

# C Medicare B CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

September 2011



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## HHS proposes broad patient rights to access clinical laboratory test result reports

### Overview

As part of the Department of Health and Human Services' (HHS) ongoing efforts to empower patients to be informed partners with their health care providers in making health care decisions, HHS has proposed rules that would give patients (and their authorized representatives) direct access to their own laboratory test result reports.

The proposed rule is being jointly issued by three agencies within HHS: The Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and the Office for Civil Rights (OCR). CMS and the CDC are responsible for laboratory regulation under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), and the OCR is responsible for administering the Privacy Rule that was issued under the Health Insurance Portability and Accountability Act of 1986 (HIPAA).

The proposed rules are also consistent with a proposed regulation under the HITECH Act that would bolster patients' rights to access their information stored in electronic health records and that would help ease the transition to nationwide adoption of electronic health records.

### Background

The proposed rules address the interplay between the CLIA rules, state laws governing direct disclosure to patients of their laboratory test results, and the Federal Privacy Rule, which currently defers to CLIA's disclosure provisions

and which preempts contrary State laws on privacy and disclosure of personal health information. Under existing CLIA regulations, a laboratory may release patient test results directly to the patient only if (1) the ordering provider expressly authorizes the laboratory to do so at the time the test is ordered, or (2) state law expressly allows for it.

The current Privacy Rule generally requires certain health care providers such as most clinical laboratories to give individuals access to their health information on request. However, the Privacy Rule's access requirements, deferring to the CLIA rules, include an exception for direct access by patients to their laboratory test result reports. Therefore, patients who reside in the 26 states without laws authorizing direct disclosure of test results to patients and those who reside in the 13 states that expressly prohibit direct disclosure, do not have access to their complete medical information.

### Provisions of the proposed rule

The proposed rule would amend the CLIA regulations to allow laboratories to give a patient his/her individual test result reports on request. At the same time, the proposed rule would eliminate the Privacy Rule's exception for an individual's access to laboratory test result reports. The amended Privacy Rule would, in turn, preempt contrary state laws governing a patient's direct access to lab result reports.

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Articles included in the Medicare B Connection represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

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## About the *Medicare B Connection*

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

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

### Who receives the Connection

Anyone may view, print, or download the Connection from our provider education website(s). Providers who cannot obtain the Connection from the Internet are required to register with us to receive a complimentary hardcopy.

Distribution of the Connection in hardcopy is limited to providers who have billed at least one Part B claim to FCSO Medicare 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 (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 Connection 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 Connection is arranged into distinct sections.

- 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
- **Contact information** for Florida and the U.S. Virgin Islands.

### The Medicare B Connection represents formal notice of coverage policies

Articles included in each edition 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.





## 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 Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at <http://www.cms.gov/manuals/downloads/clm104c30.pdf#page=41>.

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/02\\_ABN.asp](http://www.cms.gov/BNI/02_ABN.asp).

### 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.

**Note:** Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

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## 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 Contact Information section of this publication for the address in which to send written appeals requests.

## Medicare fee-for-service claim processing guidance for implementing ICD-10

### Provider types affected

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

### Provider action needed

For dates of service on and after October 1, 2013, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the International Classification of Diseases, 10th Edition (ICD-10) code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2013. Make sure your billing and coding staffs are aware of these changes.

### Key points of CR 7492

#### General reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to <http://www.cms.gov/ICD10> for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

#### General claims submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with from dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2013. Institutional claims containing ICD-9 codes for services on or after October 1, 2013, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2013, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2013, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2013, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2013, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2013, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2013. Institutional claims containing ICD-10 codes for services prior to October 1, 2013, will be RTP. Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2013, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

#### Claims that span the ICD-10 implementation date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claim processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

**Table A – Institutional Providers**

Bill type(s)	Facility type/services	Claim processing requirement	Use “From” or “Through” date
11x	Inpatient hospitals (incl. TERFHA hospitals, prospective payment system (PPS) hospitals, long term care hospitals (LTCHs), critical access hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after October 1, 2013, then the entire claim is billed using ICD-10.	Through

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ICD-10....(continued)

Bill type(s)	Facility type/services	Claim processing requirement	Use "From" or "Through" date
12x	Inpatient Part B hospital services	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
13x	Outpatient hospital	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
14x	Non-patient laboratory services	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
18x	Swing beds	If the [swing bed or SNF] claim has a discharge and/or through date on or after October 1, 2013, then the entire claim is billed using ICD-10.	Through
21x	Skilled nursing (inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/or "through" date on or after October 1, 2013, then the entire claim is billed using ICD-10.	Through
22x	Skilled nursing facilities (inpatient Part B)	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
23x	Skilled nursing facilities (outpatient)	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
32x	Home health (inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span October 1, 2013, but require those claims to be submitted using ICD-10 codes.	Through
32x	Home health – request for anticipated payment (RAPs)*	* Note – RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond October 1, 2013.	*See note

continued on next page

ICD-10....(continued)

Bill type(s)	Facility type/services	Claim processing requirement	Use "From" or "Through" date
34x	Home health – (outpatient )	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
71x	Rural health clinics	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
72x	End-stage renal disease (ESRD)	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
73x	Federally qualified health clinics (prior to April 1, 2010)	N/A – Always ICD-9 code set.	n/a
74x	Outpatient therapy	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
75x	Comprehensive outpatient rehab facilities	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
76x	Community mental health clinics	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
77x	Federally qualified health clinics (effective 4/4/10)	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
81x	Hospice- hospital	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From
82x	Hospice – non-hospital	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From

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ICD-10...(continued)

Bill type(s)	Facility type/services	Claim processing requirement	Use “From” or “Through” date
83x	Hospice – hospital-based	N/A	n/a
85x	Critical access hospital	Split claims – Require providers split the claim so all ICD-9 codes remain on one claim with DOS through September 30, 2013, and all ICD-10 codes placed on the other claim with DOS beginning October 1, 2013, and later.	From

**Table B - Special Outpatient Claims Processing Circumstances**

Scenario	Claim processing requirement	Use “From” or “Through” date
3-day /1-day payment window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after October 1, 2013, the claim must be billed with ICD-10 for those bundled outpatient services.	Through

**Table C – Professional Claims**

Type of Claim	Claim Processing Requirement	Use “From” or “Through” date
All anesthesia claims	Anesthesia procedures that begin on September 30, 2013, but end on October 1, 2013, are to be billed with ICD-9 diagnosis codes and use September 30, 2013 as both the “from” and “through” date.	From

**Table D –Supplier Claims**

Supplier Type	Claim Processing Requirement	Use “From” or “Through” date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of October 1, 2013 (i.e., the “from” date of service occurs prior to October 1, 2013, and the “to” date of service occurs after October 1, 2013).	From

**Additional information**

The official instruction, CR 7492 issued to your carrier, FI, RHHI, or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R950OTN.pdf>.

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

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 Implementation Date: January 1, 2012

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## Ambulatory Surgical Center

### October 2011 update of the ambulatory surgery center payment system

#### Provider types affected

This article is for ambulatory surgery centers (ASCs), who submit claims to Medicare administrative contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

#### Provider action needed

This article is based on change request (CR) 7547 which describes changes to, and billing instructions for, payment policies implemented in the October 2011 ASC payment system update.

CR 7547 provides information regarding three newly-created Healthcare Common Procedure Coding System (HCPCS) codes that will be added to the ASC list of covered ancillary services effective October 1, 2011. No new HCPCS codes are being added to the ASC list of covered surgical procedures for October 1, 2011. Be sure your billing staff is aware of these changes.

#### Background

Medicare policy under the revised ASC payment system requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated on a quarterly basis.

#### Key points of CR 7547

##### New category II CPT codes separately payable under the ASC payment system, effective October 1, 2011

Two new category II CPT codes have been created for payable surgical procedures that are payable for dates of service on and after October 1, 2011. The new HCPCS codes, the long descriptors, the short descriptors, and payment indicators are identified in below in Table 1.

**Table 1 – Category level II codes effective, October 1, 2011**

HCPCS code	Long descriptor	Short descriptor	Payment indicator (PI) effective 10/1/2011
C1830	Powered bone marrow biopsy needle	Powered bone marrow bx needle	J7
C1840	Lens, intraocular (telescopic)	Telescopic intraocular lens	J7

One new drug and biological has been granted ASC payment status effective October 1, 2011. This item, along with the long and short descriptor, and payment indicator is identified in Table 2.

**Table 2 – New drug and biological separately payable under the ASC payment system, effective October 1, 2011**

HCPCS code	Long descriptor	Short descriptor	ASC PI
C9286	Injection, belatacept, 1 mg	Injection, belatacept	K2

**Note:** HCPCS code C9286 is a new code effective October 1, 2011.

##### Updated payment rate for HCPCS code J9185, effective July 1, 2011, through September 30, 2011

The payment rate for HCPCS code J9185 (Fludarabine phosphate inj) was incorrect in the July 2011 ASC drug file. The corrected payment rate is listed in Table 3 and has been included in the revised July 2011 ASC drug file effective for services furnished on July 1, 2011, through implementation of the October 2011 update. Suppliers who think they may have received an incorrect payment between July 1, 2011, and September 30, 2011, may request contractor adjustment of the previously processed claims.

**Table 3 – Updated payment rates for HCPCS code J9185, effective July 1, 2011, through September 30, 2011**

HCPCS code	Short descriptor	ASC payment	ASC PI
J9185	Fludarabine phosphate inj	\$104.52	K2

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October... (continued)

### Additional information

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>. The official instruction (CR 7547) issued to your Medicare MAC and/or carrier is available at <http://www.cms.gov/Transmittals/downloads/R2305CP.pdf>. CMS also reminds ASCs that HCPCS payment updates are posted quarterly at [http://www.cms.gov/ASCPayment/11\\_Addenda\\_Updates.asp](http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp).

MLN Matters® Number: MM7547

Related Change Request (CR) #: 7547

Related CR Release Date: September 15, 2011

Effective Date: October 1, 2011

Related CR Transmittal #: R2305CP

Implementation Date: October 3, 2011

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## Chiropractic Services

### Overview of Medicare policy regarding chiropractic services

**Note:** This article was revised on September 9, 2011, to clarify some of the language. No changes in policy are conveyed by these clarifications. This information was previously published in the July 2011 *Medicare B Connection*, pages 6-10.

#### Provider types affected

Chiropractors and other practitioners billing Medicare for chiropractic services are affected by this special edition article. No new policies are contained in this article.

#### Provider action needed

##### **Stop – impact to you**

This special edition article highlights Medicare policy regarding coverage of chiropractic services for Medicare beneficiaries.

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

Please review this article and go to the links listed in the information section below for further details.

##### **Go – what you need to do**

Please review your clinical documentation and billing practices. Ensure that your office staffs are aware of the correct use of codes and modifiers and Medicare coverage policy regarding chiropractic services.

#### Background

Numerous audits of chiropractic service claims have found a significant portion of the claims to have been paid inappropriately. Correct claim payment depends largely on providers complying with Medicare requirements for coverage, coding, and documentation of services. The goal of this article is to translate published Medicare coverage and payment requirements for chiropractic services into a few practical tips for better Medicare compliance to effectively lower the frequency of improper payments (and corresponding error rates).

The most common errors noted by Medicare auditors of chiropractic service claims are briefly described below.

- Technical errors such as missing signatures, date of service on the claim not found in the record, etc. In other words, specific documentation that is required as a condition of payment is often missing from the beneficiary's medical record.
- Documentation that does not substantiate that all procedure(s) reported were performed. For example:
  - No documentation or insufficient documentation that all spinal levels of manipulation reported had been performed.
  - No documentation that each manipulation reported related to a relevant symptomatic spinal level.

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**Chiropractic.... (continued)**

- Insufficient or absent documentation that all procedures or services were medically reasonable and necessary. In other words, the submitted documentation was not sufficient for Medicare auditors to determine whether the services furnished were medically necessary. Examples of insufficient or absent documentation for purposes of determining medical necessity are as follows:
  - Required elements of the history and examination were absent
  - Treatment plan absent or insufficient
- Treatment furnished was “maintenance therapy. As discussed later in this article, Medicare pays only for medically necessary chiropractic services, which are limited to active/corrective manual manipulations of the spine to correct subluxations. When further improvement cannot reasonably be expected from continuing care, the services are considered maintenance therapy, which is not medically necessary and therefore not a covered service under the Medicare program.
- Non-covered devices or techniques applied in performing manipulation. (See the *Key points* section of this article.)

**Previous study by the Office of Inspector General (OIG) on chiropractic care**

A recent study by the Office of Inspector General (OIG) entitled “Inappropriate Medicare Payments for Chiropractic Services” found inappropriate Medicare payments for chiropractic services.

The OIG study found that:

- Claims lack initial visit dates for treatment episodes, hindering the identification of maintenance therapy, and
- There is lack of compliance with the manual documentation requirements. For example, treatment plans, an important element in determining whether the chiropractic treatment was active/corrective in achieving specified goals, were either missing or lacked treatment goals, objective measures, or the recommended level of care.

The *Key points* section reviews Medicare policy for coverage of chiropractic services, with an emphasis on the billing and documentation requirements.

**Key points****Medicare coverage of chiropractic services**

Coverage of chiropractic services is specifically limited to treatment by means of manual manipulation (i.e., by use of the hands) of the spine to correct a subluxation. Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine, are altered, although contact between joint surfaces remains intact.

Manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. No additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor’s order is covered. If you order, take, or interpret an X-ray, or any other diagnostic test, the X-ray or other diagnostic test can be used for documentation, but Medicare coverage and payment are not available for those services. This does not affect the coverage of X-rays or other diagnostic tests furnished by other practitioners under the program.

**Subluxation may be demonstrated by X-ray or physician’s examination****X-rays**

As of January 1, 2000, an X-ray is not required by Medicare to demonstrate the subluxation. However, an X-ray may be used for this purpose if you so choose. The X-ray must have been taken reasonably close to (within 12 months prior or three months following) the beginning of treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older X-ray may be accepted if the beneficiary’s health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

**Physical examination**

To demonstrate a subluxation based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required:

1. Pain/tenderness evaluated in terms of location, quality, and intensity
2. Asymmetry/misalignment identified on a sectional or segmental level
3. Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility), and

*continued on next page*

**Chiropractic.... (continued)**

4. Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament.

**Documentation requirements must be placed in the patient's file****Initial visit**

The following documentation requirements apply whether the subluxation is demonstrated by X-ray or by physical examination:

**The history includes the following:**

- a) Symptoms causing patient to seek treatment
- b) Family history if relevant
- c) Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history)
- d) Mechanism of trauma
- e) Quality and character of symptoms/problem
- f) Onset, duration, intensity, frequency, location, and radiation of symptoms
- g) Aggravating or relieving factors, and
- h) Prior interventions, treatments, medications, secondary complaints.

**Description of the present illness, including:**

- a) Mechanism of trauma
- b) Quality and character of symptoms/problem
- c) Onset, duration, intensity, frequency, location, and radiation of symptoms
- d) Aggravating or relieving factors
- e) Prior interventions, treatments, medications, secondary complaints, and
- f) Symptoms causing patient to seek treatment.

These symptoms must bear a direct relationship to the level of subluxation. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

**Evaluation of musculoskeletal/nervous system through physical examination****Diagnosis**

The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine.

**Treatment plan should include the following:**

- a) Recommended level of care (duration and frequency of visits)
- b) Specific treatment goals, and
- c) Objective measures to evaluate treatment effectiveness.

**Date of the initial treatment****The patient's medical record**

- Validate all of the information on the face of the claim, including the patient's reported diagnosis(s), physician work (CPT code), and modifiers.
- Verify that all Medicare benefit and medical necessity requirements were met.

**Subsequent visits**

The following documentation requirements apply whether the subluxation is demonstrated by X-ray or by physical examination:

**History**

- a) Review of chief complaint
- b) Changes since last visit, and
- c) Systems review if relevant.

**Physical examination**

- a) Examination of area of spine involved in diagnosis
- b) Assessment of change in patient condition since last visit
- c) Evaluation of treatment effectiveness.

**Documentation of treatment given on day of visit**

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**Chiropractic.... (continued)****Necessity for treatment****Acute and chronic subluxation**

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by X-ray or physical examination, as described above.

Most spinal joint problems fall into the following categories:

**Acute subluxation** – A patient's condition is considered acute when the patient is being treated for a new injury, identified by X-ray or physical examination as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

**Chronic subluxation** – A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

You must place the modifier AT on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the modifier AT may not in all instances indicate that the service is reasonable and necessary.

**Maintenance therapy**

Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

The modifier AT must not be placed on the claim when maintenance therapy has been provided. Claims without the modifier AT will be considered as maintenance therapy and denied.

You should consider providing the advance beneficiary notice of noncoverage (ABN) to the beneficiary.

Chiropractors who give beneficiaries an ABN will place the modifier GA (or in rare instances modifier GZ) on the claim. The decision to deliver an ABN must be based on a genuine reason to expect that Medicare will not pay for a particular service on a specific occasion for that beneficiary due to lack of medical necessity for that service. The beneficiary can then make a reasonable and informed decision about receiving and paying for the service. If the beneficiary decides to receive the service, you must submit a claim to Medicare even though you expect that Medicare will deny the claim and that the beneficiary will pay.

Since March 3, 2008 CMS has issued one form with the official title "Advance Beneficiary Notice of Noncoverage (ABN)" (form CMS-R-131). A properly executed ABN must use this form for each date an ABN is issued and all the required fields on the form must be completed including a mandatory field for cost estimates of the items/services at issue and a valid specific reason why the chiropractor believes Medicare payment for CMT will be denied on this date for this beneficiary. ABNs should not be issued routinely citing the same reason for each occurrence. One ABN cannot be used with added lines for future dates of services. For additional instructions on the proper completion of the ABN, see [http://www.cms.gov/BNI/01\\_overview.asp](http://www.cms.gov/BNI/01_overview.asp).

**Key billing requirements**

In addition to other billing requirements explained in Medicare's manuals, it is important that you include the following information on the claim:

- The primary diagnosis of subluxation
- The initial visit or the date of exacerbation of the existing condition
- The appropriate CPT code that best describes the service
  - 98940: Chiropractic manipulative treatment (CMT); spinal, one or two regions
  - 98941: spinal, three to four regions
  - 98942: spinal, five regions, or

**Note:** 98943: CMT, extraspinal, one or more regions, is not covered by Medicare.

- The appropriate modifier that describes the services:
  - Modifier AT used on a claim when providing active/corrective treatment to treat acute or chronic subluxation
  - GA modifier used to indicate that you expect Medicare to deny a service (e.g., maintenance services) as not reasonable and necessary and that you have on file an ABN signed by the beneficiary; or

*continued on next page*

**Chiropractic.... (continued)**

- Modifier GZ used to indicate that you expect that Medicare will deny an item or service as not reasonable and necessary and that you have not had an ABN signed by the beneficiary, as appropriate.

**Note:** You must use the acute treatment modifier AT to identify services that are active/corrective treatment of acute or chronic subluxation and must document services in accordance with the Centers for Medicare & Medicaid Services' (CMS) *Medicare Benefit Policy Manual*, Chapter 15, Section 240, when submitting claims.

**Beneficiary responsibility**

For Medicare covered services, the beneficiary pays the Part B deductible and then 20 percent of the Medicare-approved amount. The beneficiary also pays all costs for any services or tests you order. If you provide an ABN, you must submit a claim to Medicare, even though you expect the beneficiary to pay and you expect Medicare to deny the claim.

**Additional information**

Providers improving their compliance with Medicare documentation requirements should lower the likelihood of continued audit identified shortcomings. In this regard, consider the following suggestions:

**Signatures**

CMS published national provider "signature" requirements in April 2010. For details, please refer to the *Medicare Program Integrity Manual*, Chapter 3; Section 3.3.2.4 at <http://www.cms.gov/manuals/downloads/pim83c03.pdf>.

**Documenting procedures**

Document procedures as soon as possible after performing them and include the code on which the service is based on that documentation. A helpful technique for assuring good documentation is to periodically self-audit claims against records to determine if the codes chosen are supported by the records. Auditing and correcting non-conforming office practices help minimize claim errors occurring with the clerical task of preparing and submitting the claim. It is helpful for practitioners who use devices to assist manipulations to clearly document the device's name, and, if necessary, send with records to auditors a device description or other information describing how the device meets CMS requirements for assistive devices.

**Medical necessity**

Thorough documentation of clinically relevant and CMS required documentation elements serve to create a clear portrait of the patient's baseline condition, treatments provided, and a treatment timeline in terms of the patient's symptomatic functional response. The patient's condition (symptoms, physical signs, and function) must be described with objective, measurable terms along with pertinent subjective information. Documentation must provide a clear description of the mechanism of injury and how it negatively impacts baseline function. A clear plan of treatment that includes treatment goals (expected duration and frequency) and the clinical milestones to be used as measures of progress is also necessary. Demonstrate progress in objective, rather than conclusory, terms. You should document modifications in the treatment plan, when needed, because of failure to satisfactorily progress in the clinically reasonable and predicted timeframe. Adequately demonstrate that treatments provide more than short term symptom control unaccompanied by durable functional improvement.

Documentation of the initial evaluation and periodic reevaluations at reasonable intervals is essential. Evaluation/reevaluation elements above need not be documented at each treatment. However, they must be documented often enough to show measurable progress or failure to progress. And, above all, they must be included with the documentation of any procedures sent to Medicare auditors.

Documentation of the initial evaluation and periodic reevaluations at reasonable intervals is essential. Evaluation/reevaluation elements above need not be documented at each treatment. However, they must be documented often enough to show measurable progress or failure to progress. And, above all, they must be included with the documentation of any procedures sent to Medicare auditors.

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

**CMS manual references**

The *Medicare Benefit Policy Manual*, Chapter 15, Section 30.5 – Chiropractor's Services and Section 240 – Chiropractic Services, can be found at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf>.

The *Medicare Claims Processing Manual*, Chapter 12, Section 220 – Chiropractic Services, may be found at <http://www.cms.gov/manuals/downloads/clm104c12.pdf>.

**Other references**

Office of Inspector General, May 2009, *Inappropriate Medicare Payments for Chiropractic Services*, may be found at <http://oig.hhs.gov/oei/reports/oei-07-07-00390.pdf>.

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**Chiropractic.... (continued)**

The Medicare Learning Network® (MLN) educational product titled, *Advance Beneficiary Notice of Noncoverage (ABN)*, may be found at [http://www.cms.gov/MLNProducts/downloads/ABN\\_Booklet\\_ICN006266.pdf](http://www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf).

The MLN educational product titled, *Addressing Misinformation Regarding Chiropractic Services and Medicare*, may be found at [http://www.cms.gov/MLNProducts/downloads/Chiropractors\\_fact\\_sheet.pdf](http://www.cms.gov/MLNProducts/downloads/Chiropractors_fact_sheet.pdf).

MLN Matters® article MM3449, *Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063*, may be found at <http://www.cms.gov/MLNMattersArticles/downloads/MM3449.pdf>.

MLN Matters® Number: SE1101 *Revised*

Related Change Request (CR) #: N/A

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Implementation Date: N/A

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## Consolidated Billing

### October quarterly update to 2011 HCPCS codes for SNF consolidated billing enforcement

**Note:** This article was revised to reflect the revised change request (CR) 7444 issued on September 23, 2011. The article was revised to add HCPCS codes J9033 and G0121 to the bullet points under *Background*. Also, the CR transmittal number, release date, and the Web address for accessing the CR were revised. All other information is the same. This information was previously published in the June 2011 *Medicare B Connection* pages 9-10.

**Provider types affected**

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

**Provider action needed**

This article is based on CR 7444 which provides the October quarterly update to the 2011 Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (CB) enforcement. CR 7444 instructs the Medicare system maintainers to add HCPCS code J0894 (Injection, decitabine, 1 mg) to the File 1 Coding List for SNF CB and to Major III.A Chemotherapy services list in the FI/A/B MAC file for dates of service on or after January 1, 2011.

**Background**

The Social Security Act (Section 1888; see [http://www.ssa.gov/OP\\_Home/ssact/title18/1888.htm](http://www.ssa.gov/OP_Home/ssact/title18/1888.htm)) codifies the SNF prospective payment system (PPS) and consolidated billing (CB), and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the CB provision of the SNF PPS. No additional services are added by these routine updates. New updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

Services excluded from the SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to Medicare contractors, including durable medical equipment (DME) MACs, will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

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**October... (continued)**

CR 7444 instructs Medicare systems maintainers to:

- Add Healthcare Common Procedure Coding System (HCPCS) code J0894 to the File 1 Coding List for SNF CB for dates of service on or after January 1, 2011;
- Add HCPCS Code J9033 to the File 1 Coding list for SNF CB for dates of service on or after October 1, 2011;
- Add HCPCS code J0894 to Major Category III. A Chemotherapy services list in the FI/A/B MAC file effective January 1, 2011;
- Add HCPCS code J9033 to Major Category III. A Chemotherapy services list in the FI/A/B MAC file effective for dates of service on or after October 1, 2011; and
- Add HCPCS code G0121 to Major Category IV services effective January 1, 2011.

Note that Medicare contractors will reprocess claims affected by CR 7444 when brought to their attention.

**Additional information**

The official instruction, CR 7444, issued to your carriers, FIs, or A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2300CP.pdf>.

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

MLN Matters® Number: MM7444

Related Change Request (CR) #: CR 7444

Related CR Release Date: September 13, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R2300CP

Implementation Date: October 3, 2011

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## 2012 annual update of HCPCS codes for SNF consolidated billing

**Provider types affected**

Physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

**What you need to know**

This article is based on change request (CR) 7552 which provides the 2012 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for skilled nursing facility consolidated billing (SNF CB) and how the updates affect edits in Medicare claim processing systems.

By the first week in December 2011:

- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (titled 2012 carrier/A/B MAC update) will be posted at <http://www.cms.gov/SNFConsolidatedBilling/>, and
- Providers who bill FIs or A/B MACs are advised that new Excel and PDF files (titled 2011 FI/A/B MAC Update) will be posted to <http://www.cms.gov/SNFConsolidatedBilling/>.

It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update in order to understand the major categories, including additional exclusions not driven by HCPCS codes.



*continued on next page*



2012.... (continued)

### Background

Medicare's claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for skilled nursing facility consolidated billing (SNF CB) contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs) which is available at <http://www.cms.gov/manuals/downloads/clm104c06.pdf>. Please note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

### Additional information

You can find the official instruction, CR 7552, issued to your carrier, FI, A/B MAC, or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2286CP.pdf>.

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

MLN Matters® Number: MM7552

Related Change Request (CR) #: CR 7552

Related CR Release Date: August 26, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2286CP

Implementation Date: January 3, 2012

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## Drugs and Biologicals

### October 2011 average sales price files now available

The Centers for Medicare & Medicaid Services (CMS) has posted the October 2011 average sales price (ASP) and not otherwise classified (NOC) pricing files and crosswalks. The ASP pricing files and crosswalks for July 2011, April 2011, January 2011, and October 2010, have also been updated. All are available for download at: <http://www.cms.gov/McrPartBDrugAvgSalesPrice/> (see left menu for year-specific links).

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

**Source:** CMS PERL 201109-42

### 2011-2012 influenza vaccine prices are now available

The Centers for Medicare & Medicaid Services (CMS) has posted the 2011-2012 seasonal influenza vaccine payment limits at: [http://www.cms.gov/McrPartBDrugAvgSalesPrice/10\\_VaccinesPricing.asp](http://www.cms.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp).

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**Source:** CMS PERL 201109-41

#### 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.

## Durable Medical Equipment

### Get ready for DMEPOS competitive bidding

The Centers for Medicare & Medicaid Services (CMS) announced the next steps for the expansion of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program to include the round 2 and the national mail order competitions.

#### Round 2

The round 2 product categories are:

- Oxygen, oxygen equipment, and supplies
- Standard (power and manual) wheelchairs, scooters, and related accessories
- Enteral nutrients, equipment, and supplies
- Continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Negative pressure wound therapy pumps and related supplies and accessories
- Support surfaces (Group 2 mattresses and overlays)



A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website, [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com); the specific ZIP codes in each round 2 competitive bidding area (CBA) are also available on the CBIC website.

#### National mail-order competition

CMS will also be conducting a national mail-order competition for diabetic testing supplies at the same time as the round 2 competition. The national mail-order competition will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

To ensure that suppliers have ample time to prepare for the competition, CMS has announced the following next steps for the program:

#### Summer 2011

- The Centers for Medicare & Medicaid Services (CMS) begins pre-bidding supplier awareness program

#### Fall 2011

- CMS announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and passwords begins

#### Winter 2012

- Bidding begins

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

- Update your contact information: The following contact information in your enrollment file at the national supplier clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update:
  - The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding); and
  - The correspondence address.

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**Competitive.... (continued)**

DMEPOS suppliers can update their enrollment via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the July 11, 2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website ([www.cms.gov/MEDICAREPROVIDERSUPENROLL](http://www.cms.gov/MEDICAREPROVIDERSUPENROLL)) or reviewing the PECOS fact sheet at [www.cms.gov/MLNProducts/downloads/MedEnroll\\_PECOS\\_DMEPOS\\_FactSheet\\_ICN904283.pdf](http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf). Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC website ([www.palmettogba.com/nsc](http://www.palmettogba.com/nsc)) and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

- **Get licensed:** Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a competitive bidding area (CBA), you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. It is very important that you make sure that current versions of all required licenses are in your enrollment file with the NSC before you bid. If any required licenses are expired or missing from your enrollment file, we can reject your bid. Suppliers bidding in the national mail-order competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.
- **Get accredited:** Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action now to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

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

The competitive bidding implementation contractor (CBIC) is the official information source for bidders. Stay informed – visit the CBIC website at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com) to subscribe to email updates and for the latest information on the DMEPOS competitive bidding program.

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

**Source:** CMS PERL 201108-39, 201109-02

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## DMEPOS competitive bidding program expansion announced

### Provider types affected

This article is for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that wish to participate in the upcoming round 2 of the Medicare DMEPOS competitive bidding program and/or the national mail-order competition for diabetic testing supplies that will occur at the same time as round 2.

### What you need to know

This article provides important information from the Centers for Medicare & Medicaid Services (CMS) regarding the next phase (round 2 and national mail-order) of Medicare's competitive bidding program for DMEPOS. If you are interested in bidding, prepare now – don't wait.

The round 2 product categories are:

- Oxygen, oxygen equipment, and supplies
- Standard (power and manual) wheelchairs, scooters, and related accessories
- Enteral nutrients, equipment, and supplies
- Continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Negative pressure wound therapy pumps and related supplies and accessories, and
- Support surfaces (group 2 mattresses and overlays).

*continued on next page*

**Expansion.... (continued)**

CMS will also be conducting a national mail-order competition for diabetic testing supplies at the same time as the Round 2 competition. The national mail-order competition will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website, <http://www.dmecompetitivebid.com>, and the specific ZIP codes in each round 2 competitive bidding area (CBA) are also available on the CBIC website.

Update your contact information: The following contact information in your enrollment file at the national supplier clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update the following:

- The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding) and
- The correspondence address.

DMEPOS suppliers can update their enrollment via the Internet-based provider enrollment, chain and ownership system (PECOS) or by using the 7/11/2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website at <http://www.cms.gov/MEDICAREPROVIDERSUPENROLL/> or reviewing the PECOS fact sheet at [http://www.cms.gov/MLNProducts/downloads/MedEnroll\\_PECOS\\_DMEPOS\\_FactSheet\\_ICN904283.pdf](http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf).

Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC website at <http://www.palmettogba.com/nsc> and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

**Get licensed:** Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a CBA, you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. It is **very important** that current versions of all required licenses are in your enrollment file with the NSC **before** you bid. If any required licenses are expired or missing from your enrollment file, CMS can reject your bid. Suppliers bidding in the National Mail-Order Competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

**Get accredited:** Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action **now** to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

**Current round 2 and national mail-order schedule**

CMS has announced the following next steps for the program to ensure that suppliers have ample time to prepare for the competition:

**Summer 2011**

- CMS begins pre-bidding supplier awareness program;

**Fall 2011**

- CMS announces bidding schedule;
- CMS begins bidder education program; and
- Bidder registration period to obtain user ID and passwords begins.

**Winter 2012**

- Bidding begins.

**Additional information**

The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders. Stay informed - visit the CBIC website at <http://www.dmecompetitivebid.com/> to subscribe to e-mail updates and for the latest information.

For more information on the DMEPOS competitive bidding program, visit <http://www.cms.gov/dmeposcompetitivebid/>.

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**Expansion.... (continued)**

Information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at [http://www.cms.gov/MedicareProviderSupEnroll/01\\_Overview.asp](http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp).

The press release about the expanded competitive bidding program may be found at [http://www.cms.gov/apps/media/press\\_releases.asp](http://www.cms.gov/apps/media/press_releases.asp).

To view the fact sheet titled *Next Steps For Expansion Of The Medicare Durable Medical Equipment, Prosthetics, Orthotics, And Supplies* go to [http://www.cms.gov/apps/media/fact\\_sheets.asp](http://www.cms.gov/apps/media/fact_sheets.asp).

MLN Matters® Number: SE1127  
 Related Change Request (CR) #: NA  
 Related CR Release Date: NA  
 Effective Date: NA  
 Related CR Transmittal #: NA  
 Implementation Date: NA

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## Laboratory/Pathology

### Annual clotting factor furnishing fee update 2012

**Provider types affected**

This article is for physicians and other providers billing Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services related to the administration of clotting factors to Medicare beneficiaries.

**Provider action needed**

Change request (CR) 7543, from which this article is taken, announces that for calendar year 2012, the clotting factor furnishing fee of \$0.181 per unit is included in the published payment limit for clotting factors and will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the average sales price (ASP) or not otherwise classified (NOC) drug pricing files. Please be sure your billing staffs are aware of this fee update.

**Background**

Section 1842(o)(5)(C) of the Social Security Act (added by the Medicare Modernization Act Section 303(e)(1)) requires, beginning January 1, 2005, that a clotting factor furnishing fee be paid separately if you furnish clotting factor; unless the costs associated with furnishing the clotting factor are paid through another payment system.

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the ASP Medicare Part B drug pricing file, or the not otherwise classified (NOC) pricing file; your carrier, FI, RHHI, or A/B MAC must make payment for the clotting factor as well as make payment for the furnishing fee.

The clotting factor furnishing fee is updated each calendar year based on the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year. The clotting factor furnishing fees applicable for dates of service in each calendar year (CY) are listed below:

Clotting factor furnishing fee	
CY 2005	\$0.140 per unit
CY 2006	\$0.146 per unit
CY 2007	\$0.152 per unit
CY 2008	\$0.158 per unit
CY 2009	\$0.164 per unit
CY 2010	\$0.170 per unit
CY 2011	\$0.176 per unit
CY 2012	\$0.181 per unit

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**Clotting.... (continued)**

For dates of service January 1, 2012, through December 31, 2012, the clotting factor furnishing fee of \$0.181 per unit is included in the published payment limit for clotting factors and will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the ASP or NOC drug pricing files.

**Additional information**

You can find the official instruction, CR 7543, issued to your carrier, FI, RHHI, or A/B MAC by visiting <http://www.cms.gov/transmittals/downloads/R2279CP.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: MM7543

Related Change Request (CR) #: CR 7543

Related CR Release Date: August 19, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2279CP

Implementation Date: January 3, 2012

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## Clinical laboratory fee schedule – Medicare travel allowance fees for collection of specimens

**Provider types affected**

Clinical laboratories submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for specimen collection services provided to Medicare beneficiaries are affected.

**Provider action needed**

This article is based on CR 7526, which revises the payment of travel allowances for specimen collection services when billed on a per mileage basis using Healthcare Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat rate basis, using HCPCS code P9604 for calendar year (CY) 2011.

The per mile travel allowance (P9603) for services on or after July 1, 2011, is \$1.01 per mile and the per flat-rate trip basis travel allowance (P9604) is \$10.05. Payment of the travel allowance is made only if a specimen collection fee is also payable. Your Medicare contractor has the option of establishing a higher per mile rate in excess of the minimum \$1.01 per mile (actual total of \$1.005 rounded up to reflect systems capabilities) if local conditions warrant it. Be sure your staffs are aware of these changes.

**Background**

CR 7526 revises the CY 2011 payment of travel allowances when billed either on a:

- Per mileage basis using HCPCS code P9603, or
- Flat rate basis using HCPCS code P9604.

**Note:** Payment of the travel allowance is made only if a specimen collection fee is also payable.

The travel allowance is intended to cover the estimated travel costs of collecting a specimen, including the laboratory technician's salary and travel expenses.

Medicare contractors have the discretion to choose either the mileage basis or flat rate. In addition, your Medicare contractor can choose how to set each type of allowance. Also, many contractors established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip for both Medicare and non-Medicare patients. This is done either:

- At the time the claim is submitted by the laboratory, or
- When the flat rate is set by the Medicare contractor.

**Per mile travel allowance (P9603)** – The per mile travel allowance is a minimum of \$1.01 per mile. This per mile travel allowance rate is used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

*continued on next page*

**Clinical.... (continued)**

The allowance per mile rate was computed using the federal mileage rate of \$0.555 per mile plus an additional \$0.45 per mile to cover the technician's time and travel costs for a total of \$1.01 per mile (actual total of \$1.005 rounded up to reflect systems capabilities). At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

**Per flat-rate trip basis travel allowance (P9604)** – The per flat-rate trip basis travel allowance is \$10.05.

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.

**Additional information**

The official instruction, CR 7526, issued to your FI, carrier and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2306CP.pdf>. If you have any questions, please contact your FI, carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7526

Related Change Request (CR) #: 7526

Related CR Release Date: September 16, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: R2306CP

Implementation Date: November 29, 2011

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## Changes to the laboratory NCD edit software for October 2011

**Note:** This article was revised on September 6, 2011, to reflect a revised change request (CR) 7507. The CR was revised to add some codes and delete some codes from the various national coverage determinations (NCDs). In addition, the CR release date, transmittal number, and the Web address for accessing the CR have been revised. This information was previously published in the August 2011 *Medicare B Connection*, pages 16-17.

**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 CR 7507, which announces the changes that will be included in the October 2011 release of Medicare's edit module for clinical diagnostic laboratory NCDs. The last quarterly release of the edit module was issued in April 2011. Be sure billing staff know about 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 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>, 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 7507 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2011. These changes become effective for services furnished on or after October 1, 2011. The changes that are effective for dates of service on and after October 1, 2011 are as follows:

**For codes that are denied by Medicare for all 23 lab NCDs**

- Delete ICD-9-CM code V19.1 from the list of ICD-9-CM codes that are denied by Medicare for all 23 lab NCDs.
- Add ICD-9-CM codes V19.11 and V19.19 to the list of ICD-9-CM codes that are denied by Medicare for all 23 lab NCDs.

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**NCD.... (continued)****For codes that are covered by Medicare for the HIV testing**

- Add ICD-9-CM codes 512.81, 512.82, and 512.83 to the list of codes covered by Medicare for HIV testing (diagnosis) (190.14) NCD.
- Delete ICD-9-CM code 512.8 from that same list.

**For codes that do not support medical necessity for the blood counts**

- Add ICD-9-CM codes 726.13, V40.31, V40.39, and V54.82 to the list of ICD-9-CM codes that do not support medical necessity for the blood counts (190.15) NCD.
- Delete ICD-9-CM codes 718.60 and V40.3 from that list.

**For partial thromboplastin time**

- Delete ICD-9-CM codes 286.5, 444.0, and 596.8 from the list of ICD-9-CM codes that are covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- Add ICD-9-CM codes 286.52, 286.53, 286.59, 444.01, 444.09, 596.81, 596.82, 596.83, and 596.89 to the list of ICD-9-CM codes that are covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.

**For prothrombin time**

- Delete ICD-9-CM codes 286.5, 425.1, 444.0, 596.8, and 997.4 from the list of ICD-9-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- Add ICD-9-CM codes 286.52, 286.53, 286.59, 414.4, 415.13, 425.11, 425.18, 444.01, 444.09, 573.5, 596.81, 596.82, 596.83, 596.89, 997.41, 997.49, and V12.55 to the list of ICD-9-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.

**For serum iron studies**

- Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, and 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.
- Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 282.40, 282.43, 282.44, 282.45, 282.46, 282.47, 286.52, 286.53, 286.59, and 573.5 to the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.

**For blood glucose testing**

- Add ICD-9-CM codes 414.4, V23.42 and V23.87 to the list of ICD-9-CM codes that are covered by Medicare for the for blood glucose testing (190.20) NCD.

**For glycated hemoglobin/glycated protein**

- Delete ICD-9-CM code V12.2 from the list of ICD-9-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
- Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.

**For thyroid testing**

- Delete ICD-9-CM code V12.2 from the list of covered ICD-9-CM codes for the thyroid testing (190.22) NCD.
- Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the thyroid testing (190.22) NCD.

**For lipids testing**

- Delete ICD-9-CM code 444.0 from the list of ICD-9-CM codes that are covered by Medicare for the lipids testing (190.23) NCD.
- Add ICD-9-CM codes 414.4, 444.01, 444.09, and 573.5 to the list of ICD-9-CM codes that are covered by Medicare for the lipids testing (190.23) NCD.

**For digoxin therapeutic drug assay***continued on next page*



**NCD.... (continued)**

- Add ICD-9-CM codes 414.4, 425.11, 425.18, 444.01, 44.09, and 573.5 to the list of codes covered by Medicare for the digoxin therapeutic drug assay (190.24) NCD.

**For alpha-fetoprotein**

- Delete ICD-9-CM codes 425.1 and 793.1 from the list of codes covered by Medicare for the alpha-fetoprotein (190.25) NCD.
  - Add ICD-9-CM codes 414.4, 425.11, 425.18, 444.01, 444.09, 573.5, 793.11, and 793.19 to the same list of covered codes.

**For human chorionic gonadotropin**

- Delete ICD-9-CM code 631 from the list of ICD-9-CM codes that are covered by Medicare for the human chorionic gonadotropin (190.27) NCD.
- Add ICD-9-CM codes 631.0 and 631.8 to the list of ICD-9-CM codes that are covered by Medicare for the human chorionic gonadotropin (190.27) NCD.

**For gamma glutamyl transferase**

- Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, and 173.9 from the list of covered ICD-9-CM codes for the gamma glutamyl transferase (190.32) NCD.
- Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, and 573.5 to the list of ICD-9-CM codes that are covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

Add ICD-9-CM code 573.5 to the list of codes covered by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.

**For fecal occult blood test**

- Delete ICD-9-CM code 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the fecal occult blood test (190.34) NCD.
- Add ICD-9-CM codes 286.52, 286.53, and 286.59 to the list of ICD-9-CM codes that are covered by Medicare for the fecal occult blood test (190.34) NCD.

**Additional information**

The official instruction, CR 7507 issued to your carrier, FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2298CP.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: MM7507 *Revised*

Related Change Request (CR) #: 7507

Related CR Release Date: September 2, 2011

Effective Date: October 1, 2011

Related CR Transmittal #: R2298CP

Implementation Date: October 3, 2011

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## Affordable Care Act – Section 3113 – laboratory demonstration for certain complex diagnostic tests (replaces CR 7278)

**Note:** This article was rescinded and replaced on August 29, 2011, by *MLN Matters*<sup>®</sup> article MM7516, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM7516.pdf>. This information was previously published in the June 2011 *Medicare B Connection*, pages 21-23.

MLN Matters<sup>®</sup> Number: MM7413 *Rescinded*  
Related Change Request (CR) #: 7413  
Related CR Release Date: July 15, 2011  
Effective Dates: January 1, 2012  
Related CR Transmittal #: R2226CP and R74DEMO  
Implementation Date: January 3, 2012

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## Medicare Physician Fee Schedule Database

### October update to the 2011 Medicare physician fee schedule database

#### Provider types affected

Physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), 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) 7528 and instructs Medicare contractors to download and implement a new Medicare physician fee schedule database (MPFSDB) as of October 3, 2011. Affected providers should be aware that Medicare contractors will only adjust claims brought to their attention. Please make sure your billing staff is aware of these changes.

#### Background

Section 1848 (c) (4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. In order to reflect appropriate payment policy in line with the CY 2011 MPFS final rule, the MPFSDB has been updated effective January 1, 2011, and new payment files have been created.

The original payment files were issued to Medicare contractors based upon the CY 2011 MPFS final rule, published in the *Federal Register* on November 29, 2010, as modified by the final rule correction notice, published in the *Federal Register* on January 11, 2011, and relevant statutory changes applicable January 1, 2011. CR 7528 amends those payment files.

For the October 2011 update, there are no new or deleted Healthcare Common Procedure Coding System (HCPCS) codes. However, there are a number of HCPCS codes with MPFS payment indicator changes. Those changes are listed in the table attached to CR 7528, which is available at <http://www.cms.gov/transmittals/downloads/R2276CP.pdf>.

Medicare contractors will not search their files to adjust claims already processed prior to implementation of these changes. However, they will adjust any impacted claims that you bring to their attention.

#### Additional information

The official instruction, CR 7528 issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2276CP.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>.

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**MPFSDB.... (continued)**

MLN Matters® Number: MM7528  
Related Change Request (CR) #: 7528  
Related CR Release Date: August 19, 2011  
Effective Date: January 1, 2011  
Related CR Transmittal #: R2276CP  
Implementation Date: October 3, 2011

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## Radiology

### Magnetic resonance imaging in Medicare beneficiaries with FDA-approved implanted permanent pacemakers

#### Provider types affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries [FI], carriers, or A/B Medicare administrative contractors [A/B MAC]) for providing magnetic resonance imaging (MRI) services to Medicare beneficiaries are affected.

#### What you need to know

This article, based on change request (CR) 7441, informs you that Medicare believes that the evidence is adequate to conclude that MRIs improve health outcomes for Medicare beneficiaries with implanted pacemakers (PMs) when the PMs are used according to the Food and Drug Administration (FDA)-approved labeling for use in an MRI environment. Effective for services on or after July 7, 2011, Medicare will allow coverage of MRIs for beneficiaries with implanted PMs when the PMs are used according to the FDA-approved labeling for use in an MRI environment.

Effective for claims with dates of service on or after July 7, 2011, you should include the following information on MRI claims for beneficiaries with implanted PMs that are FDA-approved for use in an MRI environment:

- Appropriate MRI code
- Modifier KX
- ICD-9 code V45.01 (cardiac pacemaker)

Inclusion of the modifier KX on the claim line(s) means that the provider attests that documentation is on file verifying that FDA-approved labeling requirements are met. For such claims without the modifier KX, Medicare will deny MRI line items using the following remittance advice messages:

- Group code of CO (contractual obligation)
- Claim adjustment reason code (CARC) 188 (This product/procedure is only covered when used according to FDA recommendations.)

As described previously in the *MLN Matters*® article MM7296 (<http://www.cms.gov/MLN MattersArticles/downloads/MM7296.pdf>), Medicare posted a separate decision on February 24, 2011, that allows coverage of MRIs for beneficiaries with implanted PMs or implantable cardioverter defibrillators (ICDs) for use in an MRI environment in a Medicare-approved clinical study. This policy is effective for claims with dates of service on and after February 24, 2011. Providers should follow the instructions issued in the MM7296 article and the additional instructions referenced below.

The following information should be included on MRI claims for beneficiaries with implanted PMs or ICDs for use in an MRI environment in a Medicare-approved clinical study:

- Appropriate MRI code
- Modifier Q0
- ICD-9 code V70.7 Examination of participant in clinical trial (institutional claims only)
- Condition code 30 (institutional claims only)

*continued on next page*

**MRI... (continued)**

- ICD-9 code V45.02 (automatic cardiac defibrillator) or CPT code V45.01 (cardiac pacemaker)

MRI claims for beneficiaries with implanted PMs or ICDs for use in an MRI environment in a Medicare-approved clinical study that do not include all the line items listed above will be denied using the following remittance messages:

- Group code of CO
- CARC B5 (Coverage/program guidelines were not met or were exceeded)
- Remittance advice remarks 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 [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have Web access, you may contact the contractor to request a copy of the NCD).

Providers are reminded that ICD-10 implementation occurs on October 1, 2013. At that time the ICD-9 codes mentioned above will be replaced by the appropriate ICD-10 codes, which are:

- ICD-10 - Z006: Encounter for examination for normal comparison and control in clinical research program
- ICD-10- Z950: Presence of cardiac pacemaker
- ICD-10- Z95810: Presence of automatic implantable cardiac defibrillator

Medicare payment for these services is as follows:

- Professional claims (practitioners and suppliers) – based on the Medicare physician fee schedule (MPFS).
- Inpatient (type of bill (TOB) 11x) – prospective payment system (PPS), based on the diagnosis-related group.
- Hospital outpatient departments (TOB 13x) – outpatient PPS, based on the ambulatory payment classification.
- Rural health clinics (RHCs)/federally qualified health centers (FQHCs) (TOB 71x/77x) – all-inclusive rate, professional component only, based on the visit furnished to the RHC/FQHC beneficiary to receive the MRI. The technical component is outside the scope of the RHC/FQHC benefit. Therefore the provider of the technical service bills their carrier or A/B MAC on the ANSI X12N 837P or hardcopy Form CMS-1500 and payment is made under the MPFS.
- Critical access hospitals (CAHs) (85x) – for CAHs that elected the optional method of payment for outpatient services, the payment for technical services would be the same as the CAHs that did not elect the optional method, which is reasonable cost. The FI or A/B MAC pays the professional component at 115 percent of the MPFS.

Medicare will not adjust claims automatically that were processed prior to implementation of CR 7441. However, they will adjust such claims that you bring to the attention of your Medicare contractor.

Please be sure that your staffs are aware of these changes.

**Additional information**

To view the article, MM7296, “Magnetic Resonance Imaging (MRI) in Medicare Beneficiaries with Implanted Permanent Pacemakers (PMs) or Implantable Cardioverter Defibrillators (ICDs),” visit <http://www.cms.gov/MLN MattersArticles/Downloads/MM7296.pdf>.

The official instruction, CR 7441, was issued to your FI, carrier, or A/B MAC regarding this change in two transmittals. The first modified the *National Coverage Determinations Manual* and is at <http://www.cms.gov/Transmittals/downloads/R135NCD.pdf>. The second updates the *Medicare Claims Processing Manual* and is at <http://www.cms.gov/Transmittals/downloads/R2307CP.pdf>.

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

MLN Matters® Number: MM7441

Related Change Request (CR) #: 7441

Related CR Release Date: September 22, 2011

Effective Date: July 7, 2011

Related CR Transmittal #: R2307CP and R135NCD

Implementation Date: September 26, 2011

*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.*



## General Coverage

### Clarification to Chapter 26, Section 10.4 – Items 14-33 – Provider of Service or Supplier Information

#### Provider types affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers and Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

#### What you need to know

This article is based on change request (CR) 7538 and clarifies the manual section specified in the article title to confirm that the changes implemented in change request (CR) 6947 are applicable only to services payable under the Medicare physician fee schedule and anesthesia services.

Specifically, CR 7538 clarifies Chapter 26, Section 10.4 of the *Medicare Claims Processing Manual* to confirm that the changes implemented in CR 6947 are applicable only to services payable under the Medicare physician fee schedule and anesthesia services. Please make sure your billing staff is aware of these changes.

#### Additional information

The official instruction, CR 7538, issued to your carrier and/or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2284CP.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: MM7538

Related Change Request (CR) #: 7538

Related CR Release Date: August 26, 2011

Effective Date: September 26, 2011

Related CR Transmittal #: R2284CP

Implementation Date: September 26, 2011

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#### Find fees faster: Try FCSO's fee schedule lookup

Now you can find the fee schedule information you need faster than ever before with FCSO's redesigned fee schedule lookup, located at [http://medicare.fcso.com/Fee\\_lookup/fee\\_schedule.asp](http://medicare.fcso.com/Fee_lookup/fee_schedule.asp). This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

## Help planning for version 5010 and ICD-10 is available from CMS

Do you need help with the transition to version 5010 or planning for ICD-10? The Centers for Medicare & Medicaid Services (CMS) has created an [interactive timeline widget](#) that is now available on the CMS' ICD-10 and version 5010 compliance timelines page. This user-friendly tool can help you and your organization:

- Understand what you should be doing right now to prepare for the switches to version 5010 and ICD-10
- Know the steps you'll need to take in the future and when
- Stay on top of approaching transition deadlines to help manage the implementation process



The content of the widget is tailored with specific information for large and small provider practices, payers, and vendors. Also available are printer-friendly versions of the timeline information to download and use as check lists.

CMS also has other [new resources](#) to help you transition, including fact sheets and frequently asked questions for both version 5010 and ICD-10. With the version 5010 deadline fast approaching, it will be important to take advantage of these new resources now to ensure you are on the right track.

The transitions to version 5010 and ICD-10 involve significant preparations, and the transitions also require business and systems changes throughout health care industry. CMS is committed to helping you better prepare for version 5010 and ICD-10.

### Keep up to date on version 5010 and ICD-10

Please visit [CMS' ICD-10 website](#) for the latest news and resources to

help you prepare, and visit CMS' ICD-10 and version 5010 compliance timelines page to download and share the widget today.

**Source:** CMS PERL 201109-25

## Are you prepared for version 5010?

Summer is coming to an end, and the version 5010 transition deadline is now only four months away. As the January 1, 2012, deadline approaches, your transition should be well underway. There are certain steps to be taking now during the fall to make sure you are on track for a smooth transition.

### If you are a provider, you should:

- Continue external testing and making any revisions to systems based on previous internal testing
- Test those transactions that are used on a daily basis, such as claims and eligibility determinations

### If you are a payer, you should:

- Continue to coordinate the transition to the new formats and testing with providers, clearinghouses, billing services, and other business partners
- Complete external testing and your version 5010 transition by Saturday, December 31, 2011, to achieve level II compliance

### If you are a vendor, you should:

- Continue to conduct external trading partner testing of version 5010 with customers to achieve level II compliance
- Conduct solution rollout and provide customer support for the version 5010 transition through the January 1, 2012, compliance date

### Keep up-to-date on version 5010 and ICD-10

For more information visit the CMS website. Please visit [version 5010](#) for the most current information on all 5010 issues and visit [CMS ICD-10](#) for the latest news and resources on ICD-10 to help you prepare.

**Source:** CMS PERL 201109-33

## HIPAA 5010 & D.0 – implementation calendar and important reminders

During the transition to Health Insurance Portability and Accountability Act (HIPAA) versions 5010 and D.0., you will be periodically reminded of important items and dates that may be of specific interest to the Medicare fee-for-service (FFS) provider/supplier community. Please see below to learn about current, upcoming, and past events that have taken place during this implementation process.

### Announcements

The HIPAA 5010 compliance date is fast-approaching. There are only five months left until full implementation on January 1, 2012. Please contact your local Medicare administrative contractor (MAC) and test now.

### Reminders

January 1, 2011, marked the beginning of the 5010/D.0. transition year.

[Versions 5010 & D.0 FAQs Now Available!](#)

[National Testing Day Message Now Available!](#)

[5010/D.0 Errata requirements and testing schedule can be found here](#)

[Contact your MAC for their testing schedule](#)

### Readiness assessment

[Have you done the following to be ready for 5010/D.0.?](#)

[What do you need to have in place to test with your Medicare administrative contractor \(MAC\)?](#)

[Do you know the implications of not being ready?](#)

### Implementation calendar

#### Upcoming events

##### October 2011

October 5: MAC hosted outreach and education session -- last push for implementation

October 24-27: [WEDI 2011 fall conference](#) \*

##### December 2011

December 31: End of the transition year, and the beginning of 5010 production environment

#### Past events

##### June 2010

June 15: [5010 national call – ICD-10/5010 national provider call](#)

June 30: [5010 national call – 837 institutional claim transaction](#)

##### July 2010

July 28: [5010 national call – 276/277 claim status inquiry and response transaction set](#)

##### August 2010

August 25: [5010 national call – 835 remittance advice transaction](#)

##### September 2010

September 27: [5010 national call – acknowledgement transactions \(TA1, 999, 277CA\)](#)

##### October 2010

October 13: [5010/D.0. errata requirements and testing schedule released](#)

October 27: [5010 national call – NCPDP version D.0. transaction](#)

##### November 2010

November 4: [Version 5010 resource card published](#)

November 8: [WEDI 2010 fall conference](#) \*

November 17: [5010 national call – coordination of benefits \(COB\)](#)

##### December 2010

December 8: [5010 national call – MAC outreach and education activities and transaction-specific testing protocols](#)

##### January 2011

January 1: Beginning of transition year

January 11: [HIMSS 5010 industry readiness update](#) \*

January 19: [5010 national call – errata/companion guides](#)

January 25-27: [4th WEDI 5010 and ICD-10 Implementation Forums – Advancing Down the Implementation](#)

[Highway: Moving Forward with Testing to Attain Implementation](#) \*

##### February 2011

February 20-24: [Healthcare Information and Management Systems Society \(HIMSS\) 11th Annual Conference & Exhibition](#) \*

*continued on next page*

**HIPAA....(continued)****March 2011**

March 1: [New readiness assessment – Do you know the implications of not being ready?](#)

March 30: [CMS-hosted 5010 national call – provider testing and readiness](#)

**April 2011**

April 4-11: Version 5010 test education week

April 27: MAC hosted outreach and education session – are you ready to test?

**May 2011**

May 2-5: [20th Annual WEDI National Conference](#) \*

May 25: [Medicare fee-for-service national call – call to action – test](#)

**June 2011**

June 15: National MAC Testing Day

June 29: [CMS-hosted Medicare fee-for-service national call – question & answer session](#)

**July 2011**

July 20: MAC hosted outreach and education session – troubleshooting with your MAC

**August 2011**

August 22-26: National MAC Testing Week

August 31: [CMS-hosted Medicare FFS national call – MAC panel questions & answers](#)

**September 2011**

September 14: CMS-hosted Medicare FFS national call – question & answer session

For older national call information, please visit the [5010 National Calls section of CMS' versions 5010 & D.O. Web page](#)

\* Information about events in which the Centers for Medicare & Medicaid Services (CMS) Medicare FFS staff participates may be applicable to the health care industry at large, though it is geared toward the Medicare FFS audience.

**Source:** CMS PERL 201109-06

## Populating REF segment – other claim related adjustment – for healthcare claim payment/advice or transaction 835 version 5010A1

**Note:** This article was revised on September 6, 2011, due to changes in change request (CR) 7484. The CR was revised to add qualifier “FI” in loop 2100 NM1 – Service Provider Name under special situations where the NPI is not available - enabling Medicare to report the federal taxpayer’s identification number instead of NPI if NPI is not available for the rendering provider and the rendering provider is different from the payee. The CR release date, transmittal number, and the Web address for accessing the CR were also revised. This information was previously published in the August 2011 *Medicare B Connection*, page 28.

**Provider types affected**

This article is for physicians, other providers, and suppliers who bill Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), regional home health intermediaries (RHHIs), or durable medical equipment Medicare administrative contractors (DME MACs) for Part B services provided to Medicare beneficiaries.

**Provider action needed****Stop – impact to you**

The Centers for Medicare and Medicaid Services (CMS) has decided that populating the healthcare claim payment/advice or transaction 835 version 5010A1 REF segment (other claim related adjustment) at loop 2100 (for Part B) would provide useful information to providers and suppliers, and starting in January 2012, this segment will be populated for the Part B remittance advice.

**Caution – what you need to know**

CR 7484, from which this article is taken, instructs Medicare systems, effective January 1, 2012, to populate the REF segment (other claim related adjustment) at loop 2100 with qualifiers designated in the updated flat file attached to CR 7484. Note that CR also updates the 835 flat file by adding:

- PLB code 90
- Qualifier “PQ” to be used in loop 1000B REF – Payee Additional Information under some special situations where the national provider identifier (NPI) is not available, and

*continued on next page*



**Populating ... (continued)**

- Qualifier “F1” to be used in loop 2100 NM1 – service payable under some special situations where NPI is not available.

**Go – what you need to do**

You should make sure that your billing staffs are aware of this change.

**Background**

Currently the healthcare claim payment/advice or transaction 835 REF segment (other claim related adjustment) at loop 2100 is not being populated for the Part B remittance advice, and the 835 flat file identifies this with a note: “N/U by Part B.”

CMS has decided that using this segment would provide useful information to providers and suppliers. Therefore, CR 7484, from which this article is taken, instructs the VIPS Medicare system (VMS) and the multi-carrier system (MCS) to populate this segment, effective January 1, 2012, under specific situations (e.g., for cost avoid claims) using one of the qualifiers included in the updated flat file that is an attachment to CR 7484.

Specifically, VMS and MCS will use one of the following reference identification qualifiers in REF01 as appropriate:

- 28: Employee identification number
- 6P: Group number

(When they use this 6P qualifier, they will also populate NM1 – corrected priority payer name segment at loop 2100 and REF02 with the other insured group number for the payer identified in NM1, and use claim status code 2 in CLP02 in CLP – claim payment information segment at loop 2100);

- EA: Medical record identification number
- F8: Original reference

**Note:** Medicare will update Medicare Remit Easy Print (MREP) software to include this additional REF segment in the MREP remittance advice for version 5010A1.

**Additional information**

You can find the official instruction, CR 7484, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R959OTN.pdf>. You will find the updated 835 T 5010A1 flat file containing the qualifiers as an attachment to that CR.

Additionally, you can learn more about CMS’s implementation activities to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010A1 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0, by going to [http://www.cms.gov/MFFS5010D0/01\\_Overview.asp](http://www.cms.gov/MFFS5010D0/01_Overview.asp).

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

MLN Matters® Number: MM7484 *Revised*

Related Change Request (CR) #: CR 7484

Related CR Release Date: September 2, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R959OTN

Implementation Date: January 3, 2012

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## Incentive Programs

### Newly enrolled eligible primary care practitioners may participate in PCIP

Newly-enrolled eligible primary care practitioners may participate in Medicare's Primary Care Incentive Payment Program (PCIP). Review the *Medicare Learning Network*® MLN Matters article MM7267 at <http://www.CMS.gov/mlnmattersarticles/downloads/MM7267.pdf> and stay tuned for additional information.

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

**Source:** CMS PERL 201109-32

### Greater flexibility in e-Prescribing means greater success

By Patrick Conway, M.D., MSc, CMS Chief Medical Officer and Director of the Office of Clinical Standards & Quality

Electronic prescribing plays a vital role in improving patient care and helping make our health care system more efficient. With electronic prescribing, providers can better manage patient prescriptions, reducing drug interactions or other preventable prescription errors. The Centers for Medicare & Medicaid Services (CMS) has made several changes in the newly released final rule for the 2011 electronic prescribing (eRx) incentive program that will encourage more doctors and other health care professionals to adopt this technology and give them the added flexibility to help them succeed. In particular, the changes will better recognize those circumstances when the ability of professionals to meet the eRx requirements is limited and when the requirements clearly pose a significant hardship.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required an adjustment to payments, beginning in 2012, for eligible professionals who aren't successful electronic prescribers. After we published the 2011 Medicare Physician Fee Schedule (MPFS) Final Rule last fall, CMS heard about additional circumstances that could keep physicians and other health professionals from being successful e-prescribers. For example, some providers weren't sure whether certified electronic health record (EHR) technology that the Medicare and Medicaid EHR incentive programs require is also a "qualified" electronic prescribing system as required by the Medicare eRx incentive program. Others providers brought up additional hardship situations that the 2011 MPFS final rule didn't address.

Here's how CMS is addressing those additional concerns:

- CMS is modifying the 2011 electronic prescribing measure to say that a qualified electronic prescribing system for the purpose of the Medicare eRx incentive program includes certified EHR technology under the Medicare and Medicaid EHR incentive programs.
- CMS is adding four additional significant hardship exemptions that will make professionals exempt from the 2012 payment adjustment:
  1. Eligible professionals who register to participate in the Medicare or Medicaid EHR incentive program and adopt certified EHR technology;
  2. Eligible professionals who are unable to electronically prescribe due to local, state, or federal law or regulation;
  3. Eligible professionals who have limited prescribing activity; and
  4. Eligible professionals who have insufficient opportunities to report the e-prescribing measure due to limitations of the measure's denominator.
- The two hardship exemptions already available to professionals are:
  1. Eligible professional or group practice practices in rural areas with limited high speed internet access; and
  2. Eligible professional or group practice practices in an area with limited available pharmacies for electronic prescribing.

**Links:**

Federal Register URL: <http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22629.pdf>.

Here's the URL for the blog: <http://blog.cms.gov/2011/08/31/greater-flexibility-in-e-prescribing-means-greater-success/>.

*continued on next page*

### **Flexibility....(continued from page 1)**

The URL to the final rule on the eRx incentive program website: <http://www.cms.gov/ERXincentive/>.  
View the [CMS Fact Sheet](#).

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

**Source:** CMS PERL 201109-03

## **Accessing 2010 feedback reports for PQRI and eRx incentive programs**

The Centers for Medicare & Medicaid Services (CMS) would like to share this important information with eligible professionals who participated in the 2010 Physician Quality Reporting Initiative (PQRI) and/or the 2010 Electronic Prescribing (eRx) Incentive Programs.

**Please note:** In 2011, the PQRI program name changed to the Physician Quality Reporting System.

### **Feedback report availability**

Feedback reports for the 2010 eRx incentive program are now available. Feedback reports for the 2010 PQRI will be available in late September or early October 2011.

Feedback reports are compiled at the tax identification number (TIN) level, with individual-level reporting (by national provider identifier-level professional who reported at least on a claim submitted under that TIN period. Group practice reporting have reporting or performance data professional level.

Participants are able to use the available on the Physician and Reporting Portal (Portal), to verify organization's TIN and its NPIs. The must be the one used by the eligible and valid PQRI or eRx QDCs during at <http://www.qualitynet.org/pqri>.



[NPI-level] information for each eligible one valid eRx quality-data code (QDC) for services furnished during the reporting option (GPRO) participants will only at the TIN level and not at the eligible

“Verify Report Portlet” look-up tool, Other Health Care Professionals Quality if a 2010 feedback report exists for the TIN or NPI entered in the search field professional to submit Medicare claims that reporting period. This tool is available

If a 2010 feedback report is available for your organization's TIN and its NPIs, there are three ways to access your report:

**Individuals authorized access to CMS computer services (IACS):** Eligible professionals can log on to the secure Portal on QualityNet at <http://www.qualitynet.org/pqri> to access their feedback report(s) based on their TIN or GPRO TIN. Access to the Portal requires registration in the IACS system to obtain a user ID and password. Information on creating and/or updating an IACS account is included later in this message.

**Alternative feedback report method:** An individual eligible professional can simply call their respective carrier or Medicare administrative contractor (MAC) provider contact center to request their confidential 2010 PQRI and/or eRx feedback reports that will contain information based on the eligible professional's individual NPI. If an eligible professional reported individually as part of a group practice (not a GPRO), a report must be requested for each eligible professional in the group practice by contacting their carrier/MAC provider contact center to request a feedback report based on the individual NPI. In addition to PQRI or eRx information, these reports will provide individual eligible professionals with information on their Medicare Part B physician fee schedule (PFS) allowed charges for the respective 2010 reporting period, upon which an incentive payment is based.

**Please note:** This method of accessing feedback reports is not applicable to GPROs since there are no NPI-level feedback reports for them; only the GPRO TIN-level feedback report is available for GPROs.

For a list of provider contact centers, visit <http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

Additional information about this alternative feedback report request process can be found by accessing special edition *MLN Matters*<sup>®</sup> article [SE0922 \(Alternative Process for Individual Eligible Professionals to Access Physician Quality Reporting System \(Physician Quality Reporting, formerly called Physician Quality Reporting Initiative or PQRI\) and Electronic Prescribing \(eRx\) Feedback Reports\)](#)

**A Web-based support page:** When available, additional information on this new request method, called Quality Reporting Communication Support Page, will be provided through the usual CMS communication channels.

*continued on next page*

**Accessing....(continued)****Creating an IACS account**

TIN-level feedback reports are only available through a secured website and require an IACS account. IACS is the security system CMS uses to register users and control issuance of user IDs, passwords, and access to CMS web-based applications. Through IACS, provider organizations will be able to manage users whom they authorize to conduct transactions on their behalf, which may include staff and contractors.

Please remember that eligible professional and group practice provider enrollment information must be current in the Medicare provider enrollment chain and ownership system (PECOS) in order to request an IACS account. For more information, including a link to Internet-based PECOS, visit <http://www.cms.gov/MedicareProviderSupEnroll/>. For PECOS issues, please contact the External User Services (EUS) Help Desk from 7:00 a.m.-7:00 p.m. ET at 1-866-484-8049 or [EUSsupport@cgi.com](mailto:EUSsupport@cgi.com).

Users are encouraged to review the IACS Quick Reference Guides on the Portal prior to beginning the IACS new user registration process. The new user registration menu for CMS applications is at <https://idm.cms.hhs.gov/idm/user/newregistration.jsp>.

Any person registering for an IACS account to access program feedback reports is allowed one account. This person is the only one allowed to register for an account (someone cannot set it up for them) and must use their own email address when registering. Users should direct questions or concerns to the QualityNet Help Desk at 1-866-288-8912 or TTY 1-866-523-4759, (Monday - Friday 7:00 a.m.-7:00 p.m. CST) or via email at [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org) (<mailto:EUSsupport@cgi.com>).

**Important information on updating IACS user accounts and passwords**

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

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

An IACS account is needed to access the Portal and view or download TIN-level feedback reports. Updating IACS user accounts and passwords is essential to maintaining this access and functionality.

**Resources**

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

**Instructions on making IACS account management changes (i.e., email address, phone number, date of birth, authentication question information, password, etc.)**

1. Sign in to the account at <https://idm.cms.hhs.gov/idm/user/iacsTerms.jsp>.
2. On the My Profile page, select the appropriate link for the change.
3. Enter the desired change. A justification is required for any user/contact information changes.
4. Select Save, OK, or Next to continue.
5. Once the changes are submitted for any user/contact information, a request number will display. Record this number for reference. The request will be reflected in the system upon approval by the approver.
6. Requested changes to the password and authentication questions will be reflected upon completion.

**Note:** If you are unable to access your account, contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-866-523-4759).

**Instructions on locked IACS accounts**

- An IACS account is locked when a user enters incorrect sign on information three times consecutively.
- The account may be unlocked by utilizing the "Forgot Your Password?" option located at the login screen at <https://idm.cms.hhs.gov/idm/user/iacsTerms.jsp>.
- You must successfully answer the authentication questions (reminder that these are case sensitive).
- A new temporary password will be sent to the email address associated with your account. This will allow you to login at the above site and change the password when prompted.

*continued on next page*



**Accessing....(continued)****Instructions on expired passwords**

IACS account passwords expire every 60 days.

1. Login to the IACS account with the expired password at <https://idm.cms.hhs.gov/idm/user/iacsTerms.jsp>.
2. Change the password when prompted.
3. When a user cannot remember his or her password, the "Forgot Your Password?" option may be utilized to obtain a new temporary password. The temporary password will be sent to the registered email.

**Note:** Logging into the account at least once every 60 days keeps the account active.

Instructions on disabled IACS accounts due to inactivity

The user has not signed in successfully to the account within the past 180 days. A request needs to be made to enable the account by contacting the QualityNet Help Desk at 1-866-288-8912 or TTY 1-866-523-4759 (Monday-Friday 7:00 a.m.-7:00 p.m. CST) or via email at [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org).

**Recertification**

CMS security policy also requires that existing IACS accounts be recertified each year. Beginning 45 days prior to the IACS anniversary date, notification will be sent to the user's registered email that the account needs to be recertified. The user will receive reminders via email once a week from the initial 45 day email. Then, 15 days prior to the certification date, the user will receive a daily email providing the number of days remaining to complete the certification request. The deadline is midnight on the certification date to submit the certification request. If the request is not completed by the deadline, the user's IACS account will be archived. Once the user's account has been archived, they will be required to register to establish a new account.

**Instructions on recertifying IACS accounts**

1. Navigate to <https://applications.cms.hhs.gov>.
2. Select Enter CMS Applications Portal. Select Account Management. Select My Profile. Log into IACS and then select Certify Account Profile.
3. Review account information, enter the justification and select Next.
4. To submit the certification request, select Submit on the Annual Certification Screen.
5. Record the Request Number and select OK to complete the certification process.

Additional information about physician quality reporting can be found at <http://www.cms.gov/pqrs>.

Additional information on the eRx incentive program can be found at <http://www.cms.gov/ERXincentive>.

**Who to call for help**

Users who still have questions or need assistance should contact the QualityNet Help Desk at 1-866-288-8912 or TTY 1-877-715-6222 (Monday-Friday 7:00 a.m.-7:00 p.m. CST) or [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org).

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

**Source:** CMS PERL 201109-05

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## 2010 eRx incentive program reports are now available for download

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2010 electronic prescribing (eRx) incentive program feedback reports are now available for download on the Physician and Other Health Care Professionals Quality Reporting Portal (the Portal) available at QualityNet at <http://www.qualitynet.org/pqri>.

Taxpayer identification number (TIN) level reports on the Portal require an Individuals Authorized Access to CMS Computer Services (IACS) account.

Eligible professionals can request their national provider identifier (NPI)-level reports through the alternate feedback report fulfillment process, by contacting their carrier or Medicare administrative contractor (MAC) to request individual NPI level reports.

The following CMS resource is available to help eligible professionals understand their 2010 eRx feedback report: [A Guide for Understanding the 2010 eRx Feedback Report \[PDF 2MB\]](#).

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

**Source:** CMS PERL 201109-04

## 2011 Medicare eRx incentive program final rule published

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the *2011 Medicare electronic prescribing (eRx) incentive program final rule* was published in the *Federal Register* on September 6, 2011.

To help eligible professionals and group practices understand the key provisions and impact of the 2011 Medicare eRx incentive program final rule, *A Quick Reference Guide*, has been posted to the eRx incentive program website on the "Educational Resources" page. Frequently asked questions (FAQs) addressing the 2011 eRx final rule, as well as other information and resources about the eRx incentive program can be found at the eRx incentive program website at <http://www.cms.gov/ERxIncentive/>.

### What are the key changes addressed in the final rule?

- The final rule modifies the eRx quality measure used for certain reporting periods in calendar year (CY) 2011.
- The final rule provides additional significant hardship exemption categories for eligible professionals and group practices to request an exemption during 2011 for the 2012 eRx payment adjustment due to a significant hardship: (1) eligible professionals who register to participate in the Medicare or Medicaid EHR incentive program and adopt certified EHR technology; (2) eligible professionals who are unable to electronically prescribe due to local, state, or federal law or regulation; (3) eligible professionals who have limited prescribing activity; and (4) eligible professionals who have insufficient opportunities to report the eRx measure due to limitations of the measure's denominator.



The two hardship exemptions already available to professionals are (1) eligible professional or group practice practices in rural areas with limited high speed Internet access; and (2) eligible professional or group practice practices in an area with limited available pharmacies for electronic prescribing.

- The final rule extends the deadline for requesting significant hardship exemptions to November 1, 2011.
- The final rule allows providers to report significant hardship exemptions to the 2012 eRx payment adjustment via a Web-based tool for eligible professionals or via a mailed letter for group practices that are participating in the eRx group practice reporting option for 2011.

### What immediate impact does this have on me?

At this time, eligible professionals and group practices should determine if they are subject to the 2012 eRx payment adjustment. An eligible professional **will not** be subject to the 2012 eRx payment adjustment if one of the following applies:

- The eligible professional is not a physician (M.D., D.O., or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011, (this determination is based on the primary taxonomy code in the National Plan and Provider Enumeration System [NPPES]) and does not generally have prescribing privileges, and reports g-code G8644 (defined as not having prescribing privileges) at least one time on an eligible claim prior to June 30, 2011;
- The eligible professional does not have at least 100 cases (i.e., claims for patient services ) containing an encounter code that falls within the denominator of the eRx measure for dates of service between January 1, 2011, and June 30, 2011;
- The eligible professional's allowed charges for covered professional services submitted for the electronic prescribing measure's denominator codes is less than 10 percent of the eligible professional's total 2011 Medicare Part B PFS allowed charges;
- The eligible professional reported one of the two significant hardship code already finalized (see bullet 2 under key changes) by June 30, 2011, and CMS determines that the hardship code applies and is granted an exemption; or
- The eligible professional becomes a successful electronic prescriber for purposes of the 2012 payment adjustment by reporting the eRx measure via claims for at least 10 unique electronic prescribing events for patients in the denominator of the measure between January 1, 2011, and June 30, 2011.

A group practice that self-nominated and was selected to participate in the 2011 eRx group practice reporting option (GPRO) will not be subject to the 2012 eRx payment adjustment if **one** of the following applies:

*continued on next page*

**New....(continued)**

- The group practice reported one of the two significant hardship code already finalized (see bullet 2 under key changes) in its 2011 self-nomination letter for participation in the eRx incentive program group practice reporting option and is granted an exemption; or
- The group practice becomes a successful electronic prescriber. The group practice becomes a successful electronic prescriber for purposes of the 2012 payment adjustment by reporting the eRx measure via claims for between 75-2,500 unique eRx events (depending on the group practice size) for patients in the denominator of the measure between January 1, 2011, and June 30, 2011.

**What should I do if I believe I am subject to the 2012 eRx payment adjustment?**

If you believe you are subject to the 2012 eRx payment adjustment, you should determine if you meet any of the hardship exemptions that CMS has finalized. If you do feel you meet one of the hardship exemptions, you have until November 1, 2011, to submit your hardship exemption request and rationale.

**How do I submit a 2012 eRx payment adjustment significant hardship exemption request?**

CMS is no longer accepting significant hardship exemption requests for the 2012 eRx payment adjustment via claims. However, we are accepting hardship exemption requests through other avenues. Below are the steps you need to take to request a significant hardship exemption. Please note that the action required is different depending on whether you are an individual eligible professional or a group practice.

- **If you are participating as an individual eligible professional:** Use the new CMS provider Web page, called the [Quality Reporting Communication Support Page](#), to enter the request and supporting rationale. Your request must be submitted by November 1, 2011. [A Quality Communications Support Page User Manual](#) is available to answer questions eligible professionals may have.
- **If you are participating using the group practice reporting option (GPRO):** Group practices selected for and participating in the 2011 GPRO I or II reporting option wishing to submit a 2012 exemption request should submit a letter to:

Significant Hardship Exemptions, Centers for Medicare & Medicaid Services  
Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group  
7500 Security Boulevard, Mail Stop S3-02-01  
Baltimore, MD 21244-1850.

This letter must be postmarked no later than **November 1, 2011**.

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

**Source:** CMS PERL 201109-23

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## Suggestions being accepted for quality measures for consideration in the Physician Quality Reporting System

The Centers for Medicare & Medicaid Services (CMS) is now accepting quality measure suggestions to be considered for use in Physician Quality Reporting System future rule-making years. To learn more about the Physician Quality Reporting System Call for Measures and instructions on submitting candidate measure(s), visit the [CMS Measures Management System \(MMS\) Website](#).

**All suggestions must be received by CMS no later than October 7, 2011, 5:00 p.m. ET.**

**Please note:** Suggesting individual measures or measures for a new or existing measures group does not guarantee that the measure(s) will be included in the proposed or final sets of measures of any proposed or final rules that address the Physician Quality Reporting System. CMS will determine what individual measures and measures group(s) to include in the proposed set of quality measures; after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for Physician Quality Reporting System future rule-making years.

**Source:** CMS PERL 201109-21

## 2010 PQRI payment update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that incentive payments for the 2010 Medicare Physician Quality Reporting Initiative (PQRI) has begun for eligible professionals who met the criteria for successful reporting. Distribution of payments is scheduled to be completed by September 30.

**Please note:** The program name changed from Physician Quality Reporting Initiative (PQRI) to Physician Quality Reporting System in 2011.

Effective January 2010, CMS revised the manner in which incentive payment information is communicated to eligible professionals receiving electronic remittance advices. CMS has instructed Medicare contractors to use a new indicator of LE to indicate incentive payments instead of LS. LE will appear on the electronic remit. In an effort to further clarify the type of incentive payment issued (either PQRI or eRx incentive), CMS created a four-digit code to indicate the type of incentive and reporting year. For the 2010 PQRI incentive payments, the four-digit code is PQ10. This code will be displayed on the electronic remittance advice along with the LE indicator. For example, eligible professionals will see LE to indicate an incentive payment, along with PQ10 to identify that payment as the 2010 PQRI incentive payment. Additionally, the paper remittance advice will read, "This is a PQRI incentive payment." The year will not be included in the paper remittance.

### Contact information

If you have questions about the status of your PQRI incentive payment (during the distribution timeframe), please contact your provider contact center. The contact center directory is available at <http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

The QualityNet Help Desk is available Monday through Friday from 7:00 a.m.-7:00 p.m. CT at 1-866-288-8912 or via [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org). The help desk can also assist with program and measure-specific questions.

To assist eligible professionals understand their 2010 PQRI incentive payments, a guide titled [2010 PQRI Incentive Payments](#) is posted on the CMS website.

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

**Source:** CMS PERL 201109-22

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## Materials from July 14 EHR incentive program national call now available

Did you know that providers received almost \$400 million in Medicare and Medicaid electronic health records (EHR) incentive payments through July? Don't be left behind. Learn what you need to do to be eligible for an incentive.

The Centers for Medicare & Medicaid Services (CMS) hosted a national provider call on Thursday, July 14, titled "Medicare & Medicaid EHR Incentive Program Basics for Eligible Professionals." The materials from this call are now available and include the presentation used during the call, call transcript, and the audio recording of the call.

The agenda for this call included:

- Who is eligible?
- How much are the incentives and how are they calculated?
- How does one get started?
- What are major milestones regarding participation and payment?
- How does one report on meaningful use?
- Where helpful resources are found?
- A question and answer session

All materials from this call may be found on the CMS EHR website on the Educational Materials page at [http://www.cms.gov/EHRIncentivePrograms/Downloads/EP\\_Basics\\_for\\_July2011.zip](http://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Basics_for_July2011.zip).

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

**Source:** CMS PERL 201109-37



## Presentation from the August 30 EHR webinar regarding CQMs

On August 30, the Centers for Medicare & Medicaid Services (CMS) held a webinar to discuss the clinical quality measures (CQMs) and how to successfully report them during Stage 1 of meaningful use for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

A PDF of the webinar presentation is now available to download from the [Spotlight and Upcoming Events](#) section of the Medicare and Medicaid EHR Incentive Programs Web page.

The presentation included information on:

- An overview of the CQMs
- How to report CQMs during attestation
- Why CQMs are included in the EHR incentive programs

The webinar also included an hour-long question-and-answer session with CMS subject matter experts. In the coming weeks, a transcript with all of these questions and answers, along with a video of the webinar, will be made available online.

CMS plans to host another CQM webinar soon. Stay tuned for updates on how you can join this informational session.

### Want more information about the EHR incentive programs?

Make sure to visit the [Medicare and Medicaid EHR Incentive Programs Web page](#) for the latest news and updates on the EHR incentive programs.

**Source:** CMS PERL 201109-38

## Provider Enrollment

### Provider enrollment revalidation does not affect routine enrollment processes – continue to submit routine enrollment changes

Please note that the Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process.

Providers should continue to submit routine changes – address updates, reassignments, additions to practices, changes in authorized officials, information updates, etc. -- as they always have. If you also receive a request for revalidation from the Medicare administrative contractor (MAC), respond separately to that request. Do not submit your revalidation until requested to do so by your MAC.

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will have their enrollment revalidated under new risk screening criteria required by the Affordable Care Act (Section 6401a). Do not send in revalidated enrollment forms until you are notified to do so by your MAC. You will receive a notice to revalidate between now and March 2013.

For more information about provider enrollment revalidation, review the [Medicare Learning Network's® special edition article #SE1126](#) titled "Further Details on the Revalidation of Provider Enrollment Information."

**Source:** CMS PERL 201109-31

### All Medicare provider and supplier payments to be made by EFT

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the Affordable Care Act of 2010 (ACA) further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of the revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS-588 EFT form with the provider enrollment revalidation application.

**Source:** CMS PERL 201109-29

## Release of revised and new CMS-855 Medicare provider-supplier enrollment applications

The U.S. Office of Management and Budget recently approved changes to the Medicare provider-supplier enrollment applications (CMS-855) in order to update them from the 2008 versions, as well as the new CMS-855O application form used for the sole purpose of enrolling to order and refer items and/or services to Medicare beneficiaries. The revised and new forms are now available on the Centers for Medicare & Medicaid Services (CMS) provider-supplier website at <http://www.CMS.gov/CMSForms/CMSForms/list.asp?filtertype=dual&filtertype=keyword&keyword=855>.

Providers and suppliers enrolling for the sole purpose to order and refer are required to begin using the new CMS-855O form immediately. Providers and suppliers using the other CMS-855 forms to enroll in Medicare are encouraged to begin using the revised forms, though may continue to use the old forms through October 2011.

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

**Source:** CMS PERL 201108-40

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## Eligible practitioners who need to enroll for the sole purpose of ordering and referring

**Note:** This article was revised on September 6, 2011, to reflect the revised change request (CR) 7097 issued on September 1. The CR was revised to delete chiropractors from the list of providers who may order and/or refer. The CR release date, transmittal number, and the Web address for accessing the CR were also revised. All other information remains the same. This information was previously published in the August 2011 *Medicare B Connection*, pages 37-39.

### Provider types affected

This article is for physicians and non-physician practitioners who are eligible to order and refer items and services for Medicare beneficiaries and who are enrolling in Medicare for the sole purpose of ordering or referring.

### What you need to know

CR 7097, from which this article is taken, announces that physicians and non-physician practitioners will need to enroll in the Medicare program so they can order and refer items and services for Medicare beneficiaries.

The enrollment requirement is applicable to those physician and non-physician practitioners of a profession eligible to order and refer who are:

- Employed by the Department of Veterans Affairs (DVA), Public Health Service (PHS), Department of Defense (DOD) TRICARE, or by Medicare enrolled federally qualified health centers (FQHC), rural health clinics, (RHC), or critical access hospitals (CAH)
- Physicians in a fellowship
- Dentists, including oral surgeons
- Other employed eligible physicians and non-physician practitioners

### Background

On May 5, 2010, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* an Interim Final Rule with Comment (IFC) regulation titled, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements." This IFC proposed requirements to implement several of the provisions of the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA) (Pub. L. 111-148) designed to support the Administration's efforts to prevent and detect fraud, waste and abuse in the Medicare and Medicaid programs, and to ensure quality care for beneficiaries.

Specifically, this regulation proposed requirements to implement section 6405 of the ACA, which (effective July 6, 2010) requires home health agencies and certain Part B suppliers to include, on a claim, the legal name and national provider identifier (NPI) of the physician or non-physician practitioner who ordered or referred the billed items or services for the beneficiary.

This action means that Medicare will reimburse claims from providers and suppliers who furnished, ordered, or referred items or services to Medicare beneficiaries only when the ordering/referring provider identified in those claims is of an eligible discipline as noted in the following list, and is also enrolled in the Medicare program (has an enrollment record in the Provider enrollment, chain and ownership system [PECOS]) at the time of the service:

*continued on next page*

**Ordering....(continued)**

- Doctor of medicine or osteopathy
- Doctor of dental medicine
- Doctor of dental surgery
- Doctor of podiatric medicine
- Doctor of optometry
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife
- Clinical social worker

Further, while most physicians and non-physician practitioners enroll in the Medicare program to furnish covered services to Medicare beneficiaries, in implementing this section of the ACA, the Centers for Medicare & Medicaid Services (CMS) has become aware of certain physicians and non-physician practitioners who only order or refer items and services for Medicare beneficiaries—the services they furnish to Medicare beneficiaries are not reimbursable by the Medicare program. CR 7097 announces that such physicians and non-physician practitioners will need to enroll in the Medicare program in order to be able to continue to order or refer items or services for Medicare beneficiaries.

Specifically, if you order or refer items or services for Medicare beneficiaries and (1) you are employed by the Department of Veterans Affairs (DVA), the Public Health Service (PHS), the Department of Defense (DOD) TRICARE; or by a Medicare enrolled federally qualified health center (FQHC), rural health clinic (RHC) or critical access hospital (CAH), (2) you are in a fellowship, or (3) you are a dentist or oral surgeon, you will need to enroll in Medicare using the modified enrollment process described below. (Any provider can enroll for the sole purpose of ordering or referring, regardless of who their employer is.)

Modified enrollment process for physicians and non-physician practitioners who are enrolling solely to order and refer to enroll in Medicare for the sole purpose of ordering or referring items or services, you must do the following:

1. Complete the following sections paper of form CMS-855I (“Medicare Enrollment Application for Physicians and Non-Physician Practitioners”):
  - Section 1 – Basic Information (you would be a new enrollee)
  - Section 2 – Identifying Information (section 2A, 2B, 2D and if appropriate 2H and 2K)
  - Section 3 – Final Adverse Actions/Convictions
  - Section 13 – Contact Person
  - Section 15 – Certification Statement (must be signed and dated—blue ink recommended)
2. You must include a cover letter with this enrollment application stating that you are enrolling for the sole purpose of ordering and referring items or services for a Medicare beneficiary and cannot be reimbursed by the Medicare program for services that you may provide to Medicare beneficiaries.
3. Mail the completed enrollment application and cover letter to your designated Medicare enrollment contractor, which you can find at [http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact\\_list.pdf](http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf).

Your designated Medicare enrollment contractor will verify that the information you provided on the application meets the Medicare requirements for your profession (supplier type) and, if approved, will enter the data into PECOS. This will place you on the ordering referring file that is available on the Medicare provider/supplier enrollment website (<http://www.cms.gov/MedicareProviderSupEnroll>) and the information will be in the Medicare claims system so that claims for the items or services you ordered or referred can be paid. The designated Medicare contractor will send you a letter notifying you that you are enrolled in the Medicare program for the sole purpose of ordering and referring items or services for Medicare beneficiaries.

**Notes:**

- 1) When enrolling, you do not have to complete the CMS 460, Medicare Participating Physician or Supplier Agreement or the CMS 588, Electronic Funds Transfer (EFT) Authorization Agreement, in with the CMS-855I application. Also, license information received from a physician or practitioner employed by DVA or DOD may be active in a state other than the DVA or DVA location.

*continued on next page*

**Ordering....(continued)**

- 2) Since the abbreviated application does not require you to complete section 4 and CMS is requiring a cover letter, the Medicare enrollment contractors will reject your application if section 4 is blank and a cover letter is not attached.
- 3) You are not permitted to be reimbursed by Medicare for services you may furnish to Medicare beneficiaries.
- 4) If, in the future, you wish to be reimbursed by Medicare for services performed, you must submit the full enrollment application via the paper application(s) (CMS-855) or Internet-based PECOS; the Medicare enrollment contractor will deactivate the current information.

**Additional information**

You can find more information about enrolling in Medicare for the sole purposes of ordering and referring by going to CR 7097, located at <http://www.cms.gov/Transmittals/downloads/R387PI.pdf>. You will find the updated *Medicare Program Integrity Manual*, Chapter 15 (Medicare Provider/Supplier Enrollment), Section 16.1 (Ordering/Referring Providers Who Are Not Enrolled in Medicare) as an attachment to that CR.

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

MLN Matters® Number: MM7097 *Revised*  
Related Change Request (CR) #: 7097  
Related CR Release Date: September 1, 2011  
Effective Date: October 18, 2010  
Related CR Transmittal #: R387PI  
Implementation Date: October 18, 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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## Advanced diagnostic imaging accreditation – time is running out

As a reminder, beginning Sunday, January 1, 2012, suppliers who furnish the technical component of advanced diagnostic imaging (ADI) must be accredited in order to bill Medicare for these services. ADI procedures include magnetic resonance imaging, computed tomography, and nuclear medicine imaging such as positron emission tomography; X-ray, ultrasound, fluoroscopy, and hospital outpatient procedures are excluded. The technical component of ADI services includes the performance of the imaging procedures, not the physician interpretation.

For dates of service on or after January 1, 2012, Medicare administrative contractors will begin denying claims for the technical component of ADI, submitted under the physician fee schedule by suppliers who have not yet been accredited. Once a provider becomes accredited, they can begin billing Medicare for these services again.

For more information about ADI accreditation, including a list of accrediting organizations and details of the accreditation process, please visit [http://www.CMS.gov/MedicareProviderSupEnroll/03\\_AdvancedDiagnosticImagingAccreditation.asp](http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp). An *MLN Matters* special edition article (*SE1122 Important Reminders about Advanced Diagnostic Imaging Accreditation Requirements*) is also available at <http://www.CMS.gov/MLNMattersArticles/Downloads/SE1122.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 201109-14



## General Information

### *HHS...(continued from page 1)*

The proposed rule can be downloaded from the *Federal Register* Inspection Desk at [www.ofr.gov/inspection.aspx](http://www.ofr.gov/inspection.aspx). Comments will be accepted for 60 days, and a final rule, responding to comments will be published later this year.

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

**Source:** CMS PERL 201109-40

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## New ‘Bundled Payments for Care Improvement’ initiative will lower costs and help providers coordinate care

The U.S. Department of Health & Human Services (HHS) announced a new initiative to help improve care for patients while they are in the hospital and after they are discharged. Doctors, hospitals, and other health care providers can now apply to participate in a new program known as the Bundled Payments for Care Improvement initiative (bundled payments initiative). Made possible by the Affordable Care Act, it will align payments for services delivered across an episode of care, such as heart bypass or hip replacement, rather than paying for services separately. Bundled payments will give doctors and hospitals new incentives to coordinate care, improve the quality of care, and save money for Medicare.

“Patients don’t get care from just one person – it takes a team, and this initiative will help ensure the team is working together,” said HHS Secretary Kathleen Sebelius. “The bundled payments initiative will encourage doctors, nurses, and specialists to coordinate care.

It is a key part of our efforts to give patients better health, better care, and lower costs.”

Currently in Medicare, hospitals, physicians, and other clinicians who provide care for beneficiaries bill and are paid separately for their services. This Centers for Medicare & Medicaid Services’ (CMS) initiative will bundle care for a package of services patients receive to treat a specific medical condition during a single hospital stay and/or recovery from that stay; this is known as an episode of care. By bundling payment across providers for multiple services, providers will have a greater incentive to coordinate and ensure continuity of care across settings, resulting in better care for patients. Better coordinated care can reduce unnecessary duplication of services, reduce preventable medical errors, help patients heal without harm, and lower costs.

The bundled payments initiative is being launched by the new Center for Medicare and Medicaid Innovation (Innovation Center), which was created by the Affordable Care Act to carry out the critical task of finding new and better ways to provide and pay for health care to a growing population of Medicare and Medicaid beneficiaries.

The Innovation Center’s request for applications (RFA) outlines four broad approaches to bundled payments. Providers will have flexibility to determine which episodes of care and which services will be bundled together. By giving providers the flexibility to determine which model of bundled payments works best for them, it will be easier for organizations of different sizes and degrees of readiness to participate in this initiative.

“This bundled payment initiative responds to the overwhelming calls from the hospital and physician communities for a flexible approach to patient care improvement,” said CMS Administrator Donald Berwick, M.D. “All around the country, many of the leading health care institutions have already implemented these kinds of projects and seen positive results.”

The bundled payments initiative is based on research and previous demonstration projects that suggested this approach has tremendous potential. For example, a Medicare heart bypass surgery bundled payment demonstration saved the program \$42.3 million, or roughly 10 percent of expected costs, and saved patients \$7.9 million in coinsurance while improving care and lowering hospital mortality.

“From a patient perspective, bundled payments make sense. You want your doctors to collaborate more closely with your physical therapist, your pharmacist and your family caregivers. But that sort of common sense practice is hard to achieve without a payment system that supports coordination over fragmentation and fosters the kinds of relationships we expect our health care providers to have,” said Dr. Berwick.

Organizations interested in applying to the Bundled Payments for Care Improvement initiative must submit a letter of intent (LOI) no later than September 22, 2011, for model 1 and November 4, 2011, for models 2, 3, and 4. For more information about the various models and the initiative itself, please see the Bundled Payments for Care Improvement initiative website at <http://innovations.cms.gov/areas-of-focus/patient-care-models>.

*continued on next page*

**Bundled....(continued)**

Interested parties may obtain answers to specific questions by emailing CMS at: [BundledPayments@cms.hhs.gov](mailto:BundledPayments@cms.hhs.gov).

This initiative is part of a broader effort by the Obama Administration to improve health, improve care, and lower costs. A brief summary of other efforts, including those authorized by the Affordable Care Act, may be found at: [www.HealthCare.gov/news/factsheets/deliverysystem07272011a.html](http://www.HealthCare.gov/news/factsheets/deliverysystem07272011a.html).

For more information about the CMS Innovation Center, please visit: <http://www.innovations.cms.gov>.

**Additional information**

HHS fact sheet – <http://www.healthcare.gov/news/factsheets/bundling08232011a.html>

Federal Register posting – <http://www.gpo.gov/fdsys/pkg/FR-2011-08-25/pdf/2011-21707.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 201108-44

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## Delay in implementation of automated Medicare Secondary Payer adjustments (CR 6625)

On Friday, July 1, the Centers for Medicare & Medicaid Services (CMS) implemented change request (CR) 6625 that created a systematic process in which Medicare automatically reopens/adjusts certain Medicare Secondary Payer (MSP) claims when a beneficiary's MSP claims record was deleted or an end date was applied to an open beneficiary MSP record. This automated process no longer required physicians, providers, and suppliers to contact their Medicare contractors to adjust or reprocess these types of MSP claims. CMS informed physicians, providers, and suppliers of these changes through a Listserv message.

Due to systems issues currently affecting CR 6625, CMS directed its A/B Medicare administrative contractors, durable medical equipment Medicare administrative contractors, and legacy contractors (fiscal intermediaries [FIs] and carriers) to immediately suspend all actions on this CR. This means that our Medicare contractors are unable to automatically reopen/adjust claims when Medicare takes action to delete or terminate a previously existing MSP record. Physicians, providers, and suppliers must revert to the pre-July 1 process and contact their Medicare contractor to request re-openings/adjustments of claims that were previously considered MSP. Therefore, if you have claims that were processed since July 1 that need to be reopened/ adjusted due to Medicare now being the primary payer, you should contact your local Medicare contractor to request that action.

CMS will alert physicians, providers, and suppliers once the current issues tied to the implementation of CR 6625 have been resolved.

**Source:** CMS PERL 201109-35

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## 2011 MCPSS results are in

The results of the sixth annual Medicare Contractor Provider Satisfaction Survey (MCPSS) conducted by the Centers for Medicare & Medicaid Services (CMS) are now available. This survey offers Medicare fee-for-service (FFS) providers an opportunity to give CMS feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor.

Specifically, respondents rated Medicare FFS contractors on seven key business functions of the provider-contractor relationship: provider inquiries, provider outreach and education, claim processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. The MCPSS was distributed to a random sample of 30,000 Medicare FFS providers and suppliers that serve Medicare beneficiaries across the country.

To learn more about the results, visit the CMS Web page at [www.cms.gov/MCPSS](http://www.cms.gov/MCPSS).

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

**Source:** CMS PERL 201109-07

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## Release of CBR on chiropractic services on September 26

On Monday, September 26, the Centers for Medicare & Medicaid Services (CMS) will release a national provider comparative billing report (CBR) focused on chiropractors who practice in the office setting. It's a similar study equivalent to the one distributed last fall except this current study will focus on 2010 data and is being sent to 5,000 different providers.

The CBRs, produced by Safeguard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare a provider's billing and payment patterns to those of their peers located in the state and across the nation.

CMS has received feedback from a number of providers that this kind of data is very helpful to them, which encouraged CMS to produce more CBRs and make them available to providers.

CBR reports are only available to those providers that were selected based upon CBR topic criteria. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers comply with Medicare billing rules and improve the level of care they furnish to their Medicare patients.

For more information and to review a sample of the Chiropractic Services CBR please visit the CBR Services website, located at [www.cbrservices.com](http://www.cbrservices.com), or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

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

**Source:** CMS PERL 201109-34

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## Medicare pilot project for electronic submission of medical documentation (esMD)

### Provider types affected

This special edition (SE) article affects all Medicare fee-for-service (FFS) providers who submit medical documentation to Medicare review contractors.

### Provider action needed

#### **Stop – impact to you**

Each year, the Medicare FFS program makes billions of dollars in estimated improper payments. The Centers for Medicare & Medicaid Services (CMS) employs several types of Medicare review contractors to measure, prevent, identify, and correct these improper payments. Review contractors find the improper payments by requesting medical documentation from each provider who submitted a questionable claim. The review contractor then manually reviews the claims against the submitted medical documentation to verify the providers' compliance with Medicare's rules. Currently, review contractors request medical documentation by sending a paper letter to the provider. The provider has two options for submitting the requested records: 1) mail paper, or 2) send a fax.

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

Medicare's electronic submission of medical documentation (esMD) pilot project gives some providers a new mechanism for submitting medical documentation to review contractors. A list of review contractors that will accept esMD transactions may be found at <http://go.usa.gov/kr4>. The esMD pilot will begin in September of 2011. The primary intent of esMD is to reduce provider costs and cycle time by minimizing and eventually eliminating paper processing and mailing of medical documentation to review contractors. A secondary goal of esMD is to reduce costs and time at review contractors. In order to send medical documentation electronically to review contractors, Medicare providers, including physicians, hospitals, and suppliers, must obtain access to a CONNECT-compatible gateway.

- Certain larger providers, such as hospital chains, may choose to build their own gateway.
- Many providers may choose to obtain gateway services by entering into a contract or other arrangement with a health information handler (HIH) that offers esMD gateway services.

A list of HIHs that offer esMD services as of September 2011 may be found in the *Key points* section of this article. An updated listing of the HIHs that have been approved by CMS to offer esMD services may also be found at <http://go.usa.gov/krg>. CMS does not set the price that an HIH may charge a provider for esMD services. Providers who believe it may be more efficient to respond to documentation requests electronically are encouraged to contact one or more of the HIHs to determine if esMD services are available at a reasonable price.

*continued on next page*

**esMD....(continued)**

**Go – what you need to do**

You should know that esMD is completely voluntary. You may continue to mail or fax documentation to your review contractor.

The initial esMD system accepts portable document format (PDF) files, which means that even those providers who have paper records may utilize esMD services as long as there is a mechanism to scan the paper records into PDF files. Some HIHs may offer scanning services in addition to their esMD services.

**Key points**

The following are tentative schedules of when HIHs will be ready to offer esMD services and when review contractors will be ready to accept esMD:

HIH/Web address	Scheduled readiness*
HealthPort ( <a href="http://www.healthport.com">http://www.healthport.com</a> )	September 2011
IVANS ( <a href="http://www.ivans.com">http://www.ivans.com</a> )	September 2011
MRO ( <a href="http://www.mrocorp.com">http://www.mrocorp.com</a> )	September 2011
NaviNet ( <a href="http://www.navinet.net">http://www.navinet.net</a> )	September 2011
RISARC ( <a href="http://www.risarc.com">http://www.risarc.com</a> )	September 2011
eSolutions ( <a href="http://www.ecorpnet.com">http://www.ecorpnet.com</a> )	November 2011
Cobius ( <a href="http://www.cobius.com">http://www.cobius.com</a> )	November 2011
IOD, Inc. ( <a href="http://www.iodincorporated.com">http://www.iodincorporated.com</a> )	November 2011
Proficient Health ( <a href="http://www.proficienthealth.com">http://www.proficienthealth.com</a> )	November 2011
Craneware ( <a href="http://www.craneware.com">http://www.craneware.com</a> )	November 2011
MDClick ( <a href="http://www.mdclick.com">http://www.mdclick.com</a> )	November 2011
Medical Electronic Attachment ( <a href="http://www.mea-fast.com">http://www.mea-fast.com</a> )	November 2011
EHR Doctors ( <a href="http://www.ehrdoctors.com">http://www.ehrdoctors.com</a> )	November 2011
ApeniMED ( <a href="http://www.Apenimed.com">http://www.Apenimed.com</a> )	November 2011
HealthIT+ ( <a href="http://www.healthitplus.com">http://www.healthitplus.com</a> )	November 2011
ECC Technologies ( <a href="http://www.ecctec.com">http://www.ecctec.com</a> )	January 2012
Stratice Healthcare ( <a href="http://straticehealthcare.com/">http://straticehealthcare.com/</a> )	January 2012
AT&T ( <a href="http://www.att.com/healthcare">http://www.att.com/healthcare</a> )	January 2012
CureMD ( <a href="http://www.curemd.com">http://www.curemd.com</a> )	January 2012
MediConnect ( <a href="http://www.medicconnect.net">http://www.medicconnect.net</a> )	January 2012
MediCopy ( <a href="http://www.medicopy.net">http://www.medicopy.net</a> )	January 2012
Cal eConnect ( <a href="http://www.caleconnect.org">http://www.caleconnect.org</a> )	January 2012
LMRP Manager ( <a href="http://www.racmanager.com">http://www.racmanager.com</a> )	January 2012
SSI ( <a href="http://www.thessigroup.com/">http://www.thessigroup.com/</a> )	January 2012
Verisma Systems ( <a href="http://www.verismasystems.com">http://www.verismasystems.com</a> )	January 2012
Zydoc ( <a href="http://www.zydoc.com">http://www.zydoc.com</a> )	January 2012
Ivertex ( <a href="http://www.ivertex.com">http://www.ivertex.com</a> )	April 2012

Medicare review contractors include the recovery auditors (RACs), Medicare administrative contractors (MACs), the comprehensive error rate testing (CERT) contractor, the program error rate measurement (PERM) contractor, and zone program integrity (ZPIC) contractors. The following shows when some of these contractors will be accepting esMD transactions:

Review contractors	Scheduled readiness*
RAC A - Diversified Collection Services (DCS)	September 2011
RAC B - CGI Technologies and Solutions	September 2011
MAC J1 and J11 - Palmetto GBA	September 2011
MAC J3 - Noridian Administrative Services	September 2011
MAC J4 - Trailblazer Health Enterprises	September 2011
MAC J5 - Wisconsin Physicians Services Health Insurance Corporation	September 2011
MAC J9 - First Coast Service Options	September 2011

*continued on next page*



**esMD....(continued)**

Review contractors	Scheduled readiness*
MAC J12 - Highmark Medicare Services	September 2011
MAC J14 - NHIC	September 2011
DME MAC A - NHIC	September 2011
DME MAC D - Noridian Administrative Services, LLC	September 2011
CERT - Livanta	September 2011

\*These are anticipated dates and subject to change. Please check the esMD website (<http://www.cms.gov/ESMD>) for more information. **Note:** CMS expects that the Region C and D Recovery Auditors and remaining MACs will begin accepting esMD transactions within the next 12 months.

**Additional information**

If you have any questions, please contact the review contractor to which you wish to send esMD transactions. MAC toll-free numbers may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

For more information, visit the esMD Web page at <http://www.cms.gov/esmd>. You might also try the Twitter link, which is @CMSGov (Look for #CMS\_esMD).

For more information on the Medicare Recovery Audit program, see the *MLN Matters*® article SE1024 at <http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf>. You may contact your Recovery Auditor for questions you have of them. Their contact information is at <http://www.cms.gov/RAC/Downloads/RACcontactinfo.pdf>.

Review contractors	Scheduled readiness*
PERM - A+ Government Solutions	September 2011
MAC J10 - Cahaba Government Benefit Administrators	November 2011
MAC J13 - National Government Services	November 2011
DME MAC B - NGS	November 2011
ZPIC 1 - Safeguard Services LLC	November 2011
ZPIC 7 - Safeguard Services LLC	November 2011
RAC D - HealthDataInsights	November 2011
MAC J15 - CIGNA Government Services, LLC	January 2012
DME MAC C - Palmetto GBA	January 2012

MLN Matters® Number: SE1110  
 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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## Contractor entities at a glance: Who may contact you about specific CMS activities

### Provider types affected

All physicians, providers, and suppliers who submit claims to Medicare contractors (as defined in this article) for services and supplies provided to Medicare beneficiaries are affected.

### What you need to know

The Centers for Medicare & Medicaid Services (CMS) has received calls from providers about the various entities that may contact them with questions and requests for medical records, documentation, or other information. CMS recognizes that shifts in contracting entities due to recent Medicare Contracting Reform may be confusing. CMS has prepared this special edition article to describe the current Medicare contracting environment. In addition, this article will list the entities responsible for activities in the Medicare Program, as well as with some Medicaid claims, and explain the reasons why they may contact you. CMS has also prepared a quick reference table titled, *Contractor Entities at a Glance: Who May Contact You about Specific Centers for Medicare & Medicaid Services (CMS) Activities*, that you may provide to your office staff for easy reference. The table is available at [http://www.cms.gov/MLNProducts/downloads/ContractorEntityGuide\\_ICN906983.pdf](http://www.cms.gov/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf).

CMS understands that several of these entities may contact you concurrently. You may question whether the efforts of these entities are coordinated and whether the burden placed upon providers can be reduced. CMS constantly strives to reduce the burden on providers. However, as this article explains, certain functions are performed by different entities by design. Sometimes different entities are involved because different skill sets are needed. For example, reviewing a provider enrollment application for correctness requires different skills than reviewing medical records to determine correct diagnosis and procedure coding. Also, sometimes certain functions must be performed by different entities to protect providers and the Medicare Program. For example, appeals of claims decisions should be heard, at least at certain levels, by an entity that is separate and distinct from the entity that made the claims decision. Therefore, while CMS strives to coordinate efforts of these entities, there may be times when providers are contacted by several of the entities concurrently.

### Background

Listed below are general categories of the current entities that CMS uses under the Medicare and Medicaid programs to handle claims processing and other functions. Some of the entities are new to these programs as part of Medicare Contracting Reform. This article and the table mentioned above display the new entities in **bold type**. The table also provides websites that are available should you need further information. Finally, we explain how CMS coordinates the work of these entities so that phone calls and letters requesting medical records, documentation, or other information related to a beneficiary's claims are minimized.

### Claim processing contractors

CMS contracts with entities to process claims submitted by physicians, hospitals, and other health care providers/suppliers, and to make payment in accordance with Medicare regulations and policies. These entities, called carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), **and Medicare administrative contractors (MACs)**, are also referred to as Medicare claim processing contractors. These entities are the entry point for participating in the Medicare program as they process provider enrollment applications.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that the Secretary of the Department of Health and Human Services (DHHS) replace the current contracting authority under Title XVIII of the Social Security Act (SSA) with the new **MAC** authority.

**MACs** will be the central point in CMS' national fee-for-service (FFS) program.

- Carrier and FI workloads have or will be transitioned to **10 Part A/ B MAC** jurisdictions.
- Regional home health intermediary (RHHI) workloads are being transitioned to **four HH MAC** jurisdictions.
- Durable medical equipment (DME) workloads have been transitioned to **four DME MAC** jurisdictions.

You may access the most current Medicare Contracting Reform information to determine the effect of these changes on your practice and to view the list of current **MACs** for each jurisdiction at <http://www.cms.gov/MedicareContractingReform>.

**MACs** may contact you for a variety of reasons, such as:

- Resolving issues regarding your initial and renewal enrollment applications;
- Providing education and guidance on procedures for billing Medicare;
- Resolving issues regarding claims you submit;
- Requesting medical records related to the claims you submit for medical review;

*continued on next page*

**Glance...(continued)**

- Paying you for approved claims and/or explaining why some claims are not processed or are denied; and
- Recovering overpayments on claims previously processed.

**Program integrity contractors**

CMS contracts with program safeguard contractors (PSCs) and **zone program integrity contractors (ZPICs)**, who are responsible for identifying cases of suspected fraud and taking appropriate actions.

As a result of Medicare Contracting Reform, seven **ZPICs** were created based on the MAC jurisdictions. Eventually, PSCs will no longer exist and **ZPICs** will perform all benefit integrity work. ZPICs were created to perform program integrity for Medicare Parts A, B, C (Medicare Advantage or MA), D (Prescription Drugs, including MA-Drug Plans), durable medical equipment (DME), home health and Hospice, and Medicare-Medicaid data matches, also referred to as Medi-Medi. Since these seven **ZPICs** focus on these different aspects of the Medicare Program, it is possible that providers could hear from more than one **ZPIC**, depending on the aspects of that **ZPIC's** review and/or the nature of the services for which the provider bills Medicare.

CMS also contracts with **recovery auditors** to identify and correct underpayments and overpayments. There are four **recovery auditors**. **Recovery auditor's** responsibilities include working with providers to detect and correct Medicare improper payments. **Recovery auditors** conduct reviews of claims in the following ways:

- Automated (no medical records are needed);
- Semi-automated (medical records are supplied at the discretion of the provider to support a claim identified by data analysis as an improper payment); and
- Complex (medical record is required).

**FFS recovery auditors** contact providers to request additional documentation in support of potential improper payments. If an improper payment is determined, the **FFS recovery auditor** will send a review results letter, providing the decision and the accompanying reviewer rationale. A demand letter is issued to you by the **FFS recovery auditor** or the MAC once the claim is adjusted. The **FFS recovery auditor** will offer you an opportunity to discuss the improper payment determination with the **FFS recovery auditor** (this is outside the normal appeal process).

The **Tax Relief and Health Care Act of 2006 (TRHCA)** authorizes the **recovery audit** program for Part A and Part B Medicare services.

The **Affordable Care Act** expands the **recovery audit** program to Medicaid and Medicare Part C (Medicare Advantage or MA) and Part D (prescription drugs).

- Medicaid recovery auditors are responsible for identifying and recovering Medicaid overpayments and identifying underpayments.
- MA recovery auditors will ensure that MA plans have an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.
- Prescription Drug Plan (PDP) recovery auditors will ensure that each PDP under part D has an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.

CMS also reviews Medicare FFS claims nationally to identify improper payments, as required by the Improper Payment Information Act (IPIA) and the Improper Payments Elimination and Recovery Act (IPERA). This is accomplished through the **comprehensive error rate testing (CERT)** program. If a provider's claim is randomly chosen, the CERT program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly. If an improper payment is identified by the CERT program, your MAC will notify you and make the appropriate payment adjustment. Normal appeal rights apply to CERT-initiated denials and are handled through the routine appeal process.

CMS also reviews Medicaid and Children's Health Insurance Program (CHIP) claims to identify improper payments, as required by the IPIA and the IPERA. This is accomplished through the **Payment Error Rate Measurement (PERM)** program.

CMS reviews a sample of claims in one-third of the states each year to develop a national estimate of improper payments. PERM conducts two types of reviews on these claims:

- Medical review (medical record is required)
- Data processing reviews (this is a validation that the payment was processed correctly in a state's system)

If a provider's claim is randomly chosen, the PERM program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly.

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**Glance...(continued)**

**Medicaid integrity contractors (MICs)** are entities that contract with CMS to conduct audit-related activities for the Medicaid programs. There will be five **MIC** jurisdictions performing three primary functions:

- Review MICs, which analyze Medicaid claims data to investigate suspected/potential provider fraud, waste, or abuse;
- Audit MICs, which audit provider claims and identify overpayments; and
- Education MICs, which provide education to providers and others on payment integrity and quality-of-care issues.

Program integrity contractors may contact you to resolve problems they identify in your claims or to request medical records for claims under review.

**Specialty medical review contractors**

In an effort to continue the prevention and reduction of improper payments, CMS has contracted with a **specialty medical review contractor** to conduct medical review studies of Part A and B claims. Studies are conducted as fact-finding undertakings to allow CMS to better understand trends in billing behavior that may lead to improper payments. These studies occur on a quarterly basis and vary in topic. Claims chosen for review are selected randomly.

The **specialty medical review contractor** may contact you to request medical records for claims under review.

Also, CMS contracts with the **Medicare coordination of benefits contractor (COBC)**, a single entity, to provide a centralized COB operation. Responsibilities of the COBC include all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries. The COBC may contact you to identify Medicare secondary payer (MSP) situations quickly and accurately.

There is also a Medicare secondary payer recovery contractor (MSPRC) that performs post-payment recovery of funds paid where Medicare should not have been the primary payer. The MSPRC may contact you for information related to MSP recoveries and can issue demand letters to require payment recovery.

The last specialty contractor is the national supplier clearinghouse (NSC), which handles enrollment activities related to durable medical equipment suppliers. The NSC may contact you about your enrollment information.

**Appeals contractors and entities**

CMS contracts with entities to conduct appeals of claim determinations. These include FIs, carriers, RHHIs, and **MACs, who conduct first level appeals. Qualified independent contractors (QICs)** conduct reconsiderations, the second level of appeals. There are:

- Two Part A **QICs**,
- Two Part B **QICs**,
- One DME **QIC**,
- One Part C **QIC** for MA, and
- One Part D **QIC** for Medicare Prescriptions Drug Plans (PDPs) and MA Drug Plans.

Other appeals-related entities include the administrative law judges (ALJs) within the HHS Office of Medicare Hearings and Appeals and the Medicare Appeals Council within the HHS Departmental Appeals Board conduct the next two levels of appeal. The ALJ will send you a notice of hearing to all parties to the appeal, indicating the time and place of the hearing. The ALJ will generally issue a decision or dismissal within 90 days of receipt of a valid appeal request. The Medicare Appeals Council will generally issue a decision or dismissal within 90 days of receipt of a valid appeals request.

ALJs in the Civil Remedies Division within the HHS Departmental Appeals Board also conduct hearings on provider and supplier enrollment issues, and hearings on civil money penalties and sanctions imposed against providers and suppliers by CMS and the HHS Office of the Inspector General. For appeals of enrollment issues, the ALJ will generally issue a decision within 180 days of receipt of your request. For other types of appeals, the ALJ will issue a decision as soon as practical after the close of the hearing.

The Provider Reimbursement Review Board (PRRB) is an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination of its fiscal intermediary or the Centers for Medicare & Medicaid Services (CMS). The Medicare Geographic Classification Review Board (MGCRB) decides on requests of Prospective Payment System (PPS) hospitals for reclassification to another area (Urban or in some cases Rural) for the purposes of receiving a higher wage index.

The PRRB and the MGCRB provide appeals avenues for providers on specific matters, including cost report disputes.

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**Glance....(continued)**

When you, or a beneficiary (or an appointed representative), appeal claims decisions, any of these appeals entities may request more information from you (or your representative).

**Quality improvement contractors**

Quality improvement organizations (QIOs) provide quality of care review services and conduct quality improvement projects. CMS contracts with one QIO in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. QIOs are private, mostly not-for-profit organizations, staffed by professionals, mostly doctors and other health care professionals, responsible for the review of services provided to beneficiaries enrolled in MA plans and in FFS Medicare, including:

- Conducting expedited Medicare coverage determinations of inpatient hospital discharges and provider service terminations;
- Reviewing beneficiary complaints about quality of care, including working with the provider and reviewing medical records as part of the complaint-resolution process;
- Working with providers to accomplish national quality improvement goals;
- Implementing improvements in the quality of care;
- Contacting providers to provide technical assistance and encouraging partnerships to achieve quality goals;
- Providing technical assistance with many of the CMS value-based purchasing programs; and
- Performing provider-requested higher-weighted diagnosis related group reviews.

**Additional information**

If you have any questions, please contact your Medicare contractor (FI, carrier, 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: SE1123  
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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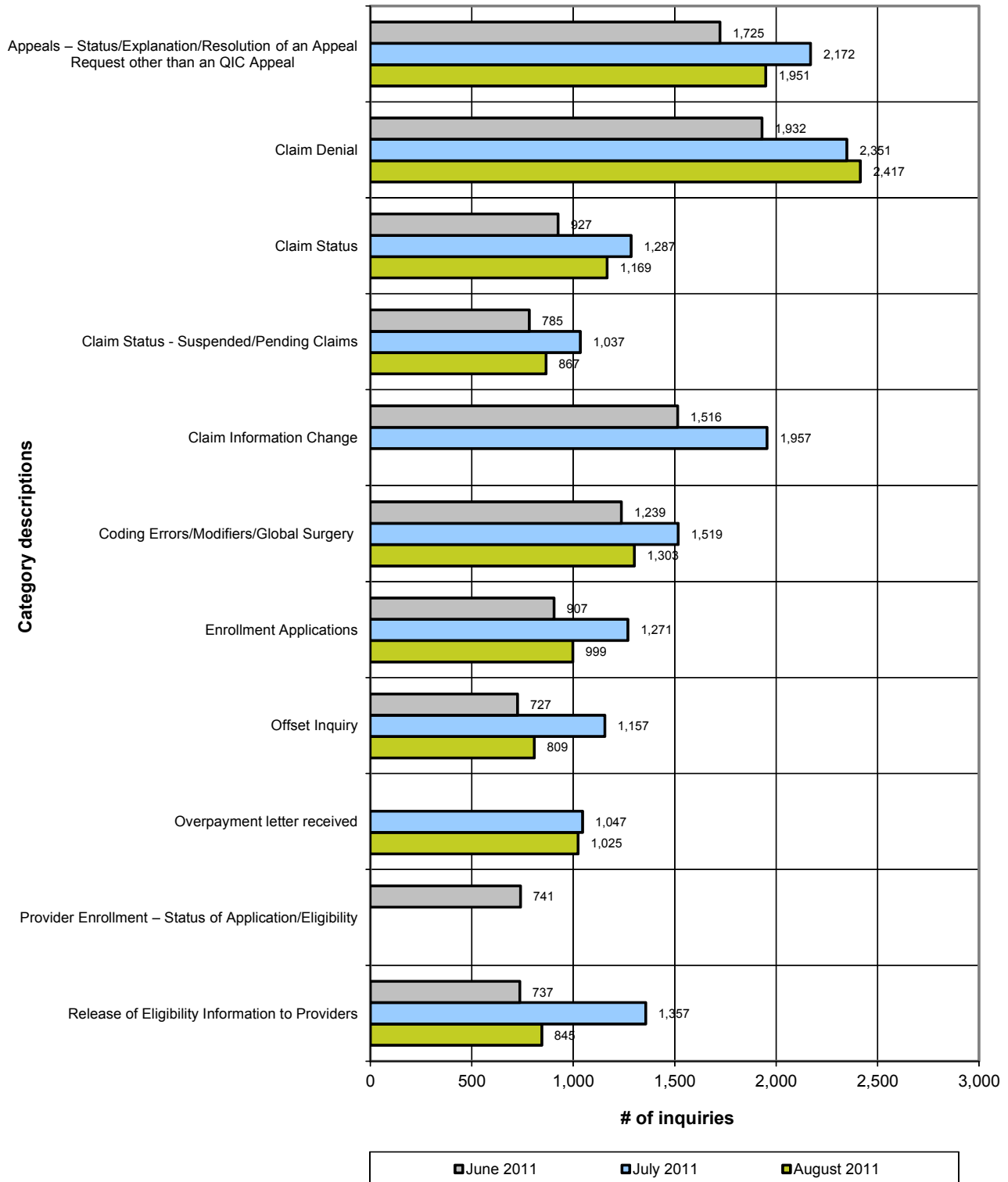
**How can the PDS help my practice?**

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at <http://medicare.fcso.com/PDS/>.

## Top inquiries, denials, and return unprocessable claims

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 June-August 2011. 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).

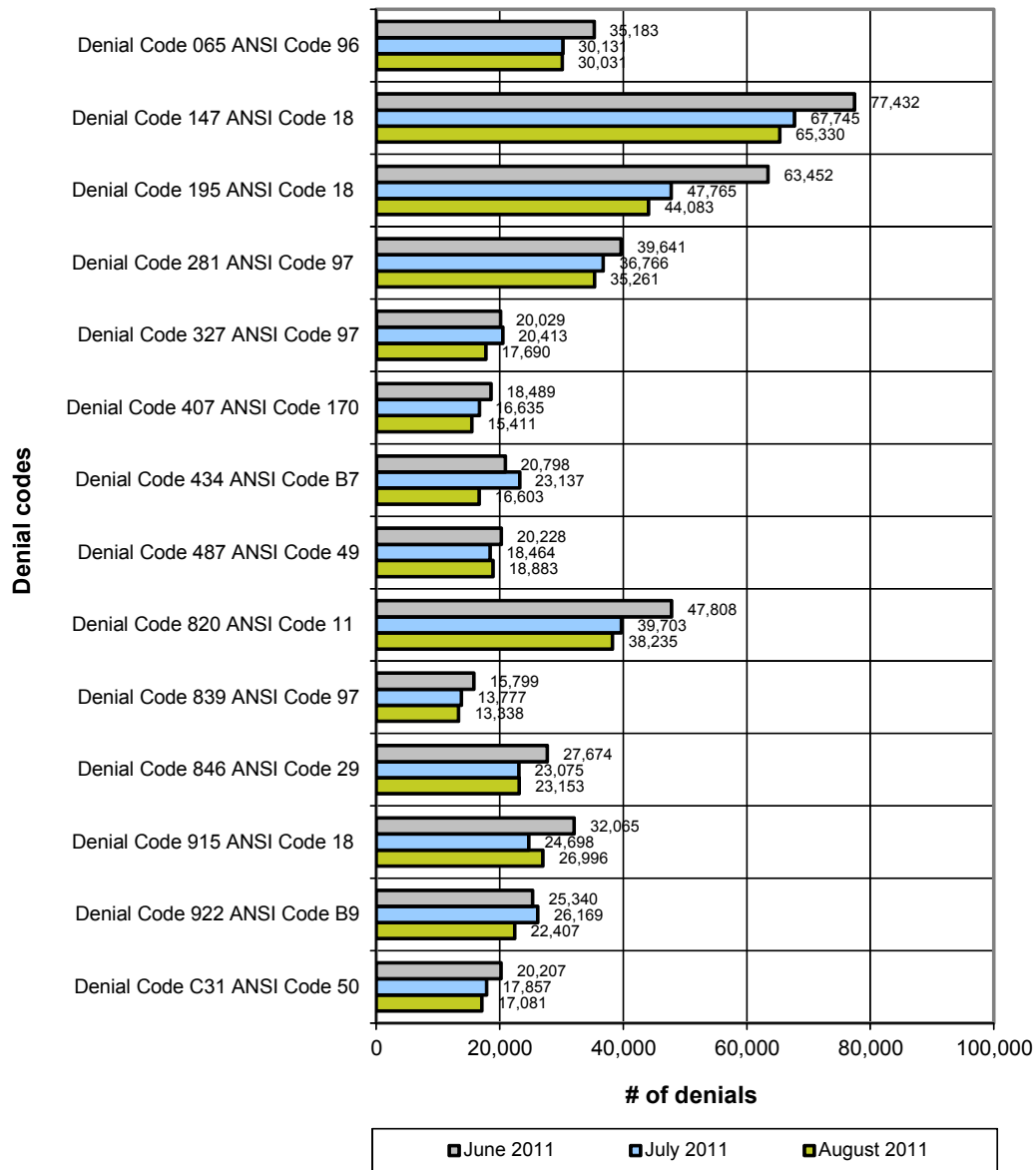
**Florida Part B top inquiries for June-August 2011**



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Top....(continued)

## Florida Part B top denials for June-August 2011



## What to do when your claim is denied

Before contacting customer service, check claim status through the IVR. The IVR will release necessary details around claim denials.

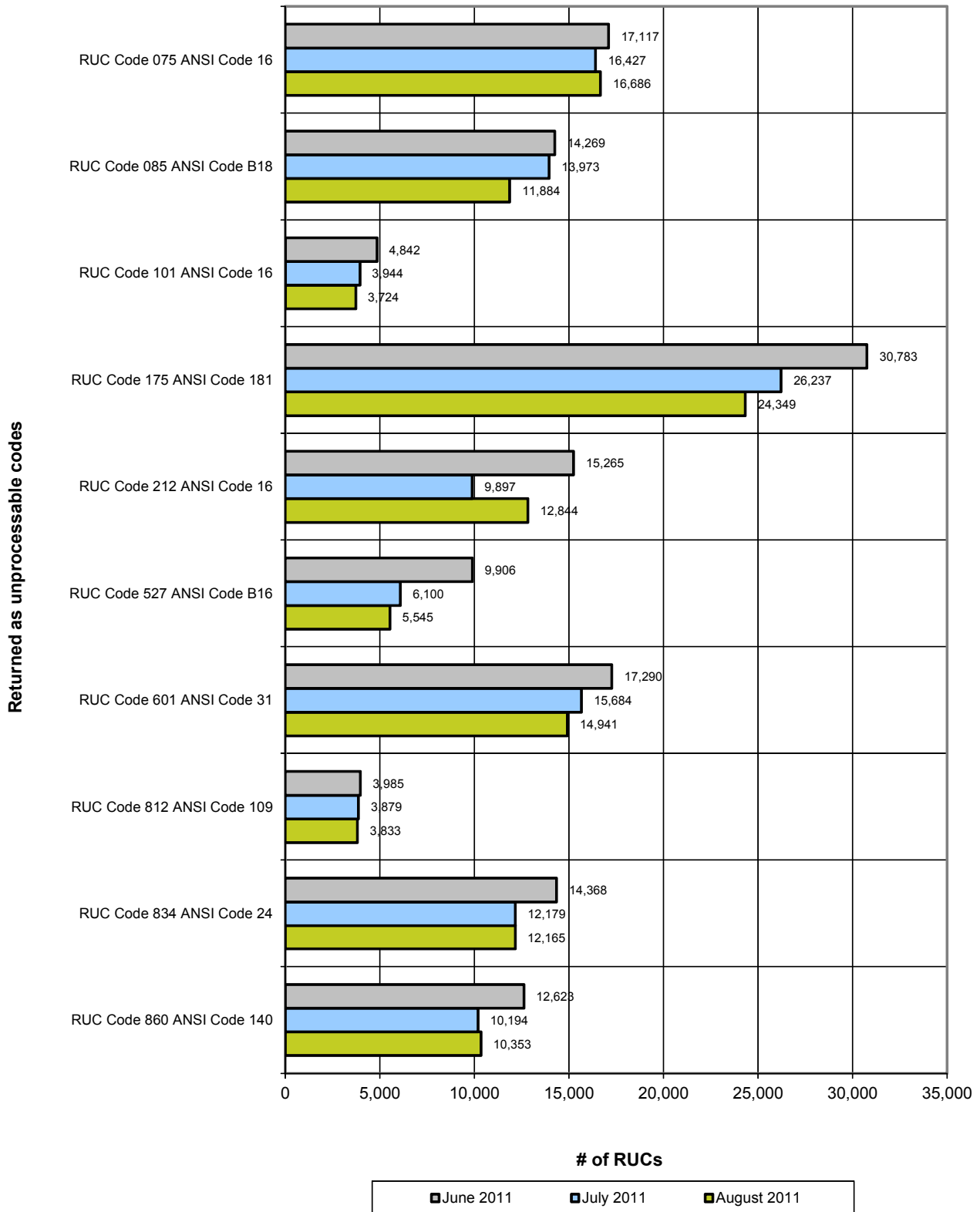
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

Refer to the [Claim completion FAQs](#), [Billing issues FAQs](#), and [Unprocessable FAQs](#) on the FCSO Medicare provider website for additional information on why claims may deny and how to correct this.

You may also refer to the [Top Part B claim denials](#) and [RUCs](#) tip sheets for tips and resources on correcting and avoiding certain claim denials.

Top....(continued)

## Florida Part B top return as unprocessable claims for June-August 2011

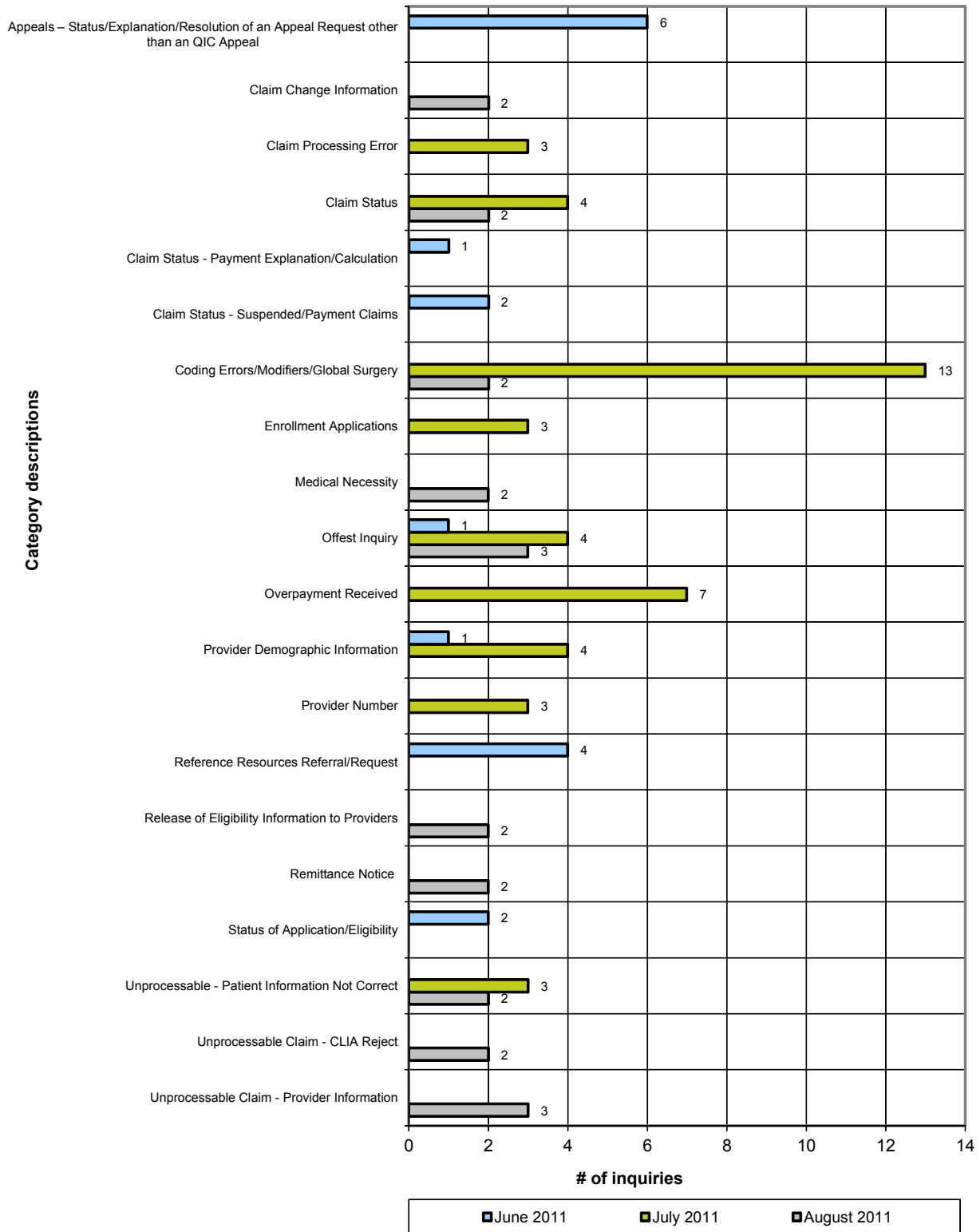


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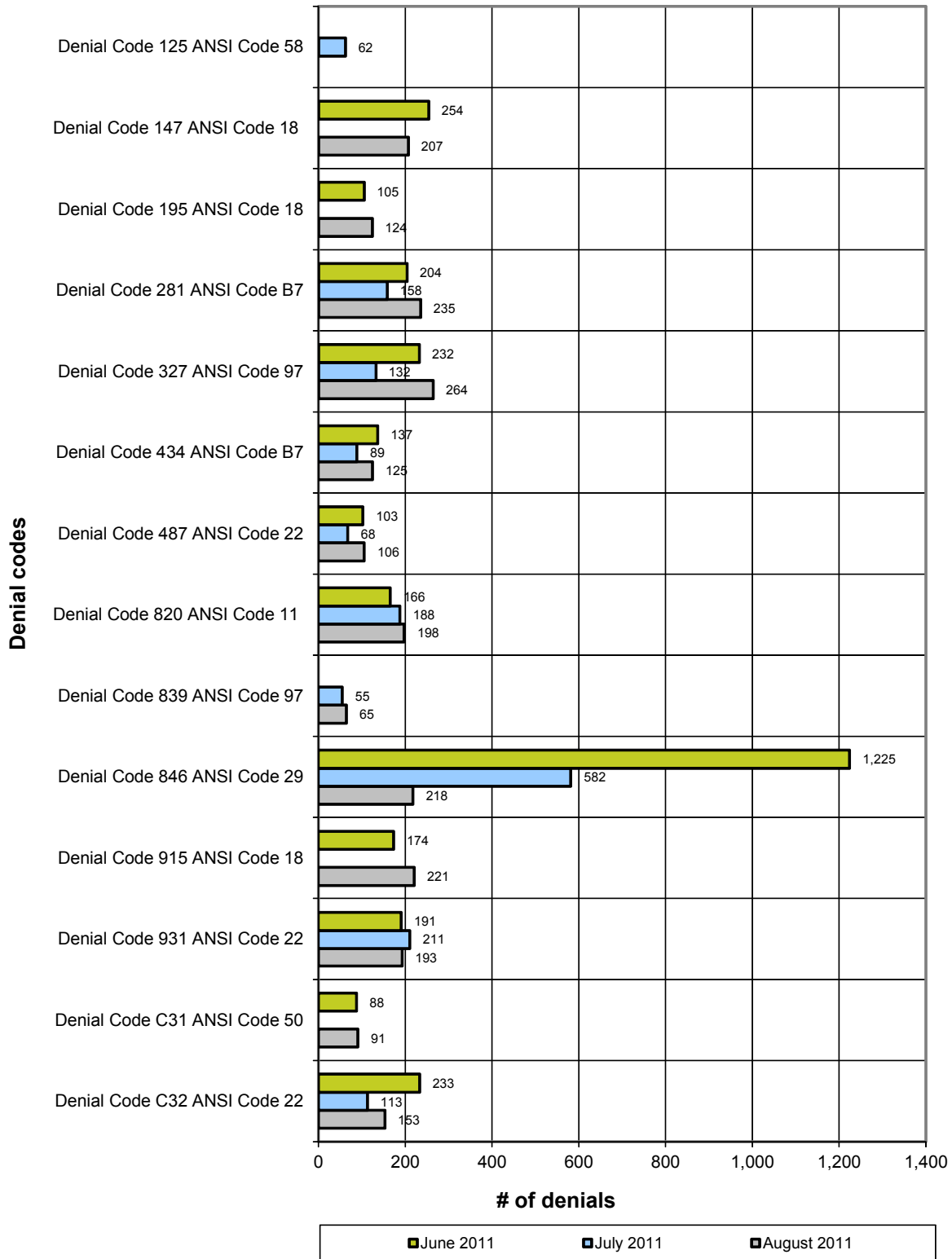
## U.S. Virgin Islands Part B top inquiries for June-August 2011



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Top....(continued)

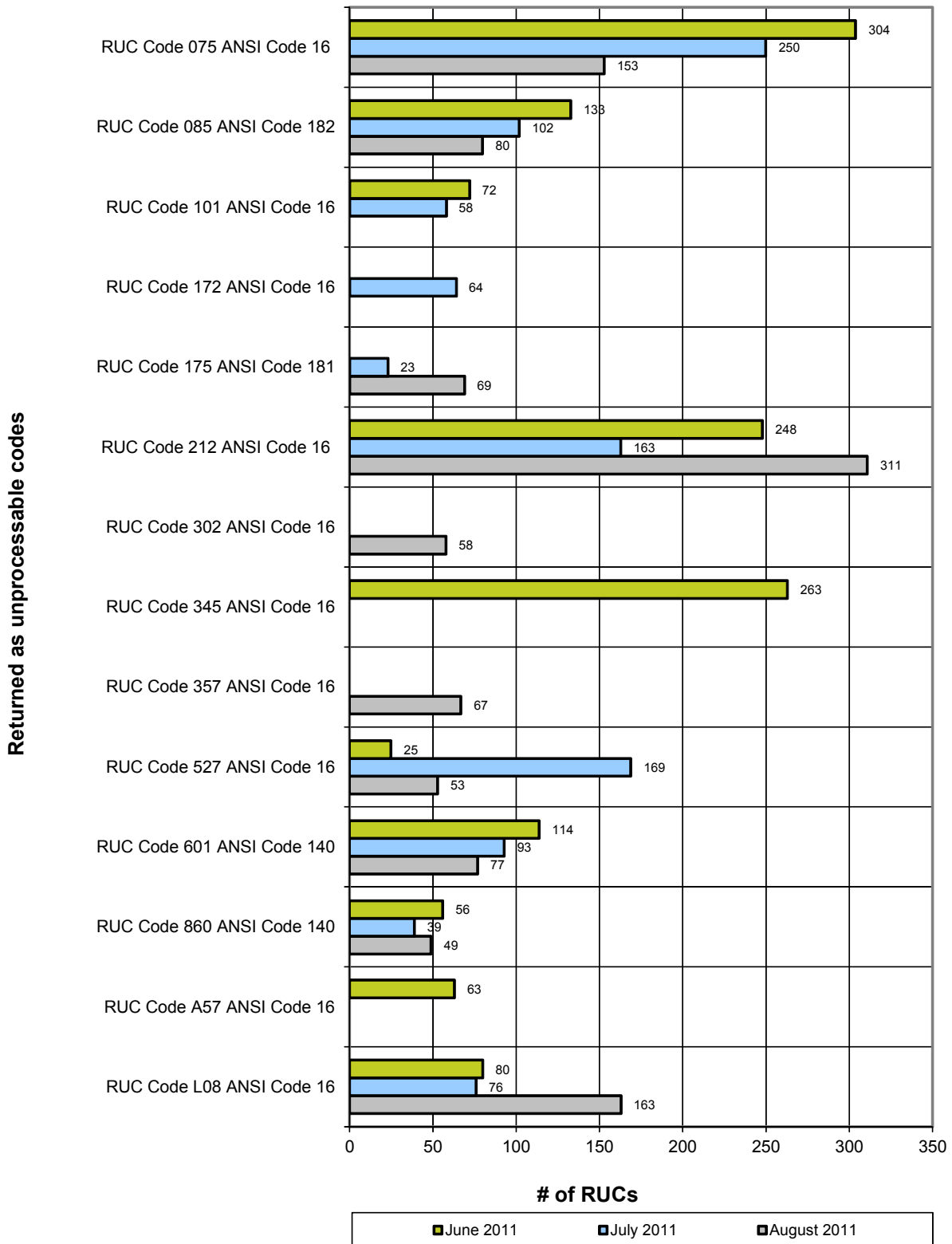
## U.S. Virgin Islands Part B top denials for June-August 2011



continued on next page

Top....(continued)

## U.S. Virgin Islands Part B top return as unprocessable claims for June-August 2011



This section of *Medicare B Connection* 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 to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage Web page at <http://medicare.fcso.com/Landing/139800.asp> for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

### Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished 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 and revised LCDs are posted to the website, subscribe to the FCSO eNews mailing list. Simply go to <http://medicare.fcso.com/Header/137525.asp>, enter your email address and select the subscription option that best meets your needs.

### More information

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

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

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## Advance beneficiary notice

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

**Note:** Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

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.

### Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? FCSO's LCD lookup, available at [http://medicare.fcso.com/coverage\\_find\\_lcds\\_and\\_ncds/lcd\\_search.asp](http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp), helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your Internet connection, the LCD search process can be completed in less than 10 seconds.



## New LCDs

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### **DRUGS AND BIOLOGICALS: Label and off-label coverage of outpatient drugs and biologicals – new LCD**

**LCD ID number: L32094 (Florida/Puerto Rico/U.S. Virgin Islands)**

The Medicare administrative contractor (MAC) for Jurisdiction 9 (J9) frequently receives inquiries from stakeholders when drugs are newly approved by the Food and Drug Administration (FDA) and/or inquires about drug coverage when there is not a national coverage determination (NCD) or local coverage determination (LCD) in play outlining coverage for a particular drug or biological. To assist the provider community in understanding the coverage requirements for drugs and biologicals that are usually not self-administered and are administered in the office, clinic or outpatient hospital, and where there are no active NCDs or LCDs outlining coverage, the MAC J9 has compiled Medicare coverage requirements for label and off-label use of drugs and biologicals into an LCD.

This new LCD gives indications and limitations of coverage, documentation requirements and utilization guidelines.

#### **Effective date**

This new LCD is effective for services rendered **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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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### **J1740: Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – new LCD**

**LCD ID number: L32100 (Florida/Puerto Rico/U.S. Virgin Islands)**

This local coverage determination (LCD) has been developed based on errors identified related to the use of certain intravenous (IV) bisphosphonates administered to male patients for the prevention and treatment of osteoporosis. It was determined that patients received IV Boniva instead of oral drugs even though there were no documented contraindications to the administration of oral medications. Some patients who received IV Boniva had normal bone mineral density test results. Additionally, certain IV bisphosphonates were administered to patients with a bone density T-score of -1.0 and -2.5 (osteopenia).

This LCD addresses certain IV bisphosphonates and outlines the indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines. In addition, a “Coding Guidelines” LCD attachment has also been developed for these medications which includes billing information.

#### **Effective date**

This new LCD is effective for services rendered **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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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### **J1740: Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – clarification to the LCD**

**LCD ID number: L32100 (Florida/Puerto Rico/U.S. Virgin Islands)**

An article was posted to the Centers for Medicare & Medicaid Services’ (CMS) website and to First Coast Service Options’ (FCSO) provider website on September 2, 2011, to begin the notice period for this local coverage determination (LCD). Since that time, the dual diagnosis requirement (represented by ICD-9-CM diagnosis code E932.0 [Adrenal cortical steroids causing adverse effects in therapeutic use]) was removed for Prolia™.

#### **Effective date**

This LCD is effective for services rendered **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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.

## 22533: Lumbar spinal fusion for instability and degenerative disc conditions – new LCD

**LCD ID number: L32076 (Florida/Puerto Rico/U.S. Virgin Islands)**

Causes of low back pain stem from a wide variety of conditions, although in some cases no specific etiology is identified. The goal of lumbar spinal fusion, also referred to as lumbar arthrodesis, is to permanently immobilize the spinal column vertebrae surrounding the disc(s) that are causing the discogenic low back pain. Surgical techniques to achieve lumbar spinal fusion are numerous, and include different surgical approaches to the spine. Spinal fusion should only be considered as a last step in the treatment of back pain and is not recommended for all persons suffering from back pain.

A local coverage determination (LCD) has been developed as a result of errors found by comprehensive error rate testing (CERT) when reviewing inpatient hospital claims for lumbar spinal fusion surgery. This LCD gives indications and limitations of coverage, *CPT* codes, documentation requirements, utilization guidelines, and coding guidelines for lumbar spinal fusion for instability and degenerative disc conditions.

### Effective date

This new LCD is effective for services rendered **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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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## 27130: Major joint replacement (hip and knee) – new LCD

**LCD ID number: L32081 (Florida/Puerto Rico/U.S. Virgin Islands)**

The November 2010 inpatient medical severity-diagnosis related group (MS-DRG) error rate for Part A Medicare administrative contractor (MAC) for jurisdiction 9 (J9) was 18.1 percent. This error rate is considerably higher than the national inpatient DRG rate. Based on comprehensive error rate testing (CERT) review findings, MS-DRG 470 (major joint replacement or reattachment of lower extremity) has been identified as being high risk for payment error, with a November 2010 payment error of 23.90 percent. 100 percent of the errors identified by CERT were due to failure of documentation in the hospital medical record to support the medical necessity of the procedure.

This local coverage determination (LCD) has been developed as a result of CERT errors identified, when reviewing inpatient hospital claims for total hip and total knee replacement surgery. This LCD gives indications and limitations of coverage, *CPT* codes, documentation requirements, utilization guidelines, ICD-9-CM diagnosis codes, ICD-9-CM procedure codes and coding guidelines for major joint replacement (hip and knee).

### Effective date

This new LCD is effective for services rendered **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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.



## 37221: Vascular stenting of lower extremity arteries – new LCD

### LCD ID number: L32102 (Florida/Puerto Rico/U.S. Virgin Islands)

Medicare administrative contractor (MAC) jurisdiction 9 (J9) will consider vascular stenting of lower extremity arteries medically reasonable and necessary for a patient under any of the circumstances as outlined in the local coverage determination (LCD) for this service.

This local coverage determination (LCD) has been developed to provide indications and limitations of coverage and/or medical necessity, ICD-9-CM codes that support medical necessity, documentation requirements and utilization guidelines for vascular stenting of lower extremity arteries. A “Coding Guidelines” LCD attachment has also been developed for this service.

#### Effective date

This new LCD is effective for services rendered **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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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## 86849: Circulating tumor cell testing – new LCD

### LCD ID number: L32098 (Florida/Puerto Rico/U.S. Virgin Islands)

Circulating tumor cells (CTCs) are rare malignant cells found in the peripheral blood which originate from the primary tumor or metastatic sites. The detection of CTCs has several proposed applications, some of which have been reported in well-designed observational studies (prospective and retrospective) of patients with metastatic cancers. There are also several controlled clinical trials in progress assessing the clinical utility of CTC results in the care of patients with metastatic cancers (application in clinical decision making that impacts patient outcomes). There are several methods of detecting CTCs which are in various stages of research and development. The low level of concentration of malignant epithelial cells in blood samples makes them difficult to detect though the push to improve surveillance and treatment of cancer patients makes CTC an area of research and development. The techniques that have been used to detect CTCs include direct methods (enrichment/detection) including Immunomagnetic Bead Separation, Immunohistochemistry (IHC), automated fluorescent methods, Dielectrophoresis and indirect methods (reverse-transcriptase polymerase chain reaction [RT-PCR] nucleic acid analysis).

This Medicare administrative contractor (MAC) jurisdiction 9 (J9) local coverage determination (LCD) addresses very limited coverage for one methodology, the CellSearch® assay (Veridex LLC, Warren, NJ) circulating tumor cell (CTC) assay. All other methods for CTC detection, including PCR (RT-PCR) assays, are non-covered. All assays of CTC are non-covered for all diagnoses for routine screening or prognostic statements (prediction of overall or progression free survival).

CTC testing per the CellSearch® assay can be covered for patients with metastatic breast, colorectal and prostate cancer when the criteria is met as outlined in this LCD, which has been developed to provide indications and limitations of coverage and/or medical necessity, ICD-9-CM codes that support medical necessity, documentation requirements and utilization guidelines for this service. In addition, a “Coding Guidelines” LCD attachment has also been developed for this service.

#### Effective date

This new LCD is effective for services rendered **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

## Revisions to LCDs

### Magnetic resonance imaging (MRI) – revision to the LCDs

**LCD ID number: L29219, L29220, L29221, L29222, L29223 (Florida)**

**LCD ID number: L29448, L29362, L29363, L29449, L29450 (Puerto Rico/U.S. Virgin Islands)**

The Centers for Medicare & Medicaid Services (CMS) issued change request 7441, transmittals 134 and 2293 on August 26, 2011. This change request outlines new coverage requirements for magnetic resonance imaging (MRI) in those patients with implanted permanent pacemakers (PMs). CMS believes that the evidence is adequate enough to conclude that MRI improves health outcomes for Medicare beneficiaries with PMs when the PMs are used according to the Food and Drug Administration (FDA) labeling for use in an MRI environment. Other contraindications that may be present in any given beneficiary would continue to apply in patients with PMs. These other contraindications are listed in the national coverage decision (NCD) for cardiac pacemakers, Pub 100-03, Chapter 1, Part 4, Section 220.2.C.1. The following LCDs have been revised according to the new requirements found in change request 7441: 73721 (MRI of any joint of the lower extremities); 70551 (MRI of the brain); 70540 (MRI of the orbit, face and/or neck); 72141 (MRI of the spine); 73218 (MRI of upper extremity).

#### Effective date

These LCD revisions are effective for claims processed **on or after September 26, 2011**, for services rendered **on or after July 7, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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: 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 noncovered services was most recently revised on September 5, 2011. Since that time, a revision was made to the LCD. New Category III CPT codes from the Centers for Medicare & Medicaid Services (CMS) Annual 2011 HCPCS Update (Change Request [CR] 7121) and Category III CPT codes from the CMS July Update to the 2011 Medicare Physician Fee Schedule Database (MPFSDB) (CR 7430) were evaluated and were determined not to be medically reasonable and necessary at this time based on the current available published evidence (e.g., peer-reviewed medical literature, published studies, etc.). Therefore, Category III CPT codes 0234T, 0235T, 0236T, 0237T, 0238T, 0254T, 0255T, 0262T, 0263T, 0264T, 0265T, and 0274T were added to the noncovered services LCD.

Under the “CPT/HCPCS Codes – Local Noncoverage Decisions – Procedures” section of the LCD, the following Category III CPT codes were added:

*0234T Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery*

*0235T Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel*

*0236T Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta*

*0237T Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; brachiocephalic trunk and branches, each vessel*

*0238T Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel*

*0254T Endovascular repair of iliac artery bifurcation (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using bifurcated endoprosthesis from the common iliac artery into both the external and internal iliac artery, unilateral;*

*0255T Endovascular repair of iliac artery bifurcation (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using bifurcated endoprosthesis from the common iliac artery into both the external and internal iliac artery, unilateral; radiological supervision and interpretation*

*continued on next page*



**NCSVCS....(continued)**

*0262T Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach*

*0263T Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest*

*0264T Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest*

*0265T Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy*

*0274T Percutaneous laminotomy/laminectomy (intradiscal approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic*

In addition, unlisted CPT code 47399 (Irreversible electroporation [e.g., NanoKnife System] - surgical ablation of soft tissue of the liver; other unlisted codes should be submitted based on the anatomical location performed) was evaluated and was determined not to be medically reasonable and necessary at this time based on the current available published evidence (e.g., peer-reviewed medical literature, published studies, etc.). Therefore, CPT code 47399 was added under the "CPT/HCPCS Codes - Local Noncoverage Decisions - Procedures" section of the LCD.

Also, CPT codes 82172, 83090GY, 86618, 86628, and 86631 were evaluated for coverage and it was determined to remove them from the "CPT/HCPCS Codes - Local Noncoverage Decisions - Laboratory Procedures" section of the LCD.

**Effective date**

The LCD revision to add CPT codes 0234T, 0235T, 0236T, 0237T, 0238T, 0254T, 0255T, 0262T, 0263T, 0264T, 0265T, 0274T, and 47399 is effective for services rendered **on or after October 16, 2011**.

The LCD revision to remove CPT codes 82172, 83090GY, 86618, 86628, and 86631 is effective for services rendered **on or after September 16, 2011**.

First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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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**93303: Transthoracic echocardiography (TTE) – revision to the LCD**

**LCD ID number: L29296 (Florida)**

**LCD ID number: L29402 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for transthoracic echocardiography (TTE) was most recently revised on October 1, 2010. Since that time, revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to update the application of coverage and clarify utilization of testing for the conditions and diagnoses listed. Also, the "Sources of Information and Basis for Decision" section of the LCD was updated.

**Effective date**

This LCD revision is effective for services rendered **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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.

## 93922: Noninvasive physiologic studies of upper or lower extremity arteries – revision to the LCD

**LCD ID number: L29237 (Florida)**

**LCD ID number: L29324 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for noninvasive physiologic studies of upper or lower extremity arteries was most recently revised on January 1, 2011. Since that time, the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised to add language to indicate that the transcutaneous oxygen tension measurements (TpO2) may be performed by personnel credentialed as a certified hyperbaric registered nurse (CHRN) or certified hyperbaric technologist (CHT) by the National Board of Diving and Hyperbaric Medical Technology (NBDHMT).

### Effective date

This LCD revision is effective for services rendered **on or after August 23, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

## Retired LCD

## J3487: Zoledronic Acid – retired LCD

**LCD ID number: L29312 (Florida)**

**LCD ID number: L29411 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for zoledronic acid was most recently revised on January 15, 2010. Since that time, a new LCD titled “bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications” (J1740) has been developed which replaces the zoledronic acid LCD. Therefore, the zoledronic acid LCD is being retired.

### Effective date

This LCD is retired effective for services rendered **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.



## Additional Information

### 2012 ICD-9-CM coding changes

The 2012 update to the ICD-9-CM diagnosis coding structure is effective for services rendered **on or after October 1, 2011**. Updated diagnosis codes must be used for all services billed on or after October 1, 2011. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Contractors will no longer be able to accept discontinued diagnosis codes for services rendered **on or after October 1, 2011**. First Coast Service Options Inc. (FCSO) has reviewed all local coverage determinations (LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2012 ICD-9-CM update. The table on the following pages lists the LCDs affected and the specific conditions revised as a result of the 2012 ICD-9-CM update:

LCD Title	2012 Changes
11600 Excision of Malignant Skin Lesions	<p><b>Removed</b> diagnosis codes 173.5, 173.6, and 173.7 for procedure codes 11600, 11601, 11602, 11603, 11604, and 11606.</p> <p><b>Removed</b> diagnosis codes 173.4, 173.6, and 173.7 for procedure codes 11620, 11621, 11622, 11623, 11624, and 11626.</p> <p><b>Removed</b> diagnosis codes 173.0, 173.1, 173.2, 173.3, and 173.8 for procedure codes 11640, 11641, 11642, 11643, 11644, and 11646.</p> <p><b>Added</b> diagnosis code ranges 173.50-173.59, 173.60-173.69, and 173.70-173.79 for procedure codes 11600, 11601, 11602, 11603, 11604, and 11606.</p> <p><b>Added</b> diagnosis code ranges 173.40-173.49, 173.60-173.69, and 173.70-173.79 for procedure codes 11620, 11621, 11622, 11623, 11624, and 11626.</p> <p><b>Added</b> diagnosis code ranges 173.00-173.09, 173.10-173.19, 173.20-173.29, 173.30-173.39, and 173.80-173.89 for procedure codes 11640, 11641, 11642, 11643, 11644, and 11646.</p>
17260 Destruction of Malignant Skin Lesions	<p><b>Removed</b> diagnosis codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, and 173.8 for procedure codes 17260, 17261, 17262, 17263, 17264, 17266, 17270, 17271, 17272, 17273, 17274, 17276, 17280, 17281, 17282, 17283, 17284, and 17286.</p> <p><b>Added</b> diagnosis code ranges 173.00-173.09, 173.10-173.19, 173.20-173.29, 173.30-173.39, 173.40-173.49, 173.50-173.59, 173.60-173.69, 173.70-173.79 and 173.80-173.89 for procedure codes 17260, 17261, 17262, 17263, 17264, 17266, 17270, 17271, 17272, 17273, 17274, 17276, 17280, 17281, 17282, 17283, 17284, and 17286.</p>
17311 Mohs Micrographic Surgery (MMS)	<p><b>Removed</b> diagnosis codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, and 173.8 for procedure codes 17311, 17312, 17313, 17314, and 17315.</p> <p><b>Added</b> diagnosis code ranges 173.00-173.09, 173.10-173.19, 173.20-173.29, 173.30-173.39, 173.40-173.49, 173.50-173.59, 173.60-173.69, 173.70-173.79 and 173.80-173.89 for procedure codes 17311, 17312, 17313, 17314, and 17315.</p>
31525 Diagnostic Laryngoscopy	<p><b>Changed</b> descriptor for diagnosis code 995.0 for procedure codes 31525 and 31575.</p>
43235 Diagnostic and Therapeutic Esophagogastroduodenoscopy	<p><b>Removed</b> diagnosis code 997.4 for procedure codes 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, and 43258.</p> <p><b>Added</b> diagnosis code range 997.41-997.49 for procedure codes 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, and 43258.</p>

continued on next page

**ICD-9-CM....(continued)**

LCD Title	2012 Changes
65855 Laser Trabeculoplasty	<p><b>Changed</b> descriptor for diagnosis code 365.01 for procedure code 65855.</p> <p><b>Added</b> diagnosis code 365.05 for procedure code 65855.</p>
66761 Iridotomy by Laser Surgery	<p><b>Added</b> diagnosis code 365.06 for procedure code 66761.</p>
70544 Magnetic Resonance Angiography (MRA)	<p><b>Removed</b> diagnosis code 444.0 for procedure codes 74185, C8900, C8901, and C8902.</p> <p><b>Added</b> diagnosis code range 444.01-444.09 for procedure codes 74185, C8900, C8901, and C8902.</p>
71275 Computed tomographic Angiography of the Chest, Heart and Coronary Arteries	<p><b>Removed</b> diagnosis codes 518.5 and 747.3 for procedure code 71275.</p> <p><b>Added</b> diagnosis code ranges 518.51-518.53 and 747.31-747.39 for procedure code 71275.</p> <p><b>Added</b> diagnosis code 414.4 for procedure codes 75571, 75572, 75573, and 75574.</p>
73218 Magnetic Resonance Imaging of Upper Extremity	<p><b>Removed</b> diagnosis code 173.6 for procedure codes 73218, 73219, 73220, 73221, 73222, and 73223. <b>Added</b> diagnosis code range 173.60-173.69 for procedure codes 73218, 73219, 73220, 73221, 73222, and 73223.</p> <p><b>Changed</b> individual diagnosis codes 999.31 and 999.39 to diagnosis code range 999.31-999.39 to include new diagnosis codes 999.32-999.34 for procedure codes 73218, 73219, 73220, 73221, 73222, and 73223.</p>
75722 Renal Angiography	<p><b>Removed</b> diagnosis code 444.0 for procedure codes 75722 and 75724.</p> <p><b>Added</b> diagnosis code range 444.01-444.09 for procedure codes 75722 and 75724.</p>
77402 Radiation Therapy for T1 Basal Cell and Squamous Cell Carcinomas of the Skin	<p><b>Removed</b> diagnosis codes 173.0, 173.1, 173.2, 173.3, 173.5, 173.6, 173.7, and 173.9 for procedure codes 77401, 77402, 77403, 77404, 77406, 77785, 77786, and 77789.</p> <p><b>Added</b> diagnosis codes 173.01, 173.02, 173.11, 173.12, 173.21, 173.22, 173.31, 173.32, 173.51, 173.52, 173.61, 173.62, 173.71, 173.72, 173.91, and 173.92 for procedure codes 77401, 77402, 77403, 77404, 77406, 77785, 77786, and 77789.</p>
77520 Proton Beam Radiotherapy	<p><b>Changed</b> diagnosis code range 173.0-173.9 to diagnosis code range 173.00-173.99 for procedure codes 77520, 77522, 77523, and 77525 (Group #2 Listing)</p>
78451 Cardiovascular Nuclear Imaging Studies	<p><b>Removed</b> diagnosis code 425.1 for procedure codes 78472, 78473, 78481, 78483, 78494, and 78496.</p> <p><b>Added</b> diagnosis code range 425.11-425.18 for procedure codes 78472, 78473, 78481, 78483, 78494, and 78496.</p> <p><b>Added</b> diagnosis code 414.4 for procedure codes 78451, 78452, 78453, 78454, 78472, 78473, 78481, 78483, 78494, and 78496.</p>
78459 Myocardial Imaging, Positron Emission Tomography (PET) Scan	<p><b>Added</b> diagnosis code 414.4 for procedure codes 78459, 78491, and 78492.</p>
80076 Hepatic (Liver) Function Panel	<p><b>Changed</b> descriptor for diagnosis code 995.0 for procedure code 80076.</p>
83735 Magnesium	<p><b>Removed</b> diagnosis code 998.0 for procedure code 83735.</p> <p><b>Added</b> diagnosis code range 998.00-998.09 for procedure code 83735.</p>

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ICD-9-CM....(continued)

LCD Title	2012 Changes
86003 Allergy Testing	<b>Changed</b> descriptor for diagnosis code 995.0 for procedure codes 86003, 95004, 95010, 95015, 95024, 95027, and 95028. <b>Changed</b> descriptors for diagnosis codes 995.60, 995.61, 995.62, 995.63, 995.64, 995.65, 995.66, 995.67, 995.68, and 995.69 for procedure codes 86003, 86005, 86160, 86161, 86162, and 95004.
90802 Interactive Psychiatric Services	<b>Changed</b> descriptors for diagnosis codes 317, 318.0, 318.1, and 318.2 for procedure codes 90802, 90810, 90811, 90812, 90813, 90814, 90815, 90823, 90824, 90826, 90827, 90828, 90829, and 90857.
90804 Individual Psychotherapy	<b>Changed</b> descriptors for diagnosis codes 317 and 318.0- 318.2 for procedure codes 90804, 90805, 90806, 90807, 90808, 90809, 90816, 90817, 90818, 90819, 90821, and 90822.
90847 Family Psychotherapy	<b>Changed</b> descriptors for diagnosis codes 317 and 318.0- 318.2 for procedure codes 90846 and 90847.
90853 Group Psychotherapy	<b>Changed</b> descriptors for diagnosis codes 317 and 318.0- 318.2 for procedure code 90853.
90862 Pharmacologic Medication Management for Psychotherapy Services	<b>Changed</b> descriptors for diagnosis codes 317 and 318.0- 318.2 for procedure codes 90862 and M0064.
92081 Visual Field Examination	<b>Removed</b> new diagnosis code range 365.70-365.74 from diagnosis code range 365.00-365.9 for procedure codes 92081, 92082, and 92083 as they are not appropriate. <b>Added</b> diagnosis codes 365.05 and 365.06 for procedure codes 92081, 92082, and 92083.
92132 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	<b>Added</b> diagnosis code 365.05 for procedure codes 92133 and 92134. <b>Added</b> diagnosis code 365.06 for procedure code 92132, 92133, and 92134.
92225 Ophthalmoscopy	<b>Added</b> diagnosis codes 365.05, 365.06, and 365.70-365.74 for procedure codes 92225 and 92226.
92285 External Ocular Photography	<b>Removed</b> diagnosis code 173.1 for procedure code 92285. <b>Added</b> diagnosis code range 173.10-173.19 for procedure code 92285.
93224 External Electrocardiography Recording	<b>Added</b> diagnosis code 414.4 for procedure codes 93224, 93225, 93226, and 93227.
93303 Transthoracic Echocardiography (TTE)	<b>Removed</b> diagnosis code 998.0 for procedure codes 93306, 93307, and 93308. <b>Added</b> diagnosis codes 414.4 and 998.00-998.09 for procedure codes 93306, 93307, and 93308. <b>Changed</b> diagnosis code range 444.0-444.9 to diagnosis code range 444.01-444.9 for procedure codes 93306, 93307, and 93308. <b>Changed</b> individual diagnosis codes 999.31 and 999.39 to diagnosis code range 999.31-999.39 to include new diagnosis codes 999.32-999.34 for procedure codes 93306, 93307, and 93308.
93312 Transesophageal Echocardiogram	<b>Removed</b> diagnosis code 747.3 for procedure codes 93312, 93313, 93314, 93315, 93316, 93317, and 93318. <b>Added</b> diagnosis codes 414.4 and 747.31-747.39 for procedure codes 93312, 93313, 93314, 93315, 93316, 93317, and 93318. <b>Changed</b> diagnosis code range 444.0-444.9 to diagnosis code range 444.01-444.9 for procedure codes 93312, 93313, 93314, 93315, 93316, 93317, and 93318.
93350 Stress Echocardiography	<b>Added</b> diagnosis code 414.4 for procedure codes 93350, 93351, and 93352.

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## ICD-9-CM....(continued)

LCD Title	2012 Changes
93701 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance	<b>Added</b> diagnosis code 414.4 for procedure code 93701.
93922 Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries	<b>Removed</b> diagnosis code 444.0 for procedure codes 93922, 93923, and 93924. <b>Added</b> diagnosis code range 444.01-444.09 for procedure codes 93922, 93923, and 93924.
93925 Duplex Scan of Lower Extremity Arteries	<b>Removed</b> diagnosis code 444.0 for procedure codes 93925 and 93926. <b>Added</b> diagnosis codes 444.01 and 444.09 for procedure codes 93925 and 93926.
93965 Non-Invasive Evaluation of Extremity Veins	<b>Added</b> diagnosis code 415.13 for procedure codes 93965, 93970, and 93971.
93975 Duplex Scanning	<b>Removed</b> diagnosis code 444.0 for procedure codes 93978 and 93979. <b>Added</b> diagnosis code range 444.01-444.09 for procedure codes 93978 and 93979.
94760 Noninvasive Ear or Pulse Oximetry for Oxygen Saturation	<b>Removed</b> diagnosis code 518.5 for procedure codes 94760, 94761, and 94762. <b>Added</b> diagnosis code range 518.51-518.53 for procedure codes 94760, 94761, and 94762.
95115 Allergen Immunotherapy	<b>Changed</b> descriptor for diagnosis code 995.0 for procedure codes 95115 and 95117.
G0237 Respiratory Therapeutic Services	<b>Removed</b> diagnosis code 516.3 for procedure codes G0237, G0238, and G0239. <b>Added</b> diagnosis code range 516.30-516.37 for procedure codes G0237, G0238, and G0239.
J0800 Corticotropin	<b>Removed</b> diagnosis code 999.5 for procedure code J0800. <b>Added</b> diagnosis code range 999.51-999.59 for procedure code J0800.
J2820 Sargramostim (GM-CSF, Leukine®)	<b>Added</b> diagnosis code 996.88 for procedure code J2820.
J7187 Hemophilia Clotting Factors	<b>Removed</b> diagnosis code 286.5 for procedure codes J7187, J7189, J7190, J7191, J7192, J7193, J7194, J7195, J7198, and Q2041. <b>Added</b> diagnosis code range 286.52-286.59 for procedure codes J7187, J7189, J7190, J7191, J7192, J7193, J7194, J7195, J7198, and Q2041.
J7308 Topical Photosensitizers used with PDT for Actinic Keratoses and Certain Skin Cancers	<b>Removed</b> diagnosis codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, and 173.8 for procedure codes J7308 and J7309. <b>Added</b> diagnosis code ranges 173.00-173.09, 173.10-173.19, 173.20-173.29, 173.30-173.39, 173.40-173.49, 173.50-173.59, 173.60-173.69, 173.70-173.79 and 173.80-173.89 for procedure codes J7308 and J7309.
J9171 Docetaxel (Taxotere®)	<b>Removed</b> diagnosis codes 173.0, 173.1, 173.2, 173.3, and 173.4 for procedure code J9171. <b>Added</b> diagnosis code ranges 173.00-173.09, 173.10-173.19, 173.20-173.29, 173.30-173.39, and 173.40-173.49 for procedure code J9171.
J9181 Etoposide, (Etopophos®, Toposar®, Vepesid®, VP-16)	<b>Changed</b> diagnosis code range 173.0-173.9 to diagnosis code range 173.00-173.99 for procedure code J9181.

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ICD-9-CM....(continued)

LCD Title	2012 Changes
J9212 Interferon	<b>Changed</b> diagnosis code range 173.0-173.9 to diagnosis code range 173.00-173.99 for procedure code J9214.
PULMDIAGSVCS Pulmonary Diagnostic Services	<p><b>Removed</b> new diagnosis code range 516.61-516.69 from diagnosis code range 516.0-516.9 for procedure codes 93720, 93721, 93722, 94010, 94060, 94070, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725, and 94750 as they are not appropriate.</p> <p><b>Removed</b> diagnosis code 793.1 for procedure codes 93720, 93721, 93722, 94010, 94060, 94070, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725, and 94750.</p> <p><b>Added</b> diagnosis codes 516.30-516.37, 516.4 and 516.5 for procedure codes 93720, 93721, 93722, 94010, 94060, 94070, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725, and 94750.</p> <p><b>Added</b> diagnosis code range 793.11-793.19 for procedure codes 93720, 93721, 93722, 94010, 94060, 94070, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725, and 94750.</p>

Coverage requirements for collection of specimen and travel allowance

Based on language in the Medicare Claims Processing Manual, Publication 100-04, Chapter 16, Section 60.1, travel allowance (P9603, P9604) and specimen collection (P9612, P9615, 36415) are not a Medicare benefit unless related to obtaining the specimen for a covered laboratory service.

Effective for claims processed on or after October 1, 2011, First Coast Service Options Inc. will implement editing to deny the following CPT/HCPCS codes when a laboratory test is denied and no other lab codes are paid on the same date of service or if no laboratory test(s) is billed on the same date of service.

Code	Description
P9603	Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually traveled
P9604	Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge
P9612	Catheterization for collection of specimen, single patient, all places of service
P9615	Catheterization for collection of specimen(s) [multiple patients]
36415	Collection of venous blood by venipuncture

## Educational Events

### Upcoming provider outreach and educational events October 2011

***Bimonthly Medicare Part B ACT: Medicare changes and hot issues***

**When:** Wednesday, October 12  
**Time:** 11:30 a.m.-1:00 p.m.

***Provider website enhancements***

**When:** Thursday, October 13  
**Time:** 11:30 a.m.-12:30 p.m.

***Bimonthly Medicare Part B ACT: Medicare data and CMS initiatives***

**When:** Wednesday, October 19  
**Time:** 2:00-3:30 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.fcsouniversity.com](http://www.fcsouniversity.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 website, [medicare.fcsso.com](http://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 offer CEUs. Learn more on the FCSO Medicare training website and explore our catalog of online courses.

## Preventive Services

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### Materials from initial preventive physical exam and annual wellness visit national provider call now available

The Centers for Medicare & Medicaid Services (CMS) hosted a national provider call on Thursday, July 21, titled “*The ABCs of the Initial Preventive Physical Examination and Annual Wellness Visit*.” Materials from this call are now available and include the presentation used during the national provider call, CMS responses to outstanding questions, call transcript (note that several post-call clarifications are included within the transcript to clarify information provided during the call), and the audio recording of the call.

All materials from this call can be found in the “Downloads” section at <http://www.CMS.gov/MLNProducts/MLM/itemdetail.asp?itemID=CMS1249934>.

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

**Source:** CMS PERL 201109-17

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### Preventive Immunizations brochure revised

This brochure is designed to provide education on Medicare’s influenza vaccine, pneumococcal vaccine, and hepatitis B vaccine benefits. To place your order for a hard copy, visit the *Medicare Learning Network*<sup>®</sup> (MLN) Product Ordering page at [http://CMS.meridianksi.com/kc/pfs/pfs\\_inkfrm\\_fl.asp?lgnfrm=reqprod&function=pfs](http://CMS.meridianksi.com/kc/pfs/pfs_inkfrm_fl.asp?lgnfrm=reqprod&function=pfs). The brochure may be found under the “Medicare Preventive Services” section (ICN 006435).

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

**Source:** CMS PERL 201109-28

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### September is Prostate Cancer Awareness Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in raising awareness and knowledge about prostate cancer and the prostate cancer screenings covered by Medicare. Prostate cancer is the most common cancer in men and the second leading cause of cancer death among men in the United States, after lung cancer. Medicare provides coverage of two types of prostate cancer screenings.

Medicare provides coverage for digital rectal exams (DREs) and prostate-specific antigen (PSA) blood tests once every 12 months for all male beneficiaries aged 50 and older. The DRE must be performed by a physician or non-physician practitioner who is authorized under state law to perform the examination; the PSA blood test must be ordered by the patient’s physician or qualified non-physician practitioner. Both screenings are covered under Medicare as a Part B benefit.

#### What can you do?

As a provider of health care to men with Medicare you can help your patients make an informed decision about prostate cancer screening:

- Talk with your patients about the nature and risk of prostate cancer.
- Share current information about prostate cancer screenings with them.
- Inform them about the prostate screenings covered by Medicare that may be appropriate for them.

#### For more information

[The Guide to Medicare Preventive Services, Chapter 12](#)  
[Medicare Preventive Services Quick Reference Information Chart](#)  
[Cancer Screenings Brochure for Physicians, Providers, Suppliers, and Other Healthcare Professionals](#)  
[Center for Disease Control and Prevention Prostate Cancer website](#)  
[Prostate Cancer Awareness Month website](#)

**Source:** CMS PERL 201109-16

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## Other Educational Resources

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### Updates from the *Medicare Learning Network*<sup>®</sup>

#### **Contractor Entities At A Glance educational tool released**

The *Medicare Learning Network*<sup>®</sup> (MLN) has released a new product titled *Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities* to provide education about the definitions and responsibilities of entities involved in various claims adjudication activities. This educational tool, which is available in downloadable format at [http://www.CMS.gov/MLNProducts/downloads/ContractorEntityGuide\\_ICN906983.pdf](http://www.CMS.gov/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf), includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers. This product will be available in hard copy format from the MLN<sup>®</sup> at a later date.

#### **Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B booklet revised**

This booklet is designed to provide education on the ABN. It includes information on when an ABN should be used and how it should be completed. To place your order, visit the MLN Product Ordering page at [http://CMS.meridianksi.com/kc/pfs/pfs\\_inkfrm\\_fl.asp?lgnfrm=reqprod&function=pfs](http://CMS.meridianksi.com/kc/pfs/pfs_inkfrm_fl.asp?lgnfrm=reqprod&function=pfs). The booklet may be found under the “General Medicare Program Information” section (ICN 006266).

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

**Source:** CMS PERL 201109-28

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### **Medicare Enrollment Guidelines for Ordering/Referring Providers fact sheet revised**

The publication titled *Medicare Enrollment Guidelines for Ordering/Referring Providers*, which is available from the *Medicare Learning Network*<sup>®</sup> at [http://www.CMS.gov/MLNProducts/downloads/MedEnroll\\_OrderReferProv\\_FactSheet\\_ICN906223.pdf](http://www.CMS.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf), was revised to remove “Doctors of Chiropractic Medicine” from the list of providers who are eligible to order/refer, as indicated in technical direction that Centers for Medicare & Medicaid Services (CMS) issued on Friday, August 12. CMS will re-issue the related policies as soon as possible. This fact sheet is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers. It includes information on the three basic requirements for ordering and referring and who may order and refer for Medicare Part A home health agency, Part B, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) beneficiary services.

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

**Source:** CMS PERL 201109-01

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### **Tobacco-Use Cessation Counseling Services brochure available in hardcopy**

The *Tobacco-Use Cessation Counseling Services* brochure is now available in a hardcopy format from the *Medicare Learning Network*<sup>®</sup>. This brochure is designed to provide education on tobacco-use cessation counseling services. To place your order, visit <http://www.CMS.gov/MLNGenInfo> on the Centers for Medicare & Medicaid Services (CMS) website, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering 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 201109-01

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## *The Medicare Overpayment Collection Process* fact sheet revised

The *Medicare Overpayment Collection Process* fact sheet, which includes the definition of a physician or supplier overpayment and information about the overpayment collection process, has been revised and is now available in downloadable format at <http://www.CMS.gov/MLNProducts/downloads/OverpaymentBrochure508-09.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 201108-42

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## *Medicare Learning Network*<sup>®</sup> provider exhibit program schedule

Mark your calendars. The *Medicare Learning Network*<sup>®</sup> will be exhibiting at the following healthcare provider conferences in the coming weeks:

### *2011 Congress of Neurological Surgeons Annual Meeting*

Saturday, October 1 through Thursday, October 6  
Walter E. Washington Convention Center, Washington, DC  
Booth #704

### *National Association for Home Care & Hospice 30th Annual Meeting & Exposition*

Saturday, October 1 through Wednesday, October 5  
Mandalay Bay Resort and Casino, Las Vegas, NV  
Booth #362

### *American Health Information Management Association Conference*

Sunday, October 2 through Wednesday, October 5  
Salt Palace Convention Center, Salt Lake City, UT  
Booth #1631

### *2011 American Medical Billing Association Conference*

Thursday, October 13 through Friday, October 14  
Planet Hollywood Resort and Casino, Las Vegas, NV  
Booth #11

### *West Virginia Rural Health Conference*

Wednesday, October 26 through Friday October 28  
Lakeview Golf Resort & Spa, Morgantown, WV

Please make note of these dates and locations and add them to your calendar. If you are interested in having a *Medicare Learning Network* exhibit at your event, please contact us at [MLNexhibits@cms.hhs.gov](mailto:MLNexhibits@cms.hhs.gov).

**Source:** CMS PERL 201109-12



### Discover your passport to Medicare training

- Register for live events
- Explore online courses
- Find CEU information
- Download recorded events

Learn more on FCSO's Medicare training website

## 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@fcso.com](mailto:AskFloridaB@fcso.com)

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

### Beneficiary

#### Toll-Free:

1-800-MEDICARE  
Hearing Impaired:  
1-800-754-7820

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

## Education event

### registration (not toll-free):

1-904-791-8103

## Electronic data interchange (EDI)

1-888-670-0940

**Option 1** - Transaction support

**Option 2** - PC-ACE support

**Option 4** - Enrollment support

**Option 5** - 5010 testing

**Option 6** - Automated response line

## DME, orthotic or prosthetic claims

Cigna Government Services  
1-866-270-4909

## Medicare Part A

Toll-Free:  
1-888-664-4112

## 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)

## Mail directory

### Claims, additional development, general correspondence

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

### Flu rosters

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

### Electronic data interchange (EDI)

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

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

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

### Provider enrollment

#### Where to mail provider/supplier applications

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

#### Provider change of address

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

and

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

### Redeterminations

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

### Redetermination overpayment

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

### Freedom of Information Act requests (FOIA)

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

### Congressional inquiries

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

### Provider education

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

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

#### Education event registration:

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

### Medicare claims for railroad retirees

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

### Fraud and abuse

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

### Local coverage determinations

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

### Post pay medical review

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

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

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

## Medicare 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** - 5010 testing

**Option 6** - Automated response line

### DME, orthotic or prosthetic claims

Cigna Government Services  
1-866-270-4909

### Medicare Part A

Toll-Free:  
1-888-664-4112



## 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
<p><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/index.asp">http://medicare.fcso.com/Publications_B/index.asp</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 2011 through September 2012.</p>	40300260	\$33		
<p><b>2011 Fee Schedule</b> – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 11, 2011, 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 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.</p> <p><b>Note:</b> Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.</p>	40300270	\$12		
Language preference: <b>English</b> [ ] <b>Español</b> [ ]				
<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)*





**Medicare B Connection**

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

**Attention Billing Manager**