

# MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

## In this issue...



### WHEN EXPERIENCE COUNTS & QUALITY MATTERS

**Positive 2.2 percent update – 2010 ambulatory surgical center files**  
*This update is effective June 1, 2010, through November 30, 2010* ..... 5

**October 2010 quarterly average sales price update and revision to prior files**  
*This update also revises the July 2010, April 2010, January 2010, and October 2009 files* .....9

**July update to the 2010 DMEPOS fee schedule**  
*Implementing fee schedule amounts for new codes and correct amounts for existing codes*.....12

**Additional HCPCS codes subject to CLIA edits**  
*Regulation requires that payment is only made for tests performed in certified facilities*.....13

**July update to the 2010 Medicare physician fee schedule database**  
*Amends payment files issued to Medicare contractors based on the 2010 MPFS final rule* .....16

**Provisions in the Affordable Care Act of 2010**  
*The Affordable Care Act extends the preventive focus of Medicare coverage*.....20

**Billing for technical component of advanced diagnostic imaging services**  
*Look for the instructional letter beginning with July 2010*.....29

**Version 5010 and ICD-10 are coming – will you be ready?**  
*Coming soon you will be able to sign up for version 5010 and ICD-10 e-mail updates*.....32

**Electronic health record incentive program meaningful use final rule**  
*Qualify for incentive payments when you adopt certified electronic health record technology*.. .....39

### Features

About the *Update!*.....3

Coverage/Reimbursement.....5

Electronic Data Interchange .....31

General Information.....33

Local Coverage Determinations (LCDs).....47

Educational Resources.....52

Addresses, Phone Numbers, and Websites.....56

Order form for Medicare Part B materials.....58

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 websites which may be accessed at: <http://medicare.fcso.com/>.

#### Routing Suggestions:

- Physician/Provider
- Office manager
- Billing/Vendor
- Nursing Staff
- Other \_\_\_\_\_



In this issue .....1  
 Table of Contents .....2

**About the Update!**  
 Quarterly provider update .....3  
 Advance beneficiary notices (ABNs).....4  
 “GA” modifier and appeals .....4

**Coverage and Reimbursement**  
**Ambulatory Surgical Center**  
 Proposed rule on policy and payment changes  
 for services in hospital outpatient departments  
 and ASCs.....5  
 Positive 2.2 percent update for the 2010 ambulatory  
 surgical center files.....5

**Consolidated Billing**  
 Enhancements to home health consolidated billing  
 enforcement.....6  
 SNF consolidated billing as it relates to certain  
 types of exceptionally intensive outpatient hospital  
 services.....7

**Drugs and Biologicals**  
 October 2010 quarterly average sales price  
 update and revision to prior files.....9  
 Dermal injection for treatment of facial  
 lipodystrophy syndrome.....10

**Durable Medical Equipment**  
 July update to the 2010 DMEPOS fee schedule .....12

**Laboratory/Pathology**  
 Additional HCPCS codes subject to CLIA edits.....13  
 October 2010 updates to the laboratory national  
 coverage determination edit.....14

**Medicare Physician Fee Schedule**  
 July update to the 2010 Medicare physician fee  
 schedule database.....16

**Preventive Services**  
 CMS to expand Medicare preventive services and  
 improve access to primary care in 2011 .....17

**Psychiatric Services**  
 New physician specialty code for geriatric  
 psychiatry .....18

**Radiology**  
 Magnetic resonance angiography .....19

**General Coverage**  
 Provisions in the Affordable Care Act of 2010 .....20  
 ICD-10 implementation information .....21  
 Medicare contractor annual update of the  
 ICD-9-CM.....25  
 Healthcare common procedure coding system  
 quarterly update – other codes .....25  
 Medicare reporting and payment of services for  
 alcohol and/or substance abuse .....26  
 Billing for technical component of advanced  
 diagnostic imaging services .....29

**Electronic Data Interchange**  
 Claim status category and claim status code update .....31  
 Vendors and providers start the conversation on  
 version 5010 and ICD-10.....31  
 Proposed rulemaking to implement HITECH Act  
 modifications to the HIPAA rules .....32  
 Version 5010 and ICD-10 are coming – will you  
 be ready? .....32

**General Information**  
 PPACA requirements for ICD-10 crosswalk  
 revisions – public forum meeting .....33  
 Solicitation for proposal to participate in the  
 Medicare imaging demonstration .....33  
 Enrollment guidance for physicians that infrequently  
 receive reimbursement.....34  
 CMS to review provider enrollment, chain and  
 ownership system process.....34  
 Declare independence from the paper enrollment  
 process – use Internet-based PECOS.....35  
 Electronic prescribing incentive program updates.....36  
 Reminder: 2010 Physician Quality Reporting  
 Initiative program.....38  
 Electronic health record incentive program  
 meaningful use final rule.....39  
 Final rule issued to establish a temporary electronic  
 health record certification program .....39  
 Fact sheets on electronic health record incentive  
 programs now available .....39  
 Written and audio transcripts of the June 15  
 ICD-10 teleconference now available.....40  
 One year anniversary of President Obama’s  
 “Year of Community Living” initiative .....40  
 Top inquiries, denials, and return unprocessable  
 claims for April-June.....41

**Local Coverage Determinations**  
 Table of contents .....47

**Educational Resources**  
**Educational Events**  
 Upcoming provider outreach and educational  
 events – August 2010 .....52

**Preventive Services**  
 Preventive services to help keep your Medicare  
 patients healthy this summer.....53  
 Medicare preventive services quick reference  
 information charts .....54

**Other Educational Resources**  
 New suite of MLN products now available for  
 billing and coding professionals .....54  
 Revised Medicare physician fee schedule fact  
 sheet now available .....55  
 CMS fact sheet on how to protect your Medicare  
 enrollment record now available.....55  
 Florida addresses, phone numbers, and websites.....56  
 U.S. Virgin Islands addresses, phone numbers,  
 and websites .....57  
 Order form for Medicare Part B materials .....58

**Medicare B Update!**

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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 website, <http://medicare.fcsocom>. In some cases, additional unscheduled special issues may be posted.

### Who receives the Update?

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

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

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

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

### Publication format

The *Update!* is arranged into distinct sections.

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

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

In addition to the above, other sections include:

- **Educational resources**, and
- **Addresses**, and **phone numbers**, and **websites** 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 website at <http://www.cms.gov/QuarterlyProviderUpdates/>.

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



## Advance beneficiary notices

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

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

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

### Patient liability notice

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

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users. Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at [http://www.cms.gov/BNI/01\\_overview.asp#TopOfPage](http://www.cms.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.gov/MLN MattersArticles/downloads/MM6136.pdf>.

### ABN modifiers

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

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

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

### GA modifier and appeals

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

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

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

#### Find out first: Subscribe to FCSO eNews

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. Subscribe to First Coast Service Options eNews, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

## Ambulatory Surgical Center

### Proposed rule on policy and payment changes for services in hospital outpatient departments and ambulatory surgical centers

Medicare beneficiaries would see a decline in their out-of-pocket costs for services they receive in hospital outpatient departments (HOPDs) in calendar year (CY) 2011 under provisions in a proposed rule issued by the Centers for Medicare & Medicaid Services (CMS). The proposed rule implements changes required by the Affordable Care Act of 2010.

The Affordable Care Act, which was enacted as the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, waives beneficiary cost-sharing for most Medicare-covered preventive services, including the initial preventive physical examination (IPPE or "Welcome to Medicare Visit"). This waiver applies not only to the 20 percent coinsurance for the physician's service, but also to any cost-sharing relating to the separate payment to the facility when the service is furnished in an HOPD, as well as those preventive services, such as colonoscopies, that may be furnished in an ambulatory surgical center (ASC).

For more information on the CY 2011 proposals for the outpatient prospective payment system (OPPS) and ASC payment system, please see <http://www.ofr.gov/inspection.aspx#special>.

Additional information may be found on the CMS website at:

**OPPS:** <http://www.cms.gov/HospitalOutpatientPPS/>

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

The news release and fact sheet were available on Tuesday, July 6 at <http://www.cms.gov/>.

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

Source: CMS PERL 201007-05

### Positive 2.2 percent update for the 2010 ambulatory surgical center files

The recent enactment of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, Section 101, resulted in a positive 2.2 percent update in the 2010 Medicare physician fee schedule (MPFS), effective June 1, 2010, through November 30, 2010.

Many payment rates under the ambulatory surgical center (ASC) payment system are controlled by payment rate information in the MPFS. In order to fully comply with this legislation, it is necessary to implement revised MPFS payment rates in the ASC payment system. Therefore, the Centers for Medicare & Medicaid Services (CMS) has provided its contractors with two sets of positive 2.2 percent ASC fee schedule (FS) and ASC payment indicator (PI) update files to test, and implement. One set of files is for ASC services furnished on or after July 1, 2010, and the second set of files is for ASC services furnished June 1, 2010, through June 30, 2010. Once installed, Medicare contractors shall use these updated payment files to process new ASC claims and shall adjust previously processed ASC claims for dates of service on or after June 1, 2010, that are brought to their attention.

In accordance with the requirements in change request (CR) 7008, contractors shall make July 2010 ASCFS data for their ASC payment localities available on their websites. The payment rates in the July 2010 ASCFS data files mirror the 2.2 percent update payment rates for services June 1, 2010-June 30, 2010, and also contain payment rates for newly established services identified in CR 7008 effective July 1, 2010.

An *MLN Matters* article which explains the requirements in CR 7008 may be found on the CMS website at <http://www.cms.gov/MLNMattersArticles/downloads/MM7008.pdf>.

CMS is aware that contractors were unable to implement the revised payment rates by the July 6, 2010, implementation date contained in CR 7008 because these files have just become available to contractors for download and testing. Contractors have been directed to have all these ASC update files in production no later than July 28, 2010. This implementation date supersedes the implementation date specified in CR 7008.

ASCs who may have received an incorrect payment determination for certain services furnished on or after June 1, 2010, through the implementation of the July 2010 ASCFS may request contractor adjustment of the previously processed claims.

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

Source: CMS PERL 201007-28

## Consolidated Billing

### Enhancements to home health consolidated billing enforcement

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

**Note:** This article was revised on June 14, 2010, to reflect the revised CR 6911 that was issued on that date. In this article, the CR release date and transmittal number were revised. Also, the Web address for accessing CR 6911 was revised. All other information remains the same. This information was previously published in the June 2010 *Medicare B Update!* pages 6-7.

#### Provider types affected

This article may impact physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

#### Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the consolidated billing provision of the home health prospective payment system (HH PPS). It is also creating a new file of HH certification information to assist suppliers and providers subject to HH consolidated billing. Make sure your billing staff is aware of these changes.

#### What you need to know

##### Consolidated billing edit modification

Non-routine supplies provided during a HH episode of care are included in Medicare's payment to the home health agency (HHA) and subject to consolidated billing edits as described in the *Medicare Claims Processing Manual*, Chapter 10, Section 20.2.1. (The revised chapter is attached to CR 6911.) If the date of service for a non-routine supply HCPCS code that is subject to HH consolidated billing falls within the dates of a HH episode, the line item was previously rejected by Medicare systems. Non-routine supply claims are submitted by suppliers on the professional claim format, which has both 'from' and 'to' dates on each line item.

When the HH consolidating billing edits were initially implemented in October 2000, the edit criteria were defined so that non-routine supply services were rejected if either the line item 'from' or 'to' date overlapped the HH episode dates. This allowed for supplies that were delivered before the HH episode began to be paid, since the prevailing practice at that time was that suppliers reported the delivery date in both the 'from' and 'to.' Medicare instructions regarding delivery of supplies intended for use over an extended period of time have since changed. Now suppliers are instructed to report the delivery date as the 'from' date and the date by which the supplies will be used in the 'to' date. When this causes the 'to' date on a supply line item subject to consolidated billing to overlap a HH episode, the service is rejected contrary to the original intent of this edit.

Effective October 1, 2010, CMS is implementing new requirements to modify this edit in order to restore the original intent to pay for supplies delivered before the HH episode began. Such supplies may have been ordered before

the need for HH care had been identified, and are appropriate for payment if all other payment conditions are met. The edit will be changed to only reject services if the "from" date on the supply line item falls within a HH episode.

##### A new file of HH certification information

Chapter 10, Section 20.1 of the *Medicare Claims Processing Manual* describes the responsibilities of suppliers and therapy providers whose services are subject to HH consolidated billing to determine before providing their services whether a beneficiary is currently in a HH episode of care. To assist these suppliers and providers in determining this, CMS is creating an additional source of information. CMS will create a new file which will store and display certifications of HH plans of care.

Medicare coverage requirements state that all HH services must be provided under a physician-ordered plan of care. Upon admission to HH care and after every 60 days of continuing care, a physician must certify that the beneficiary remains eligible for HH services and must write specific orders for the beneficiary's care. Medicare pays physicians for this service using the following two codes:

- G0179 Physician re-certification for Medicare-covered home health services Under a plan of care
- G0180 Physician certification for Medicare-covered home health services under a plan of care

Physicians submit claims for these services to Medicare contractors on the professional claim format separate from the HHA's billing their Request for Anticipated Payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for a HH episode promptly in order to receive their initial 60 percent or 50 percent payment for that episode. But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that a HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems will display for each Medicare beneficiary the date of service for either of the two codes above when these codes have been paid. Medicare systems will allow the provider to enter an inquiry date when accessing the HH certification auxiliary file. When the provider enters an inquiry date on Medicare's common working file (CWF) query screens, Medicare systems will display all certification code dates within nine months before the date entered. When the provider does not enter an inquiry date, Medicare systems will display all certification code dates within nine months before the current date as the default response.

**Enhancements to home health consolidated billing enforcement (continued)**

**Note:** Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing HH episode information, this new information is only as complete and timely as billing by providers allows it to be. This is particularly true regarding physician certification billing.

Historically, Medicare has paid certification codes for less than 40 percent of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

**Additional information**

If you have questions, please contact your Medicare RHHI/MAC at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>. The official instruction (CR 6911) issued to your Medicare RHHI/MAC is available at <http://www.cms.gov/Transmittals/downloads/R1988CP.pdf>.

MLN Matters® Number: MM6911 *Revised*

Related Change Request (CR) #: 6911

Related CR Release Date: June 14, 2010

Effective Date: October 1, 2010

Related CR Transmittal #: R1988CP

Implementation Date: October 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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## Skilled nursing facility consolidated billing as it relates to certain types of exceptionally intensive outpatient hospital services

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

**Note:** This article was revised on July 22, 2010, to include “ambulatory surgical centers” as a non-hospital setting in the *Background* section. All other information remains the same. This information was previously published in the Third Quarter 2005 *Medicare B Update!* pages 43-44.

**Provider types affected**

Skilled nursing facilities (SNFs), physicians, suppliers, providers, and imaging centers.

**Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier (DMERC).)

**Provider action needed**

This special edition article describes SNF consolidated billing (CB) as it relates to certain types of exceptionally intensive outpatient hospital services, such as magnetic resonance imaging (MRI) services, computerized axial tomography (CT) scans, and radiation therapy.

**Background**

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all

of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB, including a section on services excluded from SNF CB, see *MLN Matters* special edition article SE0431 at <http://www.cms.gov/MLNMattersArticles/downloads/se0431.pdf>.

The original CB legislation (Section 4432(b) of the Balanced Budget Act of 1997, P. L. 105-33 (BBA 1997)) specified a list of services at Section 1888(e)(2)(A)(ii) of the Social Security Act that were excluded from this provision. As with the inpatient hospital bundling requirement (Section 1862(a)(14) of the Social Security Act) on which it was modeled, the SNF CB provision excluded primarily the services of physicians and certain other practitioners.

Moreover, these services were excluded categorically, without regard to the specific setting in which they were furnished. This legislation did not authorize the Department of Health and Human Services (DHHS) to create additional categorical exclusions from CB administratively, thereby reserving this authority for the Congress itself. In fact, the Congress subsequently did enact a number of additional CB exclusions that applied uniformly to services furnished in both hospital and non-hospital settings, in Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA 1999, P.L. 106-113, Appendix F).

While the original CB legislation did not authorize DHHS to simply carve out entire categories of services from CB without regard to setting, it did define the SNF



*Skilled nursing facility consolidated billing as it relates to certain types of exceptionally intensive ..... (continued)*

CB provision in terms of services furnished to a resident of a SNF, and provided a degree of administrative discretion in defining when a beneficiary is considered to be a SNF “resident” for this purpose.

Using this authority, the Centers for Medicare & Medicaid Services (CMS) identified several types of exceptionally intensive outpatient hospital services that were well beyond the general scope of SNF care plans.

These services include:

- Emergency services
- Cardiac catheterizations
- Computerized Axial Tomography (CT) scans
- Magnetic Resonance Imaging (MRI) services
- Ambulatory surgery
- Radiation therapy
- Angiography, and
- Lymphatic and venous procedures.

CMS established that a beneficiary’s receipt of such services in the outpatient hospital setting had the effect of temporarily suspending his/her status as a SNF resident for CB purposes, thus enabling the hospital to bill Part B separately for the services. (See Title 42 of the *Code of Federal Regulations* (42 CFR), Section 411.15(p)(3)(iii).) The underlying rationale for this exclusion was that these services were so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively.

In the legislative history that accompanied the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress explicitly recognized that this administrative exclusion is specifically limited to “...certain outpatient services from a Medicare participating hospital or critical access hospital...” (emphasis added). (See the House Ways and Means Committee Report (H. Rep. No. 108-178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108-391 at 641)). **This means that the exclusion does not encompass services that are furnished in other, non-hospital settings (such as freestanding clinics or ambulatory surgical centers).**

As noted previously, in addition to the existing exclusion of certain types of intensive outpatient hospital services under the regulations at 42 CFR 411.15(p)(3)(iii), Congress has elected to exclude several categories of services from CB in the statute itself, at Sections 1888(e)(2)(A)(ii)-(iii) of the Social Security Act. Unlike the administrative exclusion discussed above, which applies solely to services furnished in the outpatient hospital setting, the statutorily excluded services are separately billable to Part B regardless of the setting (hospital versus freestanding) in which they are furnished.

For example, as amended by Section 103 of BBRA 1999, Section 1888(e)(2)(A)(iii)(II) of the Social Security Act excludes certain types of intensive chemotherapy services, regardless of whether they are furnished in a hospital or freestanding setting. Additional legislation would be required to expand the exemption of CT scans, MRI services, and radiation therapy to apply to services furnished in non-hospital settings.

Chemotherapy and its administration and radioisotopes and their administration are identified in the statute by HCPCS code. These services are separately billable in all care settings, but the exclusion applies only to the codes specified in the Social Security Act and subsequent regulations. Therefore, other services given in conjunction with an excluded code (e.g., other pharmaceuticals, medical supplies, etc.) remain bundled and should be reimbursed by the SNF to the supplier.

Please note that the professional charge for the physician who performs/interprets the radiological procedure is **not** subject to CB. Since the physician service exclusion applies to the professional component of the diagnostic radiology service, the physician bills his/her service directly to the Medicare Part B carrier for reimbursement.

**Additional information**

See *MLN Matters* special edition article SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at <http://www.cms.gov/MLNMattersArticles/downloads/se0431.pdf>.

The Centers for Medicare and Medicaid Services (CMS) MLN Consolidated Billing Web page may be found at <http://www.cms.gov/SNFConsolidatedBilling/>.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB)
- Therapy codes that must be consolidated in a noncovered stay, and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Web page may be found at <http://www.cms.gov/SNFPSPS/>.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles, and
- Links to publications (including transmittals and *Federal Register* notices).

MLN Matters Number: SE0432 *Revised*

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

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## Drugs and Biologicals

### October 2010 quarterly average sales price update and revision to prior files

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

#### Provider types affected

This article is for all physicians, providers and suppliers who submit claims to Medicare contractors (Medicare administrative contractors [MACs], fiscal intermediaries [FIs], carriers, durable medical equipment Medicare administrative contractors [DME MACs] or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

#### Provider action needed

This article is based on change request (CR) 7007 and instructs Medicare contractors to download and implement the October 2010 ASP drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised, July 2010, April 2010, January 2010, and October 2009 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 4, 2010, with dates of service October 1, 2009, through December 31, 2010. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

#### Background

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

The following table shows how the quarterly payment files will be applied:

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

**Note:** The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

#### Additional information

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

The official instruction (CR 7007) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.gov/Transmittals/downloads/R1990CP.pdf>.

MLN Matters® Number: MM7007

Related Change Request (CR) #: 7007

Related CR Release Date: June 18, 2010

Effective Date: October 1, 2010

Related CR Transmittal #: R1990CP

Implementation Date: October 4, 2010

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## Derma injections for treatment of facial lipodystrophy syndrome

*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, hospitals, and other providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for facial lipodystrophy services provided to Medicare beneficiaries.

### What you need to know

This article is based on change request (CR) 6953, which informs Medicare contractors that effective for claims with dates of service on and after March 23, 2010, derma injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using derma fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in human immunodeficiency virus (HIV)-infected Medicare beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

### Background

The Centers for Medicare & Medicaid Services (CMS) received a request for national coverage of treatments for facial LDS for human immunodeficiency virus (HIV)-infected Medicare beneficiaries. LDS is often characterized by a loss of fat that results in a facial abnormality such as severely sunken cheeks. This fat loss can arise as a complication of HIV and/or highly active antiretroviral therapy (HAART). Due to their appearance, patients with LDS may become depressed, socially isolated, and in some cases may stop their HIV treatments in an attempt to halt or reverse this complication.

### Nationally covered indications

Effective for claims with dates of service on and after March 23, 2010, derma injections for LDS are only reasonable and necessary using derma fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

### Nationally noncovered indications

- Dermal fillers that are not approved by the FDA for the treatment of LDS, and
- Dermal fillers that are used for any indication other than LDS in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments.

### Claims coding/pricing information

Effective with the July 2010 Healthcare Common Procedure Coding System (HCPCS) update, the July Medicare physician fee schedule (MPFS), and the July integrated outpatient code editor (IOCE):

- HCPCS codes Q2026, Q2027, and G0429 will be designated for derma fillers Sculptra® and Radiesse®
- HCPCS codes Q2026, Q2027, and G0429 are effective for dates of service on or after March 23, 2010
- HCPCS codes Q2026 and Q2027 are contractor-priced under the July MPFS, and
- HCPCS code G0429 is payable under the July MPFS.

However, because HCPCS Q2026, Q2027 and G0429 are not considered valid HCPCS until implementation of the July 2010 HCPCS update, providers will not be able to bill and receive payment for these HCPCS codes prior to July 6, 2010.

Therefore, included in the July 2010 HCPCS update and in the July IOCE is a temporary HCPCS code C9800, which was created to describe both the injection procedure and the derma filler product. This code provides a payment mechanism to hospital outpatient prospective payment system (OPPS) and ambulatory surgery center (ASC) providers until average sales price (ASP) or wholesale acquisition cost (WAC) pricing information becomes available. When ASP or WAC pricing information becomes available, the temporary HCPCS code will be deleted and separate payment will be made under the OPPS and ASC payment systems for HCPCS Q2026, Q2027, and G0429.

For hospital institutional non-OPPS claims, Medicare contractors will use current payment methodologies for claims for derma injections for treatment of LDS.

### Hospital and ASC billing instructions

For hospital outpatient claims, hospital institutional non-OPPS claims, and ASCs, covered derma injections for treatment of LDS must be billed by having all the required elements on the claim:

- A line with HCPCS codes Q2026 or Q2027 with a line item date of service (LIDOS) on or after March 23, 2010
- A line with HCPCS code G0249 with a LIDOS on or after March 23, 2010
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy)

Medicare will line item deny institutional claims where the LIDOS is prior to March 23, 2010.

**Note to OPPS hospitals or ASCs:** For line item dates of service on or after March 23, 2010, and until pricing information is made available to price OPPS claims, LDS claims will contain the temporary HCPCS code C9800, instead of HCPCS G0429 and HCPCS Q2026/Q2027, as shown above.

***Dermal injections for treatment of facial lipodystrophy syndrome (continued)***

**Note on all hospital claims:** An ICD-9-CM diagnosis code for a depression-comorbidity may also be required for coverage on an outpatient and/or inpatient basis as determined by the individual Medicare contractor's policy.

**Practitioner billing instructions**

Practitioners must bill covered claims for dermal injections for treatment of LDS by having all the required elements on the claim:

- A date of service (LIDOS) on or after March 23, 2010
- HCPCS codes Q2026 or Q2027
- A line with HCPCS code G0249
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy).

**Note:** An ICD-9-CM diagnosis code for a depression comorbidity may also be required for coverage based on the individual Medicare contractor's policy.

**Billing for services prior to Medicare coverage**

ASCs and practitioners billing for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following messages upon their Medicare denial:

- **Remittance advice remark code (RARC) N386:** This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- **Group code:** contractual obligation (CO)

Medicare beneficiaries whose provider bills Medicare for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following Medicare summary notice (MSN) message upon the Medicare denial:

- **21.11:** This service was not covered by Medicare at the time you received it.

**Billing for services not meeting comorbidity coverage requirements**

Hospitals and practitioners billing for dermal injections for treatment of LDS on patients that do not have on the claim both ICD-9-CM diagnosis codes of 042 and 272.6, indicating HIV and lipodystrophy will receive the following messages upon their Medicare claims denial:

- **CARC 50:** These are non-covered services because this is not deemed a 'medical necessity' by the payer. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC M386:** This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- **Group code:** contractual obligation (CO)

Medicare beneficiaries who do not meet Medicare comorbidity requirements of HIV and lipodystrophy (or even depression if deemed required by the Medicare contractor) and whose provider bills Medicare for dermal injections for treatment of LDS will receive the following MSN message upon the Medicare denial:

- **15.4:** The information provided does not support the need for this service or item.

**Additional information**

The official instruction, CR 6953, issued to your carrier, FI, and A/B MAC regarding this change via two transmittals. The first transmittal revised the *Medicare NCD Manual* and it may be viewed at <http://www.cms.gov/transmittals/downloads/R122NCD.pdf>. The second transmittal revises the *Medicare Claims Processing Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R1978CP.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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM6953

Related Change Request (CR) #: 6953

Related CR Release Date: June 4, 2010

Effective Date: March 23, 2010

Related CR Transmittal #: R122NCD and R1978CP

Implementation Date: July 6, 2010

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## Durable Medical Equipment

### July update to the 2010 DMEPOS fee schedule

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

**Note:** This article was revised on July 1, 2010, to reflect changes made to change request (CR) 6954. Language under *Key points of CR 6945* (in bold) was corrected to state that claims for codes A4336, E1036, L8031, L8032, L8629, and Q0506 will be adjusted if brought to the contractor's attention. In addition, the transmittal number, CR release date, and Web address for the CR has been changed. All other material remains the same. This information was previously published in the May 2010 *Medicare B Update!* pages 12-13.

#### Provider types affected

This article is for providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for DMEPOS provided to Medicare beneficiaries.

#### Provider action needed

This article is based on CR 6945 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

#### Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to correct any fee schedule amounts for existing codes. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by Sections 1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in 42 CFR 414.102.

#### Key points of CR 6945

- Healthcare Common Procedure Coding System (HCPCS) codes A4336, E1036, L8031, L8032, L8629, and Q0506 were added to the HCPCS file effective January 1, 2010. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2010. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for codes A4336, E1036, L8031, L8032, L8629, and Q0506 with dates of service on or after January 1, 2010, that have already been processed may be adjusted to reflect the newly established fees if brought to the attention of your Medicare contractor.
- CMS notes that they have received questions requesting clarification concerning what items and services a supplier must furnish when billing HCPCS code A4221 (Supplies for maintenance of drug infusion catheter, per week). To restate existing policy, all supplies (including dressings) used in conjunction with a durable infusion pump are billed with codes A4221 and A4222 or codes A4221 and K0552. Other codes should not be used for the separate billing of these supplies. Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. Code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via an external insulin infusion pump and the infusion sets and dressings related to subcutaneous immune globulin administration. The payment amount for code A4221 includes all necessary supplies for one week in whatever quantity is needed by the beneficiary for that week. Suppliers that bill HCPCS code A4221 are required to furnish the items and services described by the code in the quantities needed by the beneficiary for the entire week.
- CR 6945 also clarifies that modifiers RA and RB, for repair and replacement of an item, added to the HCPCS code set effective January 1, 2009, are also available for use with prosthetic and orthotic items. Additionally, the descriptors for modifiers RA and RB are being revised, effective April 1, 2010, to read as follows:
  - RA Replacement of a DME, orthotic or prosthetic item
  - RB Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair
 Suppliers should continue to use the modifier RA on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. Likewise, the modifier RB should continue to be used on DMEPOS claims to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device.)
- Under the regulations at 42 CFR 414.210(f), the reasonable useful lifetime of DMEPOS devices is five years unless Medicare program/manual instructions authorize a specific reasonable useful lifetime of less than five years for an item. After a review of product information and in consultation with the DME MAC medical officers, CMS has determined that a period shorter than five years more accurately reflects the useful lifetime expectancy for a reusable, self-adhesive nipple prosthesis. CR 6945 lowers the reasonable useful lifetime period for a reusable, self-adhesive nipple prosthesis to three months.

*July update to the 2010 DMEPOS fee schedule (continued)*

- HCPCS code Q0506 (Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only) was added to the HCPCS effective January 1, 2010. Based on information furnished by ventricular assist device (VAD) manufacturers, CMS determined that the reasonable useful lifetime of the lithium-ion battery described by HCPCS code Q0506 is 12 months. Therefore, CR 6945 is establishing edits to deny claims that are submitted for code Q0506 prior to the expiration of the batteries' reasonable useful lifetime. The reasonable useful lifetime of VAD batteries other than lithium-ion – HCPCS codes Q0496 and Q0503 – remains at six months as described in CR 3931, transmittal 613, issued July 22, 2005. Additionally, suppliers and providers will need to add HCPCS modifier RA to claims for code Q0506 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged. Per the VAD replacement policy outlined in CR 3931, if the A/B MAC, local carrier, or intermediary determines that the replacement of the lost, stolen, or irreparably damaged item is reasonable and necessary, then payment for replacement of the item can be made at any time, irrespective of the item's reasonable useful lifetime.

**Additional information**

If you have questions, please contact your Medicare DME MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

The official instruction (CR 6945) issued to your Medicare DME MAC may be found at <http://www.cms.gov/transmittals/downloads/R1993CP.pdf>.

MLN Matters® Number: MM6945 *Revised*

Related Change Request (CR) #: 6945

Related CR Release Date: July 1, 2010

Effective Date: January 1, 2010 for implementation of fee schedule amounts for codes in effect on January 1, 2010; April 1, 2010 for the descriptor revisions to modifiers RA and RB, which became effective April 1, 2010; July 1, 2010 for all other changes

Related CR Transmittal #: R1993CP

Implementation Date: July 6, 2010

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## Laboratory/Pathology

### Additional HCPCS codes subject to CLIA edits

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

#### Provider types affected

Clinical laboratories submitting claims to Medicare Part A/B Medicare administrative contractors (A/B MACs) or carriers for laboratory services provided to Medicare beneficiaries are impacted by this issue.

#### What you need to know

Change request (CR) 6985, from which this article is taken, informs your A/B MAC or carrier about additional new Healthcare Common Procedure Coding System (HCPCS) codes for 2010 that are subject to Clinical Laboratory Improvement Amendments (CLIA) edits. You should make sure that your billing staff is aware of the changes.

#### Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

Since the HCPCS codes that are considered a laboratory test under CLIA change each year, the Center for Medicare & Medicaid Services (CMS) informs carriers and MACs about the new HCPCS codes that are subject to, and those that are excluded from, CLIA edits. CR 6985, from which this article is taken, announces additional HCPCS codes that are subject to CLIA edits for 2009, but were not mentioned in CR 6812 or CR 6356.

**Note:** Please refer to *MLN Matters*® article MM6812 (Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits), released February 5, 2010; which you can find at <http://www.cms.gov/MLNMattersArticles/downloads/MM6812.pdf>. The HCPCS codes listed in the table are new for 2009 and subject to CLIA edits, and require a facility to have either:

- A CLIA certificate of registration (certificate type code 9)
- A CLIA certificate of compliance (certificate type code 1), or
- A CLIA certificate of accreditation (certificate type code 3).

A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

*Additional HCPCS codes subject to CLIA edits (continued)*

| <b>HCPCS/modifier</b> | <b>Description</b>  |
|-----------------------|---|
| G0416                 | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens            |
| G0416 TC              | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens            |
| G0416 26              | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens            |
| G0417                 | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens           |
| G0417 TC              | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens           |
| G0417 26              | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens           |
| G0418                 | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens           |
| G0418 TC              | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens           |
| G0418 26              | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens           |
| G0419                 | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens |
| G0419 TC              | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens |
| G0419 26              | Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens |

Please note that your carrier or MAC is not required to search their files to either retract payment for claims already paid or to retroactively pay claims containing these codes, but will adjust such claims that you bring to their attention.

**Additional information**

You may find the official instruction, CR 6985, issued to your carrier or A/B MAC by visiting <http://www.cms.gov/Transmittals/downloads/R7200TN.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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM6985  
 Related Change Request (CR) #: 6985  
 Related CR Release Date: June 18, 2010  
 Effective Date: January 1, 2009  
 Related CR Transmittal #: R7200TN  
 Implementation Date: July 19, 2010

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**October 2010 updates to the laboratory national coverage determination edit**

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

**Provider action needed**

This article is based on change request (CR) 7057, which announces the changes that will be included in the October 2010 release of Medicare’s edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in July 2010. Please ensure that your billing staffs are aware of these changes.

**Background**

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



**October 2010 updates to the laboratory national coverage determination edit (continued)**

Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective July 1, 2003. In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2, available at

<http://www.cms.gov/manuals/downloads/clm104c16.pdf> on the Centers for Medicare & Medicaid Services (CMS) website, the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 7057 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2010. These changes become effective for services furnished on or after October 1, 2010. The changes that are effective for dates of service on and after October 1, 2010 are as follows:

**For bacterial urine cultures:**

- Add ICD-9-CM code 780.66 to the list of ICD-9-CM codes that are covered by Medicare for the urine culture, bacterial (190.12) NCD.

**For human immunodeficiency virus (HIV) testing (diagnosis):**

- Add ICD-9-CM codes 780.66, 786.30, 786.31, and 786.39 to the list of ICD-9-CM codes that are covered by Medicare for the human immunodeficiency virus (HIV) testing (diagnosis) (190.14) NCD.
- Delete ICD-9-CM code 786.3 from the list of covered ICD-9-CM codes for the human immunodeficiency virus (HIV) testing (diagnosis) (190.14) NCD.

**For blood counts:**

- Add ICD-9-CM codes 832.2, V11.4, V25.11, V25.12, V25.13, V49.86, and V62.85 to the list of "Do Not Support Medical Necessity" ICD-9-CM codes that are covered by Medicare for the blood counts (190.15) NCD.
- Delete ICD-9-CM code V25.1 from the list of covered "Do Not Support Medical Necessity" ICD-9-CM codes for the blood counts (190.15) NCD.

**For partial thromboplastin time (PTT):**

- Add ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 287.41, 287.49, 786.30, 786.31, and 786.39 to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- Delete ICD-9-CM codes 275.0, 287.4, and 786.3 from the list of covered ICD-9-CM codes for the PTT (190.16) NCD.

**For prothrombin time:**

- Add ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 287.41, 287.49, 786.30, 786.31, 786.39, 999.80, 999.83, 999.84, and 999.85 to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (190.17) NCD.
- Delete ICD-9-CM codes 275.0, 287.4, and 786.3 from the list of covered ICD-9-CM codes covered for the prothrombin time (190.17) NCD.

- Correct a typographical error by replacing ICD-9-CM code 531.21 with ICD-9-CM code 534.21 within the code range 534.20-531.21 for the prothrombin time (190.17) NCD.

**For serum iron studies:**

- Add ICD-9-CM codes 237.73, 237.79, 275.01, 275.02, 275.03, 275.09, 287.41, 287.49, 999.80, 999.83, 999.84, and 999.85 to the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD.
- Delete ICD-9-CM codes 275.0 and 287.4 from the list of covered ICD-9-CM codes for the serum iron studies (190.18) NCD.

**For blood glucose testing:**

- Add ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 276.61, 276.69, 780.33, 787.60, 787.61, 787.62, and 787.63 to the list of ICD-9-CM codes covered by Medicare for the blood glucose testing (190.20) NCD.
- Delete ICD-9-CM codes 275.0, 276.6, and 787.6 from the list of covered ICD-9-CM codes for the blood glucose testing (190.20) NCD.

**For glycated hemoglobin/glycated protein:**

- Add ICD-9-CM codes 275.01, 275.02, 275.03, and 275.09 to the list of ICD-9-CM codes covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
- Delete ICD-9-CM code 275.0 from the list of covered ICD-9-CM codes for the glycated hemoglobin/glycated protein (190.21) NCD.

**For lipids testing:**

- Add ICD-9-CM code 278.03 to the list of ICD-9-CM codes covered by Medicare for the lipids testing (190.23) NCD.

**For digoxin therapeutic drug assay:**

- Add ICD-9-CM codes 276.61 and 276.69 to the list of ICD-9-CM codes covered by Medicare for the digoxin therapeutic drug assay (190.24) NCD.
- Delete ICD-9-CM code 276.6 from the list of covered ICD-9-CM codes for the digoxin therapeutic drug assay (190.24) NCD.

**For alpha-fetoprotein:**

- Add ICD-9-CM codes 275.01, 275.02, 275.03, and 275.09 to the list of ICD-9-CM codes covered by Medicare for the alpha-fetoprotein (190.25) NCD.
- Delete ICD-9-CM code 275.0 from the list of covered ICD-9-CM codes for the alpha-fetoprotein (190.25) NCD.

**For gamma glutamyl transferase:**

- Add ICD-9-CM codes 273.73, 237.79, 275.01, 275.02, 275.03, 275.09, 560.32, 780.66, 970.81, and 970.89 to the list of ICD-9-CM codes covered by Medicare for the gamma glutamyl transferase (190.32) NCD.
- Delete ICD-9-CM codes 275.0 and 970.8 from the list of covered ICD-9-CM codes for the gamma glutamyl transferase (190.32) NCD.

*October 2010 updates to the laboratory national coverage determination edit (continued)*

**For hepatitis panel/acute hepatitis panel:**

- Add ICD-9-CM code 780.33 to the list of ICD-9-CM codes covered by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.

**For fecal occult blood test:**

- Add ICD-9-CM codes 287.41, 287.49, and 560.32 to the list of ICD-9-CM codes covered by Medicare for the fecal occult blood test (190.34) NCD.
- Delete ICD-9-CM code 287.4 from the list of covered ICD-9-CM codes for the fecal occult blood test (190.34) NCD.

**Additional information**

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

The official instruction, CR 7057, issued to your Medicare carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2001CP.pdf>.

MLN Matters® Number: MM7057  
 Related Change Request (CR) #: 7057  
 Related CR Release Date: July 16, 2010  
 Effective Date: October 1, 2010  
 Related CR Transmittal #: R2001CP  
 Implementation Date: October 4, 2010

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## Medicare Physician Fee Schedule

### July update to the 2010 Medicare physician fee schedule database

*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 providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

**Provider action needed**

This article is based on change request (CR) 6974, which amends payment files that were issued to Medicare contractors based on the 2010 MPFS final rule. Be sure your billing staff is aware of these changes.

**Background**

The Social Security Act (Section 1848(c)(4); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1848.htm](http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) on the Internet) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Previously, payment files were issued to Medicare contractors based on the 2010 MPFS final rule. CR 6974 amends those payment files. CR 6974 provides corrections, effective for dates of service on or after January 1, 2010, to those files. These changes include the following:

| CPT/HCPCS code | Action  |
|----------------|---|
| 36148          | Multiple procedure indicator = 0  |
| 74261          | Multiple procedure indicator = 4 Diagnostic family imaging indicator = 02 |
| 74261TC        | Multiple procedure indicator = 4 Diagnostic family imaging indicator = 02 |
| 74262          | Multiple procedure indicator = 4 Diagnostic family imaging indicator = 02 |
| 74262TC        | Multiple procedure indicator = 4 Diagnostic family imaging indicator = 02 |
| 97026          | Procedure status = R  |

**Pharmacogenomic testing for warfarin response**

HCPCS code G9143 was implemented with the 2010 HCPCS file with an effective date of August 3, 2009. Currently, Medicare contractors have a 2010 MPFSDB record but not a 2009 MPFSDB record. Contractors were instructed to manually add this code to the procedure code file and the MPFSDB effective for dates of service on or after August 3, 2009.

**CPT code 90470**

CPT code 90470 became effective on September 28, 2009. However, due to an off-cycle effective date it was not included on the MPFSDB for 2009. Contractors were instructed to manually add this code to the procedure code file and the MPFSDB effective for dates of service on or after September 28, 2009.

*July update to the 2010 Medicare physician fee schedule database (continued)***Screening for the human immunodeficiency virus (HIV) infection**

On December 8, 2009, CMS issued a noncoverage decision (transmittal 118, CR 6786, dated March 23, 2010) on screening for HIV infection. Medicare contractors were instructed to manually add HCPCS codes G0432, G0433, and G0435 to the procedure code file and MPFSDB effective for dates of service on or after December 8, 2009.

**Outpatient intravenous insulin treatment (OIVIT)**

On December 23, 2009, CMS issued a noncoverage decision (transmittal 114, CR 6775, dated February 22, 2010) on the use of OIVIT. Contractors were instructed to manually add HCPCS code G9147 to the procedure code file and MPFSDB effective for dates of service on or after December 23, 2009.

**Dermal injections for treatment of facial lipodystrophy syndrome (LDS)**

In CR 6974, contractors are being instructed to manually adjust the effective date (for dates of service on or after March 23, 2010) for HCPCS codes G0429, Q2026, and Q2027 on the procedure code file and the MPFSDB:

- G0429 Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy),
- Q2026 Injection, Radiesse, 0.1ml)
- Q2027 Injection, Sculptra, 0.1ml)

**Collagen meniscus implant**

In CR 6974, contractors are being instructed to manually adjust the effective date for HCPCS code G0428 (Collagen meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex) on the procedure code file and the MPFSDB. HCPCS code G0428 is effective for dates of service on or after May 25, 2010.

**Other changes**

In addition to the above, attachment 1 of CR 6974 contains numerous adjustments of the MPFSDB for various CPT/HCPCS codes and associated indicators. This attachment to CR 6974 may be viewed at <http://www.cms.gov/Transmittals/downloads/R1992cp.pdf>.

**Additional information**

Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that are affected by these changes. However, contractors will adjust such claims that you bring to their attention.

The official instruction, CR 6974, issued to your carrier, FI, RHHI, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1992cp.pdf>.

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

MLN Matters® Number: MM6974

Related Change Request (CR) #: 6974

Related CR Release Date: June 25, 2010

Effective Date: January 1, 2010

Related CR Transmittal #: R1992CP

Implementation Date: July 6, 2010

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## Preventive Services

### CMS to expand Medicare preventive services and improve access to primary care in 2011

**Proposals would implement Affordable Care Act benefits**

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would implement key provisions in the Affordable Care Act of 2010 that expand preventive services for Medicare beneficiaries, improve payments for primary care services, and promote access to health care services in rural areas. The proposed policies would apply to payments under the Medicare physician fee schedule (MPFS) for services furnished on or after January 1, 2011.

The proposed rule would implement provisions in the Affordable Care Act that will eliminate out-of-pocket costs for beneficiaries for most preventive services, including the new annual wellness visit. This visit augments the benefits of the initial preventive physical examination (IPPE or "Welcome to Medicare Visit") with an annual wellness visit that allows the physician and patient to develop a personalized prevention plan that includes not only the preventive services generally available to the Medicare population, but additional services that may be appropriate because of the patient's individual risk factors.

The proposed rule would improve access to primary care services by implementing an incentive payment for primary care services furnished by primary care practitioners that can include physicians, nurse practitioners, clinical nurse specialists, and physician assistants. The proposed rule would also implement a payment incentive program for general surgeons performing major surgery in areas designated by the Secretary of the Department of Health & Human Services



***CMS to expand Medicare preventive services and improve access to primary care in 2011 (continued)***

(HHS) as health professional shortage areas (HPSAs), would allow physician assistants to order post-hospital extended care services in skilled nursing facilities, and would pay certified nurse midwives for their services under the MPFS at the same rates as physicians.

The entire CMS press release issued June 25 may be viewed at [http://www.cms.gov/apps/media/press\\_releases.asp](http://www.cms.gov/apps/media/press_releases.asp).

CMS issued fact sheets with additional details is available at [http://www.cms.gov/apps/media/fact\\_sheets.asp](http://www.cms.gov/apps/media/fact_sheets.asp).

The proposed rule is available at [http://www.federalregister.gov/OFRUpload/OFRData/2010-15900\\_PI.pdf](http://www.federalregister.gov/OFRUpload/OFRData/2010-15900_PI.pdf) or <http://www.federalregister.gov/inspection.aspx#special>.

CMS will accept comments on the proposed rule until August 24 and will respond to them in a final rule to be issued on or about November 1. Unless otherwise specified, the payment policies and rates adopted in the final rule will be effective for services on or after January 1, 2011.

Source: CMS PERL 201006-45

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## Psychiatric Services

### **New physician specialty code for geriatric psychiatry**

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

**Note:** This article was revised on July 20, 2010, to reflect the revised CR 6533, which was issued by the Centers for Medicare & Medicaid Services on July 19, 2010. In this article, the CR release date, transmittal number, and the Web address for accessing CR 6533 were revised. All other information remains the same. This information was previously published in the November 2009 *Medicare B Update!* page 20.

#### **Provider types affected**

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

#### **What you need to know**

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

#### **Background**

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

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

#### **Additional information**

You may find more information about the new physician specialty code for geriatric psychiatry services by going to CR 6533, located at <http://www.cms.gov/Transmittals/downloads/R2003CP.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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM6533 *Revised*  
 Related CR Release Date: October 27, 2009  
 Related CR Transmittal #: R2003CP

Related Change Request (CR) #: 6533  
 Effective Date: April 1, 2010  
 Implementation Date: April 5, 2010

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# Radiology

## Magnetic resonance angiography

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

### Provider types affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FI], carriers, and A/B Medicare administrative contractors [MAC]) for magnetic resonance angiography (MRA) services provided to Medicare beneficiaries are affected.

### Provider action needed

This article is based on change request (CR) 7040. You need to know that, effective for claims with dates of services on or after June 3, 2010, Medicare contractors will have the discretion to cover or not cover all indications of MRA (and magnetic resonance imaging [MRI]) that are not specifically nationally covered or nationally noncovered. Existing national coverage for both MRI and MRA will be maintained. Please ensure that your billing staffs are aware of these changes.

### Background

The Centers for Medicare & Medicaid Services (CMS) in October, 1995, set forth the original conditions under which MRA would be covered. Revisions to the national coverage determination (NCD) policy took place in 1997, 1999, and 2003 to expand coverage for additional indications. Currently covered indications include using MRA for specific conditions to evaluate flow in internal carotid vessels of the head and neck, peripheral arteries of lower extremities, abdomen and pelvis, and the chest. All other uses of MRA are nationally noncovered unless coverage is specifically indicated.

In addition, CMS recently reconsidered the NCD for MRI at section 220.2 of the *NCD Manual* and removed national noncoverage for MRI for blood flow determination, thereby permitting local Medicare contractors to make local coverage determinations within their respective jurisdictions effective for claims with dates of service on or after June 3, 2010. Such local determinations would apply to all indications of MRA/MRI that are not specifically covered nationally or noncovered nationally.

While reviewing published scientific evidence for the MRI reconsideration, CMS became aware of evidence that may speak to currently noncovered indications for MRA. As a result, CMS initiated this reconsideration to evaluate the current evidence for the noncovered indications for the MRA NCD at Section 220.3.C of the *NCD Manual*.

MRA is a specific application of MRI. CMS believes that the continued existence of separate NCDs is unnecessary, and that the provisions of the MRA NCD at Section 220.3 should be merged under the NCD for MRI at Section 220.2. Thus, Section 220.3, MRA, of the *NCD Manual*, will no longer appear as a separate NCD.

The effect of this change will maintain existing national coverage for both MRI and MRA, and will eliminate the noncoverage language that currently exists for MRA at section 220.3.C of the *NCD Manual*, thereby permitting local Medicare contractors to cover (or not cover) all indications of MRA (and MRI) that are not specifically nationally covered or nationally noncovered.

### Additional information

If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>. The official instruction, CR 7040, was issued to your Medicare contractor via two transmittals. The first transmittal modifies the *NCD Manual* as discussed above and that transmittal is available at <http://www.cms.gov/Transmittals/downloads/R123NCD.pdf>. The second transmittal updates the *Medicare Claims Processing Manual* and that is available at <http://www.cms.gov/Transmittals/downloads/R1998CP.pdf>.

MLN Matters® Number: MM7040

Related Change Request (CR) #: 7040

Related CR Release Date: July 9, 2010

Effective Date: June 3, 2010

Related CR Transmittal #: R1998CP and R123NCD

Implementation Date: August 9, 2010

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## General Coverage

### Provisions in the Affordable Care Act of 2010

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

#### Provider types affected

All providers that bill Medicare for services provided to Medicare beneficiaries.

#### Provider action needed

Providers should be aware of these provisions and frequently visit the Centers for Medicare & Medicaid Services (CMS) website for updates on their implementation.

#### Background

The Affordable Care Act (ACA), signed into law on March 23, 2010, includes a number of provisions designed to help physicians. Some of those changes are reflected in the notice of proposed rule making (NPRM), CMS-1503-P. (CMS is accepting comments on the proposed rule until August 24, 2010, and will respond to them in a final rule to be issued on or about November 1, 2010, that sets forth the policies and payment rates effective for services furnished to Medicare beneficiaries on or after January 1, 2011.)

#### Provisions in the Affordable Care Act Coverage of annual wellness visit providing a personalized prevention plan

The ACA extends the preventive focus of Medicare coverage, which currently pays for a one-time only initial preventive physical examination (also known as the “Welcome to Medicare Visit”). Medicare will cover annual wellness visits where beneficiaries receive personalized prevention plan services.

#### Elimination of deductible and coinsurance for most preventive services

Effective January 1, 2011, the ACA waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services, specifically for Medicare covered preventive services that have been recommended with a grade of A (“strongly recommends”) or B (“recommends”) from the U.S. Preventive Services Task Force, as well as the initial preventive physician examination and the annual wellness visit. The ACA also waives the Part B deductible for colorectal cancer screening tests that become diagnostic.

#### Incentive payments to primary care practitioners for primary care services

The ACA authorizes CMS to make incentive payments equal to 10 percent of the provider’s allowed charges for primary care services furnished by certain physician and nonphysician specialties that are designated as primary care practitioners. This provision begins with calendar year 2011. Primary care practitioners are physicians (1) who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner’s allowed charges under Part B for a prior period as determined by the Secretary of Health and Human Services.

#### Incentive payments for general surgery services in rural areas

The ACA calls for a payment incentive program to improve access to major surgical procedures – defined as those with a 10-day or 90-day global period under the Medicare physician fee schedule – in health professional shortage areas (HPSAs) between January 1, 2011, and December 31, 2016. To be eligible for the incentive payment, you must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the payment for the surgical services furnished by the general surgeon occurring in a ZIP code that is located in an area designated as a primary care HPSA.

#### Revisions to the practice expense geographic adjustment to assist rural providers

The ACA limits recognition of local differences in employee wages and office rents in the practice expense geographic adjustments (PE GPCI’s) for calendar year 2010 and 2011 as compared to the national average. Localities are held harmless to any decrease in 2010 and 2011 in their PE GPICs that would result from this alternative methodology. The new law also establishes a permanent 1.0 floor for the PE GPCI for frontier states (Montana, Wyoming, Nevada, North Dakota, and South Dakota), raising the rural area payment for physicians’ services to be no less than the national average.

#### Physician self-referral for certain imaging services

The ACA amends the in-office ancillary services exception to the self-referral law as applied to advanced imaging services, such as magnetic resonance imaging, computed tomography, and positron emission tomography, to require a physician to disclose to a patient in writing at the time of the referral that there are other suppliers of these imaging services, along with a list of other suppliers in the area in which the patient resides.

#### Misvalued codes under the physician fee schedule

The ACA requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. Building on this authority, the new rule identifies additional categories of services that may be misvalued, including codes with low work relative value units (RVUs) commonly billed in multiple units per single encounter and codes with high volume and low work RVUs.

#### Modification of equipment utilization factor for advanced imaging services

The ACA adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment to more consistently reflect the typical actual use of the equipment and, thereby, reduces payment rates for the associated procedures. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to

**Provisions in the Affordable Care Act of 2010 (continued)**

expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the ACA increases the established multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

**Maximum period for submission of Medicare claims reduced to not more than 12 months**

The ACA changes the time frame during which claims may be submitted for physicians' services to one year from the date of service, beginning with services furnished on or after January 1, 2010. This reflects a reduction in the maximum prior timely filing deadline of 15 to 27 months and aims to improve prompt payment and improve program integrity.

**Additional information**

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

You may find information (as of June 11, 2010) on CMS published regulations, CMS policy instructions, key implementation dates, and other accomplishments that relate to ACA at <https://www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf>.

Many of the new provisions outlined in the ACA are reflected in the proposed Medicare physician fee schedule regulation, which may be found at <http://www.federalregister.gov/inspection.aspx>.

You may also find a beneficiary brochure that provides information about the services and benefits of the new health care law (Medicare and the New Health Care Law — What it Means for You) at <http://www.medicare.gov/Publications/Search/Results.asp?PubID=11467&Type=PubID>.

MLN Matters® Number: SE1023

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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**ICD-10 implementation information**

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

**Provider types affected**

This issue impacts all physicians, providers, suppliers, and other covered entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health care setting.

**What you need to know**

This MLN Matters® special edition article provides information about the implementation of the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/ICD-10-PCS) code sets to help you better understand (and prepare for) the United States health care industry's change from ICD-9-CM to ICD-10 for medical diagnosis and inpatient hospital procedure coding.

The first ICD-10-related compliance date is less than two years away. On January 1, 2012, standards for electronic health transactions change from version 4010/4010A1 to version 5010. Unlike version 4010, version 5010 accommodates the ICD-10 code structure. This change occurs before the ICD-10 implementation date to allow adequate testing and implementation time.

On October 1, 2013, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry. Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

**Background****ICD-10 implementation compliance date**

On October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets.

- ICD-10-CM diagnoses codes will be used by all providers in every health care setting.
  - ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures.
  - The compliance dates are firm and not subject to change.
  - There will be no delays.
  - There will be no grace period for implementation.
- Important, please be aware:
- ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013.
  - ICD-10 codes will not be accepted for services prior to October 1, 2013.

You must begin using the ICD-10-CM codes to report diagnoses from all ambulatory and physician services on claims with dates of service on or after October 1, 2013, and for all diagnoses on claims for inpatient settings with dates of discharge that occur on or after October 1, 2013.

Additionally, you must begin using the ICD-10-PCS (procedure codes) for all hospital claims for inpatient procedures on claims with dates of discharge that occur on or after October 1, 2013.



**ICD-10 implementation information (continued)**

**Note:** Only ICD-10-CM, not ICD-10-PCS, will affect physicians. ICD-10-PCS will only be implemented for facility inpatient reporting of procedures – it will not be used for physician reporting. There will be no impact on *Current Procedural Terminology (CPT)* and Healthcare Common Procedure Coding System (HCPCS) codes. You should continue to use these codes for physician, outpatient, and ambulatory services. Physician claims for services provided to inpatient patients will continue to report *CPT* and HCPCS codes.

**What are the differences between the ICD-10-CM/ICD-10-PCS and ICD-9-CM Code Sets?**

The differences between the ICD-10 code sets and the ICD-9 code sets are primarily in the overall number of codes, their organization and structure, code composition, and level of detail. There are approximately 70,000 ICD-10-CM codes compared to approximately 14,000 ICD-9-CM diagnosis codes, and approximately 70,000 ICD-10-PCS codes compared to approximately 4,000 ICD-9-CM procedure codes.

In addition, ICD-10 codes are longer and use more alpha characters, which enable them to provide greater clinical detail and specificity in describing diagnoses and procedures. Also, terminology and disease classification have been updated to be consistent with current clinical practice.

Finally, system changes are also required to accommodate the ICD-10 codes.

**What are benefits of the ICD-10 coding system?**

The new, up-to-date classification system will provide much better data needed to:

- Measure the quality, safety, and efficacy of care
- Reduce the need for attachments to explain the patient’s condition
- Design payment systems and process claims for reimbursement
- Conduct research, epidemiological studies, and clinical trials
- Set health policy
- Support operational and strategic planning
- Design health care delivery systems
- Monitor resource utilization
- Improve clinical, financial, and administrative performance
- Prevent and detect health care fraud and abuse
- Track public health and risks

**ICD-10-CM code use and structure**

The ICD-10-CM (diagnoses) codes are to be used by all providers in all health care settings. Each ICD-10-CM code is three to seven characters, the first being an alpha character (all letters except U are used), the second character is numeric, and characters three-seven are either alpha or numeric (alpha characters are not case sensitive), with a decimal after the third character. Examples of ICD-10-CM codes follow:

- A78 – Q fever
- A69.21 – Meningitis due to Lyme disease
- O9A.311 – Physical abuse complicating pregnancy, first trimester
- S52.131A – Displaced fracture of neck of right radius, initial encounter for closed fracture

Additionally, the ICD-10-CM coding system has the following new features:

- 1) Laterality (left, right, bilateral)

For example:

- C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast
- H16.013 – Central corneal ulcer, bilateral
- L89.022 – Pressure ulcer of left elbow, stage II

- 2) Combination codes for certain conditions and common associated symptoms and manifestations

For example:

- K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding
- E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
- I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

- 3) Combination codes for poisonings and their associated external cause

For example:

- T42.3x2S – Poisoning by barbiturates, intentional self-harm, sequel

- 4) Obstetric codes identify trimester instead of episode of care

For example:

- O26.02 – Excessive weight gain in pregnancy, second trimester

- 5) Character “x” is used as a fifth character placeholder in certain six character codes to allow for future expansion and to fill in other empty characters (e.g., character five and/or six) when a code that is less than six characters in length requires a seventh character

For example:

- T46.1x5A – Adverse effect of calcium-channel blockers, initial encounter
- T15.02xD – Foreign body in cornea, left eye, subsequent encounter

- 6) Two types of excludes notes

**Excludes 1** – Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).

For example:

- Q03 – Congenital hydrocephalus (Excludes1: Acquired hydrocephalus (G91.-))

**Excludes 2** – Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).

**ICD-10 implementation information (continued)**

For example:

- L27.2 – Dermatitis due to ingested food (Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4))
- 7) Inclusion of clinical concepts that do not exist in ICD-9-CM (e.g., underdosing, blood type, blood alcohol level)
- For example:
- T45.526D – Underdosing of antithrombotic drugs, subsequent encounter
  - Z67.40 – Type O blood, Rh positive
  - Y90.6 – Blood alcohol level of 120–199 mg/100 ml
- 8) A number of codes have been significantly expanded (e.g., injuries, diabetes, substance abuse, postoperative complications)
- For example:
- E10.610 – Type 1 diabetes mellitus with diabetic neuropathic arthropathy
  - F10.182 – Alcohol abuse with alcohol-induced sleep disorder
  - T82.02xA – Displacement of heart valve prosthesis, initial encounter
- 9) Codes for postoperative complications have been expanded and a distinction made between intraoperative complications and postprocedural disorders
- For example:
- D78.01 – Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen
  - D78.21 – Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen

Finally, there are additional changes in ICD-10-CM, to include:

- Injuries are grouped by anatomical site rather than by type of injury
- Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM
- Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge
- New code definitions (e.g., definition of acute myocardial infarction is now four weeks rather than eight weeks)
- The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM.

To learn more about the ICD-10-CM coding structure you may review “Basic Introduction to ICD-10-CM” audio or written transcripts from the March 23, 2010, provider outreach conference call. Go to [http://www.cms.gov/ICD10/02c\\_CMS\\_Sponsored\\_Calls.asp#TopOfPage](http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage). Scroll to the bottom of the Web page to the *Downloads* section and

select the 2010 ICD-10 Conference Calls zip file and locate the March 23rd written or audio transcript.

**ICD-10-PCS code use and structure**

The ICD-10-PCS codes are for use only on hospital claims for inpatient procedures. ICD-10-PCS codes are not to be used on any type of physician claims for physician services provided to hospitalized patients. These codes differ from the ICD-9-CM procedure codes in that they have seven characters that can be either alpha (non-case sensitive) or numeric. The numbers zero-nine are used (letters O and I are not used to avoid confusion with numbers zero and one), and they do not contain decimals.

For example:

- 0FB03ZX – Excision of liver, percutaneous approach, diagnostic
- 0DQ10ZZ – Repair, upper esophagus, open approach

**Help with converting codes**

The general equivalence mappings (GEMs) are a tool that can be used to convert data from ICD-9-CM to ICD-10-CM/PCS and vice versa. Mapping from ICD-10-CM/PCS codes back to ICD-9-CM codes is referred to as backward mapping. Mapping from ICD-9-CM codes to ICD-10-CM/PCS codes is referred to as forward mapping. The GEMs are a comprehensive translation dictionary that can be used to accurately and effectively translate any ICD-9-CM-based data, including data for:

- Tracking quality
- Recording morbidity/mortality
- Calculating reimbursement
- Converting any ICD-9-CM-based application to ICD-10-CM/PCS

The GEMs can be used by anyone who wants to convert coded data, including:

- All payers
- All providers
- Medical researchers
- Informatics professionals
- Coding professionals—to convert large data sets
- Software vendors—to use within their own products;
- Organizations—to make mappings that suit their internal purposes or that are based on their own historical data
- Others who use coded data

The GEMs are not a substitute for learning how to use the ICD-10 codes. More information about GEMs and their use may be found at <http://www.cms.gov/ICD10> (select from the left side of the Web page ICD-10-CM or ICD-10-PCS to find the most recent GEMs).

Additional information about GEMs was provided on the following CMS sponsored conference call - May 19, 2009, “ICD-10 Implementation and General Equivalence Mappings”. Go to [http://www.cms.gov/ICD10/02c\\_CMS\\_Sponsored\\_Calls.asp](http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp), scroll to the bottom of the page, under Downloads select – 2009 ICD-10 Conference Calls to locate the audio and written transcripts.

*ICD-10 implementation information (continued)*

**What to do now in preparation for ICD-10 implementation?**

- Learn about the structure, organization, and unique features of ICD-10-CM - all provider types
- Learn about the structure, organization, and unique features of ICD-10-PCS - inpatient hospital claims
- Learn about system impact and 5010
- Use assessment tools to identify areas of strength/weakness in medical terminology and medical record documentation
- Review and refresh knowledge of medical terminology as needed based on the assessment results
- Provide additional training to refresh or expand knowledge in the biomedical sciences (anatomy, physiology, pathophysiology, pharmacology, and medical terminology)
- Plan to provide intensive coder training approximately six-nine months prior to implementation
- Allocating 16 hours of ICD-10-CM training will likely be adequate for most coders, and very proficient ICD-9-CM coders may not need that much

**Additional information**

To find additional information about ICD-10, visit <http://www.cms.gov/ICD10>. In addition, CMS makes the following resources available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page:** This site links Medicare fee-for-service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this Web page. Bookmark [http://www.cms.gov/ICD10/06\\_MedicareFeeForServiceProviderResources.asp](http://www.cms.gov/ICD10/06_MedicareFeeForServiceProviderResources.asp) and check back regularly for access to ICD-10 implementation information of importance to you. **Note:** Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.
- **CMS Sponsored National Provider Conference Calls:** During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation

of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit [http://www.cms.gov/ICD10/02c\\_CMS\\_Sponsored\\_Calls.asp#TopOfPage](http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage).

- **Frequently Asked Questions (FAQs):** To access FAQs related to ICD-10, please visit the CMS ICD-10 Web page at <http://www.cms.gov/ICD10/>, select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the “Related Links Inside CMS” section and select “ICD-10 FAQs”. Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- Workgroup for Electronic Data Interchange (WEDI) <http://www.wedi.org>, and
- Health Information and Management Systems Society (HIMSS) <http://www.himss.org/icd10>.

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**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.

## Medicare contractor annual update of the ICD-9-CM

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

### Provider types affected

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

### Provider action needed

This article is based on change request (CR) 7006, which reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

You may see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at [http://www.cms.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage), or at the National Center for Health Statistics (NCHS) website at <http://www.cdc.gov/nchs/icd9.htm> in June of each year. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

### Background

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

CMS issued CR 7006 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

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

### Additional information

For complete details regarding this CR, please see the official instruction (CR 7006) issued to your Medicare contractor, which may be found at <http://www.cms.gov/Transmittals/downloads/R2017CP.pdf>.

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters Number: MM7006

Related Change Request (CR) #: 7006

Related CR Release Date: August 4, 2010

Effective Date: October 1, 2010

Related CR Transmittal #: R2017CP

Implementation Date: October 4, 2010

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## Healthcare common procedure coding system quarterly update – other codes

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

Changes are effective on the date indicated on the update.

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

Source: CMS PERL 201007-03

### Try our E/M interactive worksheet

First Coast Service Options (FCSO) Inc. is proud of its exclusive E/M interactive worksheet, available at <http://medicare.fcso.com/EM/165590.asp>. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our Web site feedback form, available at <http://medicare.fcso.com/Feedback/160958.asp>.



## Medicare reporting and payment of services for alcohol and/or substance abuse

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

### Provider types affected

This article is for physicians, nonphysician practitioners, and other providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for certain mental health services provided to Medicare beneficiaries.

### Impact on providers

This article is informational only and does not alter existing Medicare policy nor does it introduce new policy.

### Background

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS), working with the Substance Abuse and Mental Health Services Administration (SAMHSA), to inform Medicare providers about reporting and payment for the appropriate delivery of alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention (SBIRT) services.

SBIRT is an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach is in contrast with the primary focus of specialized treatment of individuals with more severe substance use, or those who have met the criteria for diagnosis of a substance use disorder.

In the 2008 Medicare physician fee schedule (MPFS), Medicare created two Healthcare Common Procedure Coding System (HCPCS) G-codes to allow for the appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services. See MM5895 (related to CR 5895, Transmittal R1423CP, February 1, 2008 (Summary of Policies in the 2008 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount) at <http://www.cms.gov/MLN MattersArticles/downloads/MM5895.pdf>.

Additionally, these services are paid under the hospital outpatient prospective payment system (OPPS). See the January 2008 Update of the OPPS – Manualization, which includes a summary of the OPPS policies regarding these codes at <http://www.cms.gov/MLN MattersArticles/downloads/MM5946.pdf>.

These two HCPCS G-codes are:

- G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes)
- G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention greater than 30 minutes)

These HCPCS G-codes (G0396 and G0397) allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services, but only those services that are performed for the diagnosis or treatment of illness or injury.

Medicare contractors will consider payment for HCPCS codes G0396 and G0397 only when medically reasonable, and necessary (i.e., when the service is provided to evaluate and/or treat patients with signs/symptoms of illness or injury) as per the Social Security Act (Section 1862(a)(1)(A)). It is important to remember that Medicare only covers SBIRT services that are reasonable and necessary and meet the requirements of diagnosis or treatment of illness or injury.

### Structured assessment and brief intervention (SBIRT) services

Medicare pays for medically reasonable and necessary SBIRT services when they are delivered in the following settings: physicians' offices and outpatient hospitals. Providers assess for and identify individuals with, or at-risk for, substance use-related problems and furnish limited interventions/treatment.

### General principles of medical record documentation for individual mental health services

It is important to remember that all claims for Medicare services must be supported by information in the patient's medical record, and the general principles of medical record documentation for the reporting of SBIRT services for Medicare payments include the following as applicable to the specific setting/encounter (See CR 2520 [Transmittal AB-03-037] at

<http://www.cms.gov/Transmittals/downloads/AB03037.pdf>):

- Medical records should be complete and legible
- Documentation of each patient encounter should include:
  - Reason for encounter and relevant history
  - Physical examination findings and prior diagnostic test results
  - Assessment, clinical impression, and diagnosis
  - Plan for care
  - Date and legible identity of observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Documentation must denote start/stop time or total face-to-face time with the patient, because the SBIRT G-codes are time-based codes
- Past and present diagnoses should be accessible for the treating and/or consulting physician
- Appropriate health risk factors should be identified
- The patient's progress, response to changes in treatment, and revision of diagnosis should be documented, and
- The CPT and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim should be supported by documentation in the medical record.

Like all providers of services billed to Medicare, it is essential that providers of mental health services document their services fully in the medical record, because if the records are incomplete, the provider is at risk of losing Medicare payments in the event of a claims audit.

*Medicare reporting and payment of services for alcohol and/or substance abuse (continued)***Qualifications of practitioners providing mental health services that are covered under Medicare**

In order to bill Medicare, providers of mental health services must be qualified to perform the specific mental health services rendered. In order for these services to be covered, mental health professionals must be working within their state scope of practice act, and licensed (or certified) to perform mental health services by the state in which the services are performed. See CR 2520 (Transmittal AB-03-037, March 28, 2003) at <http://www.cms.gov/Transmittals/downloads/AB03037.pdf>.

**Physician**

A qualified physician must be legally authorized to practice medicine by the state in which he/she performs his/her services, and perform his/her services within the scope of his/her license as defined by state law.

**Clinical psychologist**

A clinical psychologist (CP) must hold a doctoral degree in psychology; and be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

In general, CP services are covered in the same manner as physician's services. CPs must be legally authorized to perform the services under applicable licensure laws of the state in which they are furnished.

See 42 CFR 410.71 at [http://edocket.access.gpo.gov/cfr\\_2009/octqtr/42cfr410.71.htm](http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.71.htm) and the *Medicare Benefits Policy Manual* (Chapter 15, Section 160) at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf> for the covered services of a CP.

**Clinical social workers**

A clinical social worker (CSW) must possess a master's or doctor's degree in social work; have performed at least two years of supervised clinical social work; and be licensed or certified as a clinical social worker by the state in which the services are performed.

In the case of an individual in a state that does not provide for licensure or certification, the individual must be licensed or certified at the highest level of practice provided by the laws of the state in which the services are performed. As well, the CSW must have completed at least two years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, skilled nursing facility (SNF), or clinic.

See 42 CFR 410.73 at [http://edocket.access.gpo.gov/cfr\\_2009/octqtr/42cfr410.73.htm](http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.73.htm) and the *Medicare Benefits Policy Manual* (Chapter 15, Section 170) for the covered services of a CSW.

**Nurse practitioner**

A nurse practitioner (NP) must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law. They must also be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners, or be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

NPs who applied to be a Medicare billing supplier for the first time on or after January 1, 2001, and prior to January 1, 2003, must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law. As well, they must be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners. The following organizations are recognized national certifying bodies for NPs at the advanced practice level:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses)
- Oncology Nurses Certification Corporation
- AACN Certification Corporation, and
- National Board on Certification of Hospice and Palliative Nurses.

NPs applying to be a Medicare billing provider for the first time on or after January 1, 2003, must possess a master's degree in nursing or a DNP degree from an accredited institution, be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law, and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

See 42 CFR 410.75 at [http://edocket.access.gpo.gov/cfr\\_2009/octqtr/42cfr410.75.htm](http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.75.htm) and the *Medicare Benefits Policy Manual* (Chapter 15, Section 200) for the covered services of an NP.

**Clinical nurse specialist (CNS)**

A clinical nurse specialist (CNS) must be a registered nurse who is currently licensed to practice in the state where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with state law, have a master's degree in a defined clinical area of nursing from an accredited educational institution, and be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for a CNS. The following organizations are recognized national certifying bodies for CNSs at the advanced practice level:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses)
- Oncology Nurses Certification Corporation
- AACN Certification Corporation, and

*Medicare reporting and payment of services for alcohol and/or substance abuse (continued)*

- National Board on Certification of Hospice and Palliative Nurses.  
See 42 CFR 410.76 at [http://edocket.access.gpo.gov/cfr\\_2009/octqtr/42cfr410.76.htm](http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.76.htm) and the *Medicare Benefits Policy Manual* (Chapter 15, Section 210) for the covered services of a CNS.

**Physician assistant**

A physician assistant (PA) must have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs and the Committee on Allied Health Education and Accreditation), or have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and be licensed by the state to practice as a PA.

See 42 CFR 410.74 at [http://edocket.access.gpo.gov/cfr\\_2009/octqtr/42cfr410.74.htm](http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.74.htm) and the *Medicare Benefits Policy Manual* (Chapter 15, Section 190) for the covered services of a PA.

**Medicare’s outpatient mental health treatment limitation**

Regardless of the actual expenses a beneficiary incurs in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for those services. The limitation is called the outpatient mental health treatment limitation (the limitation). The 62.5 percent limitation has been in place since the inception of the Medicare Part B program. This limitation does not apply to payment made to facilities under the OPPTS.

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends Section 1833(c) of the Social Security Act to phase out the outpatient mental health treatment limitation over a five-year period, from 2010-2014. MM6686 (related to CR 6686 – see <http://www.cms.gov/MLN MattersArticles/Downloads/MM6686.pdf>) alerts providers that CMS is phasing out the outpatient mental health treatment limitation over this five-year period.

The 62.5 percent limitation will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:

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

- January 1, 2012 – December 31, 2012, the limitation percentage is 75 percent. (Medicare pays 60 percent and the patient pays 40 percent).
- January 1, 2013 – December 31, 2013, the limitation percentage is 81.25 percent. (Medicare pays 65 percent and the patient pays 35 percent).
- January 1, 2014 – onward, the limitation percentage is 100 percent. (Medicare pays 80 percent and the patient pays 20 percent).

**Note:** There is no national policy that establishes whether the outpatient mental health treatment limitation (the limitation) applies to these SBIRT services. Therefore, the application of the limitation to the SBIRT services would be made by the local Medicare contractor.

**Additional information**

For additional details about the outpatient mental health treatment limitation, please see the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 5, Section 100.4; Chapter 9, Section 60; and Chapter 12, Section 210 & Section 210.1E) at <http://www.cms.gov/Manuals/IOM/list.asp>.

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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

For more information on SBIRT, please visit SAMHSA’s website at <http://sbirt.samhsa.gov>.

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## Billing for technical component of advanced diagnostic imaging services

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

### Provider types affected

Enrolled physicians, nonphysician practitioners, including single and multi-specialty clinics, and IDTFs who have billed the Medicare program for the technical component of advanced diagnostic testing services within the preceding six month period and who continue to have Medicare billing privileges with Medicare contractors (carriers and Part A/B Medicare administrative contractors [A/B MACs]) are affected.

### Provider action needed

#### *Stop – impact to you*

If you have billed the Medicare program for the technical component of advanced diagnostic testing services within the preceding six month period and continue to have Medicare billing privileges with Medicare contractors, you will receive a letter from your Medicare contractor advising you of the need to become accredited by January 1, 2012, in order to continue to provide these services and bill Medicare.

#### *Caution – what you need to know*

You must be accredited by one of the three Centers for Medicare & Medicaid Services (CMS) approved national accreditation organizations by January 1, 2012, in order to be eligible to continue to furnish the technical component of advanced diagnostic testing services to Medicare beneficiaries and submit claims for those services to your Medicare contractor.

#### *Go – what you need to do*

Look for the instructional letter from your Medicare contractor. Your contractor will be mailing the letter quarterly beginning with July 2010 through July 2011. If necessary, follow the instructions in the letter to become accredited by January 1, 2012, in order to continue billing for the technical component of advanced diagnostic imaging services. Make sure that your office staffs are aware of these new accreditation requirements and begin the accreditation process as soon as possible to protect your Medicare billing rights for these services.

### Background

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary, Health and Human Services, to designate organizations to accredit suppliers, including but not limited to physicians, nonphysician practitioners and independent diagnostic testing facilities, that furnish the technical component (TC) of advanced diagnostic imaging services.

### Definition of advanced diagnostic imaging procedures

MIPPA specifically defines advanced diagnostic imaging procedures as including:

- Diagnostic magnetic resonance imaging (MRI)
- Computed tomography (CT), and
- Nuclear medicine imaging, such as positron emission tomography (PET).

The law also authorized the Secretary to specify other diagnostic imaging services in consultation with physician specialty organizations and other stakeholders.

CR 6912 directs Medicare contractors to inform enrolled physicians, nonphysician practitioners and independent diagnostic testing facilities (IDTFs) by letter about the need to become accredited in order to continue to furnish the technical component of advanced diagnostic imaging services to Medicare beneficiaries on or after January 1, 2012. Medicare contractors will send the letter once each quarter for five times beginning with July 2010 through July 2011. When more than one physician or nonphysician practitioner is operating within a group, such as a single specialty or multispecialty clinic, only the group will receive the letter, not each of the individual physicians or nonphysician practitioners working for the group.

The letter will advise you that Medicare records indicate that you have furnished the technical component of advanced diagnostic imaging procedures such as diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET) within the last six months. If you are not accredited by one of the organizations shown below by January 1, 2012, you will not be eligible to bill the Medicare program for advanced diagnostic imaging services. Please note that the accreditation will apply only to the suppliers of the technical component (TC) of advanced diagnostic imaging services and not to the professional component.

CMS urges you take the necessary action to become accredited by the January 1, 2012, deadline. Since CMS expects that it may take as much as nine months from the time you initiate the accreditation process to completion, you should begin the accreditation process for advanced diagnostic imaging services as soon as possible, but not later than March 2011.

### Exclusions

MIPPA expressly excludes from the accreditation requirement x-ray, ultrasound, and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement diagnostic and screening mammography, which are subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.



***Billing for technical component of advanced diagnostic imaging services (continued)*****CMS approved national accreditation organizations**

CMS approved three national accreditation organizations – the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission – to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures. The accreditation will apply only to the suppliers of the images themselves, and not to the physician interpreting the image. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff.

To obtain additional information about the accreditation process, please contact the accreditation organizations shown below.

**American College of Radiology (ACR)**

1891 Preston White Drive  
Reston, VA 20191-4326  
1-800-770-0145  
<http://www.acr.org>

**Intersocietal Accreditation Commission (IAC)**

6021 University Boulevard, Suite 500  
Ellicott City, MD 21043  
1-800-838-2110  
<http://www.intersocietal.org>

**The Joint Commission (TJC)  
Ambulatory Care Accreditation Program**

One Renaissance Boulevard  
Oakbrook Terrace, IL 60181  
1-630-792-5286  
<http://www.jointcommission.org/AdvImaging2012>

**Additional information**

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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>. The official instruction, CR 6912, issued to your Medicare carrier and/or A/B MAC regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R727OTN.pdf>.

MLN Matters® Number: MM6912  
Related Change Request (CR) #: 6912  
Related CR Release Date: July 9, 2010  
Effective Date: August 2, 2010  
Related CR Transmittal #: R727OTN  
Implementation Date: August 13, 2010

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# Electronic Data Interchange

## Claim status category and claim status code update

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

### Provider types affected

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

### Provider action needed

This article, based on change request (CR) 7052, 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 along with the 277 Health Care Claim Acknowledgement were updated during the June 2010 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 or about July 1, 2010. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on October 4, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

### Background

The Health Insurance Portability and Accountability Act 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 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (Institutional or Professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

### Additional information

If you have questions, please contact your Medicare contractor at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

The official instruction, (CR 7052), issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2002CP.pdf>.

MLN Matters® Number: MM7052  
 Related Change Request (CR) #: 7052  
 Related CR Release Date: July 16, 2010  
 Effective Date: October 1, 2010  
 Related CR Transmittal #: R2002CP  
 Implementation Date: October 4, 2010

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## Vendors and providers start the conversation on version 5010 and ICD-10

**Providers:** The first recommended deadline for a successful transition to version 5010 is only five months away. By December 31, 2010, providers should complete their internal testing, and be ready to test with external partners beginning in January 2011.

Now is a great time for providers to check in with your vendors about their transition preparations. Not only is it important for you to make sure that you can count on them during the transition, but they are a great resource to provide you with details about what you need to do to comply with version 5010 standards and ICD-10.

**Vendors:** You play a vital role in the version 5010 and ICD-10 transition. Your customers will be looking to you for guidance to navigate them through the changes. Your products and services will be obsolete if steps are not taken now to get ready. Start talking with your customers about preparing for the version 5010 and ICD-10 transitions.

The Centers for Medicare & Medicaid Services (CMS) is here to help you both talk to each other – even help you get the conversation started if you haven't already. Go to the CMS website at <http://www.cms.gov/icd10/>, for provider and vendor resource pages that includes fact sheets with tips on asking each other the right questions. Keep up-to-date on version 5010 and ICD-10.

Please visit <http://www.cms.gov/icd10/> for the latest news. Coming soon sign up for version 5010 and ICD-10 e-mail updates.

**Version 5010 and ICD-10 are coming. Will you be ready?**

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

Source: CMS PERL 201007-09

## Proposed rulemaking to implement HITECH Act modifications to the HIPAA rules

The Department of Health & Human Services (HHS) issued a notice of proposed rulemaking on July 8, 2010, to modify the privacy, security, and enforcement rules issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, is designed to promote the widespread adoption and standardization of health information technology, and requires HHS to modify the HIPAA privacy, security, and enforcement rules to strengthen the privacy and security protections for health information and to improve the workability and effectiveness of the HIPAA rules.

The proposed modifications to the HIPAA rules issued on July 8, 2010, include provisions extending the applicability of certain of the requirement of privacy and security rules to the business associates of covered entities, establishing new limitations on the use and disclosure of protected health information for marketing and fundraising purposes, prohibiting the sale of protected health information, and expanding individuals' rights to access their information and to obtain restrictions on certain disclosures of protected health information to health plans. In addition, the proposed rule adopts provisions designed to strengthen and expand the enforcement provisions from HIPAA.

"This proposed rule strengthens the privacy and security of health information, and is an integral piece of the Administration's efforts to broaden the use of health information technology in health care today," said Georgina Verdugo, director of the HHS Office for Civil Rights (OCR). These HIPAA rules are administered and enforced by OCR.

Once it is published in the *Federal Register*, the notice of proposed rulemaking may be viewed and commented on for 60 days at <http://www.regulations.gov/search/Regs/home.html#home>.

In addition to issuing the notice of proposed rulemaking, OCR also updated its breach notification Web page.

Breaches of unsecured protected health information affecting 500 or more individuals that are reported to the HHS Secretary are now posted in a new, more accessible format that allows users to search and sort the reported breaches. Additionally, this new format includes brief summaries of the breach cases that OCR has investigated and closed, as well as the names of private practice providers who have reported breaches of unsecured protected health information to the Secretary.

Visit the OCR website for more information about this proposed rule and the updated breach notification Web page at <http://www.gov/ocr/privacy/>.

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Source: CMS PERL 201007-21

## Version 5010 and ICD-10 are coming – will you be ready?

Will you be ready for...

- The updated version 5010 standards for Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transactions on January 1, 2012?
- The International Classification of Diseases, 10th Edition (ICD-10) medical code set transition on October 1, 2013?

The Centers for Medicare & Medicaid Services (CMS) has new resources to help you prepare. Visit

<http://www.cms.gov/ICD10> and click on:

- Provider resources – to find out about basic steps medical practices can take to prepare for ICD-10 and for a fact sheet on talking with your vendors about the version 5010 and ICD-10 transitions
- Vendor resources – for tips for software vendors about talking with customers about the transitions

Software vendors, third-party billers, and clearinghouses may view materials from our recent conference at <http://www.cmsvendorconference.com>. Here you can also request information about working with CMS to help raise awareness about the version 5010 and ICD-10 transitions.

Keep up to date on version 5010 and ICD-10. Please visit <http://www.cms.gov/icd10> for the latest news and coming soon. Coming soon you will be able to sign up for version 5010 and ICD-10 e-mail updates.

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Source: CMS PERL 201006-34

## General Information

### PPACA requirements for ICD-10 crosswalk revisions – public forum meeting

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Coordination and Maintenance (C&M) Committee will convene on Wednesday and Thursday, September 15-16, 2010, at the Centers for Medicare & Medicaid Services (CMS) headquarters, 7500 Security Blvd, Baltimore, MD. The C&M Committee meeting is a public forum for the presentation of proposed modifications to the ICD-9-CM.

Section 10109(c) of the Patient Protection and Affordable Care Act and the Reconciliation Act of 2010 (PPACA) requires that the C&M Committee convene a meeting before January 1, 2011, to receive stakeholder input regarding the crosswalk between the ninth and tenth revisions of the ICD-9 and ICD-10, respectively, posted to the CMS website at <http://www.cms.gov/ICD10/> for the purpose of making appropriate revisions to said crosswalk. Section 10109(c) further requires that any revised crosswalk be treated as a code set for which a standard has been adopted by the Secretary, and that revisions to this crosswalk be posted to the CMS website.

The C&M Committee will use the first half of the first day of the September C&M Committee meeting, 9:00 a.m. to 12:30 p.m., Wednesday, September 15, 2010, to fulfill the above-referenced PPACA requirements for this meeting to be held prior to January 1, 2011, and receive public input regarding the above-referenced crosswalk revisions. Interested parties and other stakeholders should be prepared to submit their written comments and other relevant documentation at the meeting, or no later than November 12, 2010.

For the complete *Federal Register* notice, please go to <http://edocket.access.gpo.gov/2010/pdf/2010-16610.pdf>.

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Source: CMS PERL 201007-20

### Solicitation for proposal to participate in the Medicare imaging demonstration

The Centers for Medicare & Medicaid Services (CMS) has announced that it is soliciting proposals for participation in the Medicare Imaging Demonstration (MID). The MID was authorized by Section 135(b) of the Medicare Improvements for Patients and Providers Act of 2008 and will test whether the use of decision support systems (DSSs) can improve quality of care and reduce unnecessary radiation exposure and utilization by promoting appropriate ordering of advanced imaging services.

The two-year demonstration will assess the impact that DSSs used by physician practices have on the appropriateness and utilization of advanced medical imaging services ordered for the Medicare fee-for-service population. A DSS provides immediate feedback based on current medical specialty guidelines to the physician on the appropriateness of the test ordered for the patient. In addition, the demonstration will focus on magnetic resonance imaging, computed tomography, and nuclear medicine advanced imaging diagnostic services.

All current Medicare coverage and payment policies are unaffected under this demonstration. Prior authorization processes, which may be used to deny coverage for tests, are not part of the demonstration.

CMS will use “conveners” to reach eligible physicians interested in participating in the demonstration. Conveners will be responsible for recruiting physician practices, deploying a DSS that incorporates medical specialty society guidelines for the selected procedures, ensuring the DSS remains current with those guidelines, collecting and transmitting data, and distributing payments to practices for reporting data. Conveners and physician practices will be paid for reporting complete data necessary to determine the appropriateness of the test.

A wide variety of interested parties may be eligible to apply as conveners or in collaboration with other organizations to perform the responsibilities specified in the demonstration. Examples of conveners include, but are not limited to, physician groups, integrated health care delivery systems, independent practice associations, radiology benefit managers, health plans, information technology vendors, medical specialty societies, and collaborations among the above parties.

CMS is particularly interested in proposals from conveners that involve a diverse mix of physician practice sizes and types, medical specialties, and geographic areas. CMS will consider the characteristics of the physician practices and the ability of the convener to perform the functions identified in the solicitation when selecting demonstration areas. Award is contingent on the acceptance of CMS demonstration terms and conditions prior to the start of the demonstration.

Eleven advanced imaging procedures – SPECT myocardial perfusion imaging (MPI), magnetic resonance imaging (MRI) lumbar spine, computerized tomography (CT) lumbar spine, MRI brain, CT brain, CT sinus, CT thorax, CT abdomen, CT pelvis, MRI knee, and MRI shoulder – will be included in the demonstration. The 11 tests were selected based on high expenditures and utilization in the Medicare fee-for-service population and the availability of relevant medical specialty appropriateness guidelines. The law requires that the appropriateness criteria used in the demonstration be based on those developed or endorsed by medical specialty societies. CMS worked with medical specialty societies and other stakeholders, including the AQA Alliance, to solicit their input and information on available appropriateness criteria.



**Solicitation for proposal to participate in the Medicare imaging demonstration (continued)**

Applications are due to CMS by September 21, 2010.

Additional information about this demonstration including how to apply may be found at <http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1222075>. Questions on this demonstration may be submitted to CMS at [ImagingDemo135b@cms.gov](mailto:ImagingDemo135b@cms.gov)

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Source: CMS PERL 201007-44

**Enrollment guidance for physicians that infrequently receive reimbursement**

Traditionally, most physicians have enrolled in the Medicare program to furnish covered services to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, some physicians will need to enroll in the Medicare program for the sole purpose of certifying or ordering services for Medicare beneficiaries. These physicians do not send claims to a Medicare contractor for the services they furnish.

In the process of implementing the provisions contained in the Affordable Care Act, the Centers for Medicare & Medicaid services (CMS) has become aware of several unique enrollment issues for certain types of physicians or practitioners. Specifically, CMS modified the process of enrollment to accommodate the special circumstances of the following individual physicians and practitioners:

- Physicians employed by the Department of Veterans Affairs
- Physicians employed by the Public Health Service
- Physicians employed by the Department of Defense Tricare program
- Physicians employed by federally qualified health centers (FQHCs), rural health clinics (RHCs) or critical access hospitals (CAHs)
- Physicians in a fellowship
- Dentists, including oral surgeons

For details on the modifications to the enrollment process for these special circumstances, visit on the CMS website the special enrollment fact sheet for Physicians with Infrequent Reimbursements at <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SpecialEnrollmentFactsheetInfrequentPhysicianReimbursement.pdf>.

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Source: CMS PERL 201007-25

**CMS to review provider enrollment, chain and ownership system process Medicare working with ordering and referring providers and suppliers to streamline enrollment process**

The Centers for Medicare & Medicaid Services (CMS) is working with providers to address concerns about enrollment in the provider enrollment, chain and ownership system (PECOS) to ensure that Medicare beneficiaries continue to receive the health care services and items they need. PECOS is the electronic system used to enroll physicians and eligible professionals into the Medicare program.

As part of those efforts, CMS will, for the time being, not implement changes that would automatically reject claims based on orders, certifications, and referrals made by providers that have not yet had their applications approved by July 6. While more than 800,000 physicians and other health professionals have enrolled and have approved applications in the PECOS system, some providers have encountered problems. CMS is continuing to update and streamline the process, and more providers have been enrolled in the past few days.

CMS issued an interim final regulation on May 5 implementing provisions of the Affordable Care Act that permit only a Medicare enrolled physician or eligible professional to certify or order home health services, durable medical equipment, prosthetics, orthotics, and

supplies (DMEPOS), and certain items and services under Medicare Part B. The new law applies to orders, referrals and certifications made on or after July 1. The comment period for the regulation closed on July 6, after which the comments will be reviewed and considered before a final regulation is issued.

The Affordable Care Act provisions and the regulation were designed as steps to prevent fraud in Medicare by ensuring that only eligible and identifiable providers and suppliers can order and refer covered items and services to Medicare beneficiaries.

Many physicians and other providers and suppliers have continued to make good faith efforts to comply with the requirements of the law and regulation. These efforts will be a significant factor in determining the procedures and processes that will be incorporated in the final rule.

Although the regulation will be effective July 6, CMS will not implement automatic rejections of claims submitted by providers that have attempted to enroll in PECOS. However, until the automatic rejections are operational, providers should not see any change in the processing of their submitted claims; they will continue to be reviewed and paid as they have in the past.

**CMS to review provider enrollment, chain and ownership system process (continued)**

In addition, although CMS is taking a more deliberative approach to using PECOS, the agency will employ a contingency plan to meet the Affordable Care Act requirement that effective July 1, written orders and certifications are only to be issued by eligible professionals.

CMS will continue to send informational notices to providers reminding them of the need to submit or update their enrollment and will work with the provider community to provide guidance on enrollment and will process all applications expeditiously.

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Source: CMS PERL 201006-57

## Declare independence from the paper enrollment process – use Internet-based PECOS

The Internet-based provider enrollment, chain and ownership system (Internet-based PECOS) may be used in lieu of the Medicare enrollment application (i.e., Form CMS-855) to:

- Submit an initial Medicare enrollment application
- View or change your enrollment information
- Track your enrollment application through the Web submission process
- Add or change a reassignment of benefits
- Submit changes to existing Medicare enrollment information
- Reactivate an existing enrollment record
- Withdraw from the Medicare program

### Advantages of Internet-based PECOS

- Faster than paper-based enrollment (45 day processing time in most cases, versus 60 days for paper)
- Tailored application process means you only supply information relevant to your application
- Gives you more control over your enrollment information, including reassignments
- Easy to check and update your information for accuracy
- Less staff time and administrative costs to complete and submit enrollment to Medicare

### Physicians and nonphysician practitioners Using Internet-based PECOS is easy

Learn how to use the system by visiting the Medicare Physician and Non-Physician Practitioner

Getting Started Guide, available at <http://www.cms.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf>. If you encounter problems or have questions as you navigate the system, there are several resources that can help.

**So, don't wait, set your practice free from paper – start using Internet-based PECOS today.**

### Provider and supplier organizations Using Internet-based PECOS is easy

Learn how to use the system by visiting the Getting Started Guide for Provider and Supplier Organization, available at <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationGettingStarted.pdf>. Remember, creating a record in Internet-based PECOS may take several weeks for an organization provider. It is recommended that you begin this process (if necessary) well in advance of any upcoming enrollment actions. For more information on this setup process, visit our Provider and Supplier Organization Overview at <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationOverview.pdf>.

**So, don't wait, set your organization free from paper – start using Internet-based PECOS today**

Internet-based PECOS will be made available for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) later this year.

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Source: CMS PERL 201007-14, PERL 201007-13

## Tips for using Internet-based PECOS

The Internet-based provider enrollment, chain and ownership system (PECOS) may be used by providers and suppliers (except durable medical equipment, prosthetics, orthotics, and supplies suppliers) to submit Medicare enrollment applications over the Internet.

As a reminder, providers and suppliers should report application navigation, printing, or access problems with Internet-based PECOS to the external user service (EUS) help desk at 1-866-484-8049 or send an e-mail to the EUS help desk to <mailto:EUSsupport@cgi.com>. In addition, providers and suppliers must have Internet Explorer version 5.5 or higher and have the most recent version of Adobe® Acrobat Reader before initiating an enrollment action using Internet-based PECOS.

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

Source: CMS PERL 201007-06

## Electronic prescribing incentive program updates

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

### Provider types affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) physician e-Prescribing (eRx) incentive program.

### Provider action needed

CMS is issuing this special edition article to alert providers that it is not too late to start participating in the eRx incentive program to potentially qualify to receive a full-year incentive payment. Eligible professionals may begin reporting eRx at any time throughout the 2010 program year of January 1, 2010, through December 31, 2010, to be incentive eligible.

This article also provides updated information about changes to the eRx incentive program for 2010 as authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The eRx is a separate incentive program from the Physician Quality Reporting Initiative (PQRI), with different reporting requirements.

For 2010, eligible professionals who successfully report the eRx measure will become eligible to receive an eRx incentive equal to 2.0 percent of their total Medicare Part B physician fee schedule (PFS) allowed charges for services performed during the reporting period.

Be aware that beginning in 2012, eligible professionals who are not successful electronic prescribers will be subject to a PFS payment adjustment, or penalty.

### Background

The Medicare eRx began January 1, 2009, and is authorized under the MIPPA. The program provides incentives for eligible professionals who are successful electronic prescribers. A Web page dedicated to providing all the latest news on the eRx incentive program is available at <http://www.cms.gov/ERXincentive/>.

For 2010, changes have been made, regarding the eRx measure (numerator) and its reporting requirements, reporting options, reporting mechanisms, and changes to the denominator codes. These are described in detail in this article.

### eRx incentive program eligibility criteria for 2010

#### Reporting requirements

- To be considered a successful eRx prescriber and be eligible to receive an incentive payment, you must generate and report one or more electronic prescriptions associated with an eligible patient visit - a minimum of 25 unique visits per year (see denominator codes). Each visit must be accompanied by the eRx G-code (numerator code) attesting that during the patient visit at least one prescription was electronically prescribed. (See Report mechanism for 2010)
- Electronically generated refills do not count and faxes do not qualify as eRx. New prescriptions not associated with a code in the denominator of the measure specification are not accepted as an eligible patient visit and do not count towards the minimum 25 unique Rx events.
- The eligible professional's Medicare Part B PFS allowed charges for services in the eRx measure's denominator should be comprised of 10 percent or more of the eligible professional's total 2010 estimated allowed charges. (See denominator codes)

#### Qualified reporting system requirements

- Eligible professionals must have adopted a "qualified" eRx system.
- There are two types of systems: A system for eRx only (stand-alone) or an electronic health record (EHR) system with eRx functionality.
- Regardless of the type of system used, to be considered "qualified" it must be based on **all** of the following capabilities:
  - Generates a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers if available
  - Selects medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts
  - Provides information related to lower cost, therapeutically appropriate alternatives (if any). The availability of an eRx system to receive tiered formulary information, if available, would meet this requirement for 2010, and
  - Provides information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

**Note:** For the capabilities listed above, the system must employ the eRx standards adopted by the Secretary of the Department of Health and Human Services for Medicare Part D by virtue of the 2003 Medicare Modernization Act (MMA).

#### Reporting mechanisms for 2010

If you have not yet participated in the eRx program, you can begin by reporting eRx data for January 1, 2010, through December 31, 2010, using any of the following three options:

- Claims-based reporting of the eRx measure. Claims-based reporting involves the addition of a quality-data code (QDC) to claims submitted for services (occurring during the reporting period) when billing Medicare Part B. For 2010, only report one G-code (G8553 - At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.)

**Electronic prescribing incentive program updates (continued)**

- Registry-based reporting using a CMS-PQRI qualified registry. EPs have the option of using a qualified registry to assist in collecting eRx measure data and submitting 2010 data to CMS during the first quarter of 2011. The registry will submit this quality data directly to Medicare, eliminating the need for adding the QDC to the Medicare Part B claim
- EHR-based reporting, using a CMS-PQRI qualified EHR product, submitting 2010 data to CMS during the first quarter of 2011.

Eligible professionals do not need to sign up or pre-register to participate in the 2010 eRx. Reporting one QDC (G8553) for the eRx measure to CMS through claims-based reporting, or submission via a qualified registry or a qualified EHR will indicate intent to participate.

The option of reporting via the group practice reporting option (GPRO) is no longer available for the 2010 program year. The group practices have already been selected for 2010.

**Note:** Only registries and EHR vendors who have been selected by CMS for the 2010 PQRI/eRx and are on the posted list of registries/EHR vendors are eligible to be considered “qualified” for purposes of the 2010 eRx incentive program you may go to [http://www.cms.gov/ERxIncentive/08\\_Alternative%20Reporting%20Mechanism.asp#TopOfPage](http://www.cms.gov/ERxIncentive/08_Alternative%20Reporting%20Mechanism.asp#TopOfPage) (Downloads).

**eRx measure denominator codes (eligible cases) for 2010**

Patient visit during the reporting period (*Current Procedural Terminology [CPT]* or Healthcare Common Procedure Coding System [HCPCS] G-codes):

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

**Summary**

If you are routinely using a qualified system (as described above) and expect your Medicare Part B PFS charges for the codes in the denominator of the measure (as noted eRx measure denominator codes above) to make up at least 10 percent of your total Medicare Part B PFS allowed charges for 2010, you may be eligible for an incentive payment equal to two percent of your Medicare Part B PFS allowed charges for services furnished during the reporting period and you should report the eRx measure.

If you are routinely using a qualified system (as described above) but do not expect your Medicare Part B PFS charges for the codes in the denominator of the measure (as noted eRx measure denominator codes above) to make up at least 10 percent of your total Medicare Part B PFS allowed charges for 2010, you may not be eligible for the incentive payment. However, CMS encourages you to report the measure. In the event that your Medicare Part B PFS charges for the codes in the denominator of the measure do make up at least 10 percent of your total Medicare Part B PFS allowed charges for 2010, you may be eligible for the incentive payment.

**Note:** For the years 2012, 2013, and 2014, if an eligible professional is not a successful electronic prescriber for the reporting period for the year, the PFS amount for covered professional services furnished by such professionals during the year will be less than the PFS amount that would otherwise apply over the next several years by: (1) 1.0 percent for 2012; (2) 1.5 percent for 2013; and (3) 2.0 percent for 2014.

The reporting period and criteria CMS will use in 2012 to determine whether an eligible professional (or group practice) is subject to this penalty (including the circumstances under which an eligible professional or group practice could seek a hardship exemption) are addressed in the Medicare PFS proposed rule for 2011.

**Additional information**

If you have questions about how to get started with eRx, contact the QualityNet Help Desk at 866-288-8912 from 7:00 a.m.-7:00 p.m. CST or via e-mail at [qnet-support@sdps.org](mailto:qnet-support@sdps.org).

There are two fact sheets that detail the eRx program for 2010:

**2010 eRx Incentive Program Made Simple Fact Sheet** may be found at

<http://www.cms.gov/ERxIncentive/Downloads/2010eRxMadeSimpleFS032310f.pdf>

**2010 eRx Incentive Program Fact Sheet: What's New for 2010 eRx Incentive Program** may be found at

<http://www.cms.gov/ERxIncentive/Downloads/WhatsNew2010eRxFS032310f.pdf>.

Previously issued *MLN Matters* articles that outline the specifics of the program are:

- SE0922 Alternative Process for Individual Eligible Professionals to Access Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (E-Prescribing) Feedback Reports at <http://www.cms.gov/MLNMattersArticles/downloads/SE0922.pdf>
- MM6394 Program Overview: 2009 Physician Quality Reporting Initiative (PQRI) And The 2009 Electronic Prescribing (E-Prescribing) Incentive Program at <http://www.cms.gov/MLNMattersArticles/downloads/MM6394.pdf>, and
- MM6514 Coding and Reporting Principles for the Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing (E-Prescribing) Incentive Programs at <http://www.cms.gov/MLNMattersArticles/downloads/MM6514.pdf>.



**Electronic prescribing incentive program updates (continued)**

Eligible professionals may refer to the specification for the reporting method applicable to your practice at:

- Claims- and registry-based at [http://www.cms.gov/ERxIncentive/Downloads/2010\\_eRx\\_MeasureSpecificationsandReleaseNotes\\_121709.zip](http://www.cms.gov/ERxIncentive/Downloads/2010_eRx_MeasureSpecificationsandReleaseNotes_121709.zip)
- EHR-based at <http://www.cms.gov/ERxIncentive/Downloads/2010EHRMeasureSpecificationforeRxandReleaseNotes.zip>, and
- Claims-Based Reporting Principles for Electronic Prescribing (eRx) Incentive Program at <http://www.cms.gov/ERxIncentive/Downloads/Claims-BasedReportingPrinciplesforeRx122209.pdf>.

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters Number: SE1021

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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## Reminder: 2010 Physician Quality Reporting Initiative program

It is not too late to start participating in the 2010 Physician Quality Reporting Initiative (PQRI) and potentially qualify to receive incentive payments. A new six-month reporting period begins on July 1, 2010.

The 2010 Physician Quality Reporting Initiative (PQRI) has two reporting periods: 12-month (January 1-December 31) and six-month (July 1-December 31). For 2010, eligible professionals (EPs) who satisfactorily report PQRI measures for the six-month reporting period will become eligible to receive a PQRI incentive equal to 2.0 percent of their total Medicare Part B allowed charges for services performed during the reporting period.

If you have not participated in the PQRI program, you can begin by reporting PQRI data for July 1-December 31 using any of the following four options:

- Claims-based reporting of individual measures for 80 percent or more of applicable patients on at least three individual measures or on each measure if less than three measures apply
- Claims-based reporting of one measures group for 80 percent or more of applicable Medicare Part B fee-for-service (FFS) patients of each EP (with a minimum of eight patients)
- Registry-based reporting of at least three individual PQRI measures for 80 percent or more of applicable Medicare Part B FFS patients of each EP
- Registry-based reporting of one measures group for 80 percent or more of applicable Medicare Part B FFS patients of each EP (with a minimum of eight patients)

PQRI claims-based reporting involves the addition of quality-data codes (QDC) to claims submitted for services when billing Medicare Part B. EPs also have the option

of using a qualified registry to assist in collecting PQRI measure data. The registry will submit this quality data directly to Medicare, eliminating the need for adding QDCs to the Medicare Part B claim.

Eligible professionals do not need to sign up or pre-register to participate in the 2010 PQRI. Submission of QDCs for individual PQRI measures to the Centers for Medicare & Medicaid Services (CMS) through a qualified registry or for a measures group through claims or a qualified registry will indicate intent to participate.

Although there is no requirement to register prior to submitting the data, there are some preparatory steps that EPs should take prior to undertaking PQRI reporting. CMS has created many educational products that provide information about how to get started with PQRI reporting. To access all available educational resources on PQRI please visit, <http://www.cms.gov/PQRI/>. Eligible professionals are encouraged to visit the PQRI Web page often for the latest information and downloads on PQRI.

### Resources

- **2010 PQRI Implementation Guide**  
[http://www.cms.gov/PQRI/Downloads/2010\\_PQRI\\_ImplementationGuide\\_02-10-2010\\_FINAL.pdf](http://www.cms.gov/PQRI/Downloads/2010_PQRI_ImplementationGuide_02-10-2010_FINAL.pdf)
- **Qualified Registries for 2010 PQRI Reporting**  
[http://www.cms.gov/PQRI/20\\_AlternativeReportingMechanisms.asp](http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp)

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

Source: CMS PERL 201006-29, PERL 201006-49

## Electronic health record incentive program meaningful use final rule

On July 13, 2010, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) for Health Information Technology jointly announce their final rules for both electronic health record standards for certification and the Medicare and Medicaid electronic health record (EHR) incentive programs, including the definition of meaningful use.

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, eligible health-care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve specified objectives. One of the two regulations announced on July 13, 2010, defines the “meaningful use” objectives that providers must meet to qualify for the bonus payments, and the other regulation identifies the technical capabilities required for certified EHR technology.

Announcement of these regulations marks the completion of multiple steps laying the groundwork for the incentive payments program. With “meaningful use” definitions in place, EHR system vendors can ensure that their systems deliver the required capabilities, providers can be assured that the system they acquire will support achievement of “meaningful use” objectives, and a concentrated five-year national initiative to adopt and use electronic records in health care can begin.

The press release issued July 13, 2010, is available at [http://www.cms.gov/apps/media/press\\_releases.asp](http://www.cms.gov/apps/media/press_releases.asp) or <http://www.hhs.gov/news/press/2010pres/2010.html>.

Also CMS issued fact sheets on July 13 with additional details at [http://www.cms.gov/apps/media/fact\\_sheets.asp](http://www.cms.gov/apps/media/fact_sheets.asp).

To learn more about the Medicare and Medicaid EHR incentive programs, visit the CMS-dedicated website to this program, <http://www.cms.gov/EHRIncentivePrograms/>.

Here you’ll find information about eligibility, requirements, upcoming events and more. To learn more about electronic health records and certification standards, visit the HHS/ONC-website at <http://healthit.hhs.gov/portal/server.pt>.

This website is the premier place to learn about the benefits of using EHR technology in a meaningful way, local resources to assist in EHR adoption and more.

More information may be found on the CMS website at <http://www.cms.gov/EHRIncentivePrograms/>.

### Links to rules via the Federal Register

[http://www.ofr.gov/OFRUpload/OFRData/2010-17207\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2010-17207_PI.pdf)

[http://www.ofr.gov/OFRUpload/OFRData/2010-17210\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2010-17210_PI.pdf)

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

Source: CMS PERL 201007-22

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

## Final rule issued to establish a temporary electronic health record certification program

The Office of the National Coordinator (ONC) for Health Information Technology issued a final rule to establish a temporary certification program for electronic health record (EHR) technology. The press release is available at <http://www.hhs.gov/news/press/2010pres/06/20100618d.html>.

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

Source: CMS PERL 201006-26

## Fact sheets on electronic health record incentive programs now available

Office of the National Coordinator (ONC) certification and Medicare and Medicaid electronic health record (EHR) incentive program final rules: How will they impact you?

The Centers for Medicare & Medicaid Services (CMS) has issued the following two fact sheet regarding electronic health records incentive program EHR final rules:

- CMS finalizes definition of meaningful use of certified electronic health record technology  
For more information, see the fact sheet from July 16, 2010.
- CMS finalizes requirements for the Medicare electronic health record incentive program  
For more information, see the fact sheet from July 16, 2010.

Be sure to visit the CMS Web section on the Medicare & Medicaid EHR incentive programs at <http://www.cms.gov/EHRIncentivePrograms/>.

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

Source: CMS PERL 201007-39

## Written and audio transcripts of the June 15 ICD-10 teleconference now available

The written and audio transcripts of the June 15 national provider conference call, “ICD-10 Implementation in a 5010 Environment,” hosted by Centers for Medicare & Medicaid Services (CMS) is now available. You may access the transcripts at [http://www.cms.gov/ICD10/02c\\_CMS\\_Sponsored\\_Calls.asp](http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp).

In the *Downloads* section select the “June 15, 2010 ICD-10 Conference Call” zip file. This zip file contains the written and audio transcripts, as well as the slide presentation used during the teleconference.

The length of the audio transcript is 1 hour and 51 minutes.

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

Source: CMS PERL 201007-24

## One year anniversary of President Obama’s “Year of Community Living” initiative

### Eleventh anniversary of Olmstead Supreme Court ruling also observed

In honor of the one year anniversary of the Obama Administration’s “Year of Community Living,” Health & Human Services Secretary Kathleen Sebelius announced new funds for states to build innovative systems to link persons with disabilities to affordable housing in their home communities.

This new \$3.2 million, three-year contract is designed to create unprecedented collaboration between human services agencies and housing authorities at all levels of government to help persons living in institutions find homes and live more independently. The effort, “Housing Capacity Building Initiative for Community Living,” will be led by New Additions Consulting Inc.

The announcement also aids the implementation of the U.S. Supreme Court’s decision in *Olmstead v. L.C.*, which was handed down 11 years ago today. In that decision, the court ruled that, under the Americans with Disabilities Act, unnecessarily institutionalizing a person with a disability who, with proper support, can live in the community is discrimination. In its ruling, the Supreme Court said that institutionalization severely limits the person’s ability to interact with family and friends, to work, and to make a life for him or herself.

“The Department is continuing to build on the important efforts launched by the President’s Year of Community Living initiative,” said Secretary Sebelius “Our efforts are being strengthened with the support and efforts of our colleagues in the Department of Housing and Urban Development and at the Department of Justice.”

Secretary Sebelius is promoting partnerships within HHS and with other departments, including the Department of Housing and Urban Development to create a productive collaboration in ensuring that people with disabilities, seniors, and individuals with chronic conditions have new opportunities to live as valued members of their communities.

Also, the Centers for Medicare & Medicaid Services is issuing a letter to state Medicaid directors describing the extension of the “Money Follows the Person” demonstration as a result of the Affordable Care Act. This program has been a very successful partnership with states and has resulted in many individuals moving from institutional to community-based settings.

“The implementation of the Affordable Care Act helps advance the civil rights of individuals with disabilities and community living arrangements, building on the important cornerstone in the *Olmstead* decision,” said Henry Claypool, director of the Office on Disability. “Today’s announcement is yet another step in HHS’ 11-year effort to achieve that goal.”

To read more on HHS accomplishments during the “Year of Community Living,” please visit <http://www.hhs.gov/od/topics/community/keyadvances.html>.

More information about the “Money Follows the Person” program may be found at [http://www.cms.gov/CommunityServices/20\\_MFP.asp](http://www.cms.gov/CommunityServices/20_MFP.asp).

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

Source: CMS PERL 201006-39

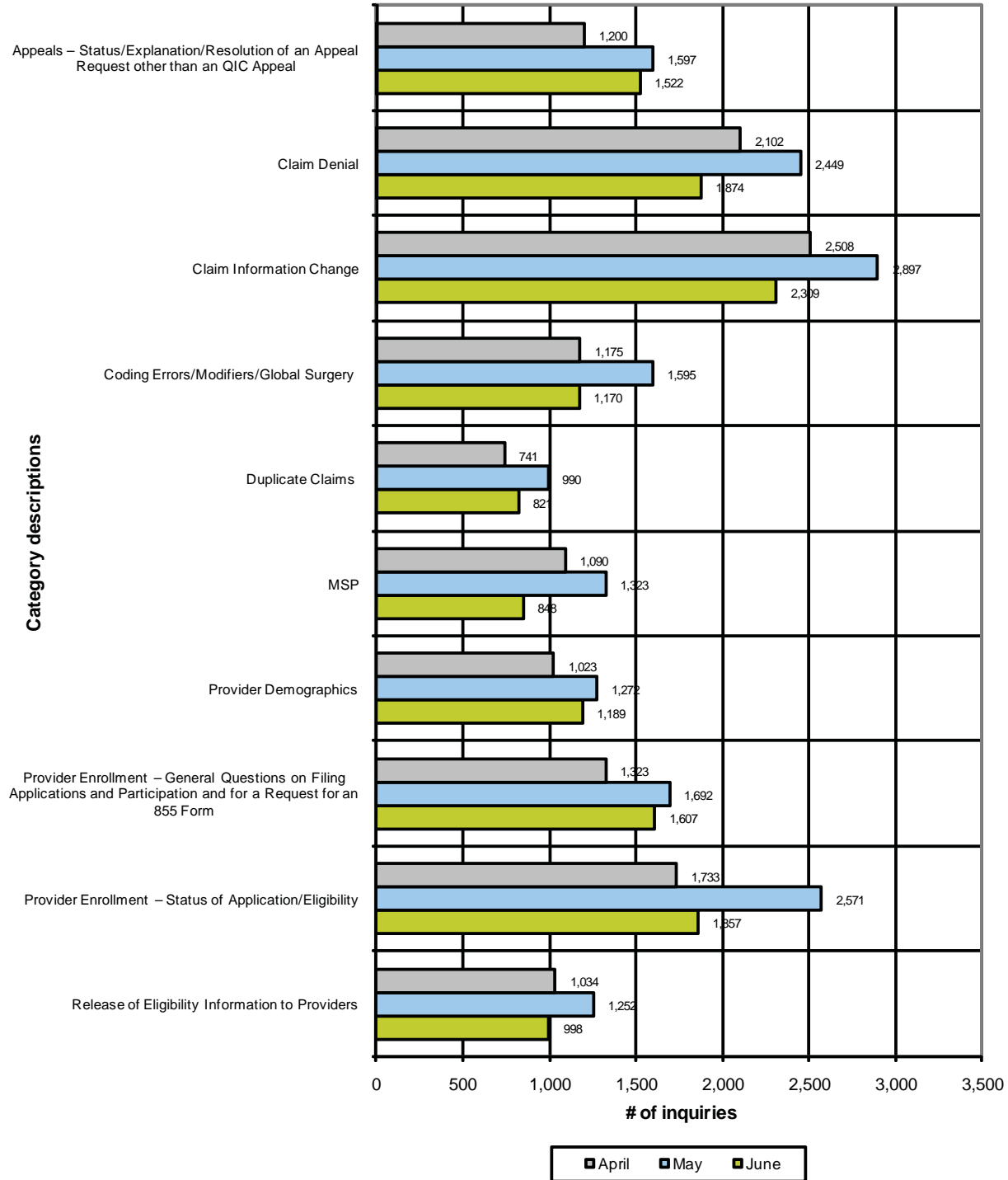
### Sign up to our eNews electronic mailing list

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

## Top inquiries, denials, and return unprocessable claims for April-June

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 April-June 2010. 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 website at [http://medicare.fcso.com/Inquiries\\_and\\_denials/index.asp](http://medicare.fcso.com/Inquiries_and_denials/index.asp).

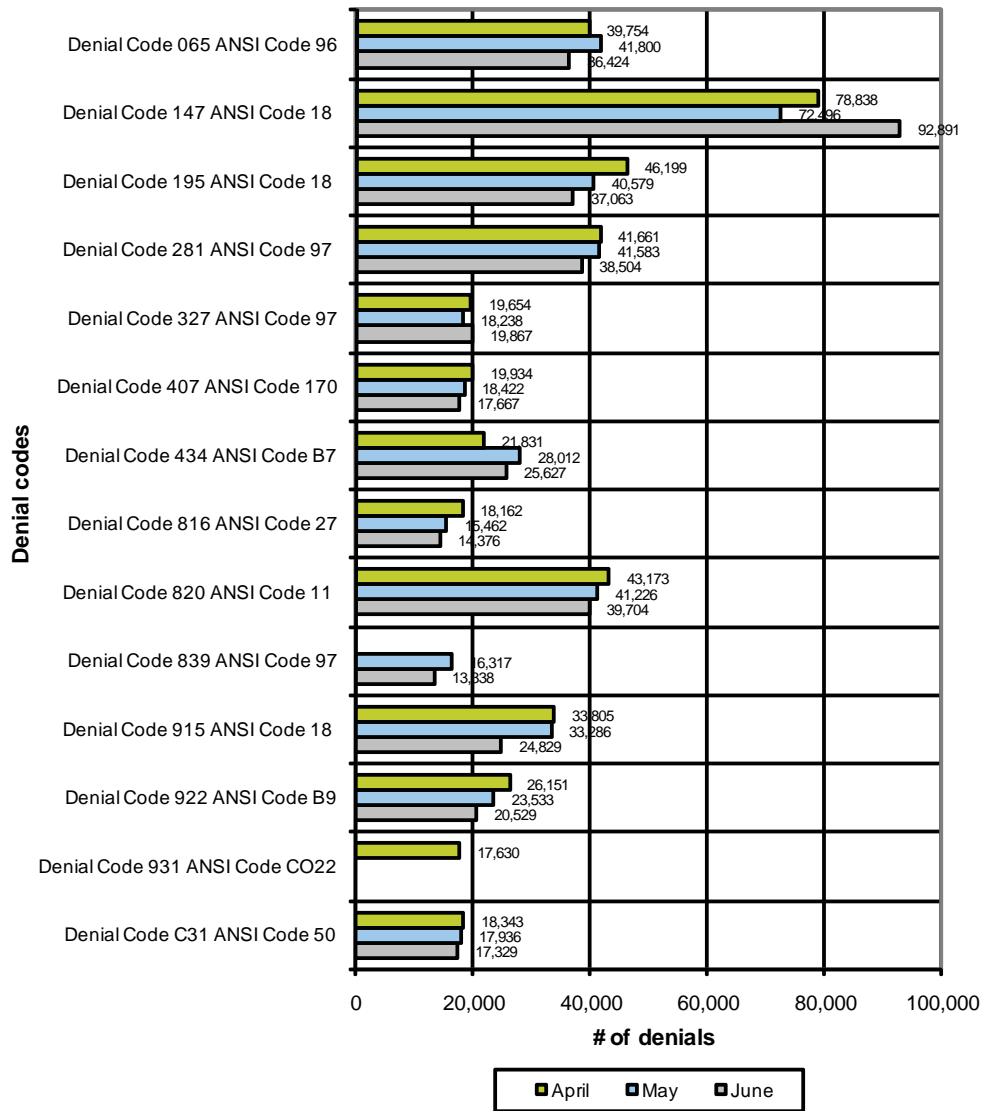
**Florida Part B top inquiries for April-June 2010**





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

Florida Part B top denials for April-June 2010



**Additional information on how to avoid duplicate claim denials**

First Coast Service Options Inc. (FCSO) strives to offer providers convenient access to the information and educational tools they need to increase their knowledge of the Medicare program. One way of doing that is offering Web-based training courses that educate providers on a myriad of topics. FCSO offers a free Web-based training (WBT) course specific to duplicate claims.

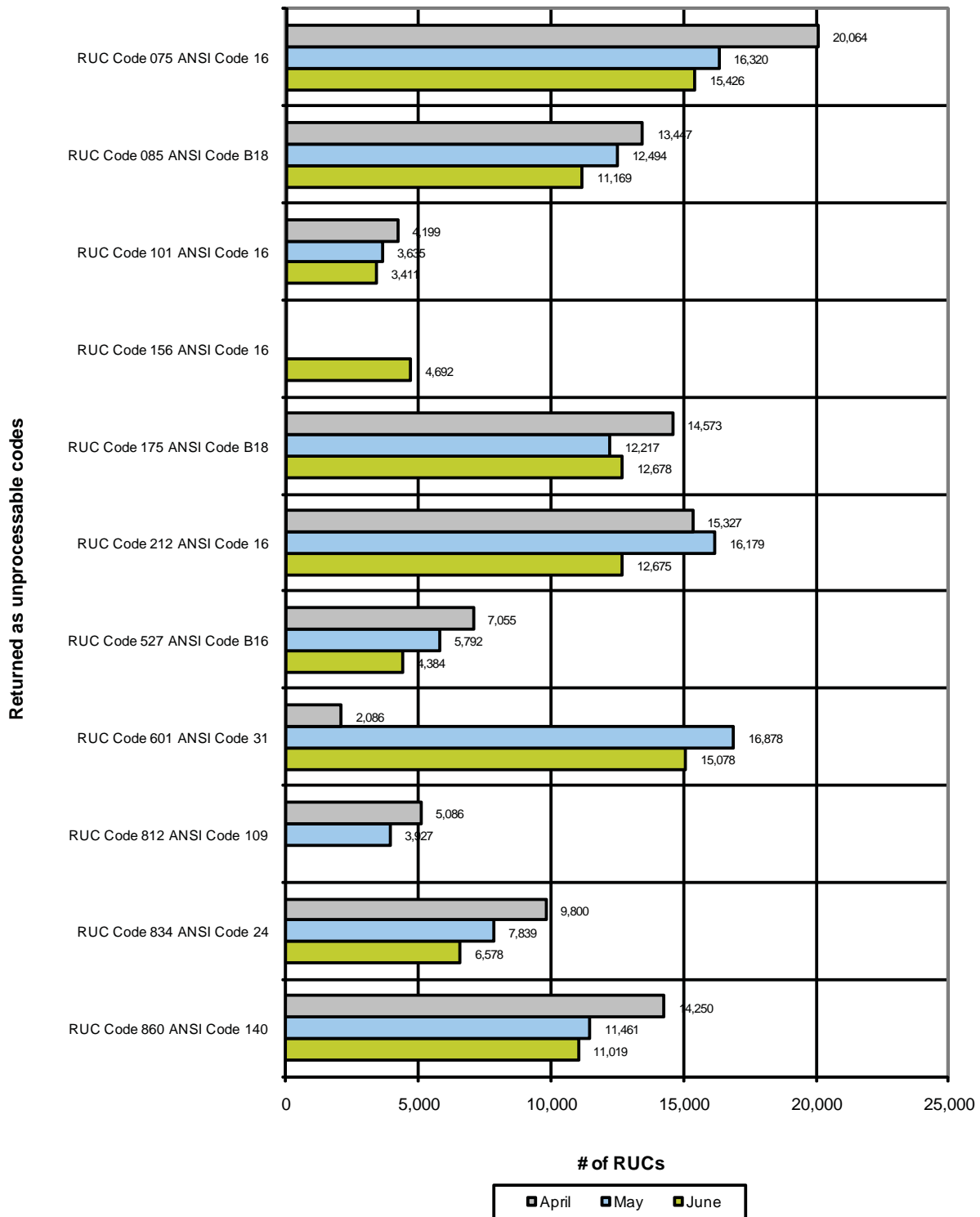
- To access the *Duplicate Claims – Part B WBT*, visit our FCSO Medicare Training website [www.fcsomedicaretraining.com](http://www.fcsomedicaretraining.com).

FCSO also offers free educational sessions throughout the year, focused on particular billing issues you may be experiencing. These may include webcasts or seminars on avoiding duplicate claims for Part B.

- Visit the FCSO Events page at <http://medicare.fcsco.com/Events/> to learn about upcoming events and link to our online learning system to review encore presentations of webcasts conducted on this topic.

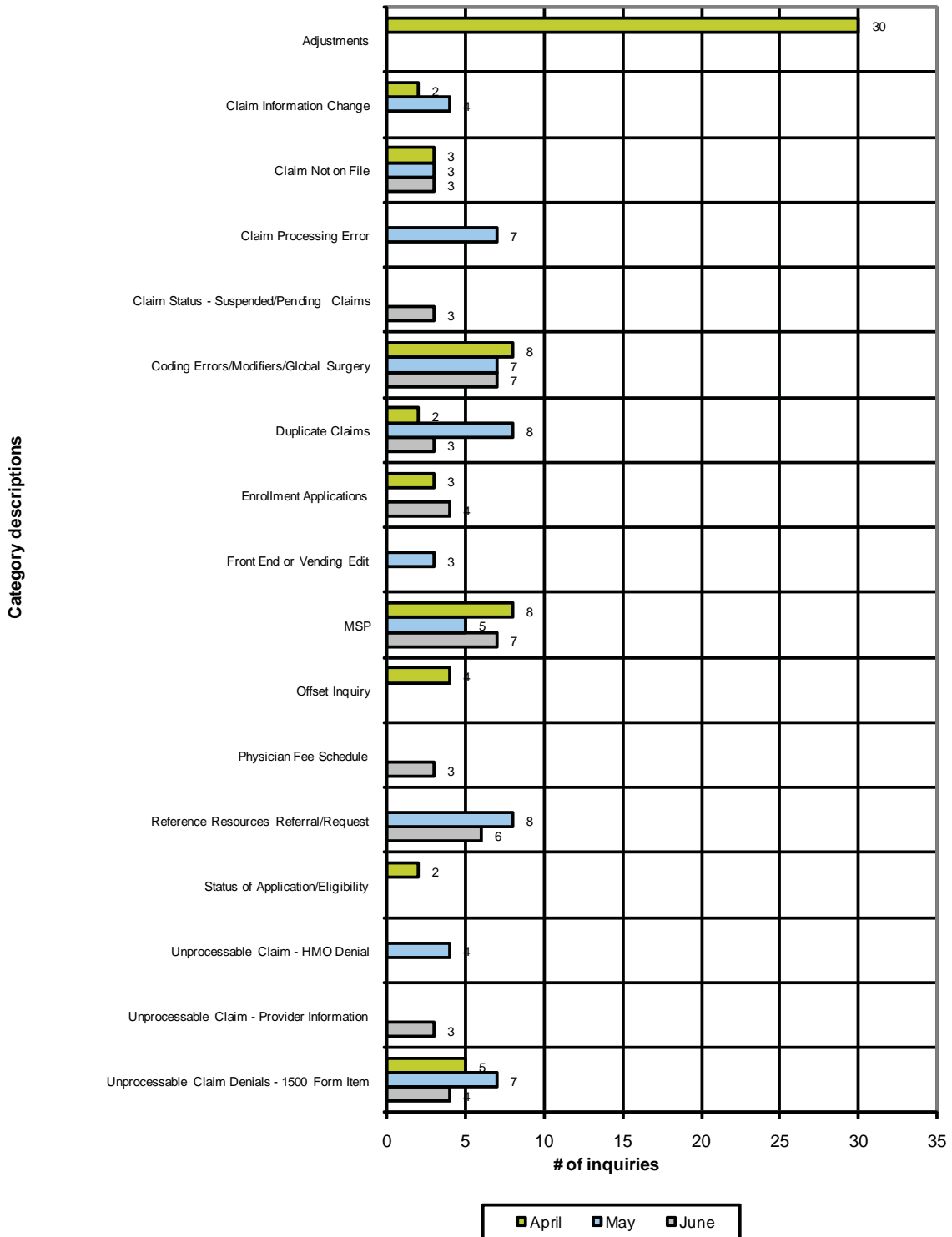
Top inquiries, denials, and return unprocessable claims for April-June (continued)

**Florida Part B top return as unprocessable claims (RUC) for April-June 2010**



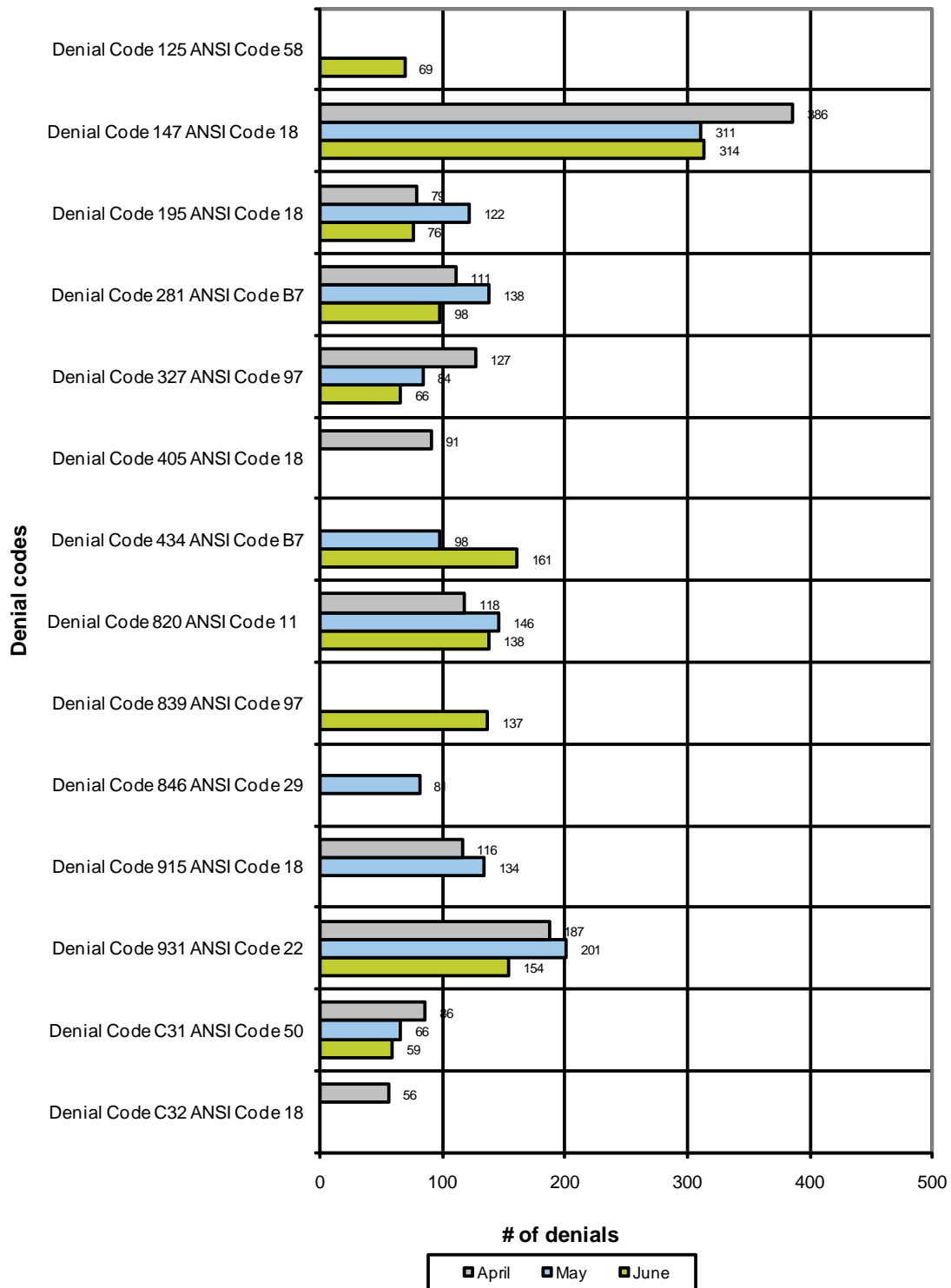
Top inquiries, denials, and return unprocessable claims for April-June (continued)

U.S. Virgin Islands Part B top inquiries for April-June 2010



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

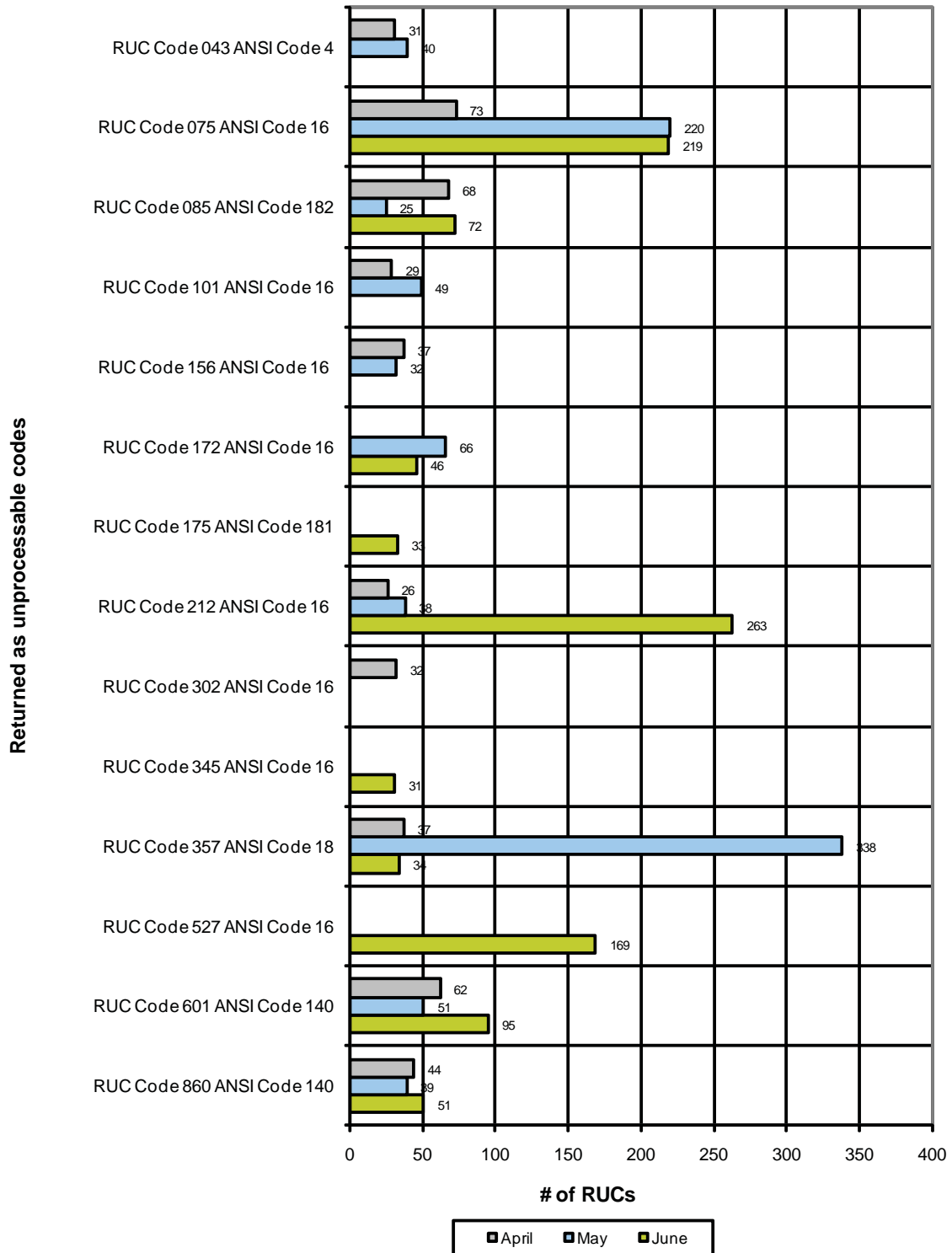
**U.S. Virgin Islands Part B top denials for April-June 2010**





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

**U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for April-June 2010**



## 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.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 website is considered the notice date.

### Electronic notification

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

### More information

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

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

### Local Coverage Determinations – Table of Contents

|  |    |
|--|----|
| Advance notice statement .....   | 47 |
| <b>Revisions to LCDs</b>   |    |
| BOTULINUM TOXINS: Botulinum toxins – revision to the LCD .....                             | 48 |
| G0430: Qualitative drug screening – revision to the LCD .....                              | 48 |
| IDTF: Independent diagnostic testing facility – coding guidelines<br>revision.....         | 49 |
| J1950: Luteinizing hormone-releasing hormone (LHRH) analogs –<br>revision to the LCD ..... | 49 |
| NCSVCS: The list of Medicare noncovered services – revision to<br>the LCD.....             | 50 |
| SKINSUB: Skin substitutes – revision to the LCD .....                                      | 50 |
| 70544: Magnetic resonance angiography (MRA) – revision to<br>the LCD.....                  | 50 |
| 77078: Bone mineral density studies – revision to the LCD .....                            | 51 |
| 93965: Non-invasive evaluation of extremity veins – revision to<br>the LCD.....            | 51 |

### Advance beneficiary notice

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

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

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

## Revisions to LCDs

### **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 most recently revised on January 1, 2010. Since that time, the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised to update the language and to add language regarding the differences in preparations for botulinum toxins. A bullet was also added under the “FDA Indications for Botox®” section for “upper limb spasticity in adult patients, to decrease the severity of increased muscle tone in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris) and finger flexors (flexor digitorum profundus and flexor digitorum sublimis)”.

The “ICD-9-CM Codes that Support Medical Necessity” section of the LCD has been revised for procedure code J0585, to add ICD-9-CM code 705.22 and to delete ICD-9-CM codes 343.0, 728.85 and 780.8. This notification serves as a 45-day notice that these deleted ICD-9-CM codes will no longer be allowed for procedure code J0585.

The “ICD-9-CM Codes that Support Medical Necessity” section of the LCD has also been revised for procedure code J0586, to add ICD-9-CM codes 333.81, 333.82, 342.11, 342.12 and 705.21.

The LCD “Coding Guidelines” attachment has been revised to add coding information and an associated table for the administration of botulinum toxins that correspond to the covered conditions addressed in the LCD.

#### **Effective date**

The above revisions to the LCD are effective for services rendered **on or after September 13, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.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.

### **G0430: Qualitative drug screening – revision to the LCD**

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

The local coverage determination (LCD) for qualitative drug screening was most recently revised on June 1, 2010. Since that time, *CPT* code 80101 (*Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class*) under the “Indications and Limitations of Coverage and/or Medical Necessity” and “*CPT*/HCPCS Code” sections of the LCD, has been deleted.

Per change request (CR) 6974, transmittal 1992, dated June 25, 2010, *CPT* code 80101 received an “I” status (Not valid for Medicare purposes) effective for dates of service on or after January 1, 2010. This requires that the code be removed from the LCD as medically necessary.

#### **Effective date**

This LCD revision is effective for claims processed **on or after July 6, 2010**, for services rendered **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.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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#### **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>.

**IDTF: Independent diagnostic testing facility – coding guidelines revision****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 most recently revised on December 8, 2009. The “Credentialing Matrix” in the “Coding Guidelines” attachment was last revised March 23, 2010. Since that time, the “Coding Guidelines” attachment has been revised for the “Supervising Physician and Interpreting Physician Qualification Requirements” in the “Credentialing Matrix” to add “Board Certified (ABNM) Nuclear Medicine” for the following CPT codes:

78000, 78001, 78003, 78006, 78007, 78010, 78011, 78015, 78016, 78018, 78020, 78070, 78075, 78102, 78103, 78104, 78110, 78111, 78120, 78121, 78122, 78130, 78135, 78140, 78185, 78190, 78191, 78195, 78201, 78202, 78205, 78206, 78215, 78216, 78220, 78223, 78230, 78231, 78232, 78258, 78261, 78262, 78264, 78267, 78268, 78270, 78271, 78272, 78278, 78282, 78290, 78291, 78300, 78305, 78306, 78315, 78320, 78350, 78414, 78428, 78445, 78451, 78452, 78453, 78454, 78456, 78457, 78458, 78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78491, 78492, 78494, 78496, 78580, 78584, 78585, 78586, 78587, 78588, 78591, 78593, 78594, 78596, 78600, 78601, 78605, 78606, 78607, 78608, 78610, 78630, 78635, 78645, 78647, 78650, 78660, 78700, 78701, 78707, 78708, 78709, 78710, 78725, 78730, 78740, 78761, 78800, 78801, 78802, 78803, 78804, 78805, 78806, 78807, 78811, 78812, 78813, 78814, 78815, 78816.

**Effective date**

This revision to the LCD “Coding Guidelines” attachment is effective for services rendered **on or after July 6, 2010**. The “Coding Guidelines” attachment has also been revised for the “Level of Physician Supervision” in the “Credentialing Matrix” in accordance with the Centers for Medicare & Medicaid Services (CMS) change request 6974, dated June 25, 2010, to revise the level of physician supervision to level “2” for the following CPT codes:

92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92552, 92553, 92555, 92556, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92585, 92586, 92587, 92588, 92601, 92602, 92603, 92604, 92620, 92621 and 92625.

**Effective date**

This revision to the LCD “Coding Guidelines” attachment is effective for claims processed **on or after July 6, 2010**, for services rendered **on or after July 1, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.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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**J1950: Luteinizing hormone-releasing hormone (LHRH) analogs – revision to the LCD****LCD ID number: L29215 (Florida)****LCD ID number: L29360 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for luteinizing hormone-releasing hormone (LHRH) analogs was most recently revised on May 7, 2010. This revision removed all language pertaining to the least costly alternative (LCA) based on instruction received by the Centers for Medicare & Medicaid Services (CMS). Additional discussion determined that the LCD revisions related to the removal of LCA language should reflect an effective date of April 19, 2010. Therefore, the LCD “Revision History” and LCD “Coding Guidelines” attachment were revised to reflect effective date April 19, 2010, the removal of the LCA provision. Because of the change in the effective date, First Coast Service Options Inc. (FCSO) will be adjusting claims that were paid at the LCA price for claims processed April 19, 2010, through May 6, 2010.

**Effective date**

This LCD revision is effective for claims processed **on or after April 19, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.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.



**NCSVCS: The list of Medicare noncovered services – revision to the LCD****LCD ID number: L29288 (Florida)****LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for the list of Medicare noncovered services was most recently revised on June 7, 2010. Since that time, based on guidance from the Centers for Medicare & Medicaid Services (CMS), the LCD for the list of Medicare noncovered services is being revised to remove CPT code 90662 (*Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use*) from the “CPT/HCPCS Codes, Local Noncoverage Decisions, Drugs and Biologicals” section of the LCD.

**Effective date**

This LCD revision is effective for services rendered **on or after July 1, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.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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**SKINSUB: Skin substitutes – revision to the LCD****LCD ID number: L29279 (Florida)****LCD ID number: L29393 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for skin substitutes was most recently revised on February 9, 2010. Since that time, a revision was made to the LCD based on change request 7008 (July 2010 Update to the Ambulatory Surgical Center [ASC] Payment System) issued by the Centers for Medicare & Medicaid Services (CMS).

A review of HCPCS code C9367 (Skin substitute, Endoform Dermal Template, per square centimeter) determined that this skin substitute code should be added to the “Non-Covered Products” section of the “CPT/HCPCS Codes” section of the LCD.

**Effective date**

This LCD revision is effective for claims processed **on or after July 6, 2010**, for services rendered **on or after July 1, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2009 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

**70544: Magnetic resonance angiography (MRA) – revision to the LCD****LCD ID number: L29218 (Florida)****LCD ID number: L29447 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for magnetic resonance angiography (MRA) was most recently revised on June 9, 2010. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS), transmittals 123 and 1998, change request 7040, dated July 9, 2010. In this regard, the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised to remove the following statement: All other uses of MRA for which CMS has not specifically indicated coverage continue to be noncovered.

**Effective date**

This LCD revision is effective for claims processed **on or after August 9, 2010**, for services rendered **on or after June 3, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.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.

**77078: Bone mineral density studies – revision to the LCD****LCD ID number: L29086 (Florida)****LCD ID number: L29101 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for bone mineral density studies was most recently revised on March 19, 2009. Since that time, the “Frequency Standards” under the “Indications and Limitations of Coverage and/or Medical Necessity” and “Utilization Guidelines” sections of the LCD have been revised to add denosumab (prolia) to the list of agents approved by the Food and Drug Administration (FDA) for osteoporosis prevention and/or treatment.

**Effective date**

This LCD revision is effective for claims processed **on or after July 13, 2010**, for dates of service **on or after June 1, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.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.

**93965: Non-invasive evaluation of extremity veins – revision to the LCD****LCD ID number: L29234 (Florida)****LCD ID number: L29369 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for non-invasive evaluation of extremity veins was most recently revised on October 1, 2009. Since that time, the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised to include descriptors for physiologic studies and plethysmography procedures. The “Training Requirements” section of the LCD has also been revised to add language regarding the definition of a physician.

In addition, the LCD “Coding Guidelines” attachment has been revised and updated. Revisions include the addition of the following statements:

- Noninvasive physiologic studies are performed using equipment separate and distinct from the duplex scanner. *CPT* code 93965 describes the evaluation of non-imaging physiologic recordings of pressures, Doppler analysis of bi-directional blood flow, plethysmography, and/or oxygen tension measurements appropriate for the anatomic area studied (2009 *CPT*).
- Performance of both physiological tests (*CPT* code 93965) and duplex scanning (*CPT* code 93970 or 93971) of extremity veins during the same encounter would not generally be expected.
- Since the signs and symptoms of arterial occlusive disease and venous disease are so divergent, the performance of simultaneous arterial and venous studies during the same encounter should be rare.
- When an uninterpretable study results in performing another type of study, only the successful study should be billed.

**Effective date**

This LCD revision is effective for services rendered **on or after July 6, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. *CPT* codes, descriptions and other data only are copyrighted 2009 American Medical Association (or other such date of publication of *CPT*). All rights reserved. Applicable FARS/DFARS apply.**

**Try our E/M interactive worksheet**

First Coast Service Options (FCSO) Inc. is proud of its exclusive E/M interactive worksheet, available at <http://medicare.fcso.com/EM/165590.asp>. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you’ve tried the E/M interactive worksheet, send us your thoughts of this resource through our Web site feedback form, available at <http://medicare.fcso.com/Feedback/160958.asp>.

## Educational Events

### Upcoming provider outreach and educational events August 2010

#### Evaluation and Management (E/M) Series: workshops covering the E/Ms of a typical patient – Session 7

When: Tuesday, August 17  
Time: 11:00 a.m. – 12:30 p.m.

#### Evaluation and Management (E/M) Series: workshops covering the E/Ms of a typical patient – Session 7

When: Thursday, August 19  
Time: 2:00 p.m. – 3:30 p.m.

#### Limitation on recoupment (935)/remittance advice Part B

When: Tuesday, August 24  
Time: 11:30 a.m. – 1:00 p.m.

#### Medicare's Medical Documentation Part B

When: Tuesday, August 31  
Time: 11:30 a.m. – 1:00 p.m.

**Note:** Unless otherwise indicated, all FCSO educational offerings are considered to be “ask-the-contractor” events, “webcast” type of event, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands

#### Two easy ways to register

**Online** – Visit our provider training website at [www.fcsomedicaretraining.com](http://www.fcsomedicaretraining.com), log on to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event.

**First-time User?** Set up an account by completing [Request User Account Form](#) online. Providers who do not have yet a national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

**Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

#### Please Note:

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

Registrant's Name: \_\_\_\_\_

Registrant's Title: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

Keep checking our Web site, [www.medicare.fcsso.com](http://www.medicare.fcsso.com), for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

#### Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the FCSO Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

#### Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses now offer CEUs. Learn more on the FCSO Medicare training website and explore our catalog of online courses.

## Preventive Services

### Preventive services to help keep your Medicare patients healthy this summer

The Centers for Medicare & Medicaid Services (CMS) asks providers to help keep their Medicare patients healthy this summer by encouraging them to take advantage of Medicare-covered preventive services. Medicare covers a wide variety of preventive services, including screening mammographies, seasonal influenza vaccinations, and screening for certain types of cancer, among other services.

#### What can you do?

Your patients rely upon you as their trusted health-care provider for advice and information to help them live longer, fuller, healthier lives. You can help protect the health of your patients by discussing their risk factors for preventable diseases, and by encouraging them to take advantage of Medicare-covered preventive services for which they qualify.

#### For more information

CMS has developed several products to educate providers about Medicare coverage, coding, and claims submission policies related to Medicare-covered preventive services, including:

- **The Medicare Learning Network Preventive Services educational products Web page** – provides descriptions and ordering information for *Medicare Learning Network (MLN)* preventive services educational products and resources for health care professionals and their staff.  
[http://www.cms.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.gov/MLNProducts/35_PreventiveServices.asp)
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals** – this comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare.  
[http://www.cms.gov/MLNProducts/downloads/mps\\_guide\\_web-061305.pdf](http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf)
- **Quick Reference Information: Medicare Preventive Services** – this chart contains coverage, coding, and payment information for the many preventive services covered by Medicare in an easy to-use quick-reference format.  
[http://www.cms.gov/MLNProducts/downloads/MPS\\_QuickReferenceChart\\_1.pdf](http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf)
- **The Medicare Preventive Services Series: Part 3 Web-based training course (WBT)** – this WBT includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including screening mammography, Pap tests, and pelvic exams. To access the WBT, please visit the MLN homepage at:  
<http://www.cms.gov/mlngeninfo>. Scroll down to “Related Links Inside CMS” and click on “WBT Modules.”
- **The preventive services educational products** – this PDF document contains links to downloadable versions of the many products the MLN has available related to Medicare-covered preventive services, including brochures, quick reference guides, and more.  
[http://www.cms.gov/MLNProducts/Downloads/education\\_products\\_prevserv.pdf](http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf)
- **The preventive services resources** – this CD-ROM contains the guide to Medicare preventive services, three-quick reference charts, and seven brochures on one easy to use CD-ROM. To order the CD, and other products that are available in hardcopy, please visit the MLN homepage at:  
<http://www.cms.gov/mlngeninfo>. Scroll down to “Related Links Inside CMS” and click on “MLN Product Ordering Page.”

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate beneficiaries about the importance of early detection of various diseases by taking advantage of the screenings and other preventive services covered by Medicare.

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

Source: CMS PERL 201007-08



## Medicare preventive services quick reference information charts

Need a quick and easy-to-use source of information to help you with Medicare-covered preventive services billing? The Medicare preventive service quick reference information charts contain coverage, coding, and billing information in an easy-to-use format and includes the following charts:

- **Quick Reference Information: Medicare Preventive Services:** This two-sided reference chart provides health-care providers with coverage, coding, and payment information on the many preventive services covered by Medicare.
- **Quick Reference Information: Medicare Immunization Billing:** This two-sided reference chart provides coverage, coding and payment information on seasonal influenza, pneumococcal, and Hepatitis B vaccinations covered by Medicare.
- **Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination (IPPE):** This two-sided reference chart provides a checklist of the elements of an IPPE as well as coding information and frequently asked questions.

All three charts are available, free-of-charge, from the *Medicare Learning Network*<sup>®</sup>, in both downloadable PDF (portable document format) and hardcopy format.

To view the PDF charts, please visit the “Preventive Services Educational Products” page at [http://www.cms.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.gov/MLNProducts/35_PreventiveServices.asp) and select the “Educational Products” link in the “Downloads” section.

To order hardcopies, please select the “MLN Product Ordering” link on the same Web page.

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

Source: CMS PERL 201007-40

## Other Educational Resources

### New suite of MLN products now available for billing and coding professionals

It is important to the Centers for Medicare & Medicaid Services (CMS) that the billing and coding professionals who work with fee-for-service providers have the timely and accurate information they need to properly bill the Medicare program. That is why CMS developed the *Medicare Learning Network*<sup>®</sup> *Suite of Products and Resources for Billing and Coding Professionals* – to help billers, coders, and other reimbursement specialists submit claims correctly the first time.

Like all *MLN* products, the suite has nationally consistent, up-to-date Medicare information prepared by subject-specific experts – and it is available at no cost. The suite consists of the following four components that offer an uncomplicated way to understand more about the Medicare program:

- The business of Medicare
- Medicare benefits and services
- Special Medicare initiatives
- General Medicare program information and resources

CMS recommends that you forward the following message to your members and any staff who may have the responsibility for developing and submitting claims (e.g., billers, coders, reimbursement specialists, and office practice managers).

#### E-mail subject line

Something new from the *Medicare Learning Network (MLN)* for billing and coding professionals”

#### Suggested message content

There is information. And then there is information from the Centers for Medicare & Medicaid Services’ (CMS) *Medicare Learning Network*<sup>®</sup> (*MLN*). As a billing and coding professional, you need Medicare information at your fingertips. That is why CMS experts developed a solution just for you — the “*Medicare Learning Network*<sup>®</sup> *Suite of Products and Resources for Billing and Coding Professionals*.” The suite contains easy-to-understand, accessible and free Medicare program information developed especially for Medicare fee-for-service (FFS) providers.

Please start here [http://www.cms.gov/MLNProducts/downloads/Billers\\_and\\_Coders\\_flyer.pdf](http://www.cms.gov/MLNProducts/downloads/Billers_and_Coders_flyer.pdf) to access current information you need to submit claims correctly the first time.

Equip yourself today with critical reimbursement solutions from the official source for Medicare FFS information. For more details, please visit the *Medicare Learning Network*: <http://www.cms.gov/MLNGenInfo/>.

Source: CMS PERL 201006-43

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## Revised Medicare physician fee schedule fact sheet now available

The downloadable version of the *Medicare Physician Fee Schedule* fact sheet (July 2010) has been revised to include information about the 2.2 percent update to the 2010 Medicare physician fee schedule (MPFS) effective for dates of service from June 1, 2010, through November 30, 2010. This publication also provides MPFS payment rate information, the MPFS payment rates formula, and MPFS resources. To access this *Medicare Learning Network* fact sheet, visit <http://www.cms.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctshst.pdf>.

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

Source: CMS PERL 201007-40

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## CMS fact sheet on how to protect your Medicare enrollment record now available

If you are a physician or nonphysician practitioner who is enrolled in Medicare, or who is planning to enroll in Medicare, it is important that you protect your Medicare enrollment information from getting into the hands of dishonest and unscrupulous people. The Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network* (MLN) has released *Medicare Fee-for-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record* as the first in a series of fact sheets designed to educate FFS providers about important Medicare enrollment information. This particular fact sheet advises FFS physicians and non-physician practitioners on how to ensure that their enrollment records are up-to-date and secure. The fact sheet is available in downloadable format on the CMS website at [http://www.cms.gov/MLNProducts/downloads/MedEnrollPrivcy\\_FactSheet\\_ICN903765.pdf](http://www.cms.gov/MLNProducts/downloads/MedEnrollPrivcy_FactSheet_ICN903765.pdf).

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

Source: CMS PERL 201007-42

### Try our E/M interactive worksheet

First Coast Service Options (FCSO) Inc. is proud of its exclusive E/M interactive worksheet, available at <http://medicare.fcso.com/EM/165590.asp>. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our Web site feedback form, available at <http://medicare.fcso.com/Feedback/160958.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/prevaling charges or fee  
schedule:**  
Medicare Part B  
Provider Outreach and Education  
P. O. Box 2078  
Jacksonville, FL 32231-0048

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

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

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

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

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

**Phone numbers**  
**Providers**  
**Toll-Free**  
**Customer Service:**  
1-866-454-9007

**Interactive Voice Response (IVR):**  
1-877-847-4992

**E-mail address:** [AskFloridaB@fcsso.com](mailto:AskFloridaB@fcsso.com)  
**FAX:** 1-904-361-0696

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

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

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

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

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

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

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

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

**Centers for Medicare & Medicaid  
Services**  
[www.cms.gov](http://www.cms.gov)

**Beneficiaries**  
**Centers for Medicare & Medicaid  
Services**  
[www.medicare.gov](http://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/prevaling charges or fee schedule:

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

#### Education event registration:

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

### Medicare claims for railroad retirees

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

### Fraud and abuse

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

### Local coverage determinations

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

### Post pay medical review

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

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

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

## Medicare websites

### Provider

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

### Centers for Medicare & Medicaid Services

[www.cms.gov](http://www.cms.gov)

### Beneficiaries

#### Centers for Medicare & Medicaid Services

[www.medicare.gov](http://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](mailto:AskFloridaB@fcso.com)

**FAX:** 1-904-361-0696

### Beneficiary customer service

1-800-MEDICARE

Hearing Impaired:

1-800-754-7820

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

### Education event registration

1-904-791-8103

### Electronic data interchange (EDI)

1-888-670-0940

**Option 1** - Transaction support

**Option 2** - PC-ACE support

**Option 4** - Enrollment support

**Option 5** - Electronic funds (check return assistance only)

**Option 6** - Automated response line

### DME, orthotic or prosthetic claims

Cigna Government Services  
1-866-270-4909

### Medicare Part A

Toll-Free:

1-866-270-4909



**Order form for Medicare Part B materials**

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

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

| Item  | Acct Number | Cost per item    | Quantity | Total cost |
|---|-------------|------------------|----------|------------|
| <b>Part B subscription</b> – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at <a href="http://medicare.fcso.com/Publications_B/">http://medicare.fcso.com/Publications_B/</a> (English) or <a href="http://medicareespanol.fcso.com/Publicaciones/">http://medicareespanol.fcso.com/Publicaciones/</a> (Español). Nonprovider 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<br>\$33 |          |            |
|   |             | CD-ROM<br>\$55   |          |            |
| <b>2010 Fee Schedule</b> – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through May 31, 2010, and June 1 through November 30, 2010, are available free of charge online at <a href="http://medicare.fcso.com/Data_files/">http://medicare.fcso.com/Data_files/</a> (English) or <a href="http://medicareespanol.fcso.com/Fichero_de_datos/">http://medicareespanol.fcso.com/Fichero_de_datos/</a> (Español). Additional copies or a CD-ROM are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items.<br><b>Note:</b> Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications. | 40300270    | Hardcopy<br>\$12 |          |            |
|   |             | CD-ROM<br>\$6    |          |            |

Language preference: **English** [ ] **Español** [ ]

|                             |                                    |    |
|-----------------------------|------------------------------------|----|
| <i>Please write legibly</i> | Subtotal                           | \$ |
|                             | Tax ( <b>add % for your area</b> ) | \$ |
|                             | Total                              | \$ |

**Mail this form with payment to:**

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

Contact Name: \_\_\_\_\_

Provider/Office Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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***MEDICARE B Update!***

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

**◆ ATTENTION BILLING MANAGER ◆**