

# C Medicare B CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

April 2012



## In this issue

The latest listing of DMEPOS codes to determine which contractor to bill your services.....	15
Change request (CR) 7745 instructs the contractor to download and implement a new MPFSDB.....	43
CR 7767 summarizes the new law that prevents payment cuts from taking effect March 1.....	45
CMS implements a new fraud prevention program.....	60

## Health reform tools to combat Medicare fraud

The Secretary of the Department of Health and Human Services (HHS) and the Attorney General hosted the "Seventh Regional Health Care Fraud Prevention Summit" Wednesday, April 4. At this Chicago summit highlighting a new high-tech war against health care fraud, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder discussed how the Affordable Care Act and the Obama administration's Health Care Fraud Prevention and Enforcement Action Team (HEAT) are helping fight Medicare fraud.

The regional summits bring together a wide array of public and private partners, and are part of the HEAT partnership between HHS and the Department of Justice to prevent and combat health care fraud. The Obama administration's HEAT efforts have resulted in record-breaking health care fraud recoveries. In fiscal year (FY) 2011, for the second year in a row, the departments' anti-fraud activities resulted in more than \$4 billion in recoveries, an all-time high.

New tools provided by the Affordable Care Act are strengthening the Obama administration's efforts to fight health care fraud. As a result of Affordable Care Act provisions:

- Criminals face tougher sentences for health care fraud, 20-50 percent longer for crimes that involve more than \$1 million in losses
- Contractors that police the Medicare program for waste, fraud, and abuse will expand their work to

Medicaid, Medicare Advantage, and Medicare Part D programs

- Government entities, including states, the Centers for Medicare & Medicaid Services (CMS), and law enforcement partners at the Office of the Inspector General (OIG) and DOJ, have greater abilities to work together and share information so that CMS can prevent money from going to bad actors by using its authority to suspend payments to providers and suppliers engaged in suspected fraudulent activity

On Wednesday, April 4, the Obama administration also announced more progress from its anti-fraud efforts, beyond the nearly \$4.1 billion recovered last year:

- In the early phase of revalidating the enrollment of providers in Medicare, 234 providers were removed from the program because they were deceased, debarred, or excluded by other federal agencies, or were found to be in false storefronts or otherwise invalid business locations
- In 2011, HHS revoked 4,850 Medicaid providers and suppliers and deactivated 56,733 Medicare providers and suppliers as HHS took steps to close vulnerabilities in the Medicare program
- In 2011, HHS saved \$208 million through pre-payment edits that stop implausible claims before they're paid

*(continued on page 64)*



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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

## About the Medicare B Connection

About the Medicare B Connection.....	3
Advance beneficiary notices.....	4
GA modifier and appeals.....	4

## Claims

July update to the correct coding edits.....	5
Guidance for correct claims submission when secondary payers are involved.....	6

## Coverage/Reimbursement

### Ambulatory Surgical Center

April 2012 update of the ASC payment system.....	8
--	---

### Drugs and Biologicals

July 2012 ASP Medicare Part B pricing files and revisions to prior quarterly pricing files.....	12
Pharmacy billing for drugs provided “incident to” a physician service.....	14

### Durable Medical Equipment

2012 jurisdiction list for DMEPOS codes.....	15
2012 DMEPOS jurisdiction listing.....	16
DMEPOS competitive bidding round 1 recompute announced.....	26
New report: Competitive bidding saving money for taxpayers and people with Medicare.....	28

### Laboratory/Pathology

Clinical laboratory fee schedule – new waived tests.....	28
New waived tests.....	29
HCPCS codes subject to and excluded from CLIA edits.....	30

### Mental Health

Screening and behavioral counseling to reduce alcohol misuse.....	32
Screening for depression in adults.....	35

### Preventive Services

Intensive behavioral therapy for CVD.....	38
---	----

### Radiology

MPPR on certain diagnostic imaging procedures.....	41
--	----

### General Coverage

April update to the 2012 MPFS.....	43
Emergency March 2012 update to the CY 2012 MPFSDB.....	45
Quarterly update for HCPCS codes effective July 1.....	47
ICD-10 compliance delayed until Oct 1, 2014.....	48
Information about the Middle Class Tax Relief and Job Creation Act of 2012.....	48
Revised and clarified POS coding instructions.....	50

### Electronic Data Interchange

ICD-10: It’s closer than it seems – have you completed your 5010 implementation?.....	54
Version 5010 FAQs and view 5010 page and resources.....	54
CARC, RARC, MREP, and PC Print update.....	55
All payments to be made by EFT.....	58
Claim status category and claim status codes update.....	59

### General Information

#### Fraud

Information on fraud prevention initiatives.....	60
Questionable billing by suppliers of lower limb prostheses.....	61

## Provider Enrollment

Sign your Medicare enrollment application electronically.....	64
General update to Chapter 15 of the Program Integrity Manual (PIM) Part V.....	65
Expansion of the current scope of editing for ordering/referring providers.....	66

## Incentive Programs

Latest success data on provider participation in EHR.....	68
Quality Reporting Communication Support page now available.....	69
Medicare Quality Reporting Incentive Programs manual update.....	70
Message from Social Security.....	70
Questions and answers about registration for the EHR.....	71
Results of 2010 Physician Quality Reporting System and eRx.....	72
Louisiana’s Medicaid EHR incentive program first in nation to issue an incentive payment for eligible professionals for meaningful use.....	72

## General Information

Redesigned Medicare summary notices.....	73
New program to improve care, control Medicare costs.....	74
Reminder of how reasonable cost principles apply to provider taxes on Medicare cost reports.....	75
CMS.gov website upgrade completed.....	75

## Claim and Inquiry Summary Data

Top inquiries, denials, and return unprocessable claims.....	76
What to do when your claim is denied.....	77

## Local Coverage Determinations

Contents.....	79
---------------	----

## Educational Resources

Upcoming provider outreach and educational events – May-June 2012.....	90
--	----

## Preventive Services

April is Alcohol Awareness Month.....	91
‘National Colorectal Cancer Awareness Month’ – don’t forget to follow-up.....	92
April is National Cancer Control Month.....	93

## Other Educational Resources

HHS Secretary Sebelius’s statement on ‘National Minority Health Month’.....	94
Two new CME modules available on Medscape.....	94
‘7 Ways to Protect Yourself from Medical Identity Theft’.....	95
Targeted release of comparative billing report on cardiology services on April 23.....	95

## Contact Information

Florida Contact Information.....	96
U.S. Virgin Islands Contact Information.....	97

## Order form

Order form for Part B materials.....	98
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The Medicare B Connection is published monthly by First Coast Service Options Inc.’s Provider Outreach & Education division to provide timely and useful information to Medicare Part B providers.

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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.fcsso.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.

## July update to the correct coding edits

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians submitting claims to Medicare carriers and/or A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 7802 which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in April, 2012.

### Background

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

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

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

The latest package of CCI edits, version 18.2, is effective July 1, 2012, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in two tables:

- Column 1/Column 2 Correct Coding Edits
- Mutually Exclusive Code (MEC) Edits

Additional information about the CCI, including the current CCI and mutually exclusive code (MEC) edits, is available at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>.

### Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, (Chapter 23, Section 20.9) which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>.

The official instruction, CR 7802, issued to your carrier or and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2434CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters<sup>®</sup> Number: MM7802

Related Change Request (CR) #: CR 7802

Related CR Release Date: March 30, 2012

Effective Date: July 1, 2012

Related CR Transmittal #:R2434CP

Implementation Date: July 2, 2012

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## Guidance for correct claims submission when secondary payers are involved

### Provider types affected

This *MLN Matters*® special edition (SE) article is intended for providers, physicians, and suppliers who bill Medicare contractors (Part A/B Medicare administrative contractors [A/B MACs], durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and carriers [hereafter referred to as Medicare contractors]) for services provided to Medicare beneficiaries.

### Provider action needed

To ensure accurate claim submissions and timely payment, providers, physicians, and other suppliers should:

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer for related services.



- Use specific and correct diagnosis codes, especially for accident related claims.

**Remember:** A properly filed claim prevents Medicare contractors from inappropriately denying claims and expedites the payment process.

### Background

#### Collect full beneficiary health insurance information

It is the responsibility of all Medicare providers, physicians, and other suppliers to identify the correct primary payer by asking their patients or patients' representative questions concerning the beneficiary's Medicare secondary payer (MSP) status. The model hospital admissions questionnaire, published by the Centers for Medicare & Medicaid Services (CMS), may be used as a guide to collect this information from beneficiaries. This tool is available online in the *MSP Manual* in Chapter 3, Section 20.2.1 at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf>. Physicians and

other suppliers may also use this questionnaire to ensure MSP information is captured for use at the time of billing, so that the appropriate primary payer is billed before Medicare as required by law.

#### Identify and bill the correct primary payer

Medicare regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items before submitting a claim to Medicare. When another insurer is identified as the primary payer, bill that insurer first. After receiving the primary payer remittance advice, then bill Medicare as the secondary payer, if appropriate. If a patient is seen for multiple services, each service should be billed to the appropriate primary payer.

#### Accident related claims

If the beneficiary has an open MSP liability (L), no-fault (NF), or workers' compensation (WC) record, bill the L, NF, or WC insurer primary for accident-related claims first. **Do not deny treatment.**

#### To expedite processing and payment, the following steps should be followed:

1. Submit the accident related claim to the L, NF, or WC insurer first. If the insurer denies the claim, then bill Medicare for payment. It is important that you include all necessary MSP payment information, as found on the primary payer's remittance advice (e.g., claim adjustment reason code specifying reason for denial), on the claim sent to Medicare. **If the L, NF, or WC insurer did not make payment for the accident related services, Medicare will need this information to process your claim accordingly. If you follow these procedures, you do not need to wait 120 days to submit your claim to Medicare for payment.**
2. If the beneficiary has both a group health plan (GHP) MSP coverage and L, NF, or WC coverage, you are required to submit a claim to the GHP insurer and the L, NF, or WC insurer before submitting the claim to Medicare. Once you receive the GHP remittance advice, include the GHP information along with the remittance advice information from the L, NF, and WC insurer with your claim to Medicare. If the claim is sent to Medicare without the GHP information, and there is an open GHP MSP record on file, Medicare will deny your claim.
3. In situations where there is no L, NF, or WC accident or injury, but the beneficiary has employer GHP coverage that is primary to Medicare, you must submit the claim to the GHP insurer first before submitting the claim to Medicare for secondary payment.

*(continued on next page)*

**Secondary (continued)**

**If you believe a claim was inappropriately denied:**

- Ensure that you have submitted a correctly completed claim to the appropriate payer(s).
- Contact your Medicare contractor if you still have reason to believe a claim was denied inappropriately.
- You may need to provide information to your Medicare contractor that demonstrates why the claim was denied inappropriately. For example, a diagnosis code may have been mistakenly applied to the beneficiary's L, NF, or WC MSP record. Indicate to the Medicare contractor that the service performed is not related to the accident or injury, and Medicare should adjust and pay the claim if it is a Medicare covered and payable service.

**Contact the coordination of benefit contractor (COBC) at 1-800-999-1118 if a beneficiary's MSP record needs to be updated.**

- The COBC collects, manages, and maintains other insurance coverage for Medicare beneficiaries.
- Providers, physicians, or other suppliers may request an update to an MSP record if they have the appropriate documentation to substantiate the change. The documentation may need to be faxed to the COBC at 734-957-9598, or the beneficiary may need to be on the line to validate the change.
- Please do not call the COBC to adjust claims or about mistaken payments. They will not be able to assist you.

**Key points**

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer(s) for related services.
- For multiple services, bill each responsible payer(s) separately. Do not combine unrelated services on the same claim to Medicare. Consequently, if you render treatment to a beneficiary for accident related services and non-accident related services, do not submit both sets of services on the same claim to Medicare. Send separate claims to Medicare: one claim for services related to the accident and another claim for services not related to the accident.

- Providers, physicians, and other suppliers should always use specific diagnosis codes related to the accident or injury. Doing so will promote accurate and timely payments.
- Providers should report directly to the COBC any changes to beneficiary, spouse and/or family member's employment, accident, illness, or injury, federal program coverage changes, or any other insurance coverage information.

**Additional information**

Specific claim-based issues or questions (including claim processing) should be addressed to the Medicare claim processing contractor at their toll-free number found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

If you need to report new beneficiary coverage that may be primary to Medicare or have questions regarding MSP status or claims investigation activities, contact the COBC's toll-free lines. For more information on contacting the COBC or the Medicare Coordination of Benefits process, visit the Medicare Coordination of Benefits Web page at <http://www.cms.hhs.gov/Medicare/Coordination-of-Benefits/COBGeneralInformation/index.html>.

The Medicare Learning Network (MLN) has a *Medicare Secondary Payer Fact Sheet for Provider, Physician, and Other Supplier Billing Staff (ICN 006903)* at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MSP\\_Fact\\_Sheet.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MSP_Fact_Sheet.pdf).

This fact sheet is designed to provide education on the MSP provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the COBC.

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## Ambulatory Surgical Center

### April 2012 update of the ambulatory surgical center payment system

#### Provider types affected

This *MLN Matters*® article for change request (CR) 7754 is intended for physicians and ambulatory surgical centers (ASCs) who submit claims to Medicare contractors (carriers and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries and paid under the ASC payment system.

#### Provider action needed

This article is based on CR 7754, which describes changes to and billing instructions for various payment policies implemented in the April 2012 ASC payment system update. CR 7754 also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

#### April 2012 updates

Policy under the 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 quarterly.

The key ASC updates effective on April 1, 2012, are as follows:

#### New service (fluorescent vascular angiography)

The following new packaged service has been created where there have not previously been specific codes available that describe the service. It is assigned under the ASC payment system, with an effective date of April 1, 2012.



**Table 1 – Fluorescent vascular angiography**

HCPCS	Effective date	Short descriptor	Long descriptor	ASC payment indicator (PI)
C9733	4/01/2012	Non-ophthalmic FVA	Non-ophthalmic fluorescent vascular angiography	N1

HCPCS code C9733 describes SPY® fluorescence vascular angiography and other types of non-ophthalmic fluorescent vascular angiography.

ASCs are reminded that since Medicare contractors pay the lesser of 80 percent of actual charge or the ASC payment rate for the separately payable procedure, and because this comparison is made at the claim line-item level, facilities may not be paid appropriately if they unbundle charges and separately report packaged codes and related charges as a separate line-item.

#### Billing for drugs, biologicals, and radiopharmaceuticals

##### Drugs and biologicals with payments based on average sales price, effective April 1, 2012

Payment for separately payable drugs and biologicals based on the average sales prices (ASPs) are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, the Centers for Medicare & Medicaid Services (CMS) will incorporate changes to the payment rates in the April 2012 release of the ASC drug file. The updated payment rates, effective April 1, 2012, will be included in the April 2012 update of the ASC payment system Addendum BB, which will be posted at <http://www.cms.gov/ascpayment/ascrn/itemdetail.asp?itemid=CMS1216691>.

##### New HCPCS codes for drugs and biologicals separately payable under the ASC payment system effective April 1, 2012

Four drugs and biologicals have been granted ASC payment status effective April 1, 2012. These items, along

*(continued on next page)*



**ASC (continued)**

with their descriptors and APC assignments, are identified in the following table:

**Table 2 – New drugs and biologicals separately payable, effective April 1, 2012**

HCPCS code	Long descriptor	Short descriptor	ASC PI
C9288	Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vial	Inj, centruroides (scorpion)	K2
C9289	Injection, asparaginase erwinia chrysanthemi, 1,000 international units (I.U.)	Inj, erwinia chrysanthemi	K2
C9290	Injection, bupivacaine liposome, 1 mg	Inj, bupivacaine liposome	K2
C9291	Injection, aflibercept, 2 mg vial	Injection, aflibercept	K2

**Note: Additional information on HCPCS Code C9291 (Injection, aflibercept, 2 mg vial)**

Eylea (aflibercept) is packaged in a sterile, 3 mL single use vial containing a 0.278 mL fill of 40 mg/mL Eylea (NDC 61755-0005-02). As approved by the Food and Drug Administration (FDA), the recommended dose for Eylea is 2 mg every four weeks, followed by 2 mg every eight weeks. Payment for HCPCS code C9291 is for the entire contents of the single-use vial, which is labeled as providing a 2 mg dose of aflibercept. As indicated in 42 CFR 414.904, CMS calculates an ASP payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label, and any additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit. In addition, no payment is made for amounts of product in excess of that reflected on the FDA-approved label.

**Updated payment rates for certain HCPCS codes, effective July 1, 2011, through September 30, 2011**

The payment rates for several HCPCS codes were incorrect in the July 2011 ASC drug file. The corrected payment rates are listed in Table 3 and have been installed in the revised July 2011 ASC drug file, effective for services furnished on July 1, 2011, through September 30, 2011 and processed prior to the implementation of the April 2012 ASC quarterly update. Suppliers who have received an incorrect payment for dates of service July 1, 2011, through September 30, 2011, may request contractor adjustment of the previously processed claims.

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

HCPCS code	Short descriptor	Corrected payment rate	ASC PI
J0735	Clonidine hydrochloride	\$35.67	K2
J1212	Dimethyl sulfoxide 50% 50 ML	\$84.55	K2
J1756	Iron sucrose injection	\$0.34	K2
J9245	Inj melphalan hydrochl 50 MG	\$1,308.97	K2

**Updated payment rates for certain HCPCS codes, effective October 1, 2011, through December 31, 2011**

The payment rates for several HCPCS codes were incorrect in the October 2011 ASC drug file. The corrected payment rates are listed in Table 4 and have been installed in the revised October 2011 ASC drug file, effective for services furnished on October 1, 2011, through December 31, 2011, and processed prior to the implementation of the April 2012 ASC quarterly update. Suppliers who have received an incorrect payment for dates of service October 1, 2011, through December 31, 2011, may request contractor adjustment of the previously processed claims.

**Table 4 – Updated payment rates for certain HCPCS codes, effective October 1, 2011, through December 31, 2011**

HCPCS code	Short descriptor	Corrected payment rate	ASC PI
J0735	Clonidine hydrochloride	\$30.54	K2
J1212	Dimethyl sulfoxide 50% 50 ML	\$84.86	K2
J1742	Ibutilide fumarate injection	\$126.92	K2
J9245	Inj melphalan hydrochl 50 MG	\$1,280.08	K2

**Billing for skin substitutes**

ASCs should only report the HCPCS codes describing products that can be used as skin substitutes, as listed in Table 5, when these products are used with one of the *Current Procedural Terminology (CPT)* codes describing

(continued on next page)

**ASC (continued)**

the application of a skin substitute (15271-15278). Skin substitute products that are used with procedures outside the CPT code range of 15271-15278 are considered packaged and should not be separately reported.

**Table 5 – Skin substitute HCPCS codes that are separately billable, effective April 1, 2012, when performed with CPT codes 15271-15278**

HCPCS code	Short descriptor	ASC PI
C9358	SurgiMend, fetal	K2
C9360	SurgiMend, neonatal	K2
C9363	Integra Meshed Bil Wound Mat	K2
C9366	EpiFix wound cover	K2
C9367	Endoform Dermal Template	K2
Q4101	Apligraf	K2
Q4102	Oasis wound matrix	K2
Q4103	Oasis burn matrix	K2
Q4104	Integra BMWD	K2
Q4105	Integra DRT	K2
Q4106	Dermagraft	K2
Q4107	Graftjacket	K2
Q4108	Integra matrix	K2
Q4110	Primatrix	K2
Q4111	Gammagraft	K2
Q4112	Cymetra injectable	K2
Q4113	Graftjacket xpress	K2
Q4114	Integra flowable wound matri	K2
Q4115	Alloskin	K2
Q4116	Alloderm	K2
Q4118	Matristem micromatrix	K2
Q4119	Matristem wound matrix	K2
Q4121	Theraskin	K2
Q4122	Dermacell	K2
Q4124	Oasis Ultra Tri-Layer Matrix	K2

**ASC quality measures**

In the calendar year (CY) 2012 OP/ASC final rule (CMS-1525-FC), CMS established a quality reporting program for ASCs and adopted five quality measures, including four outcome measures and one surgical infection control measure beginning in CY 2012 for the CY 2014 payment determination. (See <http://www.cms.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1253621&intNumPerPage=10>). The ASC quality measures, HCPCS codes, and their descriptions are included in the following table:

**Table 6 – ASC quality measures, HCPCS codes, descriptors, and PIs for claims beginning April 1, 2012**

ASC quality measures	G-code	Long descriptor	Short descriptor	ASC PI
	G8907	Patient documented not to have experienced any of the following events: a burn prior to discharge, a fall within the facility, wrong site/side/patient/procedure/implant event, a hospital transfer or hospital admission upon discharge from the facility.	Pt doc no events on discharge	M5
Patient burn	G8908	Patient documented to have received a burn prior to discharge	Pt doc w burn prior to D/C	M5

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ASC (continued)

ASC quality measures	G-code	Long descriptor	Short descriptor	ASC PI
	G8909	Patient documented not to have received a burn prior to discharge	Pt doc no burn prior to D/C	M5
Patient fall in ASC facility	G8910	Patient documented to have experienced a fall within ASC	Pt doc to have fall in ASC	M5
	G8911	Patient documented not to have experienced a fall within ASC	Pt doc no fall in ASC	M5
Wrong site, wrong side, wrong patient, wrong procedure, wrong implant event	G8912	Patient documented to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event	Pt doc with wrong event	M5
	G8913	Patient documented not to have experienced a wrong site, wrong side, wrong patient, wrong procedure or wrong implant event	Pt doc no wrong event	M5
Hospital transfer/admission	G8914	Patient documented to have experienced a hospital transfer or hospital admission upon discharge from ASC	Pt trans to hosp post D/C	M5
	G8915	Patient documented not to have experienced a hospital transfer or hospital admission upon discharge from ASC	Pt not trans to hosp at D/C	M5
Timing of Prophylactic antibiotic administration for SSI prevention	G8916	Patient with preoperative order for IV antibiotic surgical site infection  (SSI ) prophylaxis, antibiotic initiated on time	Pt w IV AB given on time	M5
	G8917	Patient with preoperative order for IV antibiotic surgical site infection  (SSI ) prophylaxis, antibiotic not initiated on time	Pt w IV AB not given on time	M5
	G8918	Patient without preoperative order for IV antibiotic surgical site infection  ( SSI ) prophylaxis	Pt w/o preop order IV AB prop	M5

ASCs may begin to report these quality measures on submitted ASC facility claims beginning with dates of service of April 1, 2012.

Additional information on the ASC quality reporting program and the required reporting of ASC measure submission timeframes and other program requirements is available on pages 76FR74492-74517 in the CY 2012 OPPTS/ASC Final rule. CMS-1525-FC is available at <http://www.cms.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1253621&intNumPerPage=10>.

**Corrected ASC payment rates for April 2012**

CMS made corrections to the CY 2012 ASC payment rates and payment indicators issued in the CY 2012 OPPTS/ASC final rule with comment period (CMS-1525-FC), in a correction notice published in the *Federal Register* on January 4, 2012 (CMS-1525-CN). CMS will make additional corrections to CMS-1525-FC, in an upcoming correction notice. The April 2012 ASCFS file included in this transmittal is impacted by these corrections and  
*(continued on next page)*

**ASC (continued)**

reflect the corrected rates. These payment rates are retroactive to dates of service beginning with January 1, 2012. To view the revised ASC payment rates see the CMS April 2012 ASC Approved HCPCS Code and Payment Rates addenda, which have been updated to reflect these corrections and have been posted at [http://www.cms.gov/ASCPayment/11\\_Addenda\\_Updates.asp#TopOfPage](http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp#TopOfPage).

The ASCPI file is not impacted by these corrections but includes the April 2012 payment indicators.

Suppliers who think they may have received an incorrect payment between January 1, 2012, and March 31, 2012, may request contractor adjustment of the previously processed claims.

**Coverage determinations**

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Carriers/MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, carriers/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

**Additional information**

The official instruction, CR 7754, issued to your carriers and MACs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2425CP.pdf>.

If you have any questions, please contact your carrier or MAC at their toll-free number, which may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7754

Related Change Request (CR) #: CR 7754

Related CR Release Date: March 16, 2012

Effective Date: April 1, 2012

Related CR Transmittal #: R2425CP

Implementation Date: April 2, 2012

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## Drugs and Biologicals

### July 2012 quarterly average sales price Medicare Part B drug pricing files and revisions to prior quarterly pricing files

**Provider types affected**

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

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

Medicare will use the July 2012 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 2, 2012, with dates of service July 1, 2012, through September 30, 2012.

**Caution – what you need to know**

Change request (CR) 7810, from which this article is taken, instructs your Medicare contractors to download and implement the July 2012 ASP Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised April 2012, January 2012, October 2011, and July 2011 files.

*(continued on next page)*



**ASP (continued)**

**Go – what you need to do**

You should make sure that your billing staffs are aware of the release of these July 2012 ASP Medicare Part B drug files.

**Background**

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf>.)



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

Files	Effective for dates of service
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011

**Additional information**

You can find the official instruction, CR 7810, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2440CP.pdf>. 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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

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Related CR Release Date: April 6, 2012

Effective Date: July 1, 2012

Related CR Transmittal #: R2440CP

Implementation Date: July 2, 2012

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**Be proactive: Use the PDS report**

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- Benefit from peer comparisons
- Prevent recurring billing issues
- Improve your bottom line

Accessible through FCSO's PDS portal at <http://medicare.fcso.com/reporting/index.asp>

## Pharmacy billing for drugs provided “incident to” a physician service

**Note:** This article was revised on April 10, 2012, to reflect the revised change request (CR) 7397 issued on April 4. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7397 were revised. All other information remains the same. This information was previously published in the December 2011 *Medicare B Connection*, Pages 6-7.

### Provider types affected

Pharmacies that submit claims for drugs to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), A/B Medicare administrative contractors (A/B MACs), and durable medical equipment MACs) are affected.

### What you should know

This article is based on CR 7397, which clarifies policy with respect to restrictions on pharmacy billing for drugs provided “incident to” a physician service. The CR also clarifies policy for the local determination of payment limits for drugs that are not nationally determined. This article notes that CR 7397 rescinds and fully replaces CR 7109. Please be sure your staffs are aware of this update.

### Background

#### Pharmacies billing drugs

Pharmacies may bill Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through any piece of durable medical equipment.

- Claims for these drugs are generally submitted to the durable medical equipment Medicare administrative contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.
- In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician’s service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

The DME MAC, A/B MAC, or carrier will make payment to the pharmacy for these drugs, when deemed to be covered and reasonable and necessary. All bills submitted to the DME MAC, A/B MAC, or carrier must be submitted on an assigned basis by the pharmacy.

When drugs may not be billed by pharmacies to Medicare Part B

Pharmacies, suppliers and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration “incident to” a physician service, such as refilling an implanted drug pump. These claims will be denied.

Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary. When these drugs are administered in the physician’s office to a beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. In this case, the drugs are being administered “incident to” a physician’s service and pharmacies may not bill Medicare Part B under the “incident to” provision.

### Payment limits

The payment limits for drugs and biologicals that are not included in the average sales price (ASP) Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under the outpatient prospective payment system (OPPS) where the payment allowance limit is 95 percent of the published average wholesale price (AWP). In determining the payment limit based on WAC, the payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention.

### Additional information

The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2437CP.pdf>.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

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**Pharmacy (continued)**

The following manual sections regarding billing drugs and biological and “incident to” services may be helpful:

- *Medicare Claims Processing Manual*, Chapter 17, Sections 20.1.3 and 50.B, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>, and
- *Medicare Benefit Policy Manual*, Chapter 15, Sections 50.3 and 60.1, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>.

MLN Matters® Number: MM7397 *Revised*

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Effective Date: January 1, 2013

Related CR Transmittal #: R2437CP

Implementation Date: January 1, 2013

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## Durable Medical Equipment

### 2012 jurisdiction list for DMEPOS HCPCS codes

#### Provider types affected

This *MLN Matters*® article is intended for suppliers submitting claims to Medicare contractors (durable medical equipment Medicare administrative contractors [DME MACs], Part B carriers, and A/B MACs) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) services provided to Medicare beneficiaries are affected.

#### Provider action needed

This article is informational and based on change request (CR) 7679 that notifies suppliers that the spreadsheet containing an updated list of HCPCS codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staffs by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2012 jurisdiction list is an Excel® spreadsheet and is available under the Coding Category at <https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html>.

Note that as part of the 2012 update, HCPCS codes L8511, L8512, L8513, L8514, and L8515 are changing claim processing jurisdiction from DME MAC to joint local carrier and DME MAC jurisdiction. To facilitate the jurisdiction change, carriers and A/B MACs will manually price claims for codes L8511 through L8515 with dates of service on or after January 1, 2012, using the 2012 DMEPOS fee schedule amounts found in Attachment B of CR 7679.

#### Additional Information

The official instruction, CR 7679, issued to your Medicare A/B MAC, carrier, and DME/MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2427CP.pdf>. The 2012 jurisdiction list and Attachment B showing the 2012 DMEPOS fee schedule amounts for HCPCS codes L8511, L8512, L8513, L8514, and L8515 are attached to CR 7679.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

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Implementation Date: April 23, 2012

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## 2012 DMEPOS jurisdiction listing

This article is informational and is based on change request (CR) 7679 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for durable medical equipment Medicare administrative contractor (DME MAC) and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2012 jurisdiction list is attached to CR 7679 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2427CP.pdf>. **Note that deleted codes are valid for dates of service on or before the date of deletion and updated codes are in bold.**

HCPCS	Description	Jurisdiction
A0021- A0999	Ambulance services	Local carrier
A4206- A4209	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4210	Needle free injection device	DME MAC
A4211	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4212	Non coring needle or stylet with or without catheter	Local carrier
A4213- A4215	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4216- A4218	Saline	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4220	Refill kit for implantable pump	Local carrier
A4221- A4250	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4252- A4259	Diabetic supplies	DME MAC
A4261	Cervical cap for contraceptive use	Local carrier
A4262- A4263	Lacrimal duct implants	Local carrier
A4264	Contraceptive implant	Local carrier
A4265	Paraffin	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4266- A4269	Contraceptives	Local carrier
A4270	Endoscope sheath	Local carrier
A4280	Accessory for breast prosthesis	DME MAC
A4281- A4286	Accessory for breast pump	DME MAC
A4290	Sacral nerve stimulation test lead	Local carrier
A4300- A4301	Implantable catheter	Local carrier
A4305- A4306	Disposable drug delivery system	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4310- A4358	Incontinence supplies/urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.

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**Jurisdiction** *(continued)*

HCPCS	Description	Jurisdiction
A4360- A4434	Urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A4450- A4456	Tape; adhesive remover	Local carrier if incident to a physician's service (not separately payable) <b>or if supply for implanted prosthetic device.</b> If other DME MAC.
A4458	Enema bag	DME MAC
A4461- A4463	Surgical dressing holders	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4465- A4466	Non-elastic binder and elastic garment	DME MAC
A4470	Gravlee jet washer	Local carrier
A4480	Vabra aspirator	Local carrier
A4481	Tracheostomy supply	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4483	Moisture exchanger	DME MAC
A4490- A4510	Surgical stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical trays	Local carrier
A4554	Disposable underpads	DME MAC
A4556- A4558	Electrodes; lead wires; conductive paste	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4559	Coupling gel	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4561- A4562	Pessary	Local carrier
A4565	Sling	Local carrier
A4566	Shoulder abduction restrainer	DME MAC
A4570	Splint	Local carrier
A4575	Topical hyperbaric oxygen chamber, disposable	DME MAC
A4580- A4590	Casting supplies and material	Local carrier
A4595	TENS supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4600	Sleeve for intermittent limb compression device	DME MAC
A4601	Lithium Ion battery for non-prosthetic use	DME MAC
A4604	Tubing for positive airway pressure device	DME MAC
A4605	Tracheal suction catheter	DME MAC
A4606	Oxygen probe for oximeter	DME MAC
A4608	Transtracheal oxygen catheter	DME MAC
A4611- A4613	Oxygen equipment batteries and supplies	DME MAC
A4614	Peak flow rate meter	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.

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## Jurisdiction (continued)

HCPCS	Description	Jurisdiction
A4615- A4629	Oxygen and tracheostomy supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4630- A4640	DME supplies	DME MAC
A4641- A4642	Imaging agent; contrast material	Local carrier
A4648	Tissue marker, implanted	Local carrier
A4649	Miscellaneous surgical supplies	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A4650	Implantable radiation dosimeter	Local carrier
A4651- A4932	Supplies for ESRD	DME MAC ( <b>not separately payable</b> )
A5051- A5093	Additional ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A5102- A5200	Additional incontinence and ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A5500- A5513	Therapeutic shoes	DME MAC
A6000	Non-contact wound warming cover	DME MAC
A6010- A6024	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6025	Silicone gel sheet	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6154- A6411	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6412	Eye patch	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6413	Adhesive bandage	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6441- A6512	Surgical dressings	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6513	Compression burn mask	DME MAC

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**Jurisdiction** (continued)

HCPCS	Description	Jurisdiction
A6530- A6549	Compression gradient stockings	DME MAC
A6550	Supplies for negative pressure wound therapy electrical pump	DME MAC
A7000- A7002	Accessories for suction pumps	DME MAC
A7003- A7039	Accessories for nebulizers, aspirators and ventilators	DME MAC
A7040- A7041	Chest drainage supplies	Local carrier
A7042- A7043	Pleural catheter	Local carrier
A7044- A7046	Respiratory accessories	DME MAC
A7501- A7527	Tracheostomy supplies	DME MAC
A8000- A8004	Protective helmets	DME MAC
A9150	Non-prescription drugs	Local carrier
A9152- A9153	Vitamins	Local carrier
A9155	Artificial saliva	Local carrier
A9180	Lice infestation treatment	Local carrier
A9270	Noncovered items or services	DME MAC
<b>A9272</b>	<b>Disposable wound suction pump</b>	<b>DME MAC</b>
A9273	<b>Hot water bottles, ice caps or collars, and heat and/or cold wraps</b>	DME MAC
A9274- A9278	Glucose monitoring	DME MAC
A9279	Monitoring feature/device	DME MAC
A9280	Alarm device	DME MAC
A9281	Reaching/grabbing device	DME MAC
A9282	Wig	DME MAC
A9283	Foot off loading device	DME MAC
A9284	Non-electric spirometer	DME MAC
A9300	Exercise equipment	DME MAC
A9500- A9700	Supplies for radiology procedures	Local carrier
A9900	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
B4034- B9999	Enteral and parenteral therapy	DME MAC
D0120- D9999	Dental procedures	Local carrier
E0100- E0105	Canes	DME MAC
E0110- E0118	Crutches	DME MAC

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## Jurisdiction (continued)

HCPCS	Description	Jurisdiction
E0130- E0159	Walkers	DME MAC
E0160- E0175	Commodes	DME MAC
E0181- E0199	Decubitus care equipment	DME MAC
E0200- E0239	Heat/cold applications	DME MAC
E0240- E0248	Bath and toilet aids	DME MAC
E0249	Pad for heating unit	DME MAC
E0250- E0304	Hospital beds	DME MAC
E0305- E0326	Hospital bed accessories	DME MAC
E0328- E0329	Pediatric hospital beds	DME MAC
E0350- E0352	Electronic bowel irrigation system	DME MAC
E0370	Heel pad	DME MAC
E0371- E0373	Decubitus care equipment	DME MAC
E0424- E0484	Oxygen and related respiratory equipment	DME MAC
E0485- E0486	Oral device to reduce airway collapsibility	DME MAC
E0487	Electric spirometer	DME MAC
E0500	IPPB machine	DME MAC
E0550- E0585	Compressors/nebulizers	DME MAC
E0600	Suction pump	DME MAC
E0601	CPAP device	DME MAC
E0602- E0604	Breast pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage board	DME MAC
E0607	Home blood glucose monitor	DME MAC
E0610- E0615	Pacemaker monitor	DME MAC
E0616	Implantable cardiac event recorder	Local carrier
E0617	External defibrillator	DME MAC
E0618- E0619	Apnea monitor	DME MAC
E0620	Skin piercing device	DME MAC
E0621- E0636	Patient lifts	DME MAC
E0637- E0642	Standing devices/lifts	DME MAC
E0650- E0676	Pneumatic compressor and appliances	DME MAC
E0691- E0694	Ultraviolet light therapy systems	DME MAC

(continued on next page)



**Jurisdiction** *(continued)*

HCPCS	Description	Jurisdiction
E0700	Safety equipment	DME MAC
E0705	Transfer board	DME MAC
E0710	Restraints	DME MAC
E0720- E0745	Electrical nerve stimulators	DME MAC
E0746	EMG device	Local carrier
E0747- E0748	Osteogenic stimulators	DME MAC
E0749	Implantable osteogenic stimulators	Local carrier
E0755	Reflex stimulator	DME MAC
E0760	Ultrasonic osteogenic stimulator	DME MAC
E0761	Electromagnetic treatment device	DME MAC
E0762	Electrical joint stimulation device	DME MAC
E0764	Functional neuromuscular stimulator	DME MAC
E0765	Nerve stimulator	DME MAC
E0769	Electrical wound treatment device	DME MAC
E0770	Functional electrical stimulator	DME MAC
E0776	IV pole	DME MAC
E0779- E0780	External infusion pumps	DME MAC
E0781	Ambulatory infusion pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782- E0783	Infusion pumps, implantable	Local carrier
E0784	Infusion pumps, insulin	DME MAC
E0785- E0786	Implantable infusion pump catheter	Local carrier
E0791	Parenteral infusion pump	DME MAC
E0830	Ambulatory traction device	DME MAC
E0840- E0900	Traction equipment	DME MAC
E0910- E0930	Trapeze/fracture frame	DME MAC
E0935- E0936	Passive motion exercise device	DME MAC
E0940	Trapeze equipment	DME MAC
E0941	Traction equipment	DME MAC
E0942- E0945	Orthopedic devices	DME MAC
E0946- E0948	Fracture frame	DME MAC
E0950- E1298	Wheelchairs	DME MAC
E1300- E1310	Whirlpool equipment	DME MAC
E1353- E1392	Additional oxygen related equipment	DME MAC

*(continued on next page)*

## Jurisdiction (continued)

HCPCS	Description	Jurisdiction
E1399	Miscellaneous DME	Local carrier if implanted DME. If other, DME MAC.
E1405- E1406	Additional oxygen equipment	DME MAC
E1500- E1699	Artificial kidney machines and accessories	DME MAC ( <b>not separately payable</b> )
E1700- E1702	TMJ device and supplies	DME MAC
E1800- E1841	Dynamic flexion devices	DME MAC
E1902	Communication board	DME MAC
E2000	Gastric suction pump	DME MAC
E2100- E2101	Blood glucose monitors with special features	DME MAC
E2120	Pulse generator for tympanic treatment of inner ear	DME MAC
E2201- E2397	Wheelchair accessories	DME MAC
E2402	Negative pressure wound therapy pump	DME MAC
E2500- E2599	Speech generating device	DME MAC
E2601- <b>E2633</b>	Wheelchair cushions <b>and accessories</b>	DME MAC
E8000- E8002	Gait trainers	DME MAC
G0008- G0329	Misc. professional services	Local carrier
G0333	Dispensing fee	DME MAC
G0337- G0365	Misc. professional services	Local carrier
G0372	Misc. professional services	Local carrier
G0378- <b>G9156</b>	Misc. professional services	Local carrier
J0120- J3570	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified biologicals	Local carrier
J7030- J7131	Miscellaneous drugs and solutions	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7180 - J7195	Antihemophilic factor	Local carrier
J7196- J7197	Antithrombin III	Local carrier
J7198	Anti-inhibitor; per I.U.	Local carrier
J7199	Other hemophilia clotting factors	Local carrier
J7300- J7307	Intrauterine copper contraceptive	Local carrier
J7308- J7309	Aminolevulinic acid HCL	Local carrier
J7310	Ganciclovir, long-acting implant	Local carrier

(continued on next page)

**Jurisdiction** *(continued)*

HCPCS	Description	Jurisdiction
J7311- J7312	Fluocinolone acetonide, intravitreal implant	Local carrier
J7321- J7326	Hyaluronan	Local carrier
J7330	Autologous cultured chondrocytes, implant	Local carrier
J7335	Capsaicin	Local carrier
J7500- J7599	Immunosuppressive drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7604- J7699	Inhalation Solutions Implant	Local carrier if incident to a physician's. If other, DME MAC.
J7799	NOC, other than inhalation drugs through DME	Local carrier if incident to a physician's service. If other, DME MAC.
J8498	Anti-emetic drug	DME MAC
J8499	Prescription drug, oral, non-chemotherapeutic	Local carrier if incident to a physician's service. If other, DME MAC.
J8501- J8999	Oral anti-cancer drugs	DME MAC
J9000- J9999	Chemotherapy drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001- K0108	Wheelchairs	DME MAC
K0195	Elevating leg rests	DME MAC
K0455	Infusion pump used for uninterrupted administration of epoprostenal	DME MAC
K0462	Loaner equipment	DME MAC
K0552	External infusion pump supplies	DME MAC
K0601- K0605	External infusion pump batteries	DME MAC
K0606- K0609	Defibrillator accessories	DME MAC
K0669	Wheelchair cushion	DME MAC
K0672	Soft interface for orthosis	DME MAC
K0730	Inhalation drug delivery system	DME MAC
K0733	Power wheelchair accessory	DME MAC
K0738	Oxygen equipment	DME MAC
K0739	Repair or nonroutine service for DME	Local carrier if implanted DME. If other, DME MAC
K0740	Repair or Nonroutine service for oxygen equipment	DME MAC
<b>K0743- K0746</b>	<b>Suction pump and dressings</b>	<b>DME MAC</b>
K0800- K0899	Power mobility devices	DME MAC
L0112- <b>L4631</b>	Orthotics	DME MAC
L5000- L5999	Lower limb prosthetics	DME MAC
L6000- L7499	Upper limb prosthetics	DME MAC

*(continued on next page)*

## Jurisdiction (continued)

HCPCS	Description	Jurisdiction
L7510- L7520	Repair of prosthetic device	Local carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic donning sleeve	DME MAC
L7900	Vacuum erection system	DME MAC
L8000- L8485	Prosthetics	DME MAC
L8499	Unlisted procedure for miscellaneous prosthetic services	Local carrier if implanted prosthetic device. If other, DME MAC.
L8500- L8501	Artificial larynx; tracheostomy speaking valve	DME MAC
L8505	Artificial larynx accessory	DME MAC
L8507	Voice prosthesis, patient inserted	DME MAC
L8509	Voice prosthesis, inserted by a licensed health care provider	Local carrier for dates of service on or after 10/01/2010, DME MAC for dates of service prior to 10/01/2010
L8510	Voice prosthesis	DME MAC
<b>L8511- L8515</b>	<b>Voice prosthesis</b>	<b>Local carrier if used with tracheoesophageal voice prostheses inserted by a licensed health care provider. If other, DME MAC.</b>
L8600- L8699	Prosthetic implants	Local carrier
L9900	Miscellaneous Orthotic or prosthetic component or accessory	Local carrier if used with implanted prosthetic device. If other, DME MAC.
M0064- M0301	Medical services	Local carrier
P2028- P9615	Laboratory tests	Local carrier
Q0035	Influenza vaccine; cardiokymography	Local carrier
Q0081	Infusion therapy	Local carrier
Q0083- Q0085	Chemotherapy administration	Local carrier
Q0091	Smear preparation	Local carrier
Q0092	Portable X-ray setup	Local carrier
Q0111- Q0115	Miscellaneous lab services	Local carrier
Q0138- Q0139	Ferumoxytol injection	Local carrier
Q0144	Azithromycin dihydrate	Local carrier if incident to a physician's service. If other, DME MAC.
Q0162- Q0181	Anti-emetic	DME MAC
Q0478- Q0506	Ventricular assist devices	Local carrier
Q0510- Q0514	Drug dispensing fees	DME MAC
Q0515	Sermorelin acetate	Local carrier
Q1003- Q1005	New technology IOL	Local carrier
Q2004	Irrigation solution	Local carrier
Q2009	Fosphenytoin	Local carrier
Q2017	Teniposide	Local carrier

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**Jurisdiction** *(continued)*

HCPCS	Description	Jurisdiction
Q2026- Q2027	Injectable dermal fillers (Effective July 1, 2010)	Local carrier
Q2035- Q2039	Influenza vaccine	Local carrier
<b>Q2043</b>	<b>Sipuleucel-T</b>	<b>Local carrier</b>
<b>Q3001</b>	<b>Radioelements for brachytherapy, any type, each</b>	<b>Local carrier</b>
Q3014	Telehealth originating site facility fee	Local carrier
Q3025- Q3026	Vaccines	Local carrier
Q3031	Collagen skin test	Local carrier
Q4001- Q4051	Splints and casts	Local carrier
Q4074	Inhalation drug	Local carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	DME MAC for method II home dialysis. If other, local carrier.
Q4082	Drug subject to Competitive Acquisition Program	Local carrier
Q4100- Q4130	Skin substitutes	Local carrier
Q5001- Q5010	Hospice services	Local carrier
Q9951- Q9954	Imaging agents	Local carrier
Q9955- Q9957	Microspheres	Local carrier
Q9958- Q9968	Imaging agents	Local carrier
R0070- R0076	Diagnostic radiology services	Local carrier
V2020- V2025	Frames	DME MAC
V2100- V2513	Lenses	DME MAC
V2520- V2523	Hydrophilic contact lenses	Local carrier if incident to a physician's service. If other, DME MAC.
V2530- V2531	Contact lenses, scleral	DME MAC
V2599	Contact lens, other type	Local carrier if incident to a physician's service. If other, DME MAC.
V2600- V2615	Low vision aids	DME MAC
V2623- V2629	Prosthetic eyes	DME MAC
V2630- V2632	Intraocular lenses	Local carrier
V2700- V2780	Miscellaneous vision service	DME MAC
V2781	Progressive lens	DME MAC
V2782- V2784	Lenses	DME MAC

*(continued on next page)*

**Jurisdiction** (continued)

HCPCS	Description	Jurisdiction
V2785	Processing--corneal tissue	Local carrier
V2786	Lens	DME MAC
V2787- V2788	Intraocular lenses	Local carrier
V2790	Amniotic membrane	Local carrier
V2797	Vision supply	DME MAC
V2799	Miscellaneous vision service	DME MAC
V5008- V5299	Hearing services	Local carrier
V5336	Repair/modification of augmentative communicative system or device	DME MAC
V5362- V5364	Speech screening	Local carrier

**Source:** Publication 100-04, transmittal 2427, change request 7679

## DMEPOS competitive bidding round 1 recompetete announced

The Centers for Medicare & Medicaid Services (CMS) has announced plans to recompetete the supplier contracts awarded in the round 1 rebid of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. The Centers for Medicare & Medicaid Services (CMS) is required by law to recompetete contracts under the DMEPOS competitive bidding program at least once every three years. The round 1 rebid contract period for all product categories, except mail order diabetic supplies, will expire December 31, 2013. The round 1 recompetete product categories are:

- Respiratory equipment and related supplies and accessories
  - Includes oxygen, oxygen equipment, and supplies; continuous positive airway pressure (CPAP) devices, respiratory assist devices (RADs), and related supplies and accessories; and standard nebulizers
- Standard mobility equipment, and related accessories
  - Includes walkers, standard power and manual wheelchairs, scooters, and related accessories
- General home equipment and related supplies and accessories
  - Includes hospital beds and related accessories, group 1 and 2 support surfaces, transcutaneous electrical nerve stimulation (TENS) devices, commode chairs, patient lifts, and seat lifts
- Enteral nutrients, equipment, and supplies
- Negative pressure wound therapy pumps and related supplies and accessories
- External infusion pumps and supplies



CMS is conducting the round 1 recompetete in the same competitive bidding areas (CBAs) as the round 1 rebid.

A list of the specific items in each product category is available on the [competitive bidding implementation contractor \(CBIC\) website](#). The specific ZIP codes in each round 1 recompetete CBA are also available on the CBIC website.

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

- Spring 2012
  - CMS begins pre-bidding supplier awareness program

(continued on next page)

**DMEPOS** (*continued*)

- Summer 2012
  - CMS announces bidding schedule
  - CMS begins bidder education program
  - Bidder registration period to obtain user ID and password begins
- Fall 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 may 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 information:
  - 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
- The correspondence address.

DMEPOS suppliers can update their enrollment file 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 [Internet-based PECOS](#) page on the CMS website or reviewing the [PECOS fact sheet](#). 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](#).

- **Get licensed:** Contracts are only awarded to suppliers that have all required state licenses at the time of bidding. Therefore, if you are bidding for a product category in a CBA, you must ensure that all required state licenses for that product category are either on file with the NSC or received by the NSC by close of bidding. 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. Make sure that current versions of all required licenses are with the NSC before you bid. If any required licenses are expired or missing from your enrollment file, your bid(s) may be rejected.
- **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 who are not accredited by a CMS-approved accreditation organization.

More information about the DMEPOS accreditation requirements, including a list of the accreditation organizations and those who are exempt from accreditation, may be found on the [DMEPOS Accreditation](#) page on the CMS website.

Visit the [DMEPOS competitive bidding page](#) on the CMS website for more information about the DMEPOS competitive bidding program. You may also view current [CMS fact sheets](#).

**Source:** CMS PERL 201204-28

**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/>.

## New report: Competitive bidding saving money for taxpayers and people with Medicare

### Health care law expands second round, program will save up to \$42.8 billion

People with Medicare are already saving money on durable medical equipment (DME) through the Medicare competitive bidding program, according to a report issued April 18 by Department of Health and Human Services (HHS) Secretary Kathleen Sebelius.

According to the report, the program saved \$202 million in its first year in nine metropolitan statistical areas – a reduction of 42 percent in costs, and as the program expands under the Affordable Care Act and earlier law, it could save up to \$42.8 billion for taxpayers and beneficiaries over the next 10 years.

The report also released results that show, after extensive monitoring by the Centers for Medicare & Medicaid Services (CMS), there have been no negative effects on the health of people on Medicare or their access to needed supplies and services.

#### Key information in the report:

- Seniors and people with disabilities in Medicare will directly save a projected \$17.1 billion due to lower coinsurance for durable medical equipment and lower premiums for Medicare over the next decade, while taxpayers are projected to save an additional \$25.7 billion through the Medicare supplementary medical insurance trust fund because of reduced prices.
- In the first year of implementation in nine metropolitan statistical areas, through a combination of lower prices and fewer unnecessary services, the competitive bidding program saved Medicare \$202 million.
- Medicare beneficiaries in the nine areas had substantial reductions in their coinsurance for DME.
- Last year alone, people with Medicare saved up to \$105 on hospital beds, \$168 on oxygen concentrators, and \$140 on diabetic test strips.
- A real-time claims monitoring system set up to ensure that access to supplies was not compromised has found that people on Medicare continue to have access to all necessary and appropriate items.
- The Affordable Care Act expands round 2 of the DME competitive bidding program from 70 to 91 metropolitan statistical areas across the country. CMS is evaluating bids from suppliers for the 91 areas. By 2016, all areas of the country will benefit from either the competitive bidding program or lower rates based on the competitively bid rates.

[View the full report.](#)

[Full text of this excerpted CMS press release \(issued April 18\).](#)

Source: CMS PERL 201204-38

## Laboratory/Pathology

### Clinical laboratory fee schedule – new waived tests

#### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for clinical diagnostic laboratories submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors [MACs]) for services to Medicare beneficiaries.

#### Provider action needed

This article is based on change request (CR) 7766 which informs Medicare contractors and providers about changes to the clinical lab fee schedule list of waived tests under the Clinical Laboratory Improvement Amendments (CLIA). Make sure your billing staff is aware of this change.

#### Background

The Centers for Medicare & Medicaid Services (CMS) has become aware of an additional test that is appropriate for inclusion on the clinical lab fee schedule (CLFS) list of CLIA waived tests. They are updating the list at this time rather than waiting for the next annual update.

Effective for dates of service on or after January 1, 2012, the test being added to the CLFS is 86386QW (*Nuclear*  
(continued on next page)



**New (continued)**

*Matrix Protein 22 (NMP22), qualitative*. This is the latest test approved by the Food and Drug Administration (FDA) as a waived test under CLIA. The *Current Procedural Terminology (CPT)* code for this test must have the modifier QW to be recognized as a waived test.

**Additional information**

The official instruction, CR 7766 issued to your carrier or A/B MAC, regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2443CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7766  
 Related Change Request (CR) #: CR 7766  
 Related CR Release Date: April 6, 2012  
 Effective Date: January 1, 2012  
 Related CR Transmittal #: R2443CP  
 Implementation Date: July 2, 2012

*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.*

**New waived tests**

**Provider types affected**

This *MLN Matters®* article is intended for clinical diagnostic laboratories submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors [MACs]) for services to Medicare beneficiaries.

**Provider action needed**

**Stop – impact to you**

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

**Caution – what you need to know**

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *CPT* codes that the Centers for Medicare & Medicaid Services (CMS) considers to be laboratory tests under CLIA (and thus requiring certification) change each year. Change request (CR) 7795, from which this article is taken, informs carriers and MACs about the latest new *CPT* codes that are subject to CLIA edits.

**Go – what you need to do**

Make sure that your billing staffs are aware of these CLIA-related changes for 2012 and that you remain current with certification requirements.

**Background**

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The *CPT* codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attached list (i.e., *CPT* codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.000

CPT code	Effective date	Description
G0434QW	April 22, 2011	Diagnostic Test Group Clarity Multiple Drug Screen Cups
87804QW	December 9, 2011	<i>BD Veritor System for Rapid Detection of Flu A+B (For use with nasal and nasopharyngeal swabs) {Includes a Reader}</i>
G0434QW	December 14, 2011	Alere Toxicology Services Alere iCassette DX Drug Screen
82055QW	January 6, 2012	<i>Jant Pharmacal Corporation Accustrip Saliva Alcohol Test Strip</i>

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**Waived (continued)**

CPT code	Effective date	Description
82055QW	January 6, 2012	<i>Alfa Scientific Designs Inc. Oral-View Saliva Alcohol Test Strip</i>
83861QW	January 23, 2012	<i>TearLab Corporation TearLab Osmolarity System</i>
G0434QW	January 26, 2012	Alere iCassette Drug Screen
87804QW	January 27, 2012	Alere Influenza A & B Test (For use with nasal Swabs only.)
87808QW	February 3, 2012	Sekisui Diagnostics, LLC OSOM Trichomonas Rapid Test
87880QW	February 3, 2012	Sekisui Diagnostics LLC, OSOM Ultra Strep A Test
87880QW	March 1, 2012	Sekisui Diagnostics LLC, OSOM Strep A Test{direct from throat swab}

The new waived CPT code, 83861QW, has been assigned for the osmolarity test performed using the TearLab Corporation TearLab Osmolarity System.

**Additional information**

The official instruction, CR 7795 issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2439CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7795

Related Change Request (CR) #: CR 7795

Related CR Release Date: April 6, 2012

Effective Date: July 1, 2012

Related CR Transmittal #: R2439CP

Implementation Date: July 2, 2012

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## HCPCS codes subject to and excluded from CLIA edits

**Provider types affected**

This *MLN Matters*® article is intended for clinical laboratories and providers that submit claims to Medicare carriers and Part A/B Medicare administrative contractors (A/B MACs) for laboratory test services provided to Medicare beneficiaries.

**What you need to know**

This article is based on change request (CR) 7778 which informs Medicare carriers and A/B MACs about the new Healthcare Common Procedure Coding System (HCPCS) codes for 2012 that are subject to Clinical Laboratory Improvement Amendments (CLIA) edits and excluded from CLIA edits. Please be sure your staffs are aware of these changes.

**Background**

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests in a facility with a valid, current CLIA certificate, laboratory claims are currently edited at the CLIA certificate level.

The HCPCS codes that are considered a laboratory test under CLIA change each year. You need to know about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

**Discontinued codes**

The following HCPCS codes were discontinued on December 31, 2011:

*88107 – Cytopathology fluids, washings or brushings, except cervical or vaginal; smears and simples filter preparation with interpretation*

*88318 – Determinative histochemistry to identify chemical components (e.g., copper, zinc)*

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**CLIA (continued)**

**New codes**

There were 101 new HCPCS codes for molecular pathology (i.e., 81200 through 81408) in 2012. The testing described by these codes is subject to the CLIA regulations; however, they are not payable by Medicare. Hence, these 101 codes were not included in this CR.

The HCPCS codes listed in the chart that follows are new for 2012 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. The HCPCS codes listed below require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) are not permitted to be paid for these tests.

HCPCS	Description
0279T	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood)
0280T	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); interpretation and report
86386	<i>Nuclear Matrix Protein 22 (NMP22), qualitative</i>
87389	<i>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple-step method; HIV-1 antigens(s), with HIV-1 and HIV-2 antibodies, single result.</i>

Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims processed prior to implementation of these changes. However, they will adjust such claims that you bring to their attention.

**Additional information**

The official instruction, CR 7778, issued to your Medicare Carrier or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2441CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7778

Related Change Request (CR) #: CR 7778

Related CR Release Date: April 6, 2012

Effective Date: January 1, 2012

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Implementation Date: July 2, 2012

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**Learn the secrets to billing Medicare correctly**

Who has the power to improve your billing accuracy and efficiency? You do – visit the “Improve your billing” section at <http://medicare.fcso.com/Landing/200831.asp>, where you’ll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You’ll find FCSSO’s most popular self-help resources, including the E/M interactive worksheet, Provider Data Summary (PDS) report, and the Comparative billing report (CBR).

## Mental Health

### Screening and behavioral counseling interventions in primary care to reduce alcohol misuse

**Note:** This article was revised on March 27, 2012, to reflect the revised change request (CR) 7633 issued on March 23, 2012. As a result, in this article, the CR release date, transmittal number, and the Web address for accessing CR 7633 have been revised. Also, the article reflects the addition of claim adjustment reason code (CARC) 50 on the remittance replies on claims line items submitted with the GZ modifier. All other information is the same. This information was previously published in the December 2011 *Medicare B Connection*, Pages 22-25.

#### Provider types affected

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

#### Provider action needed

This article is based on CR 7633, which announces that effective with dates of service on and after October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual alcohol screening, and for those that screen positive, up to 4, brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries, including pregnant women. Make sure your billing staff is aware of these changes.

#### Background

Pursuant to Section 1861 (ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process if all of the following criteria are met. They must be: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare Program. CMS reviewed the USPSTF's "B" recommendation and supporting evidence for "Screening and Behavioral Counseling Intervention in Primary Care to Reduce Alcohol Misuse" preventive services and determined that all three criteria were met. According to the USPSTF (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems; and in the general adult population, risky or hazardous drinking is defined as >3 drinks per week or >3 drinks per occasion for women, and >14 drinks per week or >4 drinks per occasion for men. Harmful drinking describes those persons currently experiencing physical, social or psychological harm from alcohol use, but who do not meet criteria for dependence. Effective for claims with dates of service October 14, 2011, and later, CMS shall cover annual alcohol screening, and for those that screen positive, up to four, brief, face-to-face behavioral counseling

interventions per year for Medicare beneficiaries, including pregnant women:

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and,
- Who are competent and alert at the time that counseling is provided; and,
- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Each of the four behavioral counseling interventions must be consistent with the 5As approach that has been adopted by the USPSTF to describe such services:

1. **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
2. **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

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**Alcohol** (continued)

**Note:** Two new G codes, G0442 (Annual alcohol misuse screening, 15 minutes), and G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), are effective October 14, 2011, and will appear in the January quarterly update of the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE). For claims with dates of service on or after October 14, 2011, through December 31, 2011, your Medicare contractor will use their pricing to pay for G0442 and/or G0443. Deductible and coinsurance do not apply. Contractors will hold institutional claims received prior to April 2, 2012, with TOBs 13x, 71x, 77x, and 85x and release those claims beginning April 2, 2012. For the purposes of this covered service, the following provider specialty types may submit claims for G0442 and G0443:

- 01-General practice
- 08-Family practice
- 11-Internal medicine
- 16-Obstetrics/gynecology
- 37-Pediatric medicine
- 38-Geriatric medicine
- 42-Certified nurse midwife
- 50-Nurse practitioner
- 89-Certified clinical nurse specialist
- 97-Physician assistant

For purposes of this covered service, the following place of service (POS) codes are applicable:

- 11-Physician's office
- 22-Outpatient hospital
- 49-Independent clinic
- 71-State or local public health clinic

Claim processing/payment information

When claims for G0442 or G0443 are submitted with a place of service (POS) code that is not applicable, line-items on those claims will be denied using:

- **Claim adjustment reason code (CARC) 58:** "Treatment was deemed by the payer to have been
- **MLN Matters®** article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf> rendered in an inappropriate or invalid place of service." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remark code (RARC) N428:** "Not covered when performed in this place of service."

- **Group code CO (contractual obligation)** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed advance beneficiary notice (ABN) is not on file. Also, per <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

Medicare will deny claims for G0442 or G0443 when provided by provider specialty types other than those identified above. When such claims are denied, Medicare will use the following messages:

- **CARC 185:** "The rendering provider is not eligible to perform the service billed." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N95:** "This provider type/provider specialty may not bill this service."
- **Group code CO (contractual obligation)** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per **MLN Matters®** article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

Rural health clinics (RHCs) using type of bill (TOB) 71x and federally qualified health centers (FQHCs) using TOB 77x may submit additional revenue lines containing G0442 or G0443. Medicare will pay G0442 and G0443 in TOBs 71x and 77x based on the all-inclusive payment rate. However, Medicare will not pay G0442 or G0443 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply to claims for the initial preventive physical examination (IPPE), claims containing modifier 59, or to 77x claims containing diabetes self-management training or medical nutrition therapy services. If G0442 or G0443 is billed when an encounter/visit with the same line item date of service, Medicare will assign:

- **Group code CO** to the G0442/G0443 revenue lines; and
- **RARC 97:** "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

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**Alcohol (continued)**

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system. Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0442 or G0443 services billed with revenue codes 096x, 097x, or 098x by method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- **CARC 5:** “The procedure code/bitt type is inconsistent with the place of service.” Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC M77:** “Missing/incomplete/invalid place of service.”
- **Group code CO (contractual obligation)** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

Medicare will allow payment for both G0442 and G0443 on the same date (except in RHCs and FQHCs), but will not pay for more than one G0443 service on the same date. However, Medicare will allow both a claim for the professional service and, for TOB 13x and TOB 85x without a revenue code of 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0443 that exceed the limit of one on the same date of service will be denied using:

- **CARC 151:** “Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.”
- **RARC M86:** “Service denied because payment already made for same/similar procedure within set time frame.”
- **Group code CO (contractual obligation)** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

Medicare will track payments for G0442 screening services and G0443 counseling services so as to not permit payment for G0442 more than once in a 12-month period, and for G0443 no more than four times in a 12-month period, beginning with the date of the G0442 service. Claim lines exceeding these limits will be denied using:

- **CARC 119:** “Benefit maximum for this time period or occurrence has been reached.”
- **RARC N362:** “The number of days or units exceeds our acceptable maximum.”
- **Group code CO (contractual obligation)** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, and ELGH) along with HICR changes.

**Additional Information**

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

The official instruction, CR 7633, was issued to your Medicare FI, carrier, or A/B MAC regarding this change via two transmittals. The first transmittal modifies the *National Coverage Determinations Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R138NCD.pdf>. The second transmittal at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2433CP.pdf> modifies the *Medicare Claims Processing Manual*.

MLN Matters® Number: MM7633 *Revised*

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Related CR Transmittal #: November 23, 2011

Implementation Date: December 27, 2011, for local contractor system edits; April 2, 2012-for Medicare’s shared system edits, July 2, 2012 for provider inquiry screens & HICR changes

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## Screening for depression in adults

**Note:** This article was revised on March 27, 2012, to reflect the revised change request (CR) 7637 issued on March 23, 2012. As a result, in this article, the CR release date, transmittal number, and the Web address for accessing CR 7637 have been revised. Also, the article reflects the addition of claim adjustment reason code (CARC) 50 on the remittance replies on claims line items submitted with the GZ modifier. All other information is the same. This information was previously published in the December 2011 *Medicare B Connection*, Pages 25-28.

### Provider types affected

Physicians, non-physician practitioners, rural health clinics (RHCs), and federally qualified health centers (FQHCs) who bill Medicare contractors (carriers, fiscal intermediaries [FIs], and Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries are affected.

### Provider action needed

#### Stop – impact to you

This article is based on CR 7637, which informs Medicare contractors that, effective for claims with dates of service on and after October 14, 2011, Medicare will cover annual depression screening for adults in the primary care setting.

#### Caution – what you need to know

Effective October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

Medicare contractors will recognize new Healthcare Common Procedure Coding System (HCPCS) code, G0444, annual depression screening, 15 minutes, as a covered service.

**Note:** This code will appear on the January 2012 Medicare physicians fee schedule update. The type of service (TOS) for HCPCS code G0444 is 1. Effective October 14, 2011, beneficiary coinsurance and deductibles do not apply to claim lines with annual depression screening, G0444. For dates of service on or after October 14, 2011, through December 31, 2011, Medicare contractors will use their pricing for paying G0444 and update their HCPCS files accordingly.

#### Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding this change. Be sure your staffs are aware of this change.

### Background

Among persons older than 65 years, one in six suffers from depression. Depression in older adults is estimated to occur in 25 percent of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.

Older adults have the highest risk of suicide of all age groups. These patients are important in the primary care setting because 50-75 percent of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39% were seen during the week prior to their death. Symptoms of major depression that are felt nearly every day include, but are not limited to, feeling sad or empty; less interest in daily activities; weight loss or gain when not dieting; less ability to think or concentrate; tearfulness, feelings of worthlessness, and thoughts of death or suicide.

Section 1861(ddd) of the Social Security Act permits the Centers for Medicare & Medicaid Services (CMS) to add coverage of “additional preventive services” through the national coverage determination (NCD) process if all of the following criteria are met:

- Reasonable and necessary for the prevention or early detection of illness or disability;
- Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and,
- Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Screening for depression in adults is recommended with a grade of B by the USPSTF. The CMS reviewed the USPSTF recommendations and supporting evidence for screening depression in adults preventive services and determined that the criteria listed above was met, enabling the CMS to cover these preventive services.

Thus, effective October 14, 2011, Medicare covers annual screening for adults for depression in a primary care setting, as defined below, that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For the purposes of this NCD:

- A primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers (ASCs), independent diagnostic testing facilities, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, and hospice are not considered primary care settings under this definition.

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**Depression (continued)**

- Effective for claims with dates of service on and after April 2, 2012, contractors shall pay for annual depression screening claims, G0444, only when services are provided at the following places of service (POS):
  - 11 – Office
  - 22 – Outpatient hospital
  - 49 – Independent clinic
  - 71 – State or local public health clinic
- At a minimum level, staff-assisted depression care supports consist of clinical staff (e.g., nurse, Physician Assistant) in the primary care office who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment. More comprehensive care supports include a case manager working with the primary care physician; planned collaborative care between the primary care provider and mental health clinicians; patient education and support for patient self-management; plus attention to patient preferences regarding counseling, medications, and referral to mental health professionals with or without continuing involvement by the patient's primary care physician.
- **Note:** Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy, combination therapy (counseling and medications), or other interventions for depression. Self-help materials, telephone calls, and web-based counseling are not separately reimbursable by Medicare and are not part of this NCD.
- Screening for depression is non-covered when performed more than one time in a 12-month period. Eleven full months must elapse following the month in which the last annual depression screening took place. Medicare coinsurance and Part B deductible are waived for this preventive service.

**Claims processing/payment information**

When claim line items for annual depression screening (G0444) are submitted with a POS code that is not applicable, they will be denied using:

- **Claim adjustment reason code (CARC) 58:** "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- **Remittance advice remark code (RARC) N428:** "Not covered when performed in this place of service."
- **Group code PR (patient responsibility)** assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed advance beneficiary notice (ABN) is on file.
- **Group code CO (contractual obligation)** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

RHCs using type of bill (TOB) 71x and FQHCs using TOB 77x may submit additional revenue lines containing G0444 and Medicare will pay those lines based on the all-inclusive payment rate. However, Medicare will not pay G0444 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply, however, to claims with the initial preventive physical examination (IPPE) containing modifier 59 or to 77x claims containing diabetes self-management training or medical nutrition training services. If G0444 is billed when an encounter/visit is billed with the same line item date of service, Medicare will assign:

- **Group code CO** to the G0444 revenue line
- **RARC 97:** "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system (OPPS). Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0444 services billed with revenue codes 096x, 097x, or 098x by method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- **CARC 170:** "Payment is denied when performed/billed by this type of provider." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N428:** "Not covered when performed in this place of service."

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**Depression (continued)**

- **Group code PR** assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*<sup>®</sup> article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

For claims processed on or after April 2, 2012, Medicare will allow payment for G0444 no more than once in a 12-month period. However, Medicare will allow both a claim for the professional service, and, for TOB 13x, and TOB 85x when the revenue code is not 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0444 that exceed this limit will be denied using:

- **CARC 119:** “Benefit maximum for this time period or occurrence has been reached.”
- **RARC N362:** “The number of days or units exceeds our acceptable maximum.”
- **Group code PR** assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*<sup>®</sup> article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH) will display a next eligibility date for this service and the multi-carrier system desktop tool shall display the HCPCS G0444 depression screening sessions.

A MACs/FIs shall hold institutional claims received before April 2, 2012, with TOBs 13x, 71x, 77x, and 85x reporting HCPCS G0444.

**Additional information**

The official instruction, CR 7637, was issued to your carrier, FI, or A/B MAC regarding this change via two transmittals. The first transmittal updates the *National Coverage Determinations Manual* and is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R139NCD.pdf>. The second transmittal is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2431CP.pdf> and it updates the *Medicare Claims Processing Manual*.

If you have questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

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## Preventive Services

### Intensive behavioral therapy for cardiovascular disease

**Note:** This article was revised on March 27, 2012, to reflect the revised change request (CR) 7636 issued on March 23, 2012. As a result, in this article, the CR release date, transmittal number, and the Web address for accessing CR 7637 have been revised. Also, the article reflects the addition of CARC 50 on the remittance replies on claims line items submitted with the GZ modifier. All other information is the same. This information was previously published in the December 2011 *Medicare B Connection*, Pages 28-31.

#### Provider types affected

Primary care practitioners in a primary care setting such as the beneficiary's family practice physician, internal medicine physician, or Nurse Practitioner in the doctor's office who bill Medicare contractors (carriers, fiscal intermediaries [FIs], or Medicare administrative contractors [A/B MACs]) for providing intensive behavioral therapy (IBT) for cardiovascular disease (CVD) to Medicare beneficiaries.

#### Provider action needed

This article is based on CR 7636 which states that effective for claims with dates of service on and after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) covers IBT for CVD, inclusive of one face-to-face CVD risk reduction visit annually. The Medicare patient receiving this care must be competent and alert at the time the service is rendered and the service must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. Ensure that your billing staffs are aware of this update.

#### Background

According to Section 1861 of the Social Security Act, CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process. The preventive services must meet all of the following criteria:

- 1) Reasonable and necessary for the prevention or early detection of illness or disability;
- 2) Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- 3) Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the USPSTF recommendations and supporting evidence for IBT for CVD and determined that the criteria listed above was met, enabling CMS to cover this preventive service. Coverage of IBT for CVD, referred to as a CVD risk reduction visit, consists of the following three components:

- 1) Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years
- 2) Screening for high blood pressure in adults age 18 years and older

- 3) Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease

#### Key points

- A new HCPCS code, G0446, annual, face-to-face IBT for CVD, individual, 15 minutes, will be included in the January 2012 updates of the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE), effective for services on or after November 8, 2011.
- Medicare deductibles and coinsurance do not apply to claim lines containing HCPCS code G0446.
- For these services provided on or after November 8, 2011, through December 31, 2011, Medicare contractors will apply their pricing to claims for G0446 when billed for IBT for CVD.
- Effective for claims with dates of service on and after November 8, 2011, CMS covers one face-to-face CVD risk reduction visit annually for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.
- For the purposes of this covered service, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The following provider specialty types may submit claims for CVD risk reduction visits:

01-General practice

08-Family practice

11-Internal medicine

16-Obstetrics/gynecology

37-Pediatric medicine

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**Behaviorial (continued)**

- 38-Geriatric medicine
- 42-Certified nurse midwife
- 50-Nurse practitioner
- 89-Certified clinical nurse specialist
- 97-Physician assistant
- Medicare contractors will pay claims for G0446 only when services are provided for the following Place of Service (POS):
  - 11-Physician’s office
  - 22-Outpatient hospital
  - 49-Independent clinic
  - 71-State or local public health clinic

Note: Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition. See below for information relative to these services billed on institutional claims by RHCs, type of bill (TOB) 71x, and FQHCs, TOB 77x.

- The behavioral counseling intervention for aspirin use and healthy diet should be consistent with the Five As approach that has been adopted by the USPSTF to describe such services:
  - **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
  - **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
  - **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior.
  - **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
  - **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.
- Medicare contractors do not need to search their files for claims that may have been processed in error. However, contractors may adjust claims that are brought to their attention.

**Claim processing/payment information**

When IBT for CVD claims are submitted with a POS code that is not applicable, they will be denied using:

- **Claim adjustment reason code (CARC) 58:** “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.” Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remark code (RARC) N428:** “Not covered when performed in this place of service.”
- **Group code PR (patient responsibility)** assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed advance beneficiary notice (ABN) is on file.
- **Group code CO (contractual obligation)** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed (ABN) is not on file. Also, per *MLN Matters*® article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

Medicare will deny claims for G0446 when provided by provider specialty types other than those identified above. When such claims are denied, Medicare will use the following messages:

- **CARC 185:** “The rendering provider is not eligible to perform the service billed.” Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N95:** “This provider type/provider specialty may not bill this service.”
- **Group code PR** assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

RHCs using TOB 71x and FQHCs using TOB 77x may submit additional revenue lines containing G0446 and Medicare will pay those lines based on the all-inclusive

(continued on next page)

**Behaviorial** (*continued*)

payment rate. However, Medicare will not pay G0446 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply, however, to claims with the initial preventive physical examination (IPPE) containing modifier 59 or to 77x claims containing diabetes self-management training or medical nutrition training services. If G0446 is billed when an encounter/visit is billed with the same line item date of service, Medicare will assign:

- **Group code CO** to the G0446 revenue line; and
- **RARC 97:** “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.”  
Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system. Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0446 services billed with revenue codes 096x, 097x, or 098x by method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge.

Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- **CARC 170:** “Payment is denied when performed/billed by this type of provider.” Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N428:** “Not covered when performed in this place of service.”
- **Group code PR** assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per MLN Matters® article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

For claims processed on or after April 2, 2012, Medicare will allow payment for G0446 no more than once in a 12-month period. However, Medicare will allow both a claim for the professional service and, for TOB 13x and TOB 85x with a revenue code of 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0446 that exceed this limit will be denied using:

- **CARC 119:** “Benefit maximum for this time period or occurrence has been reached.”
- **RARC N362:** “The number of days or units exceeds our acceptable maximum.”
- **Group code PR** assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per MLN Matters® article MM7228 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7228.pdf>, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.)

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, and ELGH) will display a next eligibility date for this service.

**Additional information**

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

The official instruction, CR 7636, was issued to your Medicare FI, carrier, or A/B MAC regarding this change via two transmittals. The first transmittal modifies the *National Coverage Determinations Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R137NCD.pdf>. The second transmittal at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2432CP.pdf> modifies the *Medicare Claims Processing Manual*.

MLN Matters® Number: MM7636 *Revised*

Related Change Request (CR) #: 7636

Related CR Release Date: March 23, 2012

Effective Date: November 8, 2011

Related CR Transmittal #: R137NCD and R2432CP

Implementation Dates: December 27 for local

Medicare Contractor system edits; April 2, 2012, for

Medicare shared system edits; and July 2, 2012, CWF provider screens and HICR changes

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## Radiology

### Multiple procedure payment reduction on certain diagnostic imaging procedures

**Note:** This article was revised on April 24, 2012, add language at the end of the third paragraph of the *Background* section to clarify the impact of the MPPR on physicians in group practices. All other information remains the same. This information was previously published in the January 2012 Medicare B Connection, Pages 26-27.

#### Provider types affected

This article is for physicians, clinical diagnostic laboratories, and other providers who bill Medicare contractors (carriers or Medicare administrative contractors [A/B MACs]) for providing diagnostic imaging services to Medicare beneficiaries.

#### Provider action needed

Change request (CR) 7442, from which this article is taken, announces that Medicare is expanding the multiple procedure payment reduction (MPPR) to the professional component (PC) in addition to the technical component (TC) of certain diagnostic imaging procedures. You should make sure that your billing staffs are aware of these changes.

#### Background

Section 3134 of the Affordable Care Act (ACA) added Section 1848(c)(2)(K) of the Social Security Act which specifies that the Secretary of the Department of Health & Human Services must identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a further step in implementing this provision, Medicare is making a change to the MPPR on the certain diagnostic imaging procedures. Specifically, the Centers for Medicare & Medicaid Services (CMS) is applying the MPPR to the PC services as well as to TC services.



The MPPR on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient in the same session on the same day. Currently, the MPPR on diagnostic imaging services applies only the TC services. It applies to both TC-only services and to the TC portion of global services. Full payment is made for the service with the highest TC payment. Payment is made at 50 percent for the TC of subsequent services furnished by the same physician to the same patient in the same session on the same day.

CMS is expanding the MPPR by applying it to PC services. Full payment is made for each PC and TC service with the highest payment under the Medicare physician fee schedule (MPFS). Payment is made at 75 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day. Due to operational

considerations, at this time, CMS is not applying the imaging MPPR to group practices when different physicians in a group see the same patient on the same day. However, if the same physician within a group practice sees the same patient in the same session on the same day, the imaging MPPR will apply as of January 1, 2012.

The complete list of codes subject to the MPPR on diagnostic imaging is in Attachment 1 of CR 7442, which is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R9950TN.pdf>. The individual PC and TC services with the highest payments under the MPFS of globally billed services must be determined in order to calculate the reduction.

The current and proposed payments are summarized in the following table:

(continued on next page)

## MPPR (continued)

	Procedure 1	Procedure 2	Current total payment	Current payment calculation	Proposed total payment	Proposed payment calculation
PC	\$68	\$102	\$170	No reduction	\$153	\$102 + (.75 x \$68)
TC	\$476	\$340	\$646	\$476 + (.50 x \$340)	\$646	\$476 + (.50 x \$340)
Global	\$544	\$442	\$816	\$170 + \$476 + (.50 x \$340)	\$799	\$102 + (.75 x \$68) + \$476 + (.50 x \$340)

When applying the reduction, Medicare contractors will use modifier 51 to identify reduced PC services and reduced global services as they do today for TC services. In addition, they will append claim adjustment reason code 59 (Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia) **Note:** Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF), if present.) They will also assign group code CO (contractual obligation).

### Additional information

You will find the complete list of codes subject to the MPPR on diagnostic imaging and an example of how payments are calculated in CR 7442, which is the official instruction issued to your carrier or A/B MAC on this issue. CR 7442 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R995OTN.pdf>.

Also, see the *MLN Matters*® article MM7703 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7703.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7442 *Revised*  
 Related Change Request (CR) #: 7442  
 Related CR Release Date: November 4, 2011  
 Effective Date: January 1, 2012  
 Related CR Transmittal #: R995OTN  
 Implementation Date: January 3, 2012

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### Avoid deactivation of Medicare payments

Find out whether you have been sent a revalidation request by using the search option featured on First Coast Service Options' popular enrollment status lookup, available at <http://medicare.fcso.com/Enrollment/NPIandPTANLetterInput.asp>. You may search for revalidation requests by entering your NPI or your PTAN.



## General Coverage

### April update to the 2012 Medicare physician fee schedule database

#### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHs], 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) 7745 and instructs Medicare contractors to download and implement a new Medicare physician fee schedule database (MPFSDB). On December 23, 2011, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) became law and suspended the automatic negative update that would have taken effect with current law. TPTCCA temporarily allowed for a zero percent update to the MPFS from January 1, 2012, until February 29, 2012. On February 22, 2012, The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) was signed into law and extended the zero percent update through December 31, 2012. This new legislation contains a number of Medicare provisions which change or extend Medicare fee-for-service (FFS) policies. Specific changes to the payment files resulting from the MCTRJCA and effective March 1, 2012, will be addressed in a separate change request.

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 2012 MPFS final rule, the MPFSDB has been updated effective January 1, 2012, and new payment files have been created. Contractors will be notified when they are available. The revised payment file names and a list of the changes can be found in the attachment to this recurring update notification.

The Centers for Medicare & Medicaid Services (CMS) is correcting payments for all anesthesia codes for CY 2011 and for the first part of CY 2012. New anesthesia conversion factor files will be made available for CY 2011 and CY 2012 as part of CR 7745. Practitioners may elect to have payments adjusted on claims for anesthesia services where the provided service dates fall between January 1, 2012, and March 1, 2012. The new 2012 anesthesia conversion factor file is to be used to adjust these payments, and it is the same file to be used to calculate anesthesia claims for the rest of the 2012 calendar year (file effective date from January 1, 2012, to December 31, 2012). Medicare contractors have been previously directed to start processing anesthesia claims with the revised 2012 anesthesia conversion factor file, with dates of service, March 1, 2012, and forward. Practitioners may also elect to have payments adjusted on claims for anesthesia services, where the provided service dates fall between January 1, 2011, and December 31, 2011. The new 2011 anesthesia conversion factor file is to be used to adjust these CY 2011 payments (file effective date from January 1, 2011, to December 31, 2011). Practitioners should contact their local Medicare contractor and bring to their attention these anesthesia payment adjustments, noting that the corrected conversion factors are different for CY 2011 and CY 2012.

#### Other key points of CR 7745

Healthcare Common Procedure Coding System (HCPCS) code 92227 outpatient prospective payment system imaging cap amounts are being included in the April update files. Their omission was due to a technical error and the error has been fixed to prevent this from happening again.

The following reflects additional key changes in the April update of the CY 2012 MPFSDB:

#### HCPCS codes with revised Medicare physician fee schedule payment indicators

HCPCS Code: 43775
Short descriptor: Lap sleeve gastrectomy
Global surgery: 090
Effective date: January 1, 2012

(continued on next page)



April (continued)

HCPCS code: 92072 Short descriptor: Fit contac lens for managmnt Bilateral surgery: 2 Effective date: January 1, 2012
HCPCS code: 4050F Short descriptor: Ht care plan doc Procedure status: M Effective date: January 1, 2012

**New HCPCS codes to be added with the effective date of April 1, 2012**

HCPCS code	S0353	S0354	S0596	S3721	S8930
<b>Procedure status</b>	I	I	I	I	I
<b>Short descriptor</b>	Cancer treatment plan initial	Cancer treatment plan change	Phakic iol refractive error	Pca3 testing	Auricular electrostimulation
<b>Long descriptor</b>	Treatment planning and care coordination management for cancer initial treatment	Treatment planning and care coordination management for cancer established patient with a change of regimen	Phakic intraocular lens for correction of refractive error	Prostate cancer antigen 3 (pca3) testing	Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient
<b>Effective date</b>	04/01/2012	04/01/2012	04/01/2012	04/01/2012	04/01/2012

**New HCPCS codes to be added with the effective date of January 1, 2012**

HCPCS code	G8675	G8676	G8677	G8678	G8679	G8680
<b>Procedure status</b>	M	M	M	M	M	M
<b>Short descriptor</b>	BP Syst >= 140 mmHg	BP Diast >= 90 mmHg	BP Syst < 130 mmHg	BP Syst >=130 - 139 mmHg	BP Diast < 80 mmHg	BP Diast 80-89 mmHg
<b>Effective date</b>	01/01/2012	01/01/2012	01/01/2012	01/01/2012	01/01/2012	01/01/2012

**New HCPCS codes to be added with the effective date of July 1, 2011**

HCPCS code	G9148	G9149	G9150	G9151	G9152	G9153
<b>Procedure status</b>	R	R	R	R	R	R
<b>Short descriptor</b>	Medical Home Level I	Medical Home Level II	Medical Home Level III	MAPCP demo State		
<b>MAPCP demo community</b>	MAPCP demo physician					
<b>Effective date</b>	07/01/2011	07/01/2011	07/01/2011	07/01/2011	07/01/2011	07/01/2011

**HCPCS codes that are discontinued effective April 1, 2012**

HCPCS code	Short descriptor	Procedure status	Termination date
S3711	Circulating tumor cell test	D	04/01/2012
S3713	KRAS mutation analysis	D	04/01/2012

(continued on next page)

April (continued)

HCPCS code	Short descriptor	Procedure status	Termination date
S3818	BRCA1 gene anal	D	04/01/2012
S3819	BRCA2 gene anal	D	04/01/2012
S3820	Comp BRCA1/BRCA2	D	04/01/2012
S3822	Sing mutation brst/ovar	D	04/01/2012
S3823	3 mutation brst/ovar	D	04/01/2012
S3828	Comp MLH1 gene	D	04/01/2012
S3829	Comp MSH2 gene	D	04/01/2012
S3830	Gene test HNPCC comp	D	04/01/2012
S3831	Gene test HNPCC single	D	04/01/2012
S3835	Gene test cystic fibrosis	D	04/01/2012
S3837	Gene test hemochromato	D	04/01/2012
S3843	DNA analysis factor v	D	04/01/2012
S3847	Gene test Tay-Sachs	D	04/01/2012
S3848	Gene test Gaucher	D	04/01/2012
S3851	Gene test canavan	D	04/01/2012
S3860	Genet test cardiac ion-comp	D	04/01/2012
S3862	Genet test cardiac ion-spec	D	04/01/2012
S8049	Intraoperative radiation the	D	04/01/2012

**Additional information**

The official instruction, CR 7745, issued to your carrier, FI, RHHI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2429CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7745  
 Related Change Request (CR) #: CR 7745  
 Related CR Release Date: March 23, 2012  
 Effective Date: January 1, 2012 (unless otherwise indicated)  
 Related CR Transmittal #: R2429CP  
 Implementation Date: April 2, 2012

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**Emergency March 2012 update to the CY 2012 Medicare physician fee schedule database**

**Provider types affected**

This *MLN Matters*® article is intended for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries (RHHIs) and/or Part A/B Medicare administrative contractors [A/B MACs]) for professional services provided to Medicare beneficiaries that are paid under the MPFS.

**What you need to know**

This article is based on change request (CR) 7767, which summarizes the MCTRJCA of 2012. This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect on March 1, 2012. The new law extends the current zero percent update for such services through December 31, 2012. All updates will be reflected in the revised 2012 MPFS. Please be sure your staffs are aware of these changes.

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.

(continued on next page)

**Emergency (continued)****Background**

Payment files were issued to contractors based upon the CY 2012 MPFS final rule, published in the *Federal Register* on November 28, 2011, as modified by the final rule correction notice, published in the *Federal Register* on January 4, 2012, and relevant statutory changes applicable January 1, 2012. On December 23, 2011, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) became law and suspended the automatic negative update that would have taken effect with current law. TPTCCA temporarily allowed for a zero percent update to the MPFS from January 1, 2012, until February 29, 2012.

On Wednesday, February 22, 2012, President Obama signed into law the MCTRJCA, extending the TPTCCA zero percent update to the end of the calendar year, December 31, 2012. This new legislation contains a number of Medicare provisions which change or extend Medicare fee-for-service policies.

This one-time notification addresses the specific changes to the payment files resulting from the MCTRJCA effective March 1, 2012. The Centers for Medicare & Medicaid Services (CMS) is also correcting payments for all anesthesia codes for CY 2011 and for the first part of CY 2012.

**Medicare physician fee schedule revisions and updates**

Included in the MCTRJCA are extensions to:

1. The moratorium that allows certain pathologists and independent laboratories to bill for the technical component (TC) of physician pathology services furnished to hospital patients through June 30, 2012
2. The exceptions process for Medicare therapy caps, and
3. The continuation of the Medicare physician work geographic adjustment floor.

Further, the MCTRJCA discontinues:

1. The minimum payment for bone mass measurement, and
2. The physician fee schedule mental health 5 percent add-on payments.

**Extension of moratorium for technical component (TC) for physician pathology services**

Under previous law, including, most recently, Section 305 of the TPTCCA, a statutory moratorium allowed pathologists and independent laboratories meeting specific criteria to bill a carrier or an A/B MAC for the TC of physician pathology services furnished to hospital patients. This moratorium was set to expire on February 29, 2012. However, Section 3006 of the MCTRJCA extends the moratorium through June 30, 2012.

Pathologists and independent laboratories that had an arrangement with a hospital that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and submitted claims for payment for the TC to a carrier may continue to bill for and receive Medicare payment for these services. This policy is effective for claims with dates of service (DOS) through June 30, 2012.

**Medicare therapy caps exceptions**

Section 3005 of the MCTRJCA extends the exceptions process for Medicare therapy caps, effective for dates of service March 1, 2012, through December 31, 2012. Therapy providers may continue to request an exception to the cap by submitting therapy claims with KX modifier for services during this period. The KX modifier should continue to be used by providers when they know that the therapy cap has already been met, and documentation exists to substantiate that the therapy services are medically necessary. Your Medicare contractor will continue to process claims containing the KX modifier.

**Outpatient therapy claim processing**

Section 3005 also requires additional changes to outpatient therapy claim processing beginning October 1, 2012. These changes include (1) the temporary inclusion of therapies provided in outpatient hospital settings to the therapy cap and the exception process, (2) an additional threshold beyond which therapy services require manual medical review, and (3) the reporting of the national provider identifier of the physician that reviews the therapy plan of care. The Centers for Medicare & Medicaid Services will issue a separate change request detailing the requirements for these October 2012 changes.

**Geographic practice cost index**

The MCTRJCA extends the TPTCCA continuation of the 1.0 floor on the physician work geographic practice cost index through to the end of the calendar year, December 31, 2012. The March 1, 2012 MPFS database (MPFSDB) will reflect this extension.

**Bone mass measurement**

The MCTRJCA discontinues the minimum payment for bone mass measurement, dual-energy x-ray absorptiometry (DXA) services described CPT codes 77080 (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)*) and 77082 (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment*), effective March 1, 2012. The bone mass measurement payments will be calculated based on a standard PFS methodology for the March 1, 2012, update of the physician fee schedule.

(continued on next page)

**Emergency (continued)****Mental health add-on**

The MCTRJCA discontinues the 5 percent mental health add-on payments effective March 1, 2012. The 5 percent increase is no longer reflected in the revised MPFS payment files.

**Additional information**

The official instruction, CR 7767, issued to your Medicare carrier, FI, RHHI or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1058OTN.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

Additional information about the exception process for therapy services may be found in the *Medicare Claims Processing Manual*, Pub.100-04, Chapter 5, Section 10.3 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf>.

For background and policy information regarding payment to certain pathologists and independent laboratories for the TC of physician pathology services furnished to hospital patients, refer to *MLN Matters*® articles MM5943 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5943.pdf>) and MM5347 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5347.pdf>).

MLN Matters® Number: MM7767 Revised  
Related Change Request (CR) #: CR 7767  
Related CR Release Date: March 14, 2012  
Effective Date: March 1, 2012  
Related CR Transmittal #: R1058OTN  
Implementation Date: March 15, 2012

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## Quarterly update for HCPCS codes effective July 1

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS website at [http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS\\_Quarterly\\_Update.html](http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html). Changes are effective on the date indicated on the update.

In response to shortage of liposomal doxorubicin (Doxil), the Food and Drug Administration is permitting the temporary importation of Lipodox, a brand of liposomal doxorubicin hydrochloride; visit <http://www.FDA.gov/NewsEvents/Newsroom/PressAnnouncements/ucm292658.htm> for additional information. The CMS HCPCS quarterly update includes two new codes (Q2048 and Q2049) for liposomal doxorubicin that will become effective Sunday, July 1. The code descriptors are worded in a manner that distinguishes Lipodox and Doxil. As of Sunday, July 1, HCPCS code J9001 will not be used for Medicare billing. CMS will release a change request (CR) with additional instructions in the near future.

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

**Source:** CMS PERL 201204-07

### 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 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.

## ICD-10 compliance delayed until October 1, 2014

### New health care law provisions cut red tape and may save health care providers and health plans up to \$4.6 billion

Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced a proposed rule that would establish a unique health plan identifier under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The proposed rule would implement several administrative simplification provisions of the Affordable Care Act.

According to HHS estimates, the proposed changes would save health care providers and health plans up to \$4.6 billion over the next ten years. The estimates were included in a proposed rule that cuts red tape and simplifies administrative processes for doctors, hospitals, and health insurance plans.

The rule simplifies the administrative process for providers by proposing that health plans have a unique identifier of a standard length and format to facilitate routine use in computer systems. This will allow provider offices to automate and simplify their processes, particularly when processing bills and other transactions.

The proposed rule also delays required compliance by one year – from October 1, 2013, to October 1, 2014, – for new codes used to classify diseases and health problems. These codes, known as the International Classification of Diseases, 10th Edition (ICD-10) diagnosis and procedure codes will include new procedures and diagnoses and improve the quality of information available for quality improvement and payment purposes.

The proposed rule is the third in a series of administrative simplification rules in the new health care law. HHS released the first in July of 2011 and the second in January of 2012. It also plans to announce more in the coming months.

More information on the proposed rule is available on fact sheets at [http://www.CMS.gov/apps/media/fact\\_sheets.asp](http://www.CMS.gov/apps/media/fact_sheets.asp).

The proposed rule may be viewed at [www.ofr.gov/inspection.aspx](http://www.ofr.gov/inspection.aspx). Comments are due 30 days after publication in the *Federal Register*.

The full text of this excerpted CMS press release (issued Monday, April 9) can be found at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4329>.

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

**Source:** CMS PERL 201204-19

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## Information about the Middle Class Tax Relief and Job Creation Act of 2012

### Provider types affected

This *MLN Matters*<sup>®</sup> special edition article is intended for all providers who provide Medicare-covered services in the fee-for-service (FFS) program.

### What you need to know

On February 22, 2012, President Obama signed into law the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act). This law, which extended several provisions of the Temporary Payroll Tax Cut Elimination Act of 2011 (Continuation Act), contained several provisions that impact Medicare fee-for-service providers, as outlined below.

### Physician payment update

Section 3003 of the Jobs Creation Act extended the zero percent update for claims with dates of service on or after January 1, 2012, to February 29, 2012, all the way through December 31, 2012.

**Note:** The new law did **not** extend:

- Section 307 of the Continuation Act (the five percent physician fee schedule mental health add-on payment); or
- Section 309 of the Continuation Act (the special 2011 payment rates for bone mass measurements).

The Centers for Medicare & Medicaid Services (CMS) revised the 2012 Medicare physician fee schedule (MPFS) to reflect the expiration of both of these provisions.

*(continued on next page)*



**Relief (continued)**

This provision does not affect claims with dates of service prior to March 1, 2012. Medicare contractors posted the new mental health and bone density rates no later than March 15, 2012.

**Extension of Medicare physician work geographic adjustment floor**

Section 3004 of the law has extended the existing 1.0 floor on the physician work geographic practice cost index through December 31, 2012. As with the physician payment update, the revised 2012 MPFS will reflect this extension.

**Extension of Medicare Modernization Act Section 508 reclassifications**

Section 3001 of the law extends Section 508 reclassifications and certain special exception wage indexes from December 1, 2011, through March 31, 2012.

This section requires removing Section 508 and special exception wage date from the calculation of the reclassified wage index, if doing so raises the reclassified wage index for this period.

CMS shall assign all hospitals that receive Section 508 reclassifications and inpatient special exception reclassifications to a special wage index effective for October 2011, through March 2012.

CMS shall apply these provisions to both inpatient and outpatient hospital payments.

From January 1, 2012, through June 30, 2012, a special wage index will be applicable for affected hospital outpatient payments, special exception hospitals, and reclassified hospitals.

CMS shall make hospital inpatient and outpatient payments under both Section 302 of the Continuation Act and Section 3001 of the Job Creation Act by June 30, 2012.

**Extension of outpatient hold harmless payments**

Section 3002 of the law extends outpatient hold harmless payments through December 31, 2012, for:

- Rural hospitals, and
- Sole community hospitals with 100 or fewer beds.

**Note:** The law did **not** extend hold harmless payments for sole community hospitals with more than 100 beds. These payments expired February 29, 2012.

**Extension of exceptions process for Medicare therapy services**

Section 3005 of the law extends the exceptions process for outpatient therapy caps from March 1, 2012, through December 31, 2012, with some modifications to current therapy policies.

Outpatient therapy service providers must submit the KX modifier on their therapy claims when they

are requesting an exception to the cap for medically necessary services that they furnished through December 31, 2012.

In addition, the new law includes changes related to therapy services that a therapist furnishes in a hospital outpatient department (OPD). These changes impact the annual therapy cap in 2012 as well as the applicability of the therapy cap exception process.

CMS will provide more information about the changes that affect hospital OPDs in the future. You can also find additional information about the exception process for therapy services in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Section 10.3 at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c05.pdf>.

CMS determines therapy caps on a calendar year basis. Therefore, all beneficiaries began a new cap for outpatient therapy services they received on January 1, 2012. For physical therapy and speech language pathology services combined, the 2012 limit for beneficiary-incurred expenses is \$1,880.

There is a separate cap for occupation therapy services, which is also \$1,880 for 2012.

Deductible and coinsurance amounts for therapy services count toward the accrued amount before a beneficiary reaches the cap and also apply for services above the cap where the provider used the KX modifier.

Section 3005 also mandates that Medicare perform an annual medical review of therapy services that a therapist furnished beginning on October 1, 2012, when the therapist requested an exception when the beneficiary reached a dollar aggregate threshold amount of \$3,700, including OPD therapy services, for a year.

There are two separate \$3,700 aggregate annual thresholds: one for physical therapy and speech-language pathology services, and another for occupational therapy services.

Finally, Section 3005 requires that claims for all therapy services that therapists furnish on or after October 1, 2012, include the national provider identifier (NPI) of the physician who reviews the therapy plan. CMS will issue additional information about all of these new requirements later this year.

**Extension of moratorium on qualified pathologists and independent laboratory billing for the technical component of physician pathology services furnished to hospital patients**

Section 3006 of the law extends the moratorium through June 30, 2012. Therefore, those qualified pathologists and independent laboratories that

(continued on next page)

**Relief** *(continued)*

are eligible may continue to submit claims for the technical component of physician pathology services that they furnish to hospital patients, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date they furnish the service.

This policy continues to be effective for claims with dates of service on or after March 1, 2012, through June 30, 2012.

**Extension of ambulance add-on payments**

Section 3007 of the law extends the following Continuation Act ambulance payment provisions through December 31, 2012:

- The three percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the two percent increase for covered ground ambulance transports that originate in urban areas;
- The provision relating to air ambulance services that continues to treat any area that was designated as rural on December 31, 2006, as rural for purposes of payment under the ambulance fee schedule, and
- The provision relating to payment for ground ambulance services that increases the base rate

for transports that originate in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus).

Suppliers of ambulance services that this provision affects may continue billing as usual.

**Additional information**

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

MLN Matters® Number: SE1215  
 Related Change Request (CR) #: NA  
 Related CR Release Date: NA  
 Effective Date: NA  
 Related CR Transmittal #: NA  
 Implementation Date: NA

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**Revised and clarified place of service coding instructions**

**Note:** This article was revised on April 4, 2012, to reflect a revised change request (CR) 7631 that changed the effective and implementation dates to October 1, 2012. In addition, in this article, the CR release date, transmittal number, and the Web address for accessing CR 7631 were revised. All other information is the same. This information was previously published in the February 2012 *Medicare B Connection*, Pages 27-31.

**Provider types affected**

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers and Medicare administrative contractors [A/B MACs]) for services paid for under the Medicare physician fee schedule (MPFS). This article also applies to certain services provided by independent laboratories.

**What you need to know**

This article is based on CR 7631. It revises and clarifies national policy for POS code assignment. Instructions are provided in CR 7631 regarding the assignment of POS for all services paid under the MPFS and for certain services provided by independent laboratories. In addition to establishing a national policy for the correct assignment of POS codes, instructions are provided for the interpretation or professional component (PC) and the technical component (TC) of diagnostic tests. Please make sure your billing staff is aware of these changes.

**Background**

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under

this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction includes a POS code from the POS code set maintained by the Centers for Medicare & Medicaid Services (CMS). Under Medicare, the correct POS code assignment is also required on the paper CMS-1500 claim form (or its electronic equivalent). While CMS currently maintains the national POS code set, it is used by all other public and private health insurers, including Medicaid.

At the time a POS code is developed, CMS determines whether a MPFS facility or non-facility payment rate is appropriate for that setting and Medicare contractors are required to make payment at the MPFS rate designated for each POS code. Under the MPFS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to beneficiaries. While Medicare contractors cannot create new POS codes, they are instructed to develop local policies that develop or clarify POS setting definitions in situations where national POS policy is lacking or unclear.

*(continued on next page)*

**POS** *(continued)*

**The importance of this national policy is underscored by consistent findings, in annual and/or biennial reports from calendar year (CY) 2002 through CY 2007, by the Office of the Inspector General (OIG) that physicians and other suppliers frequently incorrectly report the POS in which they furnish services.** This improper billing is particularly problematic when physician and other suppliers furnish services in outpatient hospitals and in ambulatory surgical centers (ASCs). In a sample of paid services (for services possessing both non-facility and facility practice expenses), the OIG found a significant percent of the sampled physician/practitioner claims were incorrectly reported by physician/practitioners as occurring in the office POS when those services were furnished in outpatient hospitals or ASCs. As such, these claims were paid by the Medicare contractor at the non-facility rate – rather than the lower facility MPFS payment rate assigned to the POS codes for outpatient hospitals and ASCs.

The OIG has called on CMS to strengthen the education process and reemphasize to physicians (including non-physician practitioners and other suppliers) and their billing agents the importance of correctly coding the POS. Consequently, CR7631 adds special considerations provisions regarding use of POS codes 22 and 24, for outpatient hospitals and ASCs.

A previous CMS instruction, Transmittal 1873 (now rescinded) regarding the assignment of POS codes, instructed physicians to use the 2-digit POS code to describe where he/she was physically when rendering the service; in this instance, the POS code corresponded to the service location. (CMS-1500 claim form items 24B and 32, respectively, and the corresponding loops on the ANSI 12X N 837-P electronic format information). The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable “locality” and geographic practice cost index (GPCI)-adjusted payment for each service paid under the MPFS.

**CR 7631 establishes that for all services – with two exceptions – paid under the MPFS, that the POS code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service.** Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule will apply to the overwhelming majority of MPFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician/practitioner will be the setting in which the beneficiary received the TC of

the service. For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary’s MRI from his/her office location – POS code 22 will be used on the physician’s claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

There are two (2) exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as a hospital inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service. The correct POS code assignment will be for that setting in which the beneficiary is receiving inpatient or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22). “The Medicare Claims Processing Manual” already requires this for physician services (and for certain independent laboratory services) provided to beneficiaries in the inpatient hospital and CR 7631 clarifies this exception and extends it to beneficiaries of the outpatient hospital, as well.

**Facility and non-facility payment assignments**

**Physicians’ services are paid at facility rates for procedures furnished in the following settings:**

- Inpatient hospital (POS code 21)
- Outpatient hospital (POS code 22)
- Emergency room-hospital (POS code 23)
- Medicare-participating ambulatory surgical center (ASC) for a Healthcare Common Procedure Coding System (HCPCS) code included on the ASC approved list of procedures (POS code 24)
- Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24)
- Skilled nursing facility (SNF) for a Part A resident (POS code 31)
- Hospice – for inpatient care (POS code 34)
- Ambulance – land (POS code 41)
- Ambulance – air or water (POS code 42)
- Inpatient psychiatric facility (POS code 51)
- Psychiatric facility -- partial hospitalization (POS code 52)
- Community mental health center (POS code 53)
- Psychiatric residential treatment center (POS code 56)

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**POS (continued)**

- Comprehensive inpatient rehabilitation facility (POS code 61)

**Physicians' services are paid at non-facility rates for procedures furnished in the following settings**

- Pharmacy (POS code 01)
- School (POS code 03)
- Homeless shelter (POS code 04)
- Prison/correctional facility (POS code 09)
- Office (POS code 11)
- Home or private residence of patient (POS code 12)
- Assisted living facility (POS code 13)
- Group home (POS code 14)
- Mobile unit (POS code 15)
- Temporary lodging (POS code 16)
- Walk-in retail health clinic (POS code 17)
- Urgent care facility (POS code 20)
- Birthing center (POS code 25)
- Nursing facility and skilled nursing facilities (SNFs) to Part B residents - (POS code 32)
- Custodial care facility (POS code 33)
- Independent clinic (POS code 49)
- Federally qualified health center (POS code 50)
- Intermediate health care facility/mentally retarded (POS code 54)
- Residential substance abuse treatment facility (POS code 55)
- Non-residential substance abuse treatment facility (POS code 57)
- Mass immunization center (POS code 60)
- Comprehensive outpatient rehabilitation facility (POS code 62)
- End-stage renal disease treatment facility (POS code 65)
- State or local health clinic (POS code 71)
- Rural health clinic (POS code 72)
- Independent laboratory (POS code 81)
- Other place of service (POS code 99)

**Special guidance for selected POS codes**

CR 7631 adds clarifying or special consideration provisions for other settings as well. Those provisions are as follows:

**Special considerations for mobile unit settings (code 15)**

When services are furnished in a mobile unit, they are often provided to serve an entity for which another POS code exists. For example, a mobile unit may be sent to a physician's office or a SNF. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. However, if the mobile unit is not serving an entity which could be described by an existing POS code, the providers are to use the mobile unit POS code 15. Medicare will apply the non-facility rate to payments for services designated as being furnished in POS code 15 and apply the appropriate facility or non-facility rate for the POS code designated when a code other than the mobile unit code is indicated.

A physician or practitioner's office, even if mobile, qualifies to serve as a telehealth originating site. Assuming such an office also fulfills the requirement that it be located in either a rural health professional shortage area as defined under Section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or in a county that is not included in a metropolitan statistical area as defined in Section 1886(d)(2)(D) of the Social Security Act, the originating physician's office should use POS code 11 (office) in order to ensure appropriate payment for services on the list of Medicare telehealth services.

**Special considerations for walk-in retail health clinic (code 17) (effective no later than May 1, 2010)**

It should be noted that, while some entities in the industry may elect to use code 17 to track the setting of immunizations, Medicare continues to require its billing rules for immunizations claims, which are found in Chapter 18, Section 10 of the *Medicare Claims Processing Manual* found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf>. Providers and suppliers of immunizations must continue to follow these Medicare billing rules. However, Medicare contractors will accept and adjudicate claims containing POS code 17, even if its presence on a claim is contrary to these billing instructions.

**Special considerations for inpatient hospital (code 21)**

Providers and suppliers of immunizations must continue to follow these Medicare billing rules. However, Medicare contractors will accept and adjudicate claims containing POS code 17, even if its presence on a claim is contrary to these billing instructions.

In the case of a physician/practitioner/supplier that provides services to a patient who is an inpatient of a hospital, the inpatient hospital POS code 21 will be used irrespective of the setting where the patient actually receives the face-to-face encounter.

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**POS (continued)****Special considerations for outpatient hospital (code 22)**

Physicians/practitioners who furnish services to a hospital outpatient, including in a hospital outpatient department (including in a provider-based department of that hospital) or under arrangement to a hospital will use POS code 22.

**Note:** Physicians/practitioners who perform services in a hospital outpatient department will use POS code 22 (outpatient hospital) unless the physician maintains separate office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42 C.F.R. 413.65. Physicians will use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42 C.F.R. 413.6. Use of POS code 11 (office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.F.R. 411.353 through 411.357.

**Special consideration for ambulatory surgical centers (code 24)**

When a physician/practitioner furnishes services to a patient in a Medicare-participating ASC, the POS code 24 (ASC) will be used.

**Note:** Physicians/practitioners who perform services in a Medicare-participating ASC will use POS code 24 (ASC). Physicians are not to use POS code 11 (office) for ASC based services unless the physician has an office at the same physical location of the ASC which meets all other requirements for operating as a physician office at the same physical location as the ASC – including meeting the “distinct entity” criteria defined in the *ASC State Operations Manual* that precludes the ASC and an adjacent physician office from being open at the same time -- and the physician service was actually performed in the office suite portion of the facility. That information is in Appendix L of that manual which is at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_I\\_ambulatory.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_I_ambulatory.pdf).

**Special considerations for Hospice (code 34)**

When a physician/practitioner furnishes services to a patient under the hospice benefit, use the following guidelines to identify the appropriate POS.

When a beneficiary is in an “inpatient” respite or general “inpatient” care stay, the POS code 34 (hospice) will be used. When a beneficiary who has elected coverage under the Hospice benefit is receiving inpatient hospice care in a hospital, SNF, or hospice inpatient facility, POS code 34 (Hospice) will be used to designate the POS on the claim.

For services provided to a hospice beneficiary in an outpatient setting, such as the physician/non-physician practitioner’s office (POS 11); the beneficiary’s home (POS 12), i.e., not operated by the hospice; or other outpatient setting (e.g., outpatient hospital [POS 22]), the patient’s physician or non-physician practitioner or hospice independent attending physician or nurse practitioner, will assign the POS code that represents that setting, as appropriate.

There may be use of nursing homes as the hospice patient’s “home,” where the patient resides in the facility but is receiving a home level of care. In addition, hospices are also operating “houses” or hospice residential entities where hospice patients receive a home level of care. In these cases, physicians and non-physician practitioners, including the patient’s independent attending physician or nurse practitioner, will use the appropriate POS code representing the particular setting, e.g., POS code 32 for nursing home, POS code 13 for an assisted living facility, or POS code 14 for group home.

**Additional information**

The official instruction, CR 7631 issued to your carrier and/or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2435CP.pdf>.

If you have any questions about the correct POS code to use, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

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Related Change Request (CR) #: 7631  
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Related CR Transmittal #: R2435CP  
Implementation Date: October 1, 2012

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## ICD-10: It's closer than it seems – have you completed your 5010 implementation?

Recently, the Centers for Medicare & Medicaid Services (CMS) announced it will not initiate enforcement action against any HIPAA-covered entity for an additional three months, through Saturday, June 30, for the updated HIPAA transaction standards (ASC X12 version 5010, NCPDP versions D.0 and 3.0). Although much progress has been made in the successful receipt and processing of claims in the version 5010 format, CMS is aware that there are still challenges and issues impeding an industry-wide upgrade.

During these additional 90 days during which CMS will not initiate enforcement penalties, you should collaborate more closely with trading partners on appropriate strategies to resolve any remaining problems. Two steps providers can take to ensure a smooth upgrade include:

- Establish a line of credit: To avoid potential cash flow disruptions, providers should consider establishing or increasing a line of credit. By doing so, they can prepare for possible delays and denials in payer claims reimbursements if noncompliant version 5010 transactions are submitted.
- Check partner readiness: Because a provider's version 5010 upgrade can be dependent upon his or her vendor, it is important for providers to be aware of their vendor's transition status. If your vendor is behind schedule for version 5010 adoption, get confirmation of their timeline to be compliant, and encourage them to take action so that your system will be prepared to handle your claims.

Other steps to prepare for the version 5010 upgrade can be found in the "Version 5010: Ensuring a Smooth Transition" fact sheet, which provides an overview of several actions providers can take to maintain continuity of operations for their practices as they prepare to complete version 5010 testing.

Keep up to date on version 5010 and ICD-10. Please visit the [ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation [widget](#) today.

**CMS.gov website upgrade:** Please take note that CMS is in the process of making upgrades to the [www.CMS.gov](http://www.CMS.gov) website. If you encounter problems accessing information while on the site, please refresh the page or check back later. CMS appreciates your understanding and apologize for any inconvenience

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**Source:** CMS PERL 201203-60



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## Take a look at the version 5010 FAQs and view CMS' version 5010 page and resources

The Centers for Medicare & Medicaid Services (CMS) will not initiate enforcement action against HIPAA-covered entities for an additional three months, through Saturday, June 30, 2012, for the updated HIPAA transaction standards (ASC X12 version 5010, NCPDP versions D.0 and 3.0). CMS is aware that there are still challenges and issues affecting an industry wide upgrade. To help HIPAA-covered entities with the upgrade, CMS continues to update and improve their version 5010 resources.

### Updated frequently asked questions (FAQs) system

CMS has updated the FAQs system and the way it is organized. There are now three ways to more easily find version 5010 FAQs by going to the [CMS FAQs page](#) and:

- Click on the topic "HIPAA Administrative Simplification" on the left side of the page
- Click on the subtopic "Versions 5010 and D.0" that will appear as a dropdown under the topic (FAQs on version 5010 and D.0 will be listed on the right side of the page)
- Click on the topic "Coding" on the left side of the page

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**FAQs** *(continued)*

- Click on the subtopic “ICD-10” that will appear as a dropdown under the topic (FAQs on version 5010 will be listed out on the right side of the page)
- Entering the search term “Version 5010” in the search box on the upper left side of the page

CMS’ version 5010 and D.0 FAQs can also be found on the [version 5010 page](#) of the ICD-10 website, on the [FAQs: Versions 5010 and D.0 Transition Basics fact sheet](#). The newest FAQ recently added by CMS is:

**Question:** Is my version 5010 837 claim compliant if it includes situational data that the TR3 Report does not prohibit, and is not needed or used by a specific health plan?

**Answer:** Yes. If a submitter sends claim information to a primary payer that may not be needed by that payer, but is needed by a secondary or tertiary payer, the primary payer should disregard the unneeded information and accept the compliant claim. For example:

- A data element in the TR3 report has situational usage and language that says, “If not required by this implementation guide, do not send.”
- The submitter submits that data element because it is needed for processing by a particular payer that may be secondary or tertiary to the primary payer.
- A payer that does not need or use that data element cannot reject a claim because it contains a data element or information that it does not need or use, provided usage of the data element is compliant with the TR3 report.

**”Version 5010 Testing Readiness” fact sheet**

CMS also has a [“Version 5010 Testing Readiness”](#) fact sheet, which explains the version 5010 upgrade and necessary phase I internal and phase II external testing. This fact sheet can help providers to determine steps to successfully complete testing phases for version 5010.

Keep up to date on version 5010 and ICD-10

Please visit the [ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation [widget](#) today.

**Source:** CMS PERL 201204-20

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## CARC, RARC, MREP, and PC Print update

**Provider types affected**

This *MLN Matters*<sup>®</sup> article is intended for physicians, providers, suppliers, and vendors representing physicians/providers/suppliers receiving remittance advice from Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

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

This article is based on change request (CR) 7775 which updates claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), Medicare Remit Easy Print (MREP), and PC Print for Medicare.

**Caution – what you need to know**

CR 7775 instructs Medicare contractors and the Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated CARCs and RARCs that have been added since the last recurring code update CR (CR 7683 Transmittal 2372 published on December 22, 2011). It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software respectively. Be sure your billing staff is aware of these changes.

**Go – what you need to do**

If you use the MREP or PC Print software, be sure to download the updated software when available. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

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**CARC** (continued)**Background**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, valid CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate group code must be reported as well.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment for Medicare.

Medicare contractors will stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual "Stop Date" posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

If you use the MREP or PC Print software, be sure to download the updated software when available.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR 7775, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website is updated only three times a year and may not match the CMS release schedule.

CR 7775 lists only the changes that have been approved since the last code update CR (CR 7683 Transmittal 2372), and does not provide a complete list of codes in these two code sets. You must get the complete list for both CARC and RARC from the WPC website that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule.

The WPC website (at <http://www.wpc-edi.com/Reference> on the Internet) has four listings available for both CARC and RARC:

1. **All:** All codes including deactivated and to be deactivated codes are included in this listing.
2. **To be deactivated:** Only codes to be deactivated at a future date are included in this listing.
3. **Deactivated:** Only codes with prior deactivation effective date are included in this listing.
4. **Current:** Only currently valid codes are included in this listing.

**Note:** In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version is implemented by Medicare.

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**CARC** (continued)

**Claim adjustment reason code (CARC)**

A national code maintenance committee maintains the health care claim adjustment reason codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. To access the updated list see <http://www.wpc-edi.com/Reference>.

The new codes usually become effective when approved unless mentioned otherwise. Any modification or deactivation becomes effective on a future date to provide lead time for implementing necessary programming changes. **Exception:** The effective date for a modification may be as early as the approval or publication date if the requester can provide enough justification to have the modification become effective earlier. A health plan may decide to implement a code deactivation before the actual effective date posted on WPC website as long as the deactivated code is allowed to come in on coordination of benefits (COB) claims if the previous payer(s) has (have) used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC website to accommodate the Medicare release schedule.

The following new claim adjustment reason codes were approved by the code committee in January, and must be implemented, if appropriate for Medicare, by July 2, 2012.

**New codes – CARC**

None

**Modified codes – CARC**

Code	Modified narrative	Effective date
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	11/1/2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	11/1/2012

**Deactivated codes – CARC**

None

**Remittance advice remark codes (RARC)**

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 and 005010A1 Implementation Guide (IG)/Technical Report (TR) 3. Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non-Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Medicare uses the standard code sets (CARC and RARC) for paper remittance advice as well.

**New codes – RARC**

Code	Code narrative	Effective date
N547	A refund request (Frequency Type Code 8) was processed previously.	3/6/2012
N548	Alert: Patient's calendar year deductible has been met.	3/6/2012
N549	Alert: Patient's calendar year out-of-pocket maximum has been met.	3/6/2012
N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.	3/6/2012
N551	Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.	3/6/2012
N552	Payment adjusted to reverse a previous withhold/bonus amount.	3/6/2012
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	3/6/2012

(continued on next page)

**CARC (continued)****Modified codes – RARC**

Code	Modified narrative	Effective date
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	3/6/2012
N206	The supporting documentation does not match the information sent on the claim.	3/6/2012

**Deactivated Codes – RARC**

None

**Additional Information**

The official instruction, CR 7775, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2442CP.pdf>.

If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7775

Related Change Request (CR) #: CR 7775

Related CR Release Date: April 6, 2012

Effective Date: July 1, 2012

Related CR Transmittal #: R2442CP

Implementation Date: July 2, 2012

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## All Medicare provider and supplier payments to be made by electronic funds transfer

Existing regulations at 42 *Code of Federal Regulations* (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 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 Centers for Medicare & Medicaid Services (CMS) revalidation efforts, all suppliers and providers who are not currently receiving EFT payments are required to submit the CMS-588 EFT form with the provider enrollment revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.

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 201204-25



### Go green to get your green faster

Save time, money, and the environment all at the same time by signing up for electronic funds transfer (EFT). With EFT, funds are transferred directly to your financial institution, which means quicker reimbursement for you. To start receiving EFT, simply complete and return the EFT Authorization Agreement form at <http://www.cms.gov/cmsforms/downloads/CMS588.pdf>.



## Claim status category and claim status codes update

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians, other providers, and suppliers who submit claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

### What you need to know

This article is based on change request (CR) 7793 which explains that the Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the national Code Maintenance Committee to report the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The code sets are available at <http://www.wpc-edi.com/content/view/180/223/>. The code lists include the date when a code was added, changed, or deleted. All code changes approved during the June 2012 committee meeting will be posted on that site on or about July 1, 2012.



### Background

HIPAA requires all health care benefit payers to use claim status category codes and claim status codes to report the status of submitted claim(s). Only codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format are to be used. Proprietary codes may not be used in the X12 276/277 to report claim status.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The code sets are available at <http://www.wpc-edi.com/content/view/180/223/> or <http://www.wpc-edi.com/codes>. All code changes approved during the June 2012 committee meeting will be posted on that site on or about July 1, 2012. The code lists include specific details, including the date when a code was added, changed, or deleted. Your Medicare contractors must complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes by July 2, 2012.

### Additional information

The official instruction, CR 7793, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2436CP.pdf>.

If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters<sup>®</sup> Number: MM7793

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Related CR Release Date: March 30, 2012

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## Fraud

### Information on CMS fraud prevention: Automated provider screening and national site visit initiatives

#### Provider types affected

This *MLN Matters*<sup>®</sup> special edition article is intended for all providers and suppliers, who enroll in the Medicare program and submit fee-for-service (FFS) claims to fiscal intermediaries (FIs), carriers, A/B Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs), for services provided to Medicare beneficiaries.

#### What you need to know

This article provides you with the latest information about the Centers for Medicare & Medicaid Services (CMS) National Fraud Prevention Program (NFPP)



initiative. The initiative includes additional tools to assist CMS in its efforts to prevent fraud and abuse in the Medicare program starting with the enrollment process itself. This article describes two new processes that CMS now employs as part of the provider enrollment process: (1) Automated provider screening, and (2) implementation of a new national site visit contractor that will conduct site visits to certain providers and suppliers. This NFPP is intended to protect the Medicare program and to ensure that correct program payment is made only for covered appropriate and reasonable services provided to Medicare beneficiaries by legitimate providers of care.

#### Key information

##### National Fraud Prevention Program

The NFPP is an integral part of the CMS Fraud Prevention Initiative. The NFPP also enables CMS to proactively identify and respond to suspicious behavior, thus making the agency more effective at fighting health care fraud than ever before. The NFPP

focuses on two key program integrity gateways – provider enrollment and claims payment. By integrating these steps into one program, CMS can better ensure that it enrolls only qualified providers and pays only valid claims. CMS' comprehensive program integrity strategy is designed to stop fraudsters at every step of the process so CMS is now better able to:

- Identify and prevent bad actors from enrolling in Medicare
- Identify and remove bad actors that are already in its programs, and
- Identify and prevent payment of fraudulent claims by responding with quick administrative action.

##### Automated provider screening: Ensuring program integrity at the provider enrollment stage

CMS is implementing an automated provider screening (APS) process that will screen providers and suppliers by automating data checks and developing methods to proactively identify fraud, waste, and abuse. APS will validate provider and supplier enrollment application information using various public and private databases as well as automatically check other referential databases. APS is expected to be fully implemented mid-2012 and it will:

- Reduce provider and supplier enrollment application processing time since there will be less manual review of the databases currently used in the verification process
- On a continual basis, monitor the veracity and accuracy of all provider and supplier enrollment data including the status of licensure, sanctions or exclusions, and adverse legal actions
- Assess the individual level of risk each provider and supplier presents to the Medicare program, and
- Be used by CMS and Medicare contractors (FIs, MACs, etc.) to verify, update, and act on relevant information found during the enrollment process and on a continual enrollment basis.

APS is designed to ensure that Medicare enrolls only qualified providers and suppliers who meet and maintain compliance with its enrollment requirements.

##### National site visit contractor: Ensuring program integrity at the provider enrollment stage

(continued on next page)

**Fraud (continued)**

CMS has implemented a site visit verification process using a national site visit contractor (NSVC). The site visit verification process is a screening mechanism to prevent questionable providers and suppliers from enrolling in the Medicare program. The NSVC will conduct site visits for all providers and suppliers except for durable medical equipment, prosthetic, orthotics, and supplies (DMEPOS), which will continue to be conducted by the national supplier clearinghouse. The NSVC will verify enrollment related information during the site visit and collect specific information based on pre-defined checklists.

MSM Security Services, LLC was awarded the national site visit contract. MSM and its subcontractors, Computer Evidence Specialists, LLC (CES) and Health Integrity, LLC (HI) are authorized by CMS to conduct the provider and supplier site visits. **Inspectors performing the site visits will be employees of MSM, CES, or HI and shall possess a photo ID and a letter of authorization issued and signed by CMS that the provider or supplier may review.**

**Additional information**

To learn more about the predictive analytics process, refer to *MLN Matters*<sup>®</sup> special edition article SE1133, titled "Predictive Modeling Analysis of Medicare Claims." The article is available at <http://www.cms.gov/MLNMattersArticles/Downloads/SE1133.pdf>.

To learn more about the CMS Fraud Prevention Initiative, visit the "Fraud Prevention Toolkit" Web page at [http://www.cms.gov/Partnerships/04\\_FraudPreventionToolkit.asp](http://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp).

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## Questionable billing by suppliers of lower limb prostheses

**Provider types affected**

This *MLN Matters*<sup>®</sup> special edition article is intended for providers who bill Medicare for lower limb prostheses. No new policies are contained in this article.

**What you need to know**

This article highlights the August 2011 report from the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) study titled "Questionable Billing By Suppliers of Lower Limb Prostheses." It also discusses Medicare policy regarding the coverage of lower limb prostheses under its Part B durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) benefit.

The study was designed to meet the following objectives:

1. Identify payments for lower limb prostheses in 2009 that did not meet certain Medicare requirements
2. Identify Medicare payments for lower limb prostheses in 2009 for beneficiaries with no claims from their referring physicians
3. Identify suppliers of lower limb prostheses that had questionable billing in 2009
4. Describe the program safeguards in place in 2009 and the first half of 2010 to prevent inappropriate payments for lower limb prostheses

**Background**

Between 2005 and 2009, Medicare spending for lower prostheses increased 27 percent, from \$517 million to \$655 million. The number of Medicare beneficiaries receiving lower limb prostheses decreased by 2.5 percent, from almost 76,000 to about 74,000.

Medicare policy requires that a supplier have an order from the referring physician before providing prostheses to the beneficiary. Upon receipt of the referring physician's order, the supplier can move forward with the prostheses fitting for the beneficiary with the applicable prostheses. Medicare policy also requires that suppliers follow local coverage determination policies. These policies provide guidelines for determining the beneficiary's potential functional level and specify how suppliers must submit claims for certain types and combinations of prostheses.

The study completed by the OIG was based on an analysis of Medicare Part B claims for lower limb prostheses from 2009 and Part A and Part B claims from 2004 to 2009 for beneficiaries who received lower limb prostheses in 2009. OIG staff also completed interviews with the four DME Medicare Administrative Contractors (MACs), three Zone Program Integrity Contractors (ZPICs), and two DME Program Safeguard Contractors (PSCs). The OIG considered a paid claim did not meet the requirements if the supplier:

(continued on next page)

**Prostheses** *(continued)*

- Did not indicate whether the prosthesis was for the right or left limb
- Billed for a prosthesis for both limbs on the same date using two claims
- Did not meet potential functional level requirements
- Billed for a higher number of units of a prosthesis than allowed on a claim
- Billed for combinations of prostheses that were not allowed, or
- Billed for prostheses that were not covered.

Claims data was an additional component of the OIG’s analysis to determine the number of claims for beneficiaries with no claims from their referring physicians during the last five years and the Medicare payments for these claims. The following elements were analyzed to identify suppliers that had questionable billing:

- Suppliers that had at least 10 beneficiaries, and
- Suppliers that were paid at least \$100,000 for lower limb prostheses in 2009.

This sample included 1,632 of the 4,575 Medicare suppliers who had a paid claim for lower limb prostheses in 2009, which accounted for 92 percent of the \$655 million who billed for lower limb prostheses.

**Findings**

In 2009, the study found that:

1. In 2009, Medicare inappropriately paid \$43 million for lower limb prostheses that did not meet certain requirements. These payments could have been prevented by using claims processing edits.
2. Medicare paid an additional \$61 million for beneficiaries with no claims from their referring physicians.
3. In 2009, 267 suppliers of lower limb prostheses had questionable billing. Approximately 136 suppliers frequently submitted claims that did not meet certain Medicare requirements or were for beneficiaries with no claims from their referring physicians. An additional 131 suppliers had other questionable billing. This included billing for a high percentage of beneficiaries with no history of an amputation or missing limb or a high percentage of beneficiaries with unusual combinations of prostheses.
4. Medicare contractors conducted varying degrees of program safeguard activities related to lower limb prostheses.
  - The four DME MACs had varying claims processing edits in place, but none had edits for all requirements.

- None of the DME MACs conducted medical reviews, and not all had conducted data analyses or provided education related to lower limb prostheses.
- All ZPICs and DME PSCs conducted data analyses and opened investigations related to lower limb prostheses.

**Recommendations**

The Centers for Medicare & Medicaid Services (CMS) concurred with five of the six recommendations made by the OIG. In response to the first recommendation, to implement additional claims processing edits, CMS concurred and stated it would instruct the DME MACs to implement consistent claims processing edits based on local coverage determination requirements. In response to the second recommendation, to strengthen monitoring of billing for lower limb prostheses, CMS concurred and stated it would issue guidance to the DME MACs and instruct them to consider the measures used in the OIG report as supplemental criteria for detecting high-risk suppliers. In response to the third recommendation, to implement requirements for a face-to-face encounter to establish a beneficiary’s need for prostheses, CMS concurred and stated it is exploring its current authorities to implement such requirements. CMS also stated that it would issue an educational article to further explain policy requirements for lower limb prostheses and to providers and suppliers.

In response to the fourth recommendation, to revise the local coverage determination, CMS concurred and stated it would review the definitions for the functional levels and develop refinements as appropriate. CMS also stated it would consider adapting an algorithm to guide determination of the functional status of the beneficiary. In response to the fifth recommendation, to enhance screening for currently enrolled suppliers of lower limb prostheses, CMS did not concur and stated that it has in place sufficient tools that allow for increased scrutiny of existing DMEPOS suppliers. CMS noted that if an existing supplier meets one of several triggering events, that supplier automatically is elevated to the high-risk level. In response to the sixth recommendation, to take appropriate action on the suppliers with questionable billing, CMS concurred and stated it would share the information with the DME MACs and the Recovery Audit Contractors. Recovery Audit Contractors review Medicare claims on a post payment basis to identify inappropriate payments. The following section reviews Medicare policy for coverage of lower limb prostheses.

**Key points**

**Medicare requirements for lower limb prostheses**

Provisions of the Social Security Act (the Act) govern Medicare payment for all items or services, including lower limb prostheses. The Act states that Medicare will cover only services and items considered

*(continued on next page)*



**Prostheses (continued)**

reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

In addition, Medicare requires that a supplier have an order from a physician before providing prostheses to the beneficiary. This physician is known as the referring physician. Upon receiving the order, the supplier consults with the referring physician, as needed, to confirm the order and recommend any necessary changes and evaluates the beneficiary. The supplier fits the beneficiary with the most appropriate prostheses. The supplier then determines the group of codes that best describes the prostheses provided, choosing from 178 Healthcare Common Procedure Coding System (HCPCS) codes that are specific to lower limb prostheses.

Further, local coverage determination policies provide additional Medicare requirements for lower limb prostheses. These policies, consistent with policies for other DMEPOS, are identical across the country. The local coverage determination specifies how suppliers must submit claims for certain types and combinations of prostheses. In particular, it states that each claim must include a modifier to indicate whether the prosthesis is for the right or left limb. When a supplier provides prosthesis for each limb on the same date, the supplier must submit only one claim and include both the right and left modifiers on the claim.

The local coverage determination also has guidelines for determining the beneficiary's potential functional level. Specifically, it states that a beneficiary is placed at one of five potential functional levels based on the reasonable expectations of the supplier and the referring physician. When determining the potential functional level, suppliers must take into account the beneficiary's history, current condition, and desire to walk. The supplier then uses a modifier on the claim to indicate the beneficiary's potential functional level (K0 to K4). Prostheses are not considered medically necessary if the beneficiary has the lowest potential functional level (K0), which indicates that he or she does not have the ability or the potential to walk. In addition, for some prostheses, the local coverage determination specifies the minimum potential functional level that the beneficiary must have for the prosthesis to be considered medically necessary.

Further, the local coverage determination limits the number of certain prostheses that can be billed on a claim. If the number of units of these prostheses exceeds the limit, the additional items will be denied as not medically necessary. The local coverage determination also considers certain combinations of prostheses to be medically unnecessary. For example, certain sockets are not allowed for use with temporary base prostheses. Finally, the local coverage determination states that HCPCS L5990, a specific

type of foot addition, will be denied as not medically necessary.

In addition, CMS recently established new screening procedures for provider enrollment. For example, screening may include licensure and criminal background checks. CMS created three levels of screening – limited, moderate, and high – based on the risk of fraud, waste, and abuse. New DMEPOS suppliers were placed at the high risk level, while currently-enrolled DMEPOS suppliers were placed at the moderate risk level.

Lastly, recent legislation established a face-to-face encounter requirement for certain DMEPOS. For specified DMEPOS that require a written order prior to delivery, the referring physician must document that a physician, physician assistant, nurse practitioner, or clinical nurse specialist has had a face-to-face encounter with the beneficiary before writing the order for the item.

**Note:** You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide. You may want to review *MLN Matters*<sup>®</sup> article SE1201 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1201.pdf> for important reminders on the requirements for ordering and referring physicians.

**Additional information**

If you are unsure of, or have questions about, documentation requirements, contact your Medicare contractor at their toll-free number which may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

The entire OIG report titled "Questionable Billing By Suppliers of Lower Limb Prostheses" is available at <http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf>.

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**Tools** (*continued*)

- Prosecutions are up: the number of individuals charged with fraud increased from 797 in FY 2008 to 1430 in FY 2011 -- nearly a 75 percent increase
- In the first few weeks of enhanced site visits required under the Affordable Care Act screening requirements, HHS found 15 providers and suppliers whose business locations were non-operational and terminated their billing privileges
- Through outreach and engagement efforts, more than 49,000 complaints of fraud from seniors and people with disabilities reported to 1-800-MEDICARE were referred for further evaluation
- A recent redesign of the quarterly Medicare summary notices received by Medicare beneficiaries makes it easier to spot and report fraud

The full text of this excerpted HHS press release (issued Wednesday, April 4) can be found at <http://www.HHS.gov/news/press/2012pres/04/20120404a.html>.

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

**Source:** CMS PERL 201204-10

## Provider Enrollment

### Sign your Medicare enrollment application electronically

Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) now allows providers to sign Medicare enrollment applications electronically. Save time and expedite review of your application by using internet-based PECOS. This feature does not change who is required to sign the application.

Any organizational provider applications that are submitted via Internet-based PECOS will require the user completing the application to provide an email address for the authorized signer of the application as part of the submission process. The authorized signer can then follow the instructions in the email and electronically sign the application. This applies to applications using the following forms:

- 855A for institutional providers
- 855B for clinics, group practices, and certain other suppliers, and
- 855S for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers

In Internet-based PECOS, all Individual provider applications submitted by the individual provider that do not include new reassignments may be e-signed as part of the submission process. This applies to applications using the following forms:

- 855I for physicians and non-physician practitioners, and

- 855O for eligible ordering and referring physicians and non-physician practitioners

Any individual provider application (855I) containing new reassignments (855R) can be electronically signed as part of the submission process; however, you must select the authorized official/delegated official (AO/DO) for the organization that is accepting the reassignment and enter that official's email address. The official then will be required to follow the instruction in the email and electronically sign the application.

If an individual provider or AO/DO does not want to make use of the e-signature process, they can simply follow the current process of printing and signing the certification statement (which then needs to be mailed to the appropriate contractor).

Questions concerning a system issue regarding PECOS should be referred to the CMS EUS help desk at 866-484-8049 or [EUSupport@cgi.com](mailto:EUSupport@cgi.com).

**CMS.gov website upgrade:** Please take note that CMS is in the process of making upgrades to the [www.CMS.gov](http://www.CMS.gov) website. If you encounter problems accessing information while on the site, please refresh the page or check back later. CMS appreciates your understanding and apologize for any inconvenience.

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**Source:** CMS PERL 201203-64

## General update to Chapter 15 of the Program Integrity Manual (PIM)

### Part V

#### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians, providers, and suppliers that submit claims to Medicare carriers, fiscal intermediaries [FIs], Part A/B Medicare administrative contractors (A/B MACs) and Home Health & Hospice Medicare administrative contractors (HHH MACs) for services provided to Medicare beneficiaries.

#### What you need to know

This article is based on change request (CR) 7797, which implements changes to Chapter 15 of the *Program Integrity Manual (PIM)* – Medicare Enrollment. CR 7797 focuses on the reasons for returning CMS-855 applications in Section 15.8.1 and the policies for rejecting CMS-855 applications in Section 15.8.2 of the PIM. Please make sure your staff is familiar with these changes.

#### Key points

Providers and suppliers who bill Medicare carriers, FIs, A/B MACs and HHH MACs should take note of the following:

- Your Medicare contractor may return a Form CMS-855 submission only in the following instances:
  - The applicant sent its paper Form CMS-855 to the wrong contractor
  - The contractor received the application more than 60 days prior to the effective date listed on the application (though this does not apply to: (a) providers and suppliers submitting a Form CMS-855A application, (b) ambulatory surgical centers (ASCs), or (c) portable X-ray suppliers (PXRSS)
  - The contractor received an initial application from (a) a provider or supplier submitting a Form CMS-855A application, (b) an ASC, or (c) a PXRSS, more than 180 days prior to the effective date listed on the application
  - An old owner or new owner in a change of ownership (CHOW) submitted its application more than 90 days prior to the anticipated date of the sale (though this only applies to Form CMS-855A applications)
  - The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application
  - The provider or supplier submitted an initial application prior to the expiration of a re-enrollment bar
  - The application is not needed for the transaction in question

Providers and suppliers who bill Medicare carriers and A/B MACs take note of the following:

- If, under Section 15.8.2 of Chapter 15, a physician, non-physician practitioner, or physician or non-physician practitioner group fails to provide requested information regarding its Form CMS-855 submission within the designated timeframe, the contractor will reject (rather than deny) the application.

#### Additional information

The official instruction, CR 7797, issued to your Medicare carrier, FI, RHHI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R415PI.pdf>. Attached to CR 7997 is the revised PIM Chapter, which further details the reasons for return/rejection.

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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

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Implementation Date: May 14, 2012

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

**Note:** This article was revised on March 7, 2012, to reference *MLN Matters*® article SE1201 <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf> for important reminders on the requirements for ordering and referring physicians. Also remember that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The “To Be Announced” implementation and effective dates in this article are the correct dates. All other information is unchanged. This information was previously published in the December 2011 *Medicare B Connection*, Pages 43-44.

### Provider types affected

This article is intended for physicians, non-physician practitioners, and other Part B providers and suppliers submitting claims to carriers or Part B Medicare administrative contractors (MACs) for items or services that were ordered or referred. A separate article (MM6421) discusses similar edits affecting claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for items or services that were ordered or referred, and relates to CR 6421 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6421.pdf>.

### Provider action needed

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

### Background

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

The providers who can order/refer are:

- Doctor of medicine or osteopathy
- Dental medicine
- Dental surgery
- Podiatric medicine
- Optometry
- Physician assistant
- Certified clinical nurse specialists
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife, and
- Clinical social worker.

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

### Key points

- **During phase 1 (October 5, 2009- until further notice):** When a claim is received, the multi-carrier system (MCS) will determine if the ordering/referring provider is required for the billed service. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/

**Ordering/referring** *(continued)*

referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will continue to process but a message will be included on the remittance advice notifying the billing provider that the claims may not be paid in the future if the ordering/referring provider is not enrolled in Medicare or if the ordering/referring provider is not of the specialty eligible to order or refer.

- **During phase 2 (start date to be announced):** If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, MCS will verify that the ordering/referring provider is on the national PECOS file. If the ordering/referring provider is not on the national PECOS file, MCS will search the contractor's master provider file for the ordering/referring provider. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will not be paid.
- In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.
- Providers who order and refer may want to verify their enrollment or pending enrollment in PECOS. You may do so by:
  - Using Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) For more information, regarding PECOS enrollment go to <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Instructionsforviewingpractitionerstatus.pdf>. If no record is displayed, you do not have an enrollment record in PECOS.
  - Checking the ordering referring report at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>.
- **I don't have an enrollment record. What should I do?** Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see "Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll\\_PECOS\\_PhysNonPhys\\_FactSheet\\_ICN903764.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf).

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

**Additional information**

You can find the official instruction, CR 6417, issued to your carrier or B MAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R991OTN.pdf>.

If you have any questions, please contact your carrier or B MAC at their toll-free number, which may be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM6417 *Revised*

Related Change Request (CR) #: 6417

Related CR Release Date: November 1, 2011

Effective Dates: Phase 1: October 5, 2009,

Related CR Transmittal #: R991OTN

Implementation Dates: Phase 1: October 5, 2009, Phase 2: To Be Announced

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## Incentive Programs

### Latest success data on provider participation in EHR incentive programs

The Centers for Medicare & Medicaid Services (CMS) has released February 2012 data that highlights program-to-date (since January 2011) participation and payment totals under the Medicare and Medicaid electronic health record (EHR) incentive programs. The February report documents continued growth in registrations and payments, including:

- More than 211,500 eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) have registered for the Medicare and/or Medicaid EHR incentive programs since January 2011
  - More than 20,000 registered for the Medicare and/or Medicaid EHR incentive programs in the month of February
- More than 62,000 EPs, eligible hospitals, and CAHs have been paid for successfully participating in the Medicare and/or Medicaid EHR incentive programs
- More than \$3.8 billion has been paid in Medicare and Medicaid EHR incentive program payments to EPs, eligible hospitals, and CAHs across the country
  - More than \$738 million was paid in the month of February

Visit the “Data and Reports” page on the [EHR Incentive Programs website](#) to review more data on continued acceleration in registration and payment data.

#### Helpful resources

CMS has created several resources to help participants navigate the Medicare and Medicaid EHR incentive programs. A few key resources include:

- **An Introduction to the Medicare EHR Incentive Program for Eligible Professionals** – this interactive guide helps EPs navigate every aspect of the Medicare program and provides helpful resources and tips along the way. A Medicaid guide will be available later this spring.
- **Updated user guides** – CMS has updated the registration and attestation user guides, which walk EPs and eligible hospitals through the CMS registration and attestation system. There are five guides in total, all of which can be downloaded from the Educational Materials page of the EHR website.
- **Provider testimonial videos** – these videos, which can be found on the CMS YouTube channel, highlight providers’ experiences participating in the EHR incentive programs.

If you are considering registering for the programs, but have not done so yet, take a look at the CMS EHR website and use our eligibility tool to find out if you can participate.

**Remember:** 2012 is the last year in which EPs can receive a full incentive payment in the Medicare EHR incentive program. Beginning in 2013, EPs will receive a smaller overall total payment. Remember to register early.

**Want more information about the EHR incentive programs?** Make sure to visit the [EHR Incentive Programs website](#) for the latest news and updates on the EHR incentive programs.

**CMS.gov website upgrade:** Please take note that CMS is in the process of making upgrades to the [www.CMS.gov](#) website. If you encounter problems accessing information while on the site, please refresh the page or check back later. CMS appreciates your understanding and apologize for any inconvenience.

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

**Source:** CMS PERL 201203-65





## Quality Reporting Communication Support page now available for eRx payment adjustment hardship exemption requests

In 2009, the Centers for Medicare & Medicaid Services (CMS) implemented the Electronic Prescribing (eRx) Incentive program, which is a program that uses incentive payments and payment adjustments to encourage the use of qualified electronic prescribing systems.

From calendar year (CY) 2012 through 2014, a payment adjustment that increases each calendar year will be applied to an eligible professional's Medicare Part B physician fee schedule (PFS)-covered professional services for not becoming a successful electronic prescriber. The payment adjustment of 1.0 percent in 2012, 1.5 percent in 2013, and 2.0 percent in 2014 will result in an eligible professional or group practice participating in the eRx group practice reporting option (eRx GPRO) receiving 99.0 percent, 98.5 percent, and 98.0 percent respectively of their Medicare Part B PFS amount for covered professional services.

### Avoiding the 2013 eRx payment adjustment

Individual eligible professionals and CMS-selected group practices participating in eRx GPRO who were not successful electronic prescribers in 2011 can avoid the 2013 eRx payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2012.

### Six-month reporting requirements to avoid the 2013 payment adjustment:

- Individual eligible professionals – 10 eRx events via claims
- Small eRx GPRO – 625 eRx events via claims
- Large eRx GPRO – 2,500 eRx events via claims

For more information on individual and eRx GPRO reporting requirements, please review *MLN Matters* article "[SE1206 - 2012 Electronic Prescribing \(eRx\) Incentive Program: Future Payment Adjustments.](#)"

CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2013 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship.

### Significant hardships

The significant hardship categories are as follows:

- The eligible professional is unable to electronically prescribe due to local, state, or federal law, or regulation

- The eligible professional has or will prescribe fewer than 100 prescriptions during a six-month reporting period (January 1-June 30, 2012)
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642)
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643)

### Submitting a significant hardship code or request

To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the [Quality Reporting Communication Support page](#) (communications support page) on or between March 1-June 30, 2012. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Significant hardships associated with a G-code may be submitted via the communication support page or on at least one claim during the 2013 eRx payment adjustment reporting period (January 1-June 30, 2012). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the communication support page.

For more information on how to navigate the [communication support page](#), please reference the following documents:

["Quality Reporting Communication Support Page User Guide"](#)

[Tips for using the Quality Reporting Communication Support page](#)

For additional information and resources, please visit the [Electronic Prescribing Incentive program Web page](#).

If you have questions regarding the eRx incentive program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org). They are available Monday through Friday from 7:00 a.m.-7:00 p.m. CT.

**Source:** CMS PERL 201204-39

## Medicare Quality Reporting Incentive Programs manual update

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for physicians and other eligible professionals (EPs) who bill Medicare contractors (carriers or Medicare administrative contractors [A/B MACs]) for providing certain services to Medicare beneficiaries.

### What you need to know

This article is based on change request (CR) 7727, which informs you that a third chapter has been added to the *Medicare Quality Reporting Programs Manual*.

- This chapter describes the yearly payment instructions used by the Medicare contractors when making incentive payments described in the “Medicare Quality Reporting Incentives Manual.”
- CR 7727 manualizes existing requirements contained in existing CRs and Medicare physician fee schedule (MPFS) legislation, but does not establish any new requirements for the Physician Quality Reporting System (PQRS) and E-Prescribing (eRx) Incentive Programs.

### Background

The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a Physician Quality Reporting System, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). The Centers for Medicare & Medicaid Services (CMS) named this program the Physician Quality Reporting Initiative (PQRI). The PQRI was further modified as a result of the Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) (P. L. 110-275) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (P. L. 110-275). In 2011, the program name was changed to Physician Quality Reporting System (Physician Quality Reporting). All publicly available information on the PQRS incentive program can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.

Section 132 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) (MMSEA) authorized a new and separate incentive program for eligible professionals (EPs) who are successful e-prescribers, the E-Prescribing (eRx) Incentive program, as defined by the Medicare Improvements for Patients and Providers Act (P.L. 110-275) (MIPPA). While this program has similarities to the Physician Quality Reporting System (PQRS) incentive payment program, it is a stand-alone program with distinct reporting requirements and a separate incentive payment. All publicly available information on the eRx incentive program can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html>.

CR 7727 manualizes the information contained in existing CRs and MPFS legislation. Changes to the programs are described in the annual MPFS legislation.

### Additional information

The official instruction, CR 7727, issued to your carrier or A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R5QRI.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>.

MLN Matters<sup>®</sup> Number: MM7727

Related Change Request (CR) #: 7727

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Implementation Date: June 25, 2012

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## Message from Social Security

The Centers for Medicare & Medicaid Services (CMS) is forwarding this message on behalf of the Social Security Administration.

On Thursday, March 22, Commissioner Astrue signed an open letter to health care providers, health information managers, and medical records administrators about Social Security’s new electronic signature process for Form SSA-827, “Authorization to Disclose Information to the Social Security Administration.”

To see this important message, visit <http://go.usa.gov/EUu>. To learn about Social Security’s new electronic signature process, visit <http://go.usa.gov/PTV>.

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

**Source:** CMS PERL 201203-61

## Questions and answers about registration for the EHR incentive programs

After determining your eligibility for the electronic health record (EHR) incentive programs, you should then register as early as possible for the Medicare and/or Medicaid program. The Centers for Medicare & Medicaid Services' (CMS) EHR information center is open to assist the EHR provider community with registration and other program-related inquiries.

The center may be reached at 1-888-734-6433 (primary number) or 888-734-6563 (TTY number) from 7:30 a.m.-6:30 p.m. CT Monday through Friday, except federal holidays.

Here are a few of the information center's most frequently asked questions about registration:

**Q1:** What information should I have ready before I begin the registration process?

**A1:** When you register, you will need:

- If you are registering as an eligible hospital or Medicare eligible professional, you will need an approved enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS). Medicaid eligible professionals are not required to be enrolled in PECOS.
  - If you do not have a record in PECOS, you should still register for the Medicare and Medicaid EHR incentive programs. (**Please note:** Your eligible hospital or Medicare eligible professional registration status will remain in an "issue pending" status until you have an active enrollment record in PECOS.)
- A national provider identifier (NPI)
- A National Plan and Provider Enumeration System (NPPES) identity and access management ID and password for the individual provider
- A payee tax identification number (if you are reassigning your benefits)
- A payee NPI (if you are reassigning your benefits)

**Q2:** Which option do I select when registering on behalf of an eligible professional in the identity and access management system?

**A2:** Click on "You are requesting to act on behalf of an individual provider."

**Q3:** How can I check my registration status in the registration and attestation system?

**A3:** Log in to the registration and attestation system and click the status tab to view your registration information.

**Q4:** How do I re-submit my registration?

**A4:** To re-submit a registration, complete the following steps:

- Login to the EHR incentive program registration and attestation system
- Navigate to the registration tab
- Select the modify action for the registration
- Select the personal information registration topic
- Save the updated payee information and submit the registration.

CMS provides helpful registration guides and resources on the [registration page of the EHR website](#). Additionally, FAQs about registration can be found on the [FAQs page of the CMS website](#).

Want more information about the EHR incentive programs? Make sure to visit the [EHR incentive programs website](#) for the latest news and updates on the EHR incentive programs.

**Source:** CMS PERL 201204-31

## Results of 2010 Physician Quality Reporting System and eRx incentive program

### Data show gains in reporting quality measures and program participation rates

Results for the 2010 Physician Quality Reporting System and the 2010 electronic prescribing (eRx) incentive program show significant gains in participation and incentives paid to eligible health care professionals. The report, “2010 Physician Quality Reporting System and eRx Experience Report,” identifies key areas in which physician-level quality measures point toward future measurable results in improved quality of care delivered to Medicare beneficiaries. The full report can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.

In 2010, the Physician Quality Reporting System and the eRx incentive program combined, paid \$662,531,035 in incentives across all participation options, which represents a 72-percent increase from 2009 (\$384,704,248). The average incentive amount for individual professionals who satisfactorily reported was nearly \$2000 in the Physician Quality Reporting System for 2010 and more than \$3000 for successful electronic prescribers in the eRx incentive program.

While the Physician Quality Reporting System and the eRx incentive program were designed to promote reporting of quality data, this information can be useful for future evaluations of the quality of care furnished to Medicare beneficiaries. The 2010 eRx incentive program revealed that more than 130,000 eligible professionals and 27,000 practices implemented and used qualified electronic prescribing systems. Each patient who received electronic prescriptions has the potential to reap the demonstrated benefits of electronic prescribing such as improving prescription accuracy and reducing preventable adverse drug interactions.

More information about the Physician Quality Reporting System, including how eligible professionals can participate and the criteria for reporting to qualify for an incentive payment, is available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>. More information on how to participate in the eRx incentive program as well as more information about the 2012 eRx payment adjustment can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html>.

The full text of this excerpted CMS media factsheet (issued Fri Mar 30) can be found at <http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4320>.

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

**Source:** CMS PERL 201204-02

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## Louisiana’s Medicaid EHR incentive program first in nation to issue an incentive payment for eligible professionals for meaningful use

Louisiana is the first state in the nation to issue an incentive payment to a Medicaid-eligible professional (EP) for demonstrating meaningful use of certified electronic health record (EHR) technology for the Medicaid EHR incentive program. The Louisiana Department of Health and Hospitals made the payment to the Winn Community Health Center, a federally qualified health center (FQHC), on behalf of three EPs. The Winn Community Health Center, a small rural community center staffed by a physician, a nurse practitioner, and a physician’s assistant, was also the first FQHC in Louisiana to enroll with the state health information exchange (HIE).

Through the Medicaid EHR incentive program, EPs and eligible hospitals can receive a payment during their first year of participation for adopting, implementing, or upgrading to certified EHR technology. They must *demonstrate meaningful use* of certified EHR technology in ways that can be measured significantly in both quality and in quantity to receive continued payments after their first year. Medicaid EPs can earn a total of \$63,000 over six years.

More than 76,000 providers have already received a Medicare or Medicaid EHR incentive payment for successfully adopting, implementing, upgrading, or demonstrating meaningful use of EHRs. Of the total providers paid, more than 30,000 of them participated in the Medicaid EHR incentive program. As more Medicaid EPs begin their second year of the EHR incentive program and achieve meaningful use in 2012, thousands of additional providers will receive their EHR incentive payments. Visit the [CMS YouTube page](#) for stories from providers about their experiences with meaningful use.

### Want more information about the Medicare and Medicaid EHR incentive programs?

Make sure to visit the [EHR incentive programs website](#) for the latest news and updates.

**Source:** CMS PERL 201204-41



## General Information

### Redesigned Medicare summary notices

#### Provider types affected

This *MLN Matters*<sup>®</sup> special edition article is informational in nature and is intended for all providers who provide Medicare-covered services in the Medicare fee-for-service (FFS) program.

#### Background

The Centers for Medicare & Medicaid Services (CMS) has announced the redesign of the statement that informs Medicare beneficiaries about their claims for Medicare benefits.

#### What you need to know

CMS will make the redesigned statement, known as the Medicare summary notice (MSN), available online. Starting in 2013, CMS will mail the MSN to beneficiaries quarterly.

The MSN redesign is part of a new initiative, “Your Medicare Information: Clearer, Simpler, At Your Fingertips”. This initiative aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand.

CMS will take additional actions this year to make information about benefits, providers, and claims more accessible and easier to understand for people who have Medicare. This MSN redesign reflects more than 18 months of research and feedback from beneficiaries to provide enhanced customer service and respond to suggestions and input.

#### Features of the redesigned MSN

The redesign of the MSN includes several features that are not available in the current MSN, including:

- A clear notice on how to check the form for important facts and potential fraud
- An easy-to-understand snapshot of:
  - The beneficiary’s deductible status
  - A list of the providers they saw, and
  - Whether Medicare approved their claims.
- Clearer language, including consumer-friendly descriptions for medical procedures
- Definitions of all the column headers present in the form
- Larger fonts to make it easier to read, and
- Information on preventive services available to Medicare beneficiaries.

#### For more information

The redesigned MSN is available on [www.mymedicare.gov](http://www.mymedicare.gov), which is Medicare’s secure online service for personalized information regarding Medicare benefits and services.

To see a side-by-side comparison of the former and redesigned MSNs, please visit [http://www.cms.gov/apps/files/msn\\_changes.pdf](http://www.cms.gov/apps/files/msn_changes.pdf).

To view the CMS press release on the MSN redesign, please visit: <http://www.CMS.gov/apps/media/press/release.asp?Counter=4298>.

MLN Matters<sup>®</sup> Number: SE1218  
Related Change Request (CR) #: NA  
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## New Affordable Care Act program to improve care, control Medicare costs – off to a strong start

### Over 1.1 million beneficiaries now served by Accountable Care Organizations

**A new program that will help physicians, hospitals, and other health care providers work together to improve care for people with Medicare is off to a strong start.**

Under the new Medicare shared savings program (shared savings program), 27 accountable care organizations (ACOs) have entered into agreements with the Centers for Medicare & Medicaid Services (CMS), taking responsibility for the quality of care furnished to people with Medicare in return for the opportunity to share in savings realized through improved care. The shared savings program and other initiatives related to ACOs are made possible by the Affordable Care Act, the health care law of 2010. Participation in an ACO is purely voluntary for providers and beneficiaries and people with Medicare retain their current ability to seek treatment from any provider they wish.

The first 27 shared savings program ACOs will serve an estimated 375,000 beneficiaries in 18 states. This brings the total number of organizations participating in Medicare shared savings initiatives on Sunday, April 1 to 65, including the 32 pioneer model ACOs that were announced last December, and six physician group practice transition demonstration organizations that started in January 2011. In all, as of Sunday, April 1, more than 1.1 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives.

CMS also announced that five ACOs are participating in the advance payment ACO model beginning Sunday, April 1. This model will provide advance payment of expected shared savings to rural and physician-based ACOs participating in the shared savings program that would benefit from additional start-up resources. These resources will help build the necessary care coordination infrastructure necessary to improve patient outcomes and reduce costs, such as new staff or information technology systems. CMS is reviewing more than 50 applications for advance payments that start in July. For more information on the advanced payment ACO model, including the participating ACOs, visit <http://innovations.CMS.gov/initiatives/ACO/Advance-Payment/>.

The full text of this excerpted CMS press release (issued Tuesday, April 10) can be found at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4333>, and a media fact sheet can be found at <http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4334>.

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

**Source:** CMS PERL 201204-22

### Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our new "time limit" calculators on our Appeals of claim decisions page. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.



## Reminder of how reasonable cost principles apply to provider taxes on Medicare cost reports

Providers are reminded to comply with the longstanding Medicare reasonable cost principles when reporting allowable health care-related taxes (commonly referred to as provider taxes) on their Medicare cost reports. Use the reasonable cost principles set forth in the Medicare statute, regulations and CMS Pub. 15-1 *Provider Reimbursement Manual* (PRM-1), when determining how much, if any, of a provider tax is an allowable Medicare cost.

Although a particular provider tax may be an allowable Medicare cost, when payments associated with the assessed tax are made to the provider, Medicare will recognize only the net tax expense incurred by the provider. The net tax expense consists of taxes deemed reasonable, that have been actually incurred and paid by a provider, reduced by payments the provider received that are associated with the tax.

Pursuant to 42 CFR §§413.20, 413.24 and the PRM, providers are required to maintain financial records and statistical data for proper determination of costs payable under the program. Should the provider be unable to produce documentation to support the net tax expense incurred, contractors must disallow the entire tax claimed on the provider's Medicare cost report.

**CMS.gov website upgrade:** Please take note that the Centers for Medicare & Medicaid Services (CMS) is in the process of making upgrades to the [www.CMS.gov](http://www.CMS.gov) website. If you encounter problems accessing information while on the site, please refresh the page or check back later. CMS appreciates your understanding and apologize for any inconvenience.

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

**Source:** CMS PERL 201203-63

### CMS.gov website upgrade completed

The Centers for Medicare & Medicaid Services (CMS) has completed the upgrades to the [www.CMS.gov](http://www.CMS.gov) website. Bookmarked links to items posted in the "Downloads" sections on the CMS website have not been affected. However, if you attempt to use other bookmarked URLs, you will be redirected to the index Web page for that topic. For example, if you bookmarked the page containing national provider calls and events, you will be taken to the index page for national provider calls. Once you have arrived on the index page, select the Web page you'd like to view from the left-hand side. To correct your bookmark, once you have opened the correct page, you may create a new bookmark. CMS appreciates your understanding and apologizes for any inconvenience during this process.

- **Home health:** <http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html>
- **Hospice:** <http://www.cms.gov/Center/Provider-Type/Hospice-Center.html>

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

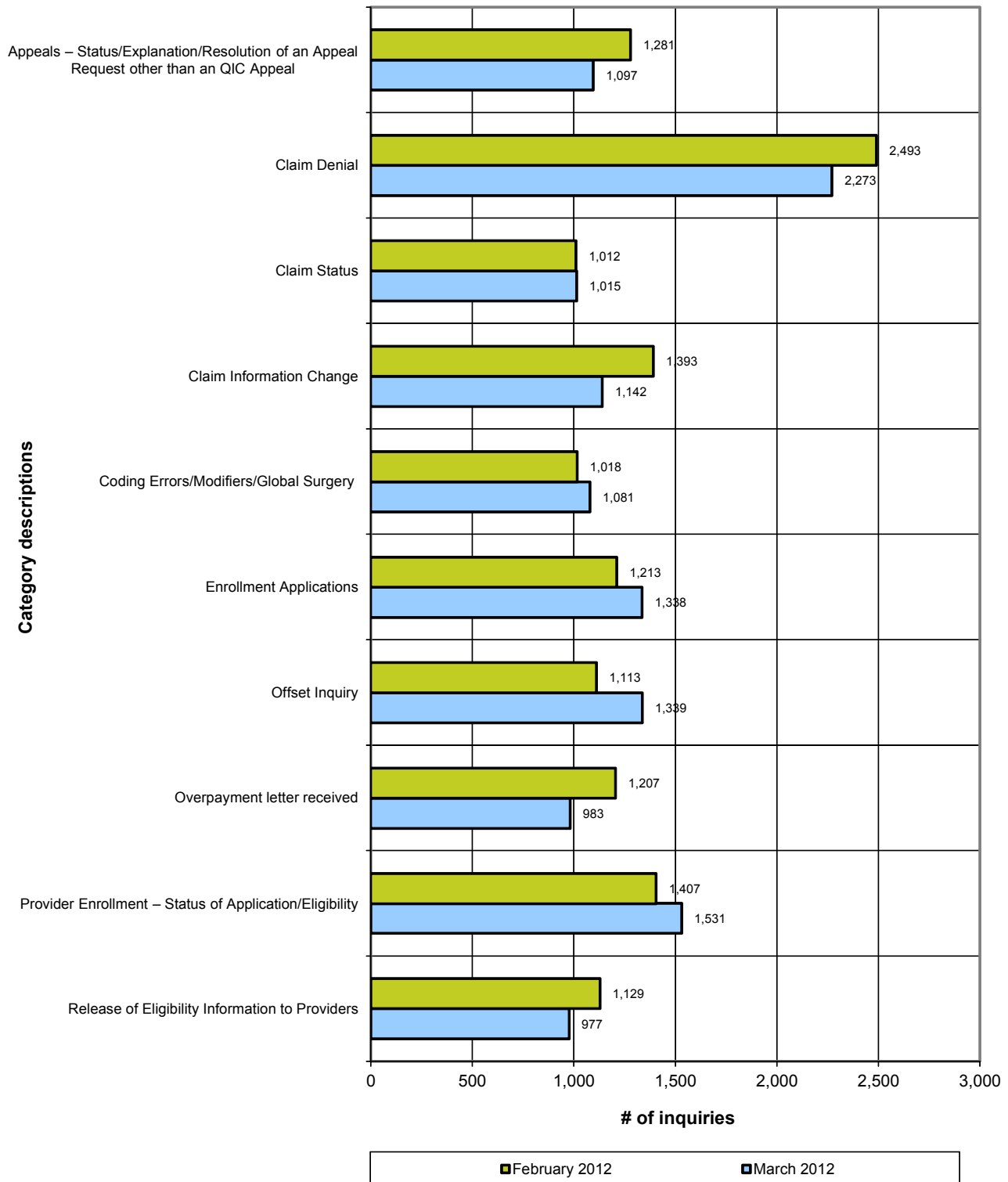
**Source:** CMS PERL 201204-16

## Top inquiries, denials, and return unprocessable claims

The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during February and March 2012.

For tips and resources to help providers 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).

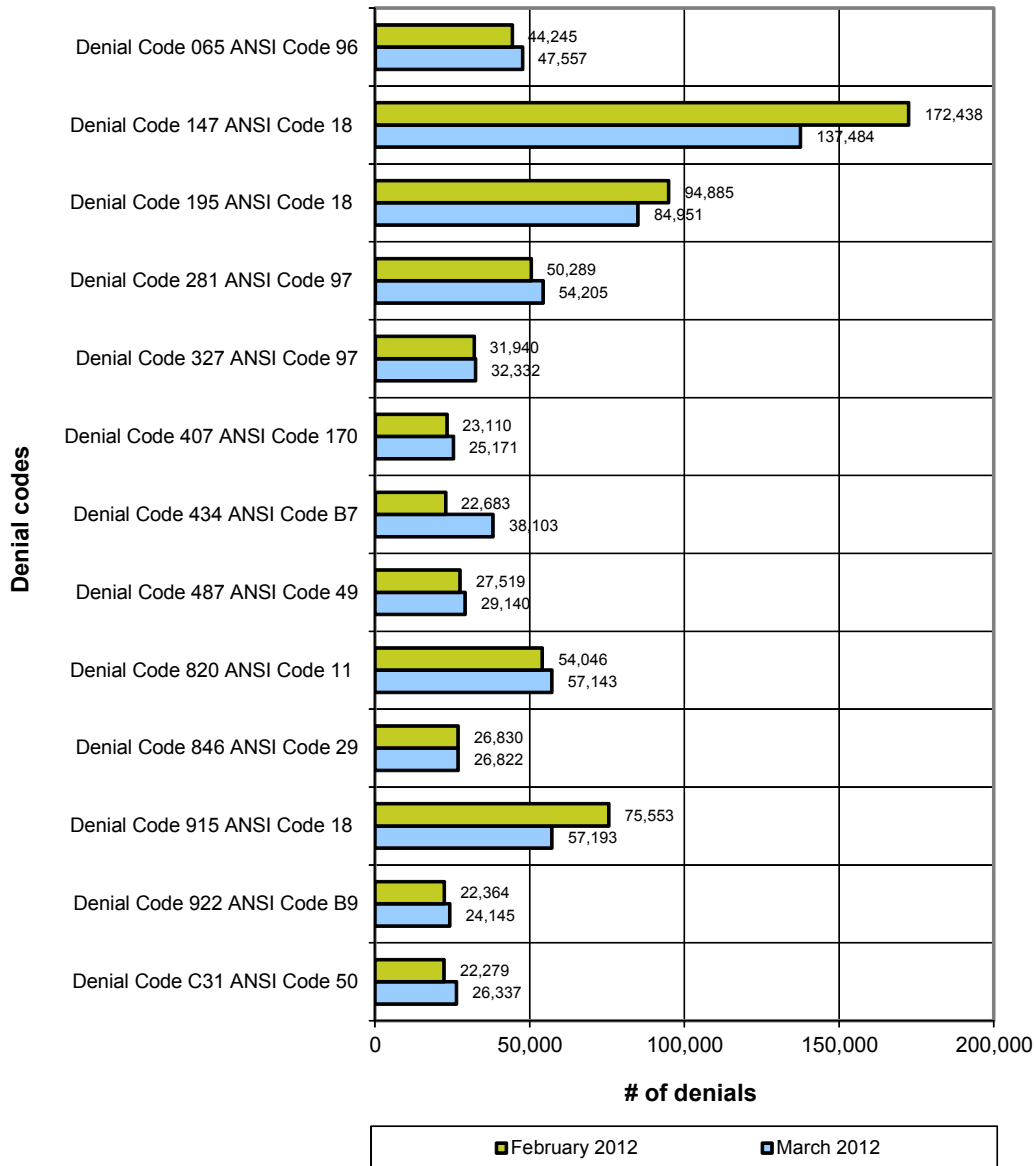
### Part B top inquiries for February-March 2012



(continued on next page)

Top (continued)

Part B top denials for February-March 2012



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.

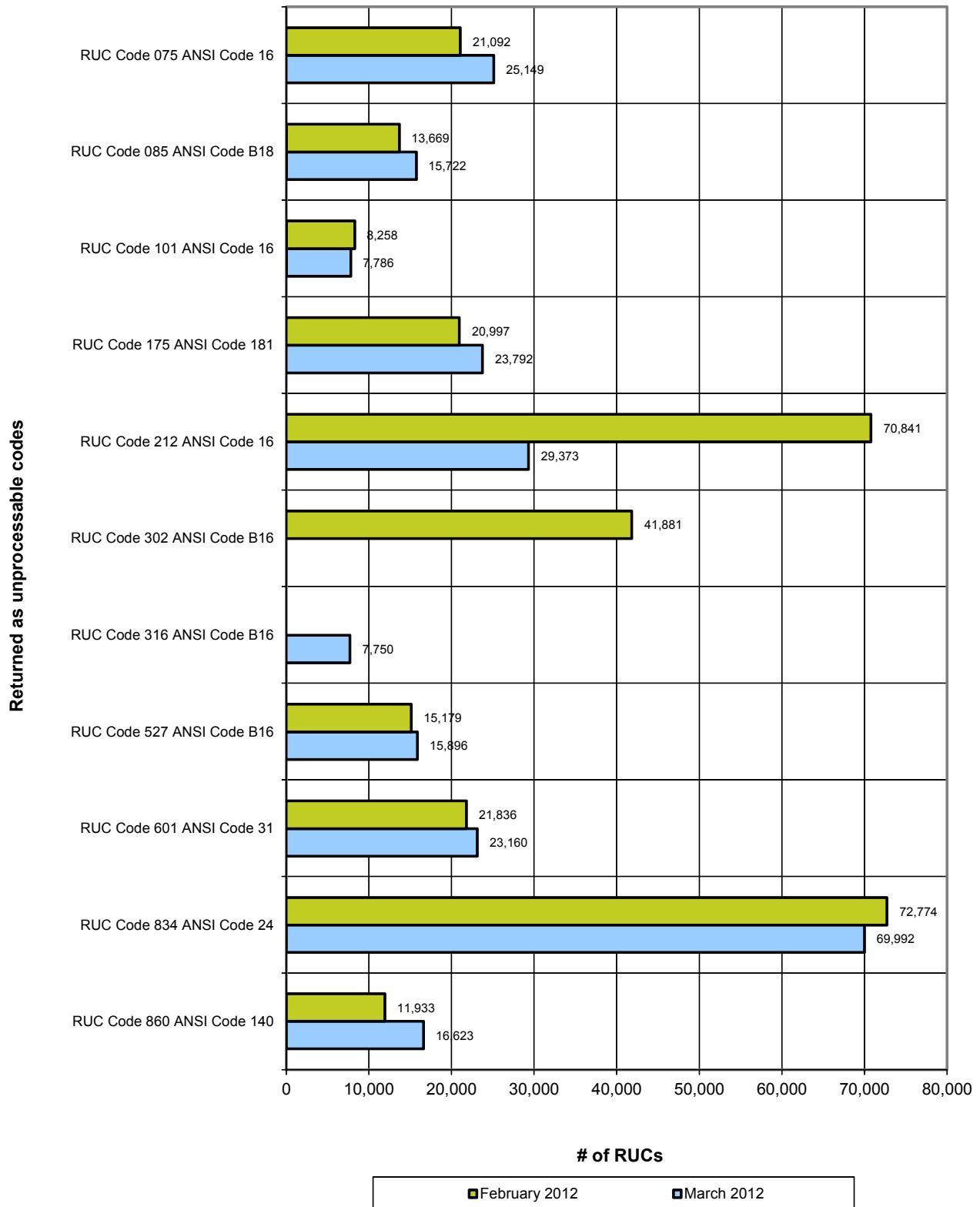
Refer to the [Claim completion FAQs](#), [Billing issues FAQs](#), and [Unprocessable FAQs](#) on the FCSO Medicare provider website for additional information on why claims may deny and how to correct this.

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)

## Part B top return as unprocessable claims for February-March 2012



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

## Contents

Advance beneficiary notice .....	79
<b>New LCDs</b>	
43201: Noncovered procedures – endoscopic treatment of gastroesophageal reflux disease (GERD).....	80
95920: Intraoperative neurophysiology testing.....	80
J9033: Bendamustine hydrochloride (Treanda®).....	81
<b>Revisions to LCDs</b>	
36470: Treatment of varicose veins of the lower extremity .....	82
67221: Ocular photodynamic therapy (OPT) with verteporfin .....	82
84999: Gene expression profiling panel for use in the management of breast cancer treatment.....	83
92015: Ophthalmological diagnostic services .....	83
BOTULINUM TOXINS: Botulinum toxins.....	83
J0897: Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications.....	84
J1745: Infliximab (Remicade™) .....	85
J9001: Doxorubicin, liposomal (Doxil) .....	85
J9041: Bortezomib (Velcade®).....	86
NCSVCS: Noncovered services .....	86
THERSVCS: Therapy and rehabilitation services .....	87
ZEVALIN: Ibritumomab tiuxetan (Zevalin®) therapy.....	87
<b>Additional Information</b>	
76499: Digital tomosynthesis (3D Mammography).....	88
Self-administered drug (SAD) list – Part B: J3490/J3590/ C9399/J1324 .....	89

## 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

### 43201: Noncovered procedures – endoscopic treatment of gastroesophageal reflux disease (GERD) – new LCD

**LCD ID number: L32485 (Florida/Puerto Rico/U.S. Virgin Islands)**

This new local coverage determination (LCD) describes endoscopic treatments of gastroesophageal reflux disease (GERD) that were evaluated for coverage. It was determined that the current published available evidence based on peer-reviewed literature is not sufficient to establish the long-term safety and efficacy of transesophageal endoscopic anti-reflux procedures as treatment for GERD. The LCD describes three transesophageal endoscopic approaches designed to treat GERD including endoscopic plication or suturing procedures; the use of radiofrequency (RF) energy; and submucosal injection or implantation of biocompatible bulking agents or polymer prosthetics. All of the procedures related to the endoscopic treatment of GERD are noncovered at this time, as new data becomes available, we will reconsider upon request.

#### Effective date

This new LCD is effective for services rendered **on or after June 12, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

### 95920: Intraoperative neurophysiology testing – new LCD

**LCD ID number: L32489 (Florida/Puerto Rico/U.S. Virgin Islands)**

Intraoperative neurophysiology testing (IONT) is the use of electrophysiology methods to test the functional integrity of certain neural structures (e.g., nerves, spinal cord, and part of the brain) during certain surgeries. The principle goal of IONT is the identification of nervous system impairment in the hope that prompt intervention will prevent deficits such as muscle weakness, loss of sensation, hearing loss, and impairment of other bodily functions, and/or to provide functional guidance to the surgeon and anesthesiologist. Secondly, the mapping techniques used to identify critical structures in the nervous system are identified electrophysiologically; the surgeon avoids these structures to prevent neurological damage from occurring. Correctable factors that can occur during surgery include circulatory disturbance, excess compression from retraction, bony structures or hematomas, or mechanical stretching.

A new local coverage determination (LCD) has been developed to give indications and limitations of coverage and/or medical necessity, CPT codes, documentation requirements, utilization guidelines, and coding guidelines for IONT.

#### Effective date

This new LCD is effective for services rendered **on or after June 12, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

#### 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.

## J9033: Bendamustine hydrochloride (Treanda®) – new LCD

### LCD ID number: L32493 (Florida/Puerto Rico/U.S. Virgin Islands)

Bendamustine hydrochloride (Treanda®) is a bifunctional mechlorethamine derivative with alkylator and antimetabolite activities. The exact mechanism of action remains unknown, however, bendamustine hydrochloride appears to act primarily as an alkylator. It is believed to inhibit DNA, RNA, and protein synthesis and subsequently apoptosis.

Bendamustine hydrochloride is approved by the Food and Drug Administration (FDA) for injection for the treatment of patients with the following indications:

- Chronic lymphocytic leukemia (CLL). Efficacy relative to first line therapies other than chlorambucil has not been established.
- Indolent B-cell non-Hodgkin lymphoma (NHL) that has progressed during or within six months of treatment of rituximab or a rituximab-containing regimen.

This new local coverage determination (LCD) addresses FDA indications as well as the following off-label indications per the National Comprehensive Cancer Network (NCCN):

- Hodgkin lymphoma – Classical Hodgkin lymphoma (Second-line or salvage therapy as a single agent with or without radiation therapy (RT) prior to autologous stem cell rescue for progressive disease or for relapsed disease in patients initially treated with chemotherapy with or without RT)
- Hodgkin lymphoma – Lymphocyte predominant Hodgkin lymphoma (Second-line or salvage therapy as a single agent or in combination with rituximab with or without RT prior to autologous stem cell rescue for progressive disease or for relapsed disease in patients initially treated with chemotherapy with or without RT)
- Multiple myeloma (Salvage therapy on or off clinical trials as a single agent for disease relapse or for progressive or refractory disease)
- Waldenström's macroglobulinemia/Lymphoplasmacytic lymphoma (Used with or without rituximab as primary therapy, salvage therapy for disease that does not respond to primary therapy or for progressive or relapsed disease)

This new LCD was developed to outline indications and limitations of coverage and/or medical necessity, ICD-9 CM codes that support medical necessity, documentation requirements and utilization guidelines for bendamustine hydrochloride (Treanda®). A coding guidelines LCD attachment was also developed which includes information on the dosage and administration of bendamustine.

#### Effective date

This new LCD is effective for services rendered **on or after June 12, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).





## Revisions to LCDs

### 36470: Treatment of varicose veins of the lower extremity – revision to the LCD

**LCD ID number: L29298 (Florida)**

**LCD ID number: L29403 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for treatment of varicose veins of the lower extremity was most recently revised June 14, 2011. Since that time, revisions were made under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD under the subheading “Endovenous ablation therapy.” Language was corrected and updated to reflect the following verbiage: one post-operative ultrasound will be allowed for follow-up care when endovenous radiofrequency ablation (ERFA) or endovenous laser treatment (EVLT) is performed. The medical record must clearly indicate that the reason for the follow up ultrasound is related to the ERFA or EVLT procedure performed.

#### Effective date

This LCD revision is effective for services rendered **on or after March 27, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

### 67221: Ocular photodynamic therapy (OPT) with verteporfin – revision to the LCD

**LCD ID number: L29239 (Florida)**

**LCD ID number: L29372 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for ocular photodynamic therapy (OPT) with verteporfin was effective for services rendered on or after February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a revision was made to the LCD based on a reconsideration request. Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD a subheading for “Limitations” was added with verbiage to include the off-labeled indication of central serous retinopathy (CSR) (ICD-9-CM code 362.41) to be reviewed on an individual consideration basis with specified criteria. In addition, the “Utilization Guidelines” section of the LCD and “Coding Guidelines” attachment were updated regarding CSR on an individual consideration basis. 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 April 23, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

## 84999: Gene expression profiling panel for use in the management of breast cancer treatment – revision to the LCD

**LCD ID number: L29184 (Florida)**

**LCD ID number: L29343 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for gene expression profiling panel for use in the management of breast cancer treatment was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, based on a reconsideration request, the LCD has been revised to add estrogen positive breast carcinoma with 1-3 positive nodes to the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD.

### Effective date

This LCD revision is effective for services rendered **on or after April 10, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

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## 92015: Ophthalmological diagnostic services – revision to the LCD

**LCD ID number: L29241 (Florida)**

**LCD ID number: L29457 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for ophthalmological diagnostic services was effective for services rendered on or after February 2, 2009, for Florida and for services rendered on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD has been revised to remove *CPT* code 92015 from the LCD as the Medicare physician fee schedule database (MPFSDB) status indicator for *CPT* code 92015 is an “N” (non-covered service). Therefore, the “Contractor’s Determination Number” was changed from 92015 to 92018. Also, under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD the range of *CPT* codes “92015-92499” was changed to “92018-92499.” In addition, the “Centers for Medicare & Medicaid Services [CMS] National Coverage Policy” section of the LCD was updated to include the reference to CMS Manual System, *Medicare Program Integrity Manual*, Pub. 100-08, Chapter 13, Section 13.1.3.

### Effective date

This LCD revision is effective for claims processed **on or after March 27, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

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## BOTULINUM TOXINS: Botulinum toxins – revision to the LCD

**LCD ID number: L29088 (Florida)**

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

The local coverage determination (LCD) for botulinum toxins was most recently revised January 1, 2012. Since that time, revisions were made under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD to remove the off-label indication for Botox® to treat neurogenic urinary incontinence and to add the new Food and Drug Administration (FDA) label indication for the treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of anticholinergic medication. In addition, the “CMS National Coverage Policy” and the “Sources of Information and Basis for Decision” sections of the LCD were updated.

(continued on next page)

**Botox (continued)****Effective date**

This LCD revision is effective for services rendered **on or after March 29, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

## J0897: Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the LCD

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

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was most recently revised January 01, 2012. Since that time, a revision was made to the LCD based upon a request and revisions to the Food and Drug Administration’s (FDA) label indications for Prolia®.

Under the “Indications and Limitations of Coverage and/or Medical necessity” section of the LCD clinical trial information and the following indications were added for Prolia®:

- Treatment of bone loss in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer
- Treatment of bone loss in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer

In addition, under the “ICD-9 Codes that Support Medical Necessity” section of the LCD the following diagnosis codes/requirements were added for Prolia® (HCPCS code J0897) and Boniva® (HCPCS code J1740):

**Boniva®**

- 198.5 Secondary malignant neoplasm of bone and bone marrow
- 731.0 Osteitis deformans without mention of bone tumor

**Prolia®**

For treatment of bone loss in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer, ICD-9-CM code 733.90 (Disorder of bone and cartilage, unspecified) is reported with ICD-9-CM code V10.3 and V07.52:

- V10.3 Personal history of malignant neoplasm of breast
- V07.52 Use of aromatase inhibitors

For treatment of bone loss in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer, ICD-9-CM code 733.90 is reported with ICD-9-CM code V10.46 and V58.69:

- V10.46 Personal history of malignant neoplasm of prostate
- V58.69 Long term (current) use of other medications

In addition, the “Documentation Requirements” section of the LCD was also updated to include the revisions to the FDA label indications for Prolia®.



(continued on next page)

**J0897 (continued)****Effective date**

This LCD revision is effective for claims processed **on or after May 1, 2012**, 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

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**J1745: Infliximab (Remicade™) – revision to the LCD**

**LCD ID number: L29198 (Florida)**

**LCD ID number: L29440 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for infliximab (Remicade™) was effective for services rendered on or after February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a revision was made to the LCD based on a reconsideration request. Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, a reference was made to the new subheading of “Limitations” for individual consideration for Takayasu’s disease (ICD-9-CM code 446.7). Under this new “Limitations” section of the LCD, language was given stating medical records may be requested for prepayment review when diagnosis code 446.7 is billed for infliximab (Remicade™). In addition, the “CMS National Coverage Policy”, “Utilization Guidelines”, and “Sources of Information and Basis for Decision” sections of the LCD were updated.

**Effective date**

This LCD revision is effective for services rendered **on or after April 23, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

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**J9001: Doxorubicin, liposomal (Doxil) – revision to the LCD**

**LCD ID number: L29157 (Florida)**

**LCD ID number: L29419 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for doxorubicin, liposomal (Doxil) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a revision was made to the LCD based on the Food and Drug Administration (FDA) label revision to approve the use of imported Lipodox to the United States on February 21, 2012. The “CPT/HCPCS Code” section of the LCD was revised to add HCPCS codes J9999 and C9399 (Ambulatory Surgical Centers [ASCs only]) and the descriptor “Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg.”

**Effective date**

This LCD revision is effective for claims processed **on or after April 24, 2012**, for services rendered **on or after February 21, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).



**J9041: Bortezomib (Velcade®) – revision to the LCD****LCD ID number: L29087 (Florida)****LCD ID number: L29102 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for bortezomib (Velcade®) was most recently revised November 1, 2011. Since that time, a revision was made to add off-label diagnoses related to the indication of multiple myeloma per the National Comprehensive Cancer Network (NCCN) compendia for the administration route of subcutaneous injection and intravenous injection. The following ICD-9-CM codes were added under the section of the LCD titled “ICD-9 Codes that Support Medical Necessity.”

- 203.10 (Plasma cell leukemia without mention of having achieved remission failed remission)
- 203.12 (Plasma cell leukemia in relapse)
- 203.80 (Other immunoproliferative neoplasms without mention of having achieved remission failed remission)
- 203.82 (Other immunoproliferative neoplasms in relapse)
- 238.6 (Neoplasm of uncertain behavior of other and unspecified sites and tissues, plasma cells)

In addition, the “Centers for Medicare & Medicaid Services (CMS) National Coverage Policy” section of the LCD was updated to include the references to CMS Manual System, *Medicare Program Integrity Manual*, Pub.100-08, Chapter 13, Section 13.1.3 and Social Security Act Section 1861(t)(2)(B). Verbiage was also updated under the “Indications and Limitations of Coverage and/or Medical Necessity” and “Sources of Information and Basis for Decision” sections of the LCD.

**Effective date**

This LCD revision is effective for services rendered **on or after April 12, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

**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 February 27, 2012. Since that time, a revision was made to the LCD. New category III CPT codes and a HCPCS code from the Centers for Medicare & Medicaid Services (CMS) annual 2012 HCPCS update (change request [CR] 7540) 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 0278T, 0282T, 0283T, 0284T, 0285T, 0286T, 0287T, 0291T, 0292T, 0293T, 0294T, 0299T, 0300T, 0301T, and HCPCS code C9732 (Ambulatory Surgical Centers [ASCs] only) were added to the “CPT/HCPCS Codes – Local Noncoverage Decisions – Procedures” section of the LCD.

Also, HCPCS code C1830 (ASCs only) and unlisted CPT codes 99199 (when billed for the SNaP wound care system – a portable, non-powered, single use suction device with dressing kit, for wound management via application of negative pressure to the wound), 20999 (when billed for the magnetic resonance guided focused ultrasound surgery (MRgFUS) [e.g., ExAblate]), and 66999 (when billed for the Insertion of ocular telescope prosthesis including removal of crystalline lens [physician’s services only]) 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, HCPCS code C1830 and unlisted CPT code 99199 were added to the “CPT/HCPCS Codes – Local Noncoverage Decisions – Devices” section of the LCD; and unlisted CPT codes 20999 and 66999 were added to the “CPT/HCPCS Codes – Local Noncoverage Decisions – Procedures” section of the LCD.

In addition, unlisted CPT code 43499 (when billed for the EsophyX® System [transoral incisionless fundoplication TIF®]) was removed from the “CPT/HCPCS Codes, Local Noncoverage Decisions – Procedures” section of the LCD and was added to the new LCD for Noncovered Procedures: Endoscopic Treatment of Gastroesophageal Reflux Disease (GERD).

*(continued on next page)*

**NCSVCS (continued)****Effective date**

This LCD revision is effective for services rendered **on or after June 12, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

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**THERSVCS: Therapy and rehabilitation services – revision to the LCD**

**LCD ID number: L29289 (Florida)**

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

The local coverage determination (LCD) and “coding guidelines” attachment for therapy and rehabilitation services were most recently revised January 1, 2012. Since that time, verbiage has been revised to reflect “until further notice” in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD under the subsection “Exception Process for Outpatient Therapy Caps” and in the LCD “Coding Guidelines” attachment under the subsection “Use of the KX Modifier.” This revision was based on information received from the Centers for Medicare & Medicaid Services (CMS).

**Effective date**

This LCD revision is effective for services rendered **on or after March 01, 2012**. 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

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**ZEVALIN: Ibritumomab tiuxetan (Zevalin®) therapy – revision to the LCD**

**LCD ID number: L29193 (Florida)**

**LCD ID number: L29348 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for ibritumomab tiuxetan (Zevalin®) therapy was most recently revised September 3, 2009. Since that time, the LCD has been revised to update current Food and Drug Administration (FDA) indications regarding the removal of the Indium-111 imaging dose and dosimetry requirements previously required as part of the Zevalin® treatment regimen. Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, language was revised to define Zevalin® and update current FDA indications. Also, the “CPT/HCPCS Codes” section of the LCD was revised to remove CPT/HCPCS codes 78802, 78804, and A9542 related to In-111 Zevalin®. Reference to HCPCS code A9542 was removed from the “ICD-9 Codes that Support Medical Necessity” section of the LCD. In addition the “CMS National Coverage Policy,” “Utilization Guidelines,” and “Sources of Information and Basis for Decision” sections of the LCD were updated. The “Coding Guidelines” attachment was also updated with this new FDA information.

**Effective date**

This LCD revision is effective for claims processed **on or after April 3, 2012**, for services rendered **on or after November 18, 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.

**Note:** To review active, future, and retired LCDs for jurisdiction 9 (J9), please [click here](#).

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## Additional Information

### 76499: Digital tomosynthesis (3D Mammography)

Digital breast tomosynthesis (3-D Mammography) is a new imaging technology used to detect breast cancer. Currently, the clinical literature does not demonstrate significant improvement in health outcomes compared to traditional 2D mammography, though clinical studies are ongoing. Medicare covers diagnostic mammography when medically reasonable and necessary and screening mammography per the preventive services benefit.

Per the Centers for Medicare & Medicaid Services (CMS) Medicare Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 20.1, Preventive and Screening Services:

*“the Mammography Quality Standards Act (MQSA) provides specific standards regarding those qualified to perform screening and diagnostic mammograms and how they should be certified. The MQSA requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards.*

*Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the Food and Drug Administration (FDA) to continue to operate. The FDA Center for Devices and Radiological Health is responsible for collecting certificate fees and surveying mammography facilities (screening and diagnostic)”.*

At this time, there is no national Medicare statement that distinguishes 2D from 3D mammography techniques. Until such clarification, 2D and 3D mammography will be reimbursed the same in Medicare Part B if program requirements are met.

Currently, there is not a consensus on the billing and coding of digital breast tomosynthesis as providers have been using the G codes for direct digital image, the unlisted code- (noting that it is not a ‘direct’ digital technique), or both. In order to ensure beneficiary access to routine care, mammography screening and diagnostic testing, MAC J9 will allow the medically reasonable and necessary diagnostic or screening mammography under the Medicare benefit as the applicable G code reimbursement only (one payment for service) and it is recommend that 76499 for breast tomosynthesis be billed with the appropriate G code.

- 76499 Unlisted diagnostic radiographic procedure (Use for Digital Breast Tomosynthesis [3-D Mammography])
- G0202 Screening mammography, producing direct digital image, bilateral, all views
- G0204 Diagnostic mammography, producing direct digital image, bilateral, all views
- G0206 Diagnostic mammography, producing direct digital image, unilateral, all views
- 77051 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)
- 77052 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)

Of note, because digital breast tomosynthesis (DBT) is a new mammographic modality, facilities wanting to use DBT on patients must meet all MQSA (Mammography Quality Standards Act) applicable requirements. See the attached Food and Drug Administration (FDA) website [http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/FacilityCertificationandInspection/ucm243765.htm?utm\\_source=fdaSearch&utm\\_medium=website&utm\\_term=dbt&utm\\_content=3](http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/FacilityCertificationandInspection/ucm243765.htm?utm_source=fdaSearch&utm_medium=website&utm_term=dbt&utm_content=3).

## Self-administered drug (SAD) list – Part B: J3490/J3590/C9399/J1324

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered on or after May 19, 2012, the following drugs have been added to the MAC J-9 Part B SAD list.

- J3490/J3590/C9399: Injection, Sylatron (peginterferon alfa-2b)
- J3490/J3590/C9399: Injection, Firazyr (icatibant)
- C9399: Injection: Exenatide injection [Byetta®]
- C9399: Injection, Anakinra [Kineret™] 100 mg
- C9399: Injection, Peginterferon alpha 2a [Pegasys®]

In addition, Enfuvirtide [Fuzeon™] has been on the SAD list as HCPCS code J3490 and has now been updated to reflect the correct HCPCS code J1324.

The evaluation of drugs for addition to the self-administered drug (SAD) list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options Inc. (FCSO) SAD lists are available through the CMS Medicare coverage database at [http://medicare.fcso.com/Self-administered\\_drugs/](http://medicare.fcso.com/Self-administered_drugs/).

### Never miss an appeals deadline again

When it comes to submitting a claims appeal request, timing is everything. Don't worry – you won't need your desk calendar to count the days to your submission deadline. Try our new "time limit" calculators on our *Appeals of claim decisions page*. Each calculator will automatically calculate when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.



## Educational Events

### Upcoming provider outreach and educational events May-June 2012

#### *Therapy cap exception process and use of the KX modifier*

**When:** Tuesday, May 22  
**Time:** 11:30 a.m.-12:30 p.m.

#### *Medifest 2012 Orlando*

**When:** Tuesday-Thursday, June 5-7  
**Time:** 11:30 a.m.-1:00 p.m.  
**Type of event:** Face-to-face

**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: \_\_\_\_\_

Email Address: \_\_\_\_\_

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

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

Keep checking our website, [medicare.fcsou.com](http://medicare.fcsou.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

### April is Alcohol Awareness Month

Alcohol Awareness Month is a nationwide campaign intended to raise awareness of the health and social problems excessive alcohol consumption can cause, not only for individuals, but their families, friends, and communities as well. According to the United States Preventive Services Task Force (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems. Harmful

drinking describes those persons currently experiencing physical, social, or psychological harm from alcohol use, but who do not meet criteria for dependence. Alcohol can interact with certain medications, impair a person's ability to engage in activities that require attention, skill, or coordination (e.g., driving), exacerbate a medical condition (e.g., gastritis), and overtime alcohol misuse can lead to cancer, liver disease, and heart problems. More than 18 million American men and women suffer from alcohol-use disorders – there are countless millions of individuals, family members, and children who experience the devastating effects of the alcohol problem of someone in their life.



The good news is Medicare now provides coverage for screening and behavioral counseling interventions in primary care to reduce alcohol misuse for eligible beneficiaries who, if determined by a primary care physician or other primary care practitioner, may need help in reducing or abstaining from alcohol consumption.

Medicare provides coverage for annual alcohol screening, and for those that screen positive, up to four brief, face-to-face, behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women:

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences);
- Who are competent and alert at the time that counseling is provided; and,
- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

#### For more information

- [National coverage determination \(NCD\) for screening and behavioral counseling interventions in primary care to reduce alcohol misuse](#)
- [“The ABCs of Providing the Initial Preventive Physical Examination \(IPPE, or “Welcome to Medicare” visit\) Quick Reference Chart”](#)
- [“The ABCs of Providing the Medicare Annual Wellness Visit \(AWV\) Quick Reference Chart”](#)
- [MLN preventive services educational products Web page](#)
- [“Substance \(Other Than Tobacco\) Abuse Structured Assessment and Brief Intervention \(SBIRT\) Services” fact sheet](#)
- [CDC Alcohol Awareness Month website](#)
- [National Council on Alcoholism and Drug Dependence, Inc. website](#)

Thank you for joining CMS in raising awareness of the negative effects of alcohol use on one's health and personal life, associated risk factors, and related preventive benefits covered by Medicare.

Source: CMS PERL 201204-23

## ‘National Colorectal Cancer Awareness Month’ – don’t forget to follow-up

“National Colorectal Cancer Awareness Month,” the month of March, is over – but that doesn’t mean that the colorectal cancer awareness messages to your patients should stop until next year. Remind patients who have taken home a fecal occult blood test kit to use it. Follow-up with patients on all screening results, even negative ones – everyone likes to hear good news. Remember, the appropriate follow-up for a positive fecal occult blood test result is a colonoscopy, not another fecal occult blood test.

### Guidelines to follow when polyps are found:

A recent survey by the National Cancer Institute found that gastroenterologists and surgeons are performing surveillance colonoscopies at more frequent intervals than those recommended by evidence-based guidelines. For example, 24 percent of gastroenterologists and 54 percent of surgeons recommended a colonoscopy, either alone or with another procedure, at least every five years after the identification of a small, benign, hyperplastic polyp. Medical guidelines do not recommend any follow-up colonoscopy for hyperplastic polyps because their presence has not been shown to increase the risk of colorectal cancer. Review the evidence-based Colorectal Cancer Screening and Surveillance Guidelines from the American Cancer Society.

### More information for health care professionals:

- [MLN® “Guide to Medicare Preventive Services for Healthcare Professionals” \(see Chapter 11\)](#)
- [MLN® Preventive Services Educational Products Web page](#)
- [MLN® “Cancer Screenings” brochure](#)
- [MLN® “Quick Reference Information: Medicare Preventive Services”](#)
- National colorectal cancer roundtable
- National Colorectal Cancer Awareness Month website
- The National Cancer Institute website

Thank you for helping the Centers for Medicare & Medicaid Services (CMS) spread the word regarding the importance of colorectal cancer screening.

**CMS.gov website upgrade:** Please take note that CMS is in the process of making upgrades to the [www.CMS.gov](http://www.CMS.gov) website. If you encounter problems accessing information while on the site, please refresh the page or check back later. CMS appreciates your understanding and apologize for any inconvenience.

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

**Source:** CMS PERL 201203-62

### Discover your passport to Medicare training

- Register for live events
- Explore online courses
- Find CEU information
- Download recorded events
- Learn more at FCSO University

Learn more at <https://medicare.fcso.com/Landing/139820.asp>.

## April is National Cancer Control Month

This year, an estimated half million Americans will lose their lives to cancer, and three times that many will be diagnosed with this devastating illness. Cancer patients are parents and grandparents, children and cherished friends; the disease touches almost all of us and casts a shadow over families and communities across our nation. Yet, today, we stand at a critical moment in cancer research that promises significant advances for patients and an accelerated pace of lifesaving discoveries. During National Cancer Control Month this April, we remember those we have lost, support Americans fighting this disease, and recommit to progress toward effective cancer control.

Prevention and screening are our best defenses against cancer. All Americans can reduce their risk by eating a healthy diet, exercising regularly, limiting sun exposure, avoiding excessive alcohol consumption, living tobacco-free, and taking advantage of appropriate regularly scheduled cancer screenings. For those covered by Medicare, regular screening with a health care professional can play a key role in preventing cancer and detecting the disease early, when it is often most treatable. Under the Affordable Care Act, more people with Medicare can now receive many preventive services at no additional cost.

### Medicare provides coverage of the following cancer screenings:

- Breast cancer (mammography and clinical breast exam)
- Cervical and vaginal cancer (pap test and pelvic exam (includes the clinical breast exam))
- Prostate cancer (prostate-specific antigen (PSA) blood test and digital rectal exam)
- Colorectal cancer
- Fecal occult blood test
- Flexible sigmoidoscopy
- Colonoscopy
- Barium enema

Studies have repeatedly demonstrated that a physician's recommendation is the most powerful factor in a patient's decision to receive preventive and screening services. By discussing Medicare-covered cancer screenings and other available options, and engaging patients in decision-making regarding their choices, you can help prevent, treat, and beat the disease. Encourage your patients to get screened – it could save their lives.

### More information for health care professionals:

- [MLN® "Guide to Medicare Preventive Services for Healthcare Professionals" \(see Chapter 11\)](#)
- [MLN® Preventive Services Educational Products Web page](#)
- [MLN® "Cancer Screenings" brochure](#)
- [MLN® "Quick Reference Information: Medicare Preventive Services"](#)
- ["Tobacco-Use Cessation Counseling Services" brochure](#)
- [National Cancer Institute website](#)
- [Smokefree.gov website](#)

**Source:** CMS PERL 201204-29

### Puzzled about your enrollment status?

Put the pieces together using the enrollment status lookup. View all active applications, specific applications, and confirm if you have been sent a revalidation request at <http://medicare.fcso.com/Enrollment/PEStatus.asp>

## Other Educational Resources

### HHS Secretary Sebelius’s statement on ‘National Minority Health Month’

In April, the Department of Health and Human Services (HHS) is commemorating “National Minority Health Month” to raise awareness of the health disparities that continue to affect racial and ethnic minorities, as well as celebrate the opportunities of the Affordable Care Act’s groundbreaking policies to reduce those health disparities.

Despite the progress the nation has made over the past 50 years, racial and ethnic minorities still lag behind the general population with regard to certain health issues. Minorities are less likely to get the preventive care they need to stay healthy; more likely to suffer from serious illnesses, such as diabetes, heart disease and colon cancer; and are less likely to have access to quality health care.

The Affordable Care Act, in conjunction with the “Action Plan to Reduce Racial and Ethnic Health Disparities” and the “National Stakeholder Strategy for Achieving Health Equity” that the HHS released one year ago, addresses the needs of minority populations and other underserved groups, by bringing down health care costs, investing in prevention, and supporting improvements in primary care and Medicare. As a result of the health care law, the country is making strides in giving every American, regardless of race or ethnicity, a fair shot at quality, affordable health coverage.

The theme for “National Minority Health Month” this year is “Health Equity Can’t Wait. Act Now in Your CommUNITY.” We are a nation of communities and we depend on each other. By recommitting ourselves to eliminating the serious and substantial health disparities faced by racial and ethnic minority Americans, we are investing in our entire nation’s physical and economic wellbeing.

To learn more about “National Minority Health Month” and what the HHS is doing to reduce minority health disparities and achieve health equity, visit <http://www.MinorityHealth.HHS.gov/ActNow>.

The full text of this excerpted HHS press release (issued Monday, April 2) can be found at <http://www.HHS.gov/news/press/2012pres/04/20120402c.html>.

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

**Source:** CMS PERL 201204-01

### Two new CME modules available on Medscape

On Thursday, March 22, a new continuing medical education (CME) module was posted on Medscape. This module provides information and continuing medical education (CME) about the Centers for Medicare & Medicaid Services’ (CMS’) health care delivery system reform efforts and can be accessed on Medscape (with a free registration) at <http://www.Medscape.org/viewarticle/760133>.

On April 3, Medscape posted a new continuing medical education (CME) module on its website titled, “*CMS and Primary Care: A New World*,” highlighting the delivery system reforms created by the Affordable Care Act.

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

**Source:** CMS PERL 201203-66, 201204-42



## ‘7 Ways to Protect Yourself from Medical Identity Theft’

Medicare fraud affects everyone – not just people with Medicare. Did you know that physicians are also vulnerable to a type of fraud called “medical identity theft?” Medical identity theft happens when a fraudster uses your unique medical identifiers to bill insurance for items or services that you never provided or prescribed.

- Keep your medical information up-to-date
- Review billing notices
- Protect your medical information
- Train your staff
- Educate your patients
- Report any suspected medical identity theft
- Protect your prescription pads

Learn more about it and how to protect yourself in the latest Medicare blog, [“7 Ways to Protect Yourself from Medical Identity Theft.”](#)

**Source:** CMS PERL 201204-12

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## Targeted release of comparative billing report on cardiology services on April 23

The Centers for Medicare & Medicaid Services (CMS) will release a national provider comparative billing report (CBR) addressing cardiology services on or around Monday, April 23.

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

These reports are not available to anyone except the providers who receive them. 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 better understand applicable Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of providers that this type of data is very helpful, and encourages them to produce and make available additional CBRs.

For more information and to review a sample of the cardiology 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 201204-04

### Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the “Improve your billing” section at <http://medicare.fcso.com/Landing/200831.asp>, where you’ll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You’ll find FCSCO’s most popular self-help resources, including the E/M interactive worksheet, Provider Data Summary (PDS) report, and the Comparative billing report (CBR).

## 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

**Email 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

### Email 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

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### 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
<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.	40300260	\$33		
<b>2012 Fee Schedule</b> – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2012, 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.  <b>Note:</b> Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	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**