings' Day
January 11 (Monday)	Eugenio Maria de Hostos
January 18 (Monday)	Martin Luther King Jr. Day
March 22 (Monday)	Emancipation Day
April 1 (Thursday)	Good Thursday (Jueves Santo)
April 2 (Friday)	Good Friday (Viernes Santo)
April 16 (Friday)	José de Diego
May 31 (Monday)	Memorial Day
July 5 (Monday)	Independence Day (observed)
July 26 (Monday)	Constitution Day
September 6 (Monday)	Labor Day
November 19 (Friday)	Discovery of Puerto Rico
November 25 (Thursday)	Thanksgiving Holiday
November 26 (Friday)	Thanksgiving Holiday
December 23 (Thursday)	Christmas Holiday (observed)
December 24 (Friday)	Christmas Holiday
December 31 (Friday)	New Year's Eve

Additional call center closures: Florida, Puerto Rico, and the U.S. Virgin Islands

Provider contact centers will be closed in observance of the following additional federal holidays:

Date	Holiday
February 15 (Monday)	Presidents Day
October 11 (Monday)	Columbus Day
November 11 (Thursday)	Veteran's Day

Interactive voice response (IVR): All providers

Toll-free telephone numbers:

Part A: 877-602-8816

Part B: 877-847-4992

Availability of specific claims information:

Part A: 7:00 a.m.-7:00 p.m., ET (Monday through Friday) and 7:00 a.m.-3:00 p.m., ET (Saturday)

Part B: 7:00 a.m.-6:30 p.m., ET (Monday through Friday) and 7:00 a.m.-3:00 p.m., ET (Saturday).

Note: Recorded information on current Medicare issues is available 24 hours a day, 7 days a week. Additional information is available at *http://medicare.fcso.com/IVR/* . FCSO is committed to continuous improvement and providing the best service for our customers.

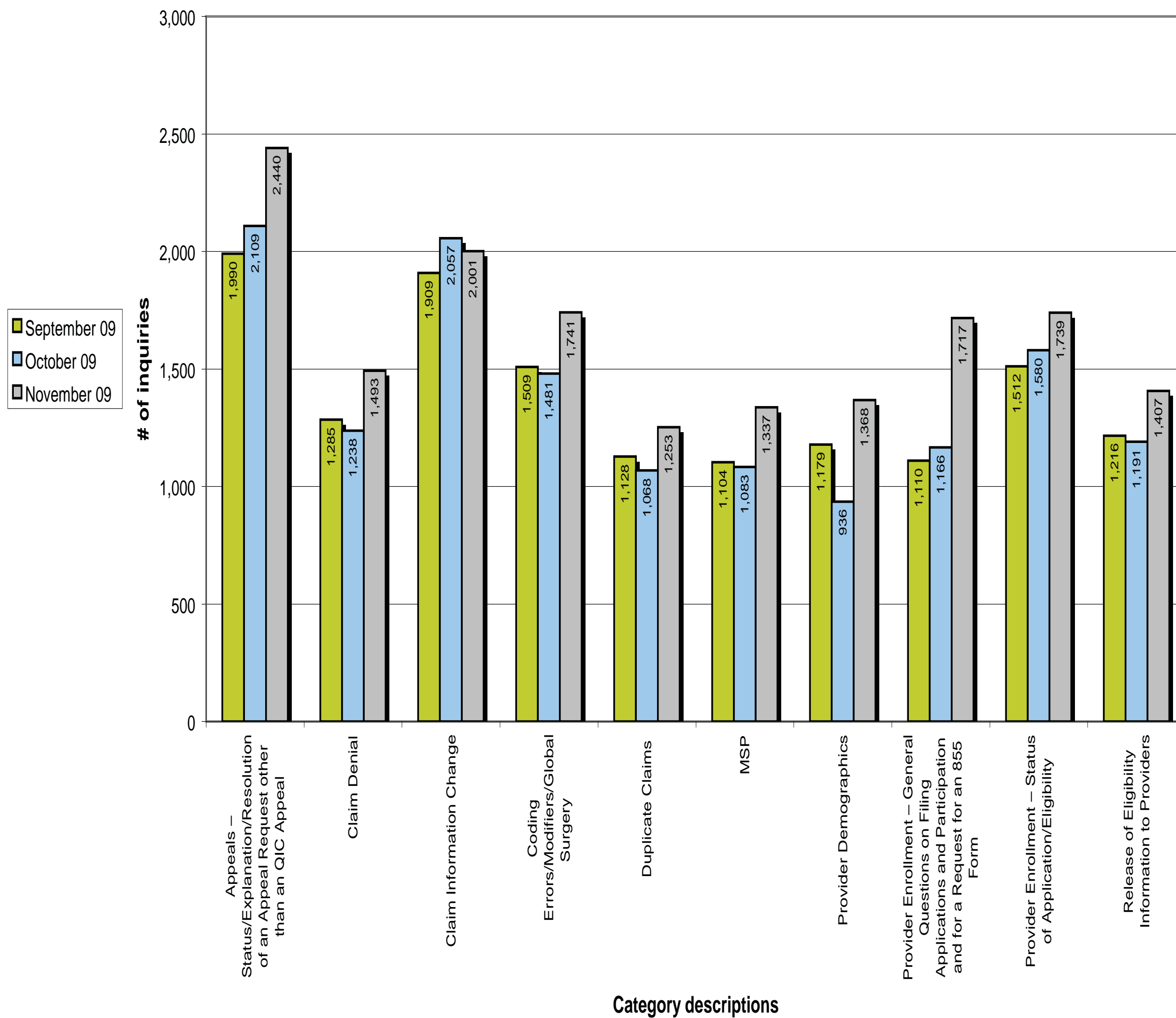
New Feedback page

One of the trends identified in the 2009 Medicare Contractor Provider Satisfaction Survey (MCPSS) was our providers' preference to have more ways to communicate with us. Our new Feedback page offers our customers the convenience of a central "hub" for communication and includes three interactive feedback, available at *http://medicare.fcso.com/feedback/*.

Top inquiries, denials, and return unprocessable claims for September–November 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 September–November 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*.

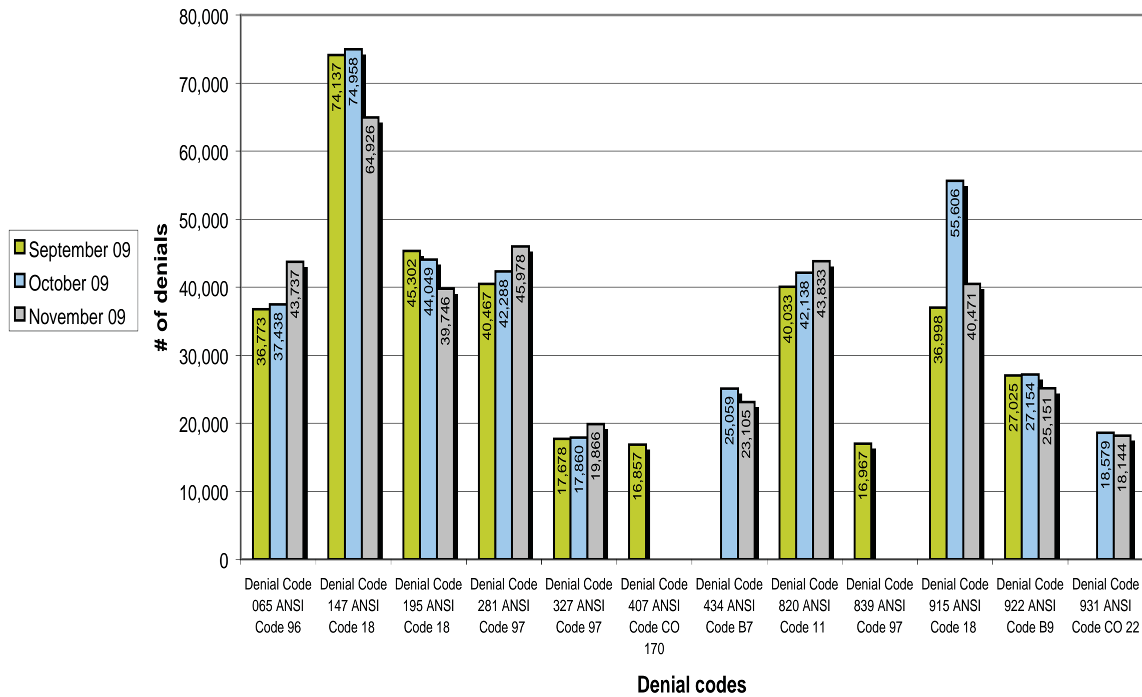
Florida Part B top inquiries for September–November 2009

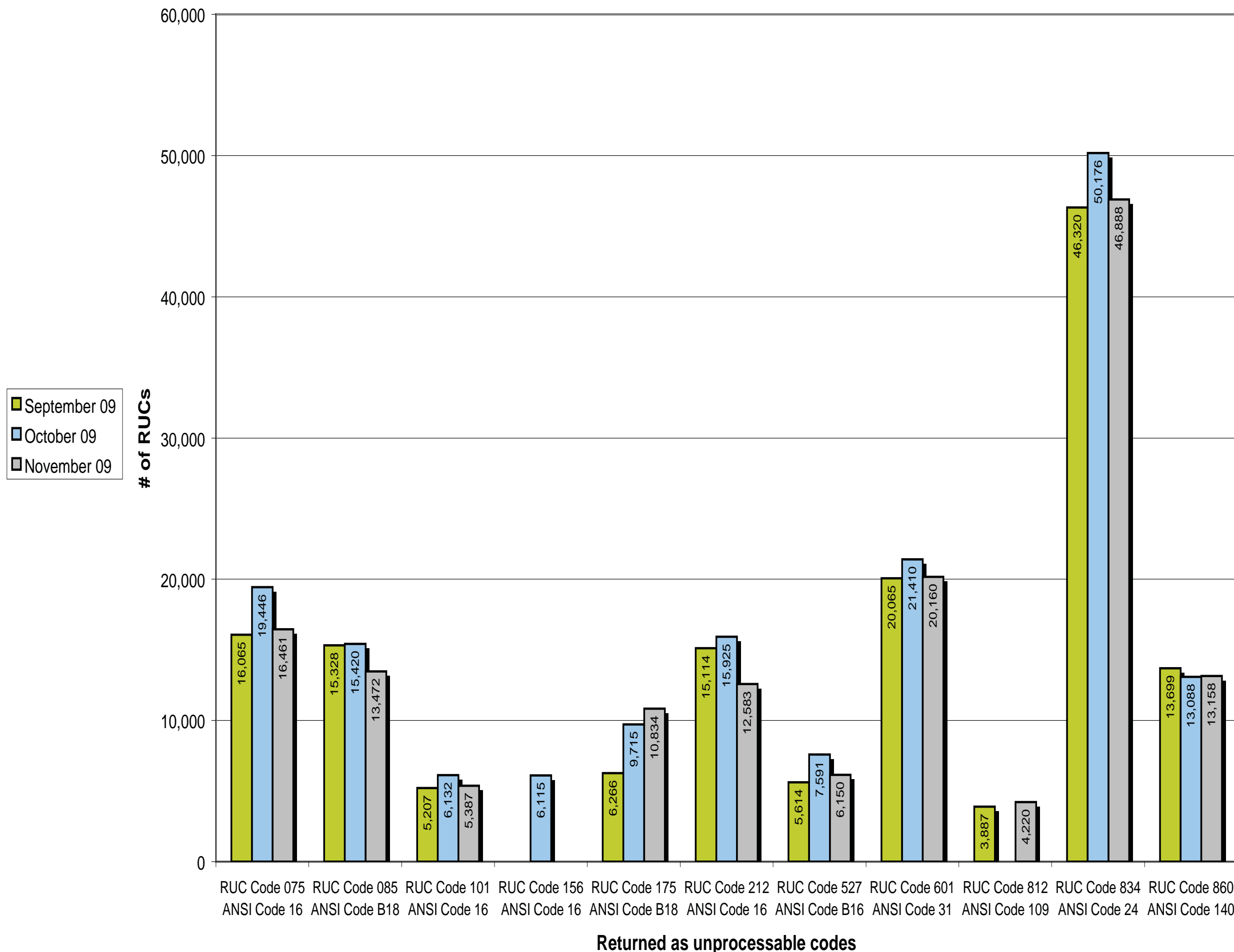


Find LCDs faster on our new medical coverage page

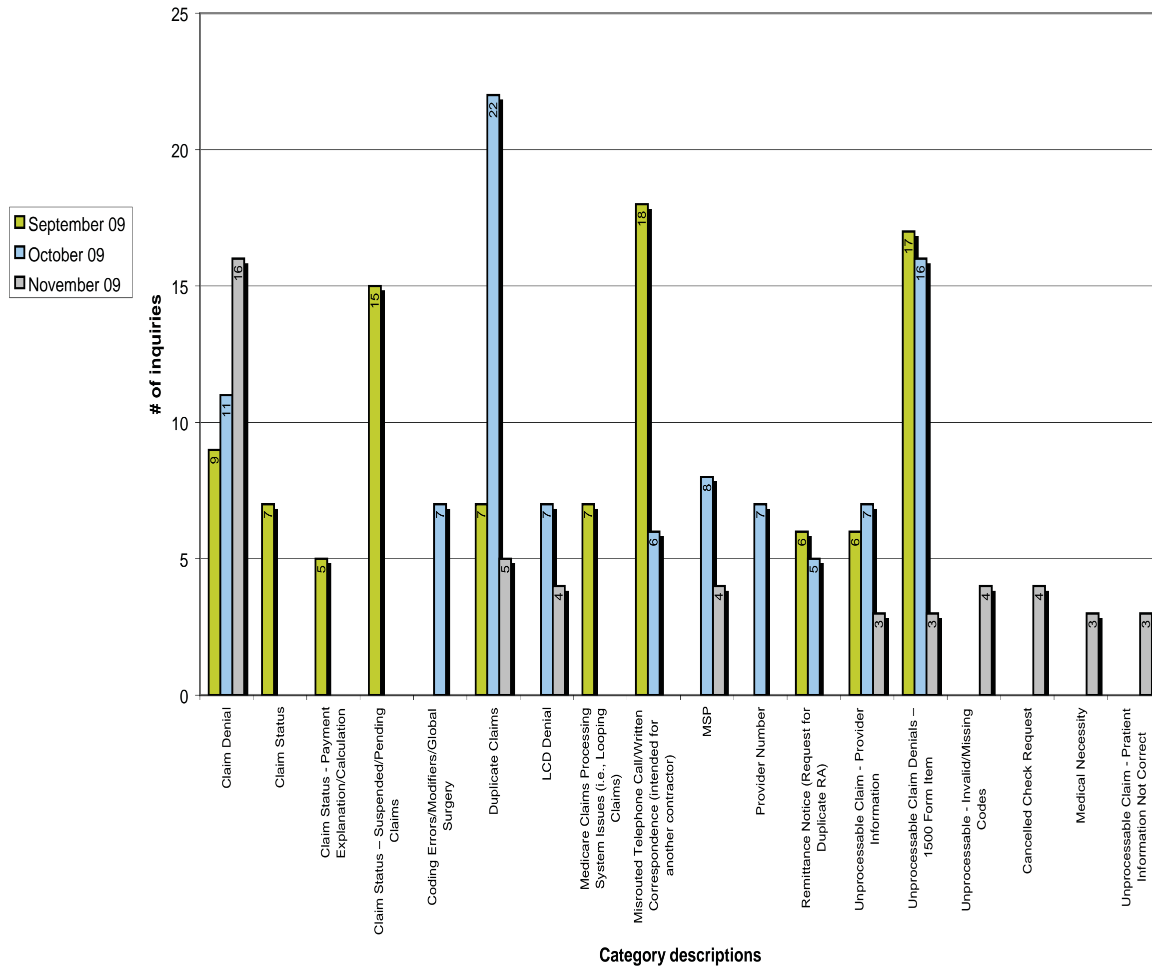
Looking for an LCD? Try the new integrated-search features on our redesigned medical coverage page. You may now search for local coverage determinations (LCDs) by procedure name or code as well as by L number. With its new features and user-friendly layout, you'll also find the medical coverage news 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–November 2009 (continued)





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



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.fcso.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.

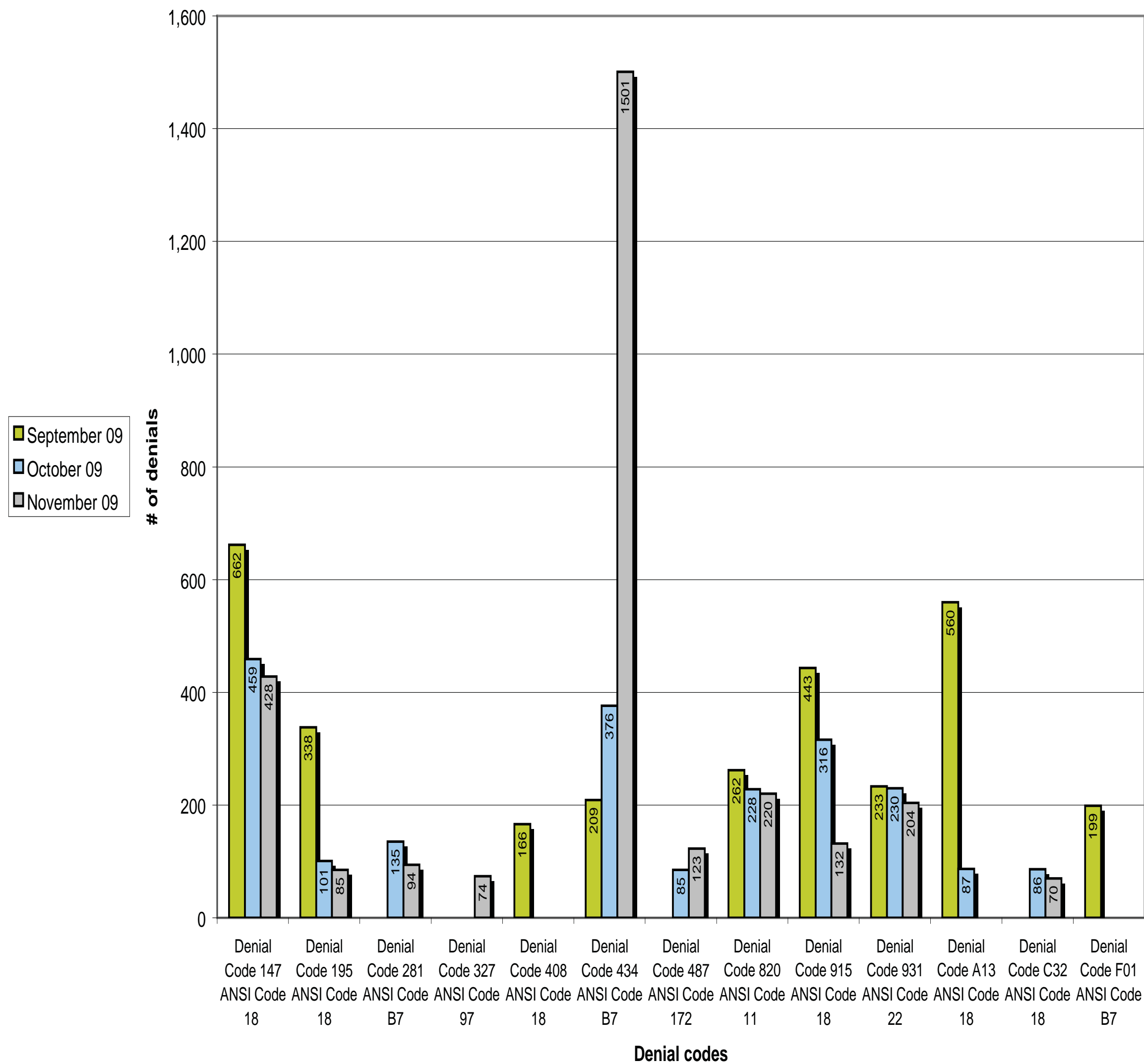
The following are minor clerical errors or omissions that may be corrected and resubmitted:

- 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–November 2009 (continued)

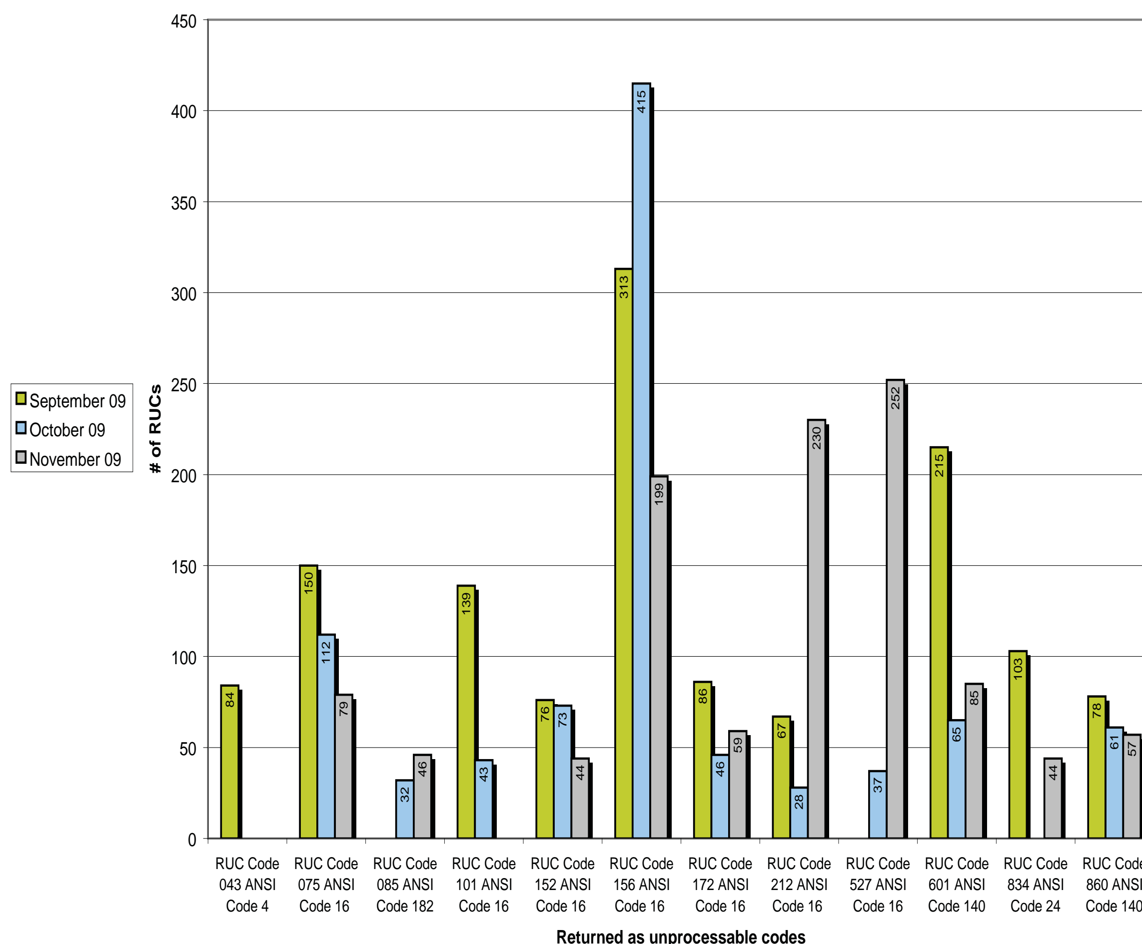


Use the PDS report to improve your Medicare billing operations

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–November 2009 (continued)

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for September–November 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/prospmedicarefeesvcpmtgen/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

Intravitreal bevacizumab (Avastin®) – article correction

LCD ID number: L29959 (Florida)
LCD ID number: L29961 (Puerto Rico/U.S. Virgin Islands)

This information is a correction to an article previously published in the October 2009 Medicare B Update! (page 40)

The local coverage determination (LCD) for intravitreal bevacizumab (Avastin®) was last revised on October 1, 2009, in accordance with the Centers for Medicare & Medicaid Services (CMS) Transmittal 1810, change request 6617, dated September 1, 2009.

Correction

Per instructions received from the Centers for Medicare & Medicaid Services (CMS), HCPCS code Q2024 (Injection, bevacizumab, 0.25 mg) should no longer be reported for services rendered on or after October 1, 2009. Therefore, the "CPT/HCPCS Codes" section of the LCD has been revised to delete HCPCS code Q2024 (Injection, bevacizumab, 0.25 mg) and replace it with HCPCS code J3490 (unclassified drugs).

Accordingly, the LCD "Coding Guidelines" attachment has also been revised to indicate HCPCS code J3490 (unclassified drugs) should be billed for intravitreal bevacizumab, along with *CPT* code *67028* (*Intravitreal injection of a pharmacologic agent*). In item 19 of CMS-1500 or its electronic equivalent "Intravitreal bevacizumab" and the "dosage" should be entered. The administration of the intravitreal injection of bevacizumab (Avastin®) must be billed on the same claim as the drug.

The LCD "Coding Guidelines" attachment has been revised to delete the following statement:

HCPCS code Q2024 (Injection, bevacizumab, 0.25 mg) should be used to appropriately describe smaller doses that total less than 10 mg of bevacizumab (Avastin®) and that this smaller dose should be billed for the Food and Drug Administration (FDA) approved treatment of metastatic colorectal cancer (i.e., ICD-9-CM codes 153.0-153.9, 154.0-154.3, 154.8, 197.5).

Effective date

This LCD revision is effective for claims processed **on or after November 25, 2009 for services rendered on or after October 1, 2009**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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New LCDs

G0430: Qualitative drug screening – new LCD

LCD ID number: L30574 (Florida/Puerto Rico/U.S. Virgin Islands)

A qualitative drug screen reports the presence of a drug in a blood or urine specimen. A blood or urine sample may be used. Urine is usually the preferred specimen type due to its sensitivity to many common drugs compared to blood specimens. A qualitative drug screen may be indicated when the history is unreliable, with a multiple-drug ingestion, with a patient in delirium or coma, for the identification of specific drugs, and to indicate when antagonists may be used.

This local coverage determination (LCD) was developed to identify indications and limitations of coverage, documentation requirements, utilization guidelines, ICD-9-CM codes and coding guidelines for qualitative drug screening.

Effective date

This new LCD is effective for services rendered **on or after January 25, 2010**. 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.

01991: Monitored anesthesia care for certain interventional pain services – new LCD

LCD ID number: L30570 (Florida, Puerto Rico & U.S. Virgin Islands)

Monitored anesthesia care (MAC) is a specific anesthetic service for a diagnostic or therapeutic procedure. This new LCD specifically addresses the use of MAC with certain interventional pain management procedures (*CPT* codes *20550, 20551, 20552, 20553, 27096, 62310, 62311, 64479, 64480, 64483, 64484, 64490, 64491, 64492, 64493, 64494*, and *64495*) where current practice supports that local anesthesia alone, inclusive of these procedures, is typical. For certain patients, the addition of mild sedation (physician service not separately payable) or moderate (conscious) sedation (*CPT* codes *99143-99150*), may be part of these minimally invasive procedures. As outlined in this LCD, the addition of MAC, a second physician service (or other qualified anesthesia provider service), to the episode of care for these services must meet, but not exceed, the patient's medical need and be furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition.

The specific indications and limitations of coverage outlined in the LCD are represented by the following *CPT* codes:

01991 *Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position*

01992 *Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position*

Medicare will consider MAC medically reasonable and necessary when the patient's condition requires the presence of a second physician represented by an anesthesiologist or qualified anesthesia provider in addition to the provider performing the procedure. The patient's medical condition or nature of the procedure must require the presence of an anesthesiologist or qualified anesthesia provider to administer the sedation if utilized, to manage the airway and vital signs, and to continually assess the patient for clinical problems and treat appropriately to ensure patient safety and comfort. The presence of an underlying condition alone or a stable treatable condition is not sufficient evidence that monitored anesthesia care is medically reasonable and necessary. In addition to indications and limitations, the LCD also includes documentation requirements, utilization guidelines and a "Coding Guidelines" attachment.

Medicare pays for reasonable and necessary MAC services on the same basis as other anesthesia services. When the patient's condition does not meet medical necessity as outlined in the indications and limitations of this LCD, the provider must append the modifier GA/GZ, as appropriate, along with the modifier QS. This will result in the appropriate denial of the services for the interventional pain management services as outlined above. MAC claims with the required modifier QS without the modifier GA/GZ should only be billed when MAC clearly meets the reasonable and necessary criteria for interventional pain injection procedures outlined in this LCD.

Effective date

This new LCD is effective for services rendered **on or after January 25, 2010**. 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.

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23700: Manipulation under anesthesia (MUA) – new LCD

LCD ID number: L30572 (Florida/Puerto Rico/U.S. Virgin Islands)

Manipulation under anesthesia (MUA) is a non-invasive procedure which combines manual manipulation of a joint with a general anesthetic. Patients who are unable to tolerate manual procedures due to pain, spasm, muscle contractures, or guarding may benefit from the use of general anesthesia prior to manipulation. Because the patient's protective reflex mechanism is absent under anesthesia, manipulation using a combination of specific short lever manipulations, passive stretches, and specific articular and postural kinesthetic maneuvers, in order to break up fibrous adhesions and scar tissue around the joint and surrounding tissue, is made less difficult. MUA should only be performed on select patients who have failed to respond to conservative therapy.

This local coverage determination (LCD) has been developed to provide indications and limitations of coverage and/or medical necessity, CPT/HCPCS codes, ICD-9 codes that support medical necessity, documentation requirements, utilization guidelines, and coding guidelines for MUA.

Effective date

This new LCD is effective for services rendered **on or after January 25, 2010**. 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.

Revisions to LCDs

BOTULINUM TOXINS: Botulinum toxins – revision to the LCD

LCD ID number: L29088 (Florida)
LCD ID number: L29103 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was last revised on April 6, 2009. Since that time, there have been several revisions to the LCD.

- The ”Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised in accordance with the U.S. Food and Drug Administration (FDA), to update the established drug names for “botulinum toxin type A” to “onabotulinumtoxinA” and to update the established drug name for “botulinum toxin type B” to “rimabotulinumtoxinB”. The LCD “Coding Guidelines” attachment has also been revised accordingly.

  Effective date

  The above revisions to the LCD are effective for services rendered **on or after the FDA approval date of July 31, 2009**.

- Botulinum toxin “abobotulinumtoxinA (Dysport™)” was approved by the FDA on April 29, 2009, for the treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain in both toxin-naïve and previously treated patients. In this regard, a new section has been added under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, “FDA indication for Dysport™”. The “*CPT*/HCPCS Codes” section of the LCD has been revised to include HCPCS code J3590 (Unclassified biologics) and the “ICD-9 Codes that Support Medical Necessity” section of the LCD has been revised to add a new section “HCPCS code J3590 (abobotulinumtoxinA [Dysport™])” and applicable ICD-9-CM codes 333.83 (Spasmodic torticollis) and 723.5 (Torticollis, unspecified). The “Sources of Information and Basis for Decision” section of the LCD has also been updated, as well as the LCD “Coding Guidelines” attachment to include coding and billing information for abobotulinumtoxinA (Dysport™).

  Effective date

  This above revision to the LCD is effective for services rendered **on or after the FDA approval date of April 29, 2009.**

- The LCD “Coding Guidelines” attachment has also been revised to delete *CPT* codes *95860, 95869* and *95870* from the list of electromyography guidance codes that may be covered if the physician has difficulty in determining the proper injection site.

  Effective date

  The above revisions to the LCD ”Coding Guidelines” attachment are effective for services rendered **on or after November 17, 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.

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G0179: Physician certification and recertification of home health services – revision to the LCD

LCD ID number: L29259 (Florida)
LCD ID number: L29467 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for physician certification and recertification of home health 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 has been revised under the "Documentation Requirements" section of the LCD to clarify that each review of a patient's plan of care must contain the signature of the physician re-certifying the home health services as well as the date of review.

Effective date

This LCD revision is effective for claims processed **on or after November 24, 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.

IDTF: Independent diagnostic testing facility (IDTF) – revision to the LCD

LCD ID number: L29195 (Florida)
LCD ID number: L29330 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was last revised on June 30, 2009. Since that time, the "Required Characteristics of an IDTF" section of the LCD has been revised to delete the following language which is no longer located in/supported by the Centers for Medicare & Medicaid Services (CMS) Manual System, *Medicare Program Integrity Manual*, Pub 100-08, Chapter 10, Section 4.19: "However, if a substantial portion of the entity's business involves the performance of diagnostic tests, the diagnostic testing services may constitute a sufficiently separate business to warrant enrollment as an IDTF (It will be considered "independent" for purposes of enrollment). In such a case, the entity can be enrolled as a physician or a group practice of physicians, but must also enroll as an IDTF. The physician or group can bill for professional fees and the diagnostic tests they perform on their own patients using their billing number; the practice must bill as an IDTF for diagnostic tests furnished to Medicare beneficiaries who are not patients of the practice".

In addition, the "Supervising Physician and Interpreting Physician Qualification Requirements" column of the "Credentialing Matrix" section of the LCD "Coding Guidelines" attachment has been revised for *CPT*/HCPCS codes *95805, 95807, 95808, 95810, 95811,* G0398, G0399 and G0400 to read: "ABMS Physician Certified by ABSM or ABMS: Sleep Medicine OR ABFM, ABIM, ABOto, or ABPN: Sleep Medicine Subspecialty Certification." The "Supervising Physician and Interpreting Physician Qualification Requirements" column of the "Credentialing Matrix" section of the LCD "Coding Guidelines"' attachment has also been revised to add "OR ABPN: Neurologist with ASN or UCNS: Neuroimaging Subspecialty Certification" for the following *CPT* codes: *70010, 70015, 70030, 70100, 70110, 70120, 70130, 70134, 70140, 70150, 70160, 70170, 70190, 70200, 70210, 70220, 70240, 70250, 70260, 70328, 70330, 70332, 70336, 70355, 70360, 70370, 70371, 70373, 70380, 70390, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 72010, 72020, 72040, 72050, 72052, 72069, 72070, 72072, 72074, 72080, 72090, 72100, 72110, 72114, 72120, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72170, 72190, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 72200, 72202, 72220, 72240, 72255, 72265, 72270, 72275, 72285, 72295, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75774, 75860, 75870, 75872, 75880, 76080, 76350, 76376, 76377, 76380, 76390, 78600, 78601, 78605, 78606, 78607, 78608, 78610, 78630, 78635, 78645, 78647, 78650, 78660, 78811*,and *78814*.

Effective date

This LCD revision is effective for services rendered **on or after December 8, 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.

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Intravitreal Bevacizumab (Avastin®) – revision to the LCD

LCD ID number: L29959 (Florida)
LCD ID number: L29961 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for intravitreal bevacizumab (Avastin®) was last revised on October 1, 2009. Since that time, there have been several revisions to this LCD.

- The "Indications" section under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to indicate the anticipated dosage is 1.25 mg (0.05ml) or less, on a yearly average of every four to six weeks, as needed, by aseptic intravitreal injection into affected eye. Treatment continues on a monthly basis until the abnormal neovascularization, vitreous hemorrhage, macular edema, subretinal fluid, and/or pigment epithelial detachment is resolved. In addition, the "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add ICD-9-CM code 362.29 (Other nondiabetic proliferative retinopathy) and the statement under the list of ICD-9-CM codes has been revised to indicate: * Per ICD-9-CM coding manual, ICD-9-CM code 362.07 requires a dual diagnosis. ICD-9-CM code 362.07 must be used with a code for diabetic retinopathy (ICD-9-CM codes 362.01-362.06). The third bullet under the "Documentation Requirements" section of the LCD has also been revised to indicate: Test results to firmly establish diagnosis by fluorescein angiogram or optical coherence tomography (OCT) for individuals with proliferative diabetic retinopathy, diabetic macular edema, retinal neovascularization, central retinal vein occlusion, venous tributary (branch) occlusion, exudative macular degeneration, and retinal edema. Tests to confirm the established diagnosis are not required for rubeosis iridis, or in the case of a vitreous hemorrhage in which the neovascularization cannot be visualized. And the "Sources of Information and Basis for Decision" section of the LCD has also been updated.

  Effective date
  The above revisions to the LCD are effective for services rendered **on or after December 4, 2009**.

- The *CPT*/HCPCS section of the LCD has been revised to add HCPCS code C9399 for use by ambulatory surgical centers (ASCs). The "Coding Guidelines" attachment has also been revised to add coding and billing information for ASCs. These revisions include: Effective for services rendered on or after January 1, 2008, in an Ambulatory Surgical Center (ASC), HCPCS code C9399 should be billed for intravitreal bevacizumab, along with *CPT* code *67028* (*Intravitreal injection of a pharmacologic agent*). In item 19 of CMS-1500 or its electronic equivalent "Intravitreal bevacizumab and the dosage" should be entered. The administration of the intravitreal injection of bevacizumab (Avastin®) must be billed on the same claim as the drug.

  Effective date
  The above revisions to the LCD and "Coding Guidelines" attachment are effective for claims processed **on or after December 4, 2009, for services rendered on or after January 1, 2008**.

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.

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

J9025: Azacitidine (Vidaza®) – revision to the LCD

LCD ID number: L29063 (Florida)
LCD ID number: L29081 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for azacitidine (Vidaza®) 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 reconsideration request was evaluated and the following revisions were made to the LCD:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for azacitidine (Vidaza®), acute myeloid leukemia was added as an off-label indication;
- Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, the diagnosis code range 205.00-205.02 was added to the LCD;
- 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 December 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.

VISCO: Viscosupplementation therapy for knee – revision to the LCD

LCD ID number: L29307 (Florida)
LCD ID number: L29408 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised on July 16, 2009. Since that time, it has come to the attention of First Coast Service Options Inc. (FCSO) that providers are using more than one viscosupplementation agent within the same course of treatment. Therefore, the "Utilization Guidelines" section of the LCD was revised to clarify that once a course of treatment has been initiated with one agent, it should be completed with the same agent.

Effective date

This LCD revision is effective for claims processed **on or after January 1, 2010**. 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.

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78460: Cardiovascular nuclear imaging studies – revision to the LCD

LCD ID number: L29093 (Florida)
LCD ID number: L29108 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cardiovascular nuclear imaging studies was last revised on October 1, 2009. Since that time, the "ICD-9 Codes that Support Medical Necessity" section of the LCD for *CPT* codes *78460, 78461, 78464, 78465, 78478* and *78480* has been revised to add ICD-9-CM code V58.69 (Long-term [current] use of other medications). ICD-9-CM code V58.69 should be used as a secondary code only and should not be billed as the primary diagnosis. The "Documentation Requirements" section of the LCD has also been revised to indicate: The medical record must document when significant resting electrocardiogram (ECG) abnormalities are present, or a medication is being used and cannot be withdrawn, that would interfere with the interpretation of a stress ECG, resulting in the selection of a myocardial perfusion study.

Effective date

This LCD revision is effective for services rendered **on or after December 8, 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.

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95004: Allergy tests – revision to the LCD

LCD ID number: L29057 (Florida)
LCD ID number: L29075 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for allergy tests was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised as follows:

- A new section, "Limitations" has been added under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.
- A list of tests that are considered to be experimental and investigational for the diagnosis and management of IgE-mediated allergic diseases has been added to the "Limitations" section under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.
- A new section, "CPT Codes that Do Not Support Medical Necessity" has been added to the LCD and includes the following *CPT* codes: *83516, 84600, 86001, 86140, 86160, 86161, 86162, 86332, *86343, 86485, *86628, 88342, 88346, 95065, *95831, *95832, *95833* and **95834* (* Indicates services which are also listed in The List of Medicare Noncovered Services LCD).
- The "ICD-9 Codes that Do Not Support Medical Necessity" section of the LCD has been revised to indicate that the ICD-9-CM codes in this section are also noncovered for *CPT* codes *86160, 86161*, and *86162*.
- The "Documentation Requirements" section of the LCD has been revised to indicate that the medical record documentation must clearly indicate the testing methodology used.
- The "Sources of Information and Basis for Decision" section of the LCD has been updated.

Effective date

This LCD revision is effective for services rendered **on or after January 25, 2010**. 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.

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2010 HCPCS local coverage determination changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2010 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

LCD Title	Changes
BOTULINUM TOXINS Botulinum Toxins	Descriptor change for HCPCS codes J0585 and J0587. Changed HCPCS code J3590 to HCPCS code J0586. Deleted HCPCS code C9399 from the "Coding Guidelines" attachment.
IDTF Independent Diagnostic Testing Facility (**Coding Guidelines only**)	Deleted *CPT* codes *0067T, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T, 0151T, 51772, 51795, 75790, 78460, 78461, 78464, 78465, 78478, 78480*, and *92569*. Added *CPT* codes *51727, 51728, 51729, 74261, 74262, 75565, 75572, 75573, 75574, 75791, 78451, 78452, 78453, 78454, 92540, 92550, 92570*, and *95905*.
Intravitreal Bevacizumab (Avastin®)	Changed HCPCS code C9399 to HCPCS code C9257
J0800 Corticotropin	Deleted HCPCS code J0835. Added HCPCS codes J0833 and J0834.
J7187 Hemophilia Clotting Factors	Descriptor change for HCPCS code J7192.
J9170 Docetaxel (Taxotere®)	Deleted HCPCS code J9170. Added HCPCS code J9171. Changed Contractor's Determination Number to J9171.

2010 HCPCS local coverage determination changes (continued)

LCD Title	Changes
NCSVCS The List of Medicare Non-covered Services	Descriptor change for *CPT* code *95806*. Deleted *CPT* codes *0144T*, 0170T**, and *0194T** from the "Local Noncoverage Decisions" section of the Local Coverage Determination (LCD). Added HCPCS code L8692 and *CPT* code *22899* (*Percutaneous intradiscal annuloplasty, any method other than electrothermal*) to the "National Non-coverage Decisions" section of the "Coding Guidelines" attachment. Added *CPT* codes *0205T*, 0206T*, 0207T*, 0208T, 0209T, 0210T, 0211T, 0212T, 0213T*, 0214T*, 0215T*, 0216T*, 0217T*, 0218T*, 0219T*, 0220T*, 0221T*, 0222T*, 46707*, 84145**, and *83987** to the "Local Noncoverage Decisions" section of the LCD.
VISCO Viscosupplementation Therapy For Knee	Deleted HCPCS code J7322. Removed HCPCS codes J3590 and C9399. Added HCPCS code J7325.
22520 Percutaneous Vertebroplasty	Descriptor change for *CPT* codes *22520, 22521, 22522, 72291*, and *72292*.
22523 Kyphoplasty	Descriptor change for *CPT* codes *72291* and *72292*.
27096 Sacroiliac Joint Injection	Descriptor change for *CPT* code *77003*.
36470 Treatment of Varicose Veins of the Lower Extremity	Descriptor change for *CPT* code *37760*. Added *CPT* code *37761*.
43644 Surgical Management of Morbid Obesity	Changed *CPT* code *43999* (*Laparoscopic sleeve gastrectomy*) to *CPT* code *43775*.
64470 Paravertebral Facet Joint Blocks	Deleted *CPT* codes *64470, 64472, 64475*, and *64476*. Added *CPT* codes *64490, 64491, 64492, 64493, 64494*, and *64495*. Changed contractor's determination number to *64490*.
64561 Sacral Neuromodulation (**Coding Guidelines only**)	Descriptor change for HCPCS code L8680.
64622 Destruction of Paravertebral Facet Joint Nerve(s) (**Coding Guidelines only**)	Deleted *CPT* codes *64470, 64472, 64475*, and *64476*. Added *CPT* codes *64490, 64491, 64492, 64493, 64494*, and *64495*.
0145T Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries	Deleted *CPT* codes *0145T, 0146T, 0147T, 0148T, 0149T, 0150T*, and *0151T*. Added *CPT* codes *75571, 75572, 75573*, and *75574*. Deleted *CPT* code *0144T* from the "Coding Guidelines" attachment. Changed contractor's determination number to *71275*.
0067T Computed Tomographic Colonography	Deleted *CPT* code *0067T*. Added *CPT* codes *74261* and *74262*. Deleted *CPT* code *0066T* from the "Coding Guidelines" attachment. Added *CPT* code *74263* to the "Coding Guidelines" attachment as informational only and noted that it is noncovered. Changed contractor's determination number to *74261*.
78460 Cardiovascular Nuclear Imaging Studies	Deleted *CPT* codes *78460, 78461, 78464, 78465, 78478*, and *78480*. Added *CPT* codes *78451, 78452, 78453*, and *78454*. Changed contractor's determination number to *78451*.

2010 HCPCS local coverage determination changes (continued)

LCD Title	Changes
85692 Syphilis Test	Descriptor change for *CPT* codes *86592* and *86593*. Deleted *CPT* code *86781*. Added *CPT* code *86780*.
92541 Vestibular Function Tests	Added *CPT* code *92540*. Changed contractor's determination number to *92540*.
93701 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance	Descriptor change for *CPT* code *93701*.
95860 Electromyography and Nerve Conduction Studies	Added *CPT* code *95905*.

*Investigational

First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Source: CMS Pub 100-04, Transmittal 1813, CR 6620

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Additional Information

Teletherapy radiation treatment guidance

Currently, there are several technologies that address guidance for the delivery of radiation therapy. The utility of inter-fraction (usually imaging) vs. intra-fraction guidance with intensity modulated radiation therapy (IMRT) or other delivery systems is emerging and more information is being published. First Coast Service Options Inc. (FCSO) currently does not have a positive coverage statement for the various systems. FCSO sees no basis for the payment of claims for multiple guidance procedures for the same date of treatment delivery. After review of the literature and discussions with some experts in the field, it seems reasonable to reimburse for one procedure for guidance/localization/tracking if the service is reasonable and necessary for the given episode of care.

Therefore, when a radiation treatment guidance code is applicable (not included in the treatment delivery service), FCSO, will consider only one of the following procedure codes for possible coverage and payment on a given treatment delivery date of service. As always, the medical record documentation must support that the service is reasonable and necessary for that patient's episode of care.

76950 *Ultrasonic guidance for placement of radiation therapy fields*

77014 *Computed tomography guidance for placement of radiation therapy fields*

77280 *Therapeutic radiology simulation-aided field setting; simple*

77399 *Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services*

77421 *Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*

0197T *Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g. 3D positional tracking, gating, 3D surface tracking), each fraction of treatment.*

Of note, *CPT* codes *76950*, *77014*, and *77421* are image guided radiation therapy (IGRT) codes and have pricing in outpatient prospective payment system (OPPS) and the Medicare Carrier System (MCS). *CPT* category III code *0197T* is an emerging technology code that is contractor priced in the MCS. It describes the Calypso® technology or other services that would meet the descriptor. The unlisted *CPT* code *77399* and *CPT* code *77280* are broad descriptors. It is recommended that *CPT* code *77280* not be used for guidance with treatment delivery.

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Educational Resources

Upcoming provider outreach and education event

January 2010 – February 2010

HIPAA version 5010

When: January 21
Time: 11:30 a.m.-1:00 p.m.
Focus: Florida, Puerto Rico, and the U.S. Virgin Islands

2010 E/M series

When: February 18
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.fcso.com/Education_resources/*, or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events.

Available 2010 Physician Quality Reporting Initiative educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the following 2010 Physician Quality Reporting Initiative (PQRI) educational products available on the PQRI Web page at http://www.cms.hhs.gov/PQRI:

2010 PQRI Quality Measure List – this document identifies the 179 quality measures (this includes 175 individual quality measures and the four measures in the back pain measures group, which are not reportable as individual PQRI quality measures) selected for the 2010 PQRI.

2010 PQRI Quality Data Code (QDC) categories – a table that outlines, for each measure, each QDC that should be reported for a corresponding quality action performed by the individual EP as noted in the measures specification. This determines how each code will be used when calculating performance rates. This also clarifies those measures that require two or more QDCs to report satisfactorily. Insufficiently reporting the QDCs (as specified in the 2010 PQRI measure specifications) will result in invalid reporting.

2010 Single Source Code Master – this file includes a numerical listing of all codes included in 2010 PQRI for incorporation into billing software.

2010 PQRI Measure Specifications Manual for Claims and Registry; Reporting of Individual Measures and Release Notes – this zip file contains two documents, which are the authoritative documents that describe the following:

- The 2010 measure specifications (including codes and reporting instructions) for the 175 individual PQRI quality measures for claims or registry-based reporting
- Changes from the 2009 PQRI measure specifications in the form of release notes delineated by measure number.

2010 PQRI Implementation Guide – provides guidance about how to implement 2010 PQRI claims-based reporting of measures to facilitate satisfactory reporting of quality data codes by EPs.

2010 PQRI Measures Groups Specifications Manual and Release Notes – measures group specifications that are different from those of the individual measures that form the group. The specifications and instructions for measures group reporting are, therefore, provided in a separate manual. This zip file contains two documents, which are the authoritative documents that describe the following:

- The 2010 measures groups specifications (including codes and reporting instructions) for the 13 PQRI measures groups for claims or registry-based reporting
- Changes from the 2009 PQRI Measures Groups Specifications Manual in the form of release notes.

Getting Started with 2010 PQRI Reporting of Measures Groups – provides guidance about implementing the 2010 PQRI measures groups.

2010 PQRI Measure Applicability Validation Process for Claims-Based Reporting of Individual Measures – provides guidance for those eligible professionals who satisfactorily submit quality-data codes for fewer than three PQRI measures and how the measure-applicability validation process will determine whether they should have submitted QDCs for additional measures.

2010 PQRI Measure - Applicability Validation Process Release Notes – the release notes for the changes occurring for the 2010 PQRI Measure Applicability Validation Process (MAV).
2010 Measure-Applicability Validation Process Flow Chart – a chart that depicts the Measure Applicability Validation Process (MAV)

Group Practice Reporting Option (GPRO) Requirements for Submission of 2010 PQRI Data – provides guidance on how a group practice can self-nominate to participate in the GPRO for 2010 data submission.

2010 PQRI GPRO Disease Modules and Preventive Care Measures – this document contains a list of the 2010 PQRI GPRO Measures.

2010 PQRI GPRO Narrative Measure Specifications – this document contains descriptions of the 2010 PQRI GPRO measures.

Registry Requirements for Submission of 2010 PQRI Data on Behalf of Eligible Professionals – this document describes the high-level requirements for a registry to qualify to submit under the registry-based reporting alternatives for 2010. This document also outlines how a registry can become qualified for 2010 data submission.

To access the 2010 PQRI educational products, visit *http://www.cms.hhs.gov/PQRI/02_Spotlight.asp#TopOfPage*. Once on the *Spotlight* page, view the listing of educational products and the corresponding Web pages where they may be found.

Further information on the 2010 PQRI Program may be found in the final 2010 Medicare physician fee schedule rule with comment period (74 FR 61788 through 61861) that was published in the *Federal Register* on October 30, 2009. The final rule may be found on the Physician Quality Reporting Initiative Web page at *http://www.cms.hhs.gov/PQRI* under the *Statute/Regulations/Program Instructions* section.

Reporting for the 2010 PQRI begins January 1, 2010. Please note there is no need to sign up or pre-register in order to participate.

Source: CMS PERL 200912-16

Available 2010 Electronic Prescribing Incentive educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the following 2010 Electronic Prescribing Incentive (eRx) Program educational products available on the eRx Web page at *http://www.cms.hhs.gov/ERxIncentive*:

2010 eRx Measure Specifications and Release Notes – provides guidance on the 2010 eRx measure specifications for claims or registry-based reporting and release notes describing changes from the 2009 eRx measure specifications.

Claims-Based Reporting Principles for the 2010 eRx Incentive Program – provides guidance on the principles for reporting the eRx measure on claims for the 2010 eRx Incentive Program.

2010 EHR Measure Specifications for eRx and Release Notes – provides guidance on the electronic health record (EHR) measure specifications for eRx and release notes. In addition it details the specifications contain a detailed description of data element names and codes.

2010 EHR Downloadable Resource – this is an Excel spreadsheet listing 2010 EHR information.

Group Practice Reporting Option (GPRO) Requirements for Submission of 2010 eRx Data – provides guidance on the Group Practice Reporting Option (GPRO) requirements for submission of 2010 eRx data.

GPRO eRx Measure Specifications – provides guidance on the specifications for the eRx measure for use in the 2010 eRx GPRO.

To access the 2010 eRx educational products, visit *http://www.cms.hhs.gov/PQRI/02_Spotlight.asp#TopOfPage*. Once on the *Spotlight* page, view the listing of educational products and the corresponding Web pages they may be found.

Further information on the 2010 eRx Incentive Program may be found in the final 2010 Medicare Physician Fee Schedule rule with comment period (74 FR 61788 through 61861) that was published in the *Federal Register* on October 30, 2009. The final rule may be found on the Electronic Prescribing Incentive Program Web page at *http://www.cms.hhs.gov/ERxIncentive* under the *Statute/Regulations/Program Instructions* section.

Reporting for the 2010 eRx begins January 1, 2010. Please note there is no need to sign up or pre-register in order to participate.

Source: CMS PERL 200912-16

Mini-poster to help educate Medicare beneficiaries about flu vaccines

The Centers for Medicare & Medicaid Services (CMS) would appreciate your help communicating with the public, especially seniors and vulnerable populations, that Medicare and Medicaid cover both the seasonal and H1N1 flu vaccines. Seniors are encouraged to get their seasonal flu vaccine as soon as possible. The vaccine that protects against the 2009 H1N1 influenza virus (sometimes called swine flu) is a separate vaccine and is now available. The first available doses of this vaccine should be given to those at highest risk of infection and complications such as children, pregnant women, health care workers, and younger adults with certain medical conditions. There is some evidence that people 65 and older are less likely than younger people to be infected with the 2009 H1N1 influenza virus.

Please share this bilingual mini-poster (available at *http://www.cms.hhs.gov/AdultImmunizations/Downloads/FluPoster2009.pdf*) with your colleagues and encourage them to post it in places where Medicare patients will see and understand the need for their seasonal flu shot and that they can get the H1N1 vaccine once the high risk groups are vaccinated.

Medicare practitioners are encouraged to refer patients to *http://www.flu.gov/* if they need more information about the seasonal and H1N1 flu vaccines. Additional information for practitioners, mass immunizers, and others who want to bill Medicare for the flu vaccines may be obtained at *http://www.cms.hhs.gov/adultimmunizations/*. The immunizers' question and answer guide (located in the *Download* section) also includes a list of regional CMS contacts (page 55) that would be helpful for those wishing to organize a large scale immunization clinic for seniors.

CMS would appreciate any feedback you can give as to the use of this poster (e.g., did your colleagues post it in their offices, was it posted in senior centers, etc.). Thank you for your help in getting this important message to Medicare beneficiaries.

Source: CMS PERL 200912-01

New MLN booklet on how to use the Medicare-coverage database search tool

Do you ever wonder about how to utilize search tools in selected areas of the CMS Web site? The searchable Medicare Coverage Database (MCD) contains all Medicare national coverage determinations (NCDs), national coverage analyses (NCAs), local coverage determinations (LCDs), and local policy articles. The *Medicare Learning Network* (*MLN*) has produced a "How To" booklet (2.5 MB), that provides an explanation of the MCD, as well as how to use the search, indexes, reports, and downloads features. The How to Use the Medicare Coverage Database booklet (November 2009) may be located at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp* on the MLN publication page. Use search keywords "how to" to locate this publication quickly. Understanding the search tool is the best way to find the information for which you are looking.

Source: CMS PERL 200912-11

Revised Hospice Payment System fact sheet

The revised Hospice Payment System fact sheet (November 2009) is now available for download. This fact sheet provides general information about the Medicare hospice benefit including:

- Coverage of hospice services
- Certification requirements
- Election periods
- How payment rates are set
- Patient coinsurance payments
- Caps on hospice payments
- Additional reporting required on hospice claims.

The fact sheet may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf*.

Source: CMS PERL 200911-38

Revised guided pathways booklets

Are you wondering how to find the latest and greatest resources by subject? The revised guided pathways (NOV 2009) booklets incorporate existing *Medicare Learning Network* (*MLN*) products and other centers resources into well-organized sections that may help Medicare fee-for-service (FFS) providers and suppliers find information to understand and navigate the Medicare program.

These booklets guide learners to Medicare program resources, FFS policies and requirements. You may access the revised guided pathways (NOV 2009) booklets at *http://www.cms.hhs.gov/MLNEdWebGuide/30_Guided_Pathways.asp* on the *Medicare Learning Network*.

Source: CMS PERL 200912-12

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*.

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/prevailing 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@fcso.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.fcso.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 Murphyt
P. O. Box 2078
Jacksonville, FL 32231-0048

Provider education

Educational purposes and review of customary/prevailing 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
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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** [ ]				
Please write legibly			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)

MEDICARE B Update!

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

♦ ATTENTION BILLING MANAGER ♦