

MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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The Medicare A Bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued after October 1, 1997, are available at no-cost from our provider Web site at <http://medicare.fcso.com/>.

Routing Suggestions:

- Medicare Manager
- Reimbursement Director
- Chief Financial Officer
- Compliance Officer
- DRG Coordinator
- _____
- _____
- _____



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About the Medicare A Bulletin

The *Medicare A Bulletin* is a comprehensive publication developed by First Coast Service Options Inc. (FCSO) for Medicare Part A providers in Florida, Puerto Rico and U.S. Virgin Islands in accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters.

The Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. Important notifications requiring communication in between publications are posted to the FCSO Medicare provider education Web site <http://medicare.fcso.com>.

Who receives the Bulletin?

Anyone may view, print or download the *Bulletin* from our provider education Web site. Providers who cannot obtain the *Bulletin* from the Internet (because of a technical barrier) are required to register with us to receive a complimentary hardcopy. Registration forms must be submitted annually or when the provider's business practices have experienced a change in circumstances that impact electronic access.

Distribution of the *Medicare Part A Bulletin* in hardcopy format is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida 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 hardcopy registration form to us.*

For additional copies, providers may purchase a separate annual subscription. A subscription order form may be found at the end of the *Educational Resources* section in each issue. Issues published since January 1997 may be downloaded from the Internet free of charge.

We use the same mailing address for *all* correspondence, and we cannot designate that the *Bulletin* be sent to a specific person/department within a medical facility. 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 CMS-855A.**

What is in the Bulletin?

The *Bulletin* is divided into sections addressing general and coverage guidelines, and facility-specific information:

- Sections comprise of administrative and general information, processing guidelines, billing issues, and Medicare coverage guidelines applicable to all Medicare Part A providers and facilities are included in the first part of the publication.
- Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section is omitted.)
- The *Local Coverage Determination* (LCD) section contains notification of new finalized medical LCDs and additions, revisions, and corrections to previously published LCDs. In addition, this section may contain information on widespread probe reviews conducted by the fiscal intermediary.
- As needed, the *Bulletin* contains *Electronic Data Interchange* and *Fraud and Abuse* sections.
- The *Educational Resources* section includes educational events and materials, such as seminar schedules, Medicare provider education Web site information, and reproducible forms.
- Important addresses and phone numbers are in the back of every issue.

The Medicare A Bulletin represents formal notice of coverage policies

Articles included in each *Medicare A Bulletin* represent formal notice that specific coverage policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

Providers may access the QPU by going to the CMS Web site at <http://www.cms.hhs.gov/QuarterlyProviderUpdates/>. Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU. ❖

GENERAL INFORMATION

Expiration of various payment provisions under the Medicare program

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

Provider types affected

All Medicare providers should take note of this article.

Provider action needed

This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected providers that a number of Medicare payment provisions, such as the following will no longer be in effect when the provisions sunset as of December 31, 2009:

- Therapy cap exceptions process
- Allowing independent laboratories to bill for the technical component of physician pathology services furnished to hospital patients

CMS continues to work with Congress on significant legislation that affects the Medicare program. We believe some or all of these provisions may be extended as part of this legislation. We encourage you to monitor activity on the Hill and stay apprised of the status of potential legislation. In the meantime, if such legislation is enacted, Medicare will notify its contractors to again process claims consistent with the extended provisions.

Claims for services furnished on or before December 31, 2009, will be processed under normal conditions.

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.

For services provided on or after January 1, 2010, health care providers may choose, to the extent possible, to hold their claims (that is, not submit their claims to Medicare) until it becomes clearer as to whether new legislation will be enacted to extend these provisions. If legislation is enacted, claims submission for affected services may resume. Otherwise, claims submitted with dates of service on or after January 1, 2010, will not be paid in accordance with expiring provisions because there would no longer be any statutory basis for such payment.

CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue. Finally, be on the alert for more information about this and other legislative provisions that may affect you.

MLN Matters® Number: SE0931

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Effective Date: January 1, 2010

Related CR Transmittal Number: N/A

Implementation Date: January 1, 2010

Source: CMS Special Edition *MLN Matters*® Article SE0931

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2009, must be paid before the end of business on March 31, 2009.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page <http://fms.treas.gov/prompt/rates.html> for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 3.250 percent is in effect through June 30, 2010.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable. ❖

Source: Publication 100-04, Chapter 1, Section 80.2.2

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Medically unlikely edits

The Centers for Medicare & Medicaid Services (CMS) developed the medically unlikely edit (MUE) program to reduce the paid claim-error rate for Medicare claims. Change request (CR) 6712 provides updates and clarifications to MUE requirements established in 2006.

Background

The medically unlikely edits are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and unlikely clinical diagnostic or therapeutic services.

As clarification, an MUE is a unit of service (UOS) edit for a HCPCS/CPT code for services that a single provider/supplier rendered to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims.

Note: The MUE program provides a method to report medically reasonable and necessary UOS in excess of an MUE.

Key points

All Medicare claim processing contractors, including contractors using the fiscal intermediary shared system (FISS) shall adjudicate MUEs **against each line of a claim rather than the entire claim**. Thus, if a HCPCS/CPT code is changed on more than one line of a claim by using CPT modifiers, the claim processing system separately adjudicates each line with that code against the MUE.

In addition, fiscal intermediaries (FIs), carriers and Medicare administrative contractors (MACs) processing claims shall deny the entire claim line if the units of service on the claim line exceed the MUE for the HCPCS/CPT code on the claim line. Providers may appeal the denied claim lines.

Since each line of a claim is adjudicated separately against the MUE of the code on that line, the appropriate use of CPT modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE. The following CPT modifiers will accomplish this purpose:

- 59 *Distinct procedural service*
- 76 *Repeat procedure by same physician*
- 77 *Repeat procedure by another physician*
- 91 *Repeat clinical diagnostic laboratory test*

Anatomic modifiers (e.g., RT, LT, F1, F2)

Note: Providers/suppliers should use modifier 59 only if no other modifier describes the service.

On or about October 1, 2008, CMS announced that it would publish at the start of each calendar quarter the majority of active MUEs and post them on the MUE Web page at http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage.

Note that, at the onset of the MUE program, all MUE values were confidential, and for use only by CMS and CMS contractors. Since October 1, 2008, CMS has published most MUE values at the start of each calendar quarter. However, some MUE values are not published and continue to be confidential information for use by CMS and CMS contractors only. The confidential MUE values shall not be shared with providers/suppliers or other parties outside the CMS contractor's organization. The files referenced in the business requirements of this CR contain both published and unpublished MUE values. In the MUE files each HCPCS code has an associated "publication indicator". A publication indicator of "0" indicates that the MUE value for that code is confidential, is not in the CMS official publication of the MUE values, and should not be shared with providers/suppliers or other parties outside the CMS contractor's organization. A publication indicator of "1" indicates that the MUE value for that code is published and may be shared with other parties.

The full set of MUEs is available for the CMS contractors only via the Baltimore data center. A test file will be available about two months before the beginning of each quarter, and the final file will be available about six weeks before the beginning of each quarter. Note that MUE file updates are a full replacement. The MUE adds, deletes, and changes lists will be available about five weeks before the beginning of each quarter.

Medically unlikely edit program policy

The national correct coding initiative (NCCI) contractor produces a table of MUEs. The table contains ASCII text and consists of six columns. (Refer to Appendix 1 – Tabular Presentation of the Format for the MUE Transmission). There are three format charts, one for contractors using the Medicare carrier system (MCS), one for contractors using the VIPS Medicare system (VMS) system, and one for the contractors using the FISS system.

Contractors shall apply MUEs to claims with a date of service on or after the beginning effective date of an edit and before or on the ending effective date.

Further, CMS is setting MUEs to auto-deny the claim line item with units of service in excess of the value in column 2 of the MUE table. Pub. 100-08, *Program Integrity Manual (PIM)*, Chapter 3, Section 5.1, indicates that automated review is acceptable for medically unlikely cases and apparent typographical errors.

CMS will set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings.

Since claim lines are denied, denials may be appealed. Appeals shall be submitted to local contractors not the MUE contractor, Correct Coding Solutions, LLC.

Note that, quarterly, the NCCI contractor will provide files to CMS with a revised table of MUEs and contractors will download via the network data mover.

If Medicare contractors identify questions or concerns regarding the MUEs, they shall bring those concerns to the attention of the NCCI contractor. The NCCI contractor may refer those concerns to CMS, and CMS may act to change the MUE limits after reviewing the issues and/or upon reviewing data and information concerning MUE claim appeals.

Medically unlikely edits (continued)

Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. A provider/supplier shall not issue an advance beneficiary notice of noncoverage (ABN) in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE. The denied units of service shall be a provider/supplier liability.

CMS will distribute the MUEs as a separate file for each shared system when the quarterly NCCI edits are distributed.

The Appendix 1 – Tabular Presentation of the Format for the MUE Transmission is available on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/R617OTN.pdf>.

Change Request (CR) Number: 6712

CR Release Date: January 8, 2009

CR Transmittal Number: R617OTN

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

Source: CMS Pub. 100-20, Transmittal 617, CR 6712

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Sunset payment of Indian Health Services

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

Provider types affected

Indian Health Service (IHS) tribe and tribal organizations and facilities submitting claims to Medicare contractors.

Provider action needed

This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected IHS physicians, IHS providers, and IHS suppliers that, per the provisions of section 630 of the MMA, certain Part B services will no longer be covered for Medicare payment when the provisions sunset as of December 31, 2009.

However, Congress is considering new legislation that may extend this provision beyond December 31, 2009. If such legislation is enacted, Medicare will notify contractors to again process claims for these IHS services.

These services include the following:

- Durable medical equipment, prosthetics, and orthotics
- Therapeutic shoes
- Clinical laboratory services
- Surgical dressings, splints and casts
- Drugs (those processed by the J4 A/B Medicare administrative contractor (MAC) and the DME MACs)
- Ambulance services
- Influenza and pneumonia vaccinations
- Screening and preventive services.

Claims for services furnished on or before December 31, 2009, will be processed under normal conditions.

For services provided on or after January 1, 2010, health care providers may choose, to the extent possible, to hold their claims (that is, not submit their claims to Medicare) until it becomes clearer as to whether new legislation will be enacted to extend this provision. If legislation is enacted, claims submission for these items and services may resume. Otherwise, claims for these items and services, submitted with dates of service on or after January 1, 2010, will be denied because there would no longer be any statutory basis for such payment.

Depending on the effective date of possible legislation which extends coverage of these items and services, claims which were originally submitted and denied may be eligible for payment. If this has occurred, the submitter must contact the entity that processes their claims to have the claims adjusted. Affected providers need not resubmit their claims nor appeal the original denial.

CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue. Finally, be on the alert for possible action by Congress to extend this provision.

MLN Matters® Number: SE0930

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Related CR Transmittal Number: N/A

Effective Date: January 1, 2010

Implementation Date: January 1, 2010

Source: CMS Special Edition *MLN Matters*® Article SE0930

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Calendar year 2010 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

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

Provider types affected

This article is for clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Provider action needed

This article is based on change request (CR) 6657, which provides instructions for the calendar year (CY) 2010 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Be sure your billing staffs are aware of these changes and the special edition *MLN Matters*® article SE1001, which is discussed later in this article.

Background

Update to fees

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for CY 2010 is (-1.4) percent. (The relevant section of the Act is available at http://www.ssa.gov/OP_Home/ssact/title18/1833.htm.)

Further, Section 145 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) adjusted the annual update by -0.5 percent through CY 2013. Therefore, the annual update for CY 2010 is (-1.9) percent. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2010 is 0 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (Pap smear), payment may also not exceed the actual charge.

Note: The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National minimum payment amounts

For a cervical or vaginal smear test (Pap smear), Medicare payment is the lesser of the local fee or the NLA, but not less than a national minimum payment amount. In addition, payment may not exceed the actual charge. The CY 2010 national minimum payment amount is \$15.13 (\$15.42 plus (-1.9) percent update for CY 2010). The affected codes for the national minimum payment amount are:

88142	88143	88147	88148	88150	88152	88153
88154	88164	88165	88166	88167	88174	88175
G0123	G0143	G0144	G0145	G0147	G0148	P3000

National limitation amounts (maximum)

For tests for which national limitation amounts (NLAs) were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Social Security Act.

Access to data file

Internet access to the CY 2010 clinical laboratory fee schedule data file is available at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the Centers for Medicare & Medicaid Services (CMS) Web site. It will be available in multiple formats: Excel, text, and comma delimited.

Public comments

On July 14, 2009, CMS hosted a public meeting to solicit input on the payment relationship between CY 2009 codes and new CY 2010 *Current Procedural Terminology (CPT)* codes. Notice of the meeting was published in the *Federal Register* on May 22, 2009, and on the CMS Web site approximately June 15, 2009. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the CMS Web site. Additional written comments from the public were accepted until September 18, 2009. CMS has posted a summary of the public comments and the rationale for their final payment determinations on the CMS Web site also.

Pricing information

The CY 2010 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

For dates of service from January 1, 2010, through December 31, 2010, the fee for clinical laboratory travel code P9603 is \$1.00 per mile and the fee for clinical laboratory travel code P9604 is \$10.00 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2010, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2010 clinical laboratory fee schedule also includes codes that have **modifier QW** to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

Similar to prior years, the CY 2010 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower

Calendar year 2010 annual update for clinical lab fee schedule and lab services subject ... (continued)

of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping information

- New CPT code 83987 is priced at the sum of the rates of CPT codes 82800 and 87015.
- New CPT code 84145 is priced at the same rate as CPT code 84146.
- New CPT code 84431 is priced at the same rate as CPT code 83520.
- New CPT code 86305 is priced at the same rate as CPT code 86316.
- New CPT code 86352 is priced at the sum of the rates of CPT codes 86353 and 82397.
- New CPT code 86780 is priced at the same rate as CPT code 86781.
- New CPT code 86825 is priced at three times the rate of CPT code 86356.
- New CPT code 86826 is priced at the same rate as CPT code 86356.
- New CPT code 87150 is priced at the same rate as CPT code 87798.
- New CPT code 87153 is priced at the sum of the rates of CPT codes 83891, 83898, 83904, 83912, and half of code 87900.
- New CPT code 87493 is priced at the same rate as CPT code 87798.
- New CPT code 88738 is priced at the same rate as CPT code 88740.
- New CPT code 80069QW is priced at the same rate as CPT code 80069 beginning December 4, 2008.
- New CPT code 82040QW is priced at the same rate as CPT code 82040 beginning January 1, 2009.
- New CPT code 82043QW is priced at the same rate as CPT code 82043 beginning October 1, 2009.
- New CPT code 82550QW is priced at the same rate as CPT code 82550 beginning December 4, 2008.
- New CPT code 87905QW is priced at the same rate as CPT code 87905 beginning January 1, 2009.
- CPT code 83876 is priced at the same rate as CPT code 83880.
- HCPCS code G0430 is priced at the same rate as CPT code 80100.
- HCPCS code G0431 is priced at the same rate as CPT code 80101.
- CPT code 82307 is deleted beginning January 1, 2010.
- CPT code 82042QW is deleted beginning July 1, 2009.
- CPT code 83520QW is deleted beginning October 1, 2009.
- CPT code 86781 is deleted beginning January 1, 2010.
- For CY 2010, there are no new test codes to be gap filled.

Special information regarding codes G0430, G0431, 80100, and 80101

A special edition *MLN Matters*[®] article is available regarding the use of these four codes. That article is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1001.pdf> on the CMS Web site. Clinical laboratories billing these codes should review this special edition article for important information regarding the billing of these codes, especially for services from January 1, 2010, through March 31, 2010, inclusive.

Laboratory costs subject to reasonable charge payment in CY 2010

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 *Code of Federal Regulations* (CFR) 405.502 through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as prescribed by Section 1842(b)(3) of the Act and 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2010 is 0 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8. That manual is available on the CMS Web site at <http://www.cms.hhs.gov/manuals/IOM/list.asp>.

If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual*, Chapter 8, Section 60.3 instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood products					
P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9044	P9050	P9051	P9052
P9053	P9054	P9055	P9056	P9057	P9058
P9059	P9060				

Also, the following codes should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Section 20.5 through 20.54:

P9010	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058

Calendar year 2010 annual update for clinical lab fee schedule and lab services subject ... (continued)

Note: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine					
86850	86860	86870	86880	86885	86886
86890	86891	86900	86901	86903	86904
86905	86906	86920	86921	86922	86923
86927	86930	86931	86932	86945	86950
86960	86965	86970	86971	86972	86975
86976	86977	86978	86985		

Reproductive medicine procedures					
89250	89251	89253	89354	89255	89257
89258	89259	89260	89261	89264	89268
89272	89280	89281	89290	89291	89335
89342	89343	89344	89346	89352	89353
89354	89356				

Additional information

The official instruction (CR 6657) issued to your Medicare MAC, carrier, and/or FI may be found on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1884CP.pdf>.

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

MLN Matters® Number: MM6657

Related Change Request (CR) Number: 6657

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Related CR Transmittal Number: R1884CP

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1884, CR 6657

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Additional information regarding the calendar year 2010 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

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

Provider types affected

This article is for clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Provider action needed

This article describes how clinical diagnostic laboratories should bill for certain types of tests that are covered under Medicare and paid based on the clinical laboratory fee schedule (CLFS). Specifically, the article addresses billing of four HCPCS/CPT codes (G0430, G0431, 80100, and 80101) during the period of January 1, 2010, through March 31, 2010. Further information will be provided regarding billing after March 31, 2010. Be sure billing staff are aware of these changes.

Background

Each year, the Centers for Medicare & Medicaid Services (CMS) hosts an annual public meeting concerning new test codes that have been established by the *Common Procedural Terminology* (CPT) committee and that will be covered by Medicare and paid based on the CLFS.

Additional information regarding the calendar year 2010 annual update for clinical lab fee schedule ... (continued)

This year, two new G codes were established: G0430 and G0431. When these two new codes were introduced at the annual public meeting during 2009, members of the laboratory industry expressed concern about how these two new codes would be described and when they should be billed. This article seeks to clarify these issues.

It came to CMS' attention that some companies were using questionable billing practices concerning *CPT* codes 80100 and 80101. In addition, *CPT* code 80100 describes only chromatographic testing for the presence of drugs, which left certain laboratories unable to bill accurately when this type of testing was performed, but the chromatographic method was not utilized. Therefore, CMS created two new G codes to operate in place of and alongside *CPT* codes 80100 and 80101.

Following are the current definitions of all test *CPT*/*HCPCS* codes addressed in this issue:

- 80100: *Drug screen, qualitative; multiple drug classes chromatographic method, each procedure*
- G0430: *Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure*
- 80101: *Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class*
- 80101QW: *Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class*
- G0431: *Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class*

From January 1, 2010, through March 31, 2010, when performing a qualitative drug screening test for multiple drug classes using chromatographic methods, *CPT* code

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Scheduled release of modifications to the HCPCS code set

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS Web site at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp.

Changes are effective on the date indicated on the update. ❖

Source: CMS PERL 201001-03

November 19 ICD-10-CM/PCS conference call transcript summaries

The Centers for Medicare & Medicaid Services (CMS) conducted an ICD-10-CM/PCS (clinical modification and procedure coding system) Medicare severity – diagnosis related group conversion project national provider conference call on November 19, 2009.

Written and audio transcript summaries of the call are now available for download on the CMS Web site at http://www.cms.hhs.gov/ICD10/06a_2009_CMS_Sponsored_Calls.asp. ❖

Source: CMS PERL 201001-01

80100 is the appropriate code to bill. New test HCPCS code G0430 was created to limit the billing to one time per procedure and to remove the limitation of the method (chromatographic) when this method is not being used in the performance of the test. As a result, when performing a qualitative drug screening test for multiple drug classes that does not use chromatographic methods, new test HCPCS code G0430 is the appropriate code to bill.

New test HCPCS code G0431 is a direct replacement for *CPT* code 80101. However, CMS is delaying this replacement until April 1, 2010.

Similarly, from January 1, 2010, through March 31, 2010, when performing a qualitative drug screening test for a single class of drugs, regardless of the testing methodology, those clinical laboratories that do not require a CLIA certificate of waiver should bill new test HCPCS code G0431. Those clinical laboratories that do require a CLIA certificate of waiver should continue to utilize *CPT* code 80101QW.

Further direction on this matter will be provided by April 1, 2010.

Additional information

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

MLN Matters® Number: SE1001

Related Change Request (CR) Number: 6657

Related CR Release Date: N/A

Related CR Transmittal Number: N/A

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

Source: CMS Special Edition *MLN Matters*® Article SE1001

Emergency update to the 2010 Medicare physician fee schedule database

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

Note: The files associated with change request (CR) 6796 include a legislative change to the calendar year (CY) 2010 conversion factor update and changes as a result of technical corrections to the malpractice relative value units. The conversion factor for CY 2010 is \$36.0846.

Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or 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 CR 6796 which amends payment files that were issued to Medicare contractors based on the 2010 MPFS final rule. Be sure your billing staff is aware of these changes.

Background

The Social Security Act (Section 1848(c)(4); see http://www.ssa.gov/OP_Home/ssact/title18/1847.htm) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Previously, payment files were issued to Medicare contractors based on the 2010 MPFS final rule. CR 6796 amends those payment files. CR 6796 provides corrections, effective for dates of service on or after January 1, 2010, to those files. These changes include the following:

CPT/HCPCS	Action
0575F	Procedure status: M
20550	Bilateral indicator: 1
4270F	Procedure status: M
4280F	Procedure status: M
50543	Bilateral indicator: 1
50548	Bilateral indicator: 1
80100	Procedure status: X
A4641	Procedure status: C

CPT/HCPCS	Action
A4642	Procedure status: C
A9698	Procedure status: X
S2118	Procedure status: I
S2270	Procedure status: I
S3628	Procedure status: I
S3711	Procedure status: I
S3860	Procedure status: I
S3861	Procedure status: I
S3862	Procedure status: I
S9433	Procedure status: I

In addition, the relative value units (RVUs) of a number of CPT/HCPCS (19340, 42145, 64490, 64491, 64492, 64493, 64494, 64495, 77785, 77785TC, 77786, 77786TC, 77787, 77787TC, 93740, and 93770) were changed. To view the specific RVU changes for these codes, see Attachment 1 of CR 6796 on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1887CP.pdf>.

Additional information

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

MLN Matters® Number: MM6796
 Related Change Request (CR) Number: 6796
 Related CR Release Date: January 6, 2010
 Related CR Transmittal Number: R1887CP
 Effective Date: January 1, 2010
 Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1887, CR 6796

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Modification to the 2010 Healthcare Common Procedure Coding System code set

The Centers for Medicare & Medicaid Services (CMS) has released a modification to the Healthcare Common Procedure Coding System (HCPCS) code set. CMS has revised the definition for HCPCS code L8680 to “Implantable neurostimulator electrode, each”. In making this change, the calendar year (CY) 2010 definition for HCPCS code L8680 reverts to the definition reflected in the CY 2009 HCPCS code set. This change has been posted to the 2010 HCPCS corrections document located on the CMS HCPCS Web page at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp>. ❖

Source: CMS PERL 200912-24

Place and date of service instructions for interpretation of diagnostic tests

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

Provider types affected

Physicians and other providers who bill Medicare fiscal intermediaries [FI], carriers, or Medicare administrative contractors (A/B MAC) for the furnishing and interpretation of diagnostic tests.

What you need to know

Change request (CR) 6375, from which this article is taken, informs Medicare contractors (FIs, carriers, and A/B MACs) about the correct place of service (POS) codes and the date of service (DOS) for the interpretation of diagnostic tests. Be sure your billing staff is aware of the correct DOS and is aware of how Medicare contractors determine correct POS coding to assure proper payment of your claims.

Background

You may find the instructions that CR 6375 provides your Medicare contractor regarding the correct POS and DOS codes for the interpretation (or professional component) of diagnostic tests in this *Background* section. Please note that place of service (POS) codes do not determine Medicare payment for the interpretation of a diagnostic test, but rather reflect where the service was provided.

Date of service codes

As of July 1, 2010, Medicare contractors will consider, and providers must remember, that the appropriate DOS for the professional component is the actual calendar date that the interpretation was performed. For example, if the test or technical component was performed on April 30 and the interpretation was read on May 2, the actual calendar date or DOS for the performance of the test is April 30 and the actual calendar date or DOS for the interpretation or read of the test is May 2.

Note: Special rules apply for the DOS of the technical component of clinical laboratory and pathology specimens and are contained in 42 CFR 414.510.

Place of service codes

A description of the correct POS codes for performing the interpretation of diagnostic tests in various locations is provided as follows:

Interpretation performed in physician's home

If the interpretation takes place in a physician's home, the POS would be either "office" (POS 11 – if it meets the definition of an office) or "other" (POS 99).

Interpretation performed in a hotel room

If the interpretation takes place in a hotel room, the POS would be "office" (POS 11) if the hotel room is considered as the physician's office. If both the physician and the patient are located in the hotel room at the time that the interpretation is performed, the POS code would most likely be the new POS code for "temporary lodging" (POS 16). If the hotel room is neither the office of the physician nor the temporary lodging of the patient then the correct code would be "other" (POS 99).

Interpretation provided telephonically by wireless remote

As described in the *Medicare Benefit Policy Manual* Chapter 15 (Covered Medical and Other Health Services), Section 30 (Physician Services); Diagnostic tests (such as a radiological image, an electrocardiogram, an electroencephalogram, or a tissue sample) can also be interpreted through the use of a telecommunications system, obviating the requirement for a face-to-face encounter with the patient. The POS code for such a removed interpretation is generally the place where the interpretation is read, using the cited ZIP code as the documentation for the setting where the interpretation takes place. (The *Medicare Benefit Policy Manual* is available on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.)

Interpretation performed in an office suite that is neither the test location nor the physician's office

If the interpretation is performed in a location other than the physician group's main location, and that location meets the definition of an office, the POS code is "office" (POS 11). If the physician performs the interpretation from home, the POS code is either "office" (POS 11), or "other" (POS 99).

Interpretation provided under arrangement to a hospital

If a diagnostic test has separate technical component and professional components, and is provided under arrangements to a hospital, the physician who reads the test can bill and be paid for the professional component.

If the interpretation is performed in the hospital setting, the POS code is "hospital outpatient" (POS 22). If it is performed at a location other than the location of the physician's office and the location meets the definition of an office, the POS code is "office" (POS 11). If the physician performs the interpretation from home, the POS code is either "office" (POS 11), or "other" (POS 99).

When, on the other hand, a physician performs a diagnostic test under arrangements to a hospital, and the test and the interpretation are not separately billable; the physician cannot bill for the interpretation. The hospital is the only entity that can bill for the diagnostic test which includes the interpretation, and there is no POS code for the interpretation. The POS code for the test including the interpretation is "hospital outpatient" (POS 22).

Interpretation not performed under skilled nursing facility-consolidated billing

Physician services are one of the service categories excluded by law from skilled nursing facility (SNF) consolidated billing provision. Physician services are separately billable to the Medicare Part B carrier. So, since many diagnostic tests include both a technical component and a professional component, two bills will need to be generated. For example, the physician service exclusion applies only to the professional component of a SNF diagnostic radiology service (representing the physician's

Place and date of service instructions for interpretation of diagnostic tests (continued)

interpretation of the diagnostic test). Again, the physician service for the interpretation is billed directly to the Medicare Part B carrier.

Interpretation of purchased diagnostic services

The *Medicare Claims Processing Manual* Chapter 13 (Radiology Services and Other Diagnostic Procedures), Section 20.2.4 (Purchased Diagnostic Tests – Carriers) provides the physician billing requirements applicable to purchased diagnostic services. (This manual is also available on the CMS Web site at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.)

In addition, the POS code rules are the same for both diagnostic tests/interpretations and for purchased diagnostic tests/interpretations (those that are not personally performed or supervised by a physician), both requiring the appropriate POS code and the ZIP code.

Most commonly, the service's purchaser performs the interpretation and purchases the technical component. In this case, the technical component provider must be enrolled in the Medicare program and the purchaser can bill for both the professional component and the technical component.

In less common specified circumstances, the interpretation may be purchased from another entity and the purchaser can bill for the interpretation even though they did not perform it; but the interpreting physician must be enrolled in Medicare.

In either circumstance, the services must be performed in the "United States," which means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

Interpretation provided outside of the United States

Generally, Medicare will not pay for health care or supplies performed/provided outside the United States (U.S.). As above, the term "outside the U.S." means anywhere other than the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

The exceptions to the "outside the U.S." exclusion are the following:

- The patient is in the U.S. when a medical emergency occurs and the foreign hospital is closer than the nearest U.S. hospital that can treat the illness or injury.
- The patient is traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the illness or injury. The requirement of traveling through Canada "without unreasonable delay" is determined by Medicare on a case-by-case basis.
- The patient lives in the U.S. and the foreign hospital is closer to his/her home than the nearest U.S. hospital

that can treat their medical condition, regardless of whether it is an emergency.

- The patient is on board a ship and receives emergency or non-emergency services in the territorial waters of the U.S.

Note: Physician and ambulance services furnished in connection with a covered foreign hospitalization above are also covered.

The POS code that should be used for Medicare-covered services that meet one of these exceptions to the "outside the U.S." exclusion is the place where the service was actually furnished (e.g., the hospital emergency room or cruise ship, etc.).

When determining which POS code to use in these situations, you should note that CMS clarified in the Medicare Benefit Policy Manual, chapter 16, (General Exclusions From Coverage), Section 60 (Services Not Provided Within United States) that:

"Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States. For example, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India".

Note: In all cases in which the appropriate POS code may be unclear, your Medicare contractor makes the final determination of which code applies.

Additional information

You may find the official instruction, CR 6375, issued to your FI, carrier, or A/B MAC by visiting the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1873CP.pdf>.

You will find the updated sections of the *Medicare Claims Processing Manual* Chapter 26 (Completing and Processing Form CMS-1500 Data Set) as an attachment to that CR.

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

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Source: CMS Pub. 100-04, Transmittal 1873, CR 6375

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Billing for services related to voluntary uses of advance beneficiary notices of noncoverage

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article MM6563 to reflect revisions to change request (CR) 6563. The CR release date, transmittal number, and the Web address for accessing CR 6563 were revised. All other information remains the same. The *MLN Matters* article MM67563 was published in the November 2009 *Medicare A Bulletin* (pages 6-7).

Provider types affected

Physicians, hospitals and other providers, and suppliers who bill Medicare fiscal intermediaries (FI) or A/B Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6563, from which this article is taken, announces recent instructions for the use of modifiers in association with advance beneficiary notices (ABN). Specifically, effective April 1, 2010, two HCPCS level II modifiers have been updated to distinguish between voluntary, and required, uses of liability notices. Those modifiers are:

- **Modifier GA** has been redefined to mean “Waiver of liability statement issued as required by payer policy,” and should be used to report when a required ABN was issued for a service.
- A new **modifier GX** has been created with the definition “Notice of liability issued, voluntary under payer policy” and is to be used to report when a voluntary ABN was issued for a service.

Make sure that your billing staffs are aware of these ABN modifier changes.

Background

In CR 6136 (revised form CMS-R-131 Advance Beneficiary Notice of Noncoverage) released September 5, 2008, CMS revised instructions for providers in the use of ABNs. Prior to these instructions, providers who voluntarily issued patients notices announcing that particular services were either excluded from Medicare coverage by statute, or were services for which no Medicare benefit category exists, used the Notice of Exclusion from Medicare Benefits form (NEMB – now a retired form) or notices that they developed themselves.

With these revised instructions, providers for the first time were allowed to use ABNs to voluntarily provide such notices. (You can read the *MLN Matters*® article associated with this CR by going to the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6136.pdf>.)

CR 6563, from which this article is taken, announces that two HCPCS level II modifiers have been updated to allow the voluntary uses of liability notices to be distinguished from the required uses. Specifically, **modifier GA** has been redefined to mean “Waiver of liability statement issued as required by payer policy.” It should only be used to report when a required ABN was issued for a service, and should not be reported in association with any other liability-related modifier and should continue to be submitted with covered charges. Please note that Medicare

systems will now deny institutional claims submitted with **modifier GA** as a beneficiary liability (rather than subjecting them to possible medical review), and the beneficiary will have the right to appeal this determination. Medicare processing of professional claims with this modifier is not changing.

In addition, a new **modifier GX**, has been created with the definition “Notice of liability issued, voluntary under payer policy” which should be used to report when a voluntary ABN was issued for a service. You may use the **modifier GX** to provide beneficiaries with voluntary notice of liability regarding services excluded from Medicare coverage by statute, and in these cases, you may report it on the same line as certain other liability-related modifiers. Please note that the **modifier GX** must be submitted with noncovered charges only, and your FI or A/B MAC will deny the claim as a beneficiary liability.

You should be aware of some details in the use of these modifiers.

Modifier GA

- Medicare systems will automatically deny lines submitted with the **modifier GA** and covered charges on institutional claims
- Medicare systems will assign beneficiary liability to claims automatically denied when the **modifier GA** is present
- Medicare will use claim adjustment reason code 50 (These are noncovered services because this is not deemed a ‘medical necessity’ by the payer) when denying lines due to the presence of the **modifier GA**.

Modifier GX

- Medicare systems will recognize and allow the **modifier GX** on claims, but will return your claim if the **modifier GX** is used on any line reporting covered charges
- Medicare systems will allow the **modifier GX** to be reported on the same line as the following modifiers that indicator beneficiary liability: **Modifier GY** (Item or service statutorily excluded or does not meet the definition of any Medicare benefit), **modifier TS** (Follow-up service)
- Medicare systems will return your claim if the **modifier GX** is reported on the same line as any of the following liability-related modifiers:

Modifier EY – no doctor’s order on file

Modifier GA, GL – medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN

Billing for services related to voluntary uses of advance beneficiary notices of noncoverage (continued)

Modifier GZ – item or service expected to be denied as not reasonable and necessary

Modifier KB – beneficiary requested upgrade for ABN, more than four modifiers identified on claim

Modifier QL – patient pronounced dead after ambulance is called

Modifier TQ – basic life support transport by a volunteer ambulance provider

- Medicare systems will automatically deny lines (using claim adjustment reason code 50) submitted with the **modifier GX** and noncovered charges, and will assign beneficiary liability to claims automatically denied when the **modifier GX** is present.

Note: Other than the policy and processing changes described in CR 6563, all other policies and processes regarding noncovered charges and liability continue as stated in the *Medicare Claims Processing Manual*, Chapter 1 (General Billing Requirements), Section 60 (Provider Billing of Noncovered Charges) and in the requirements defined in previous change requests.

Additional information

You may find more information about billing for services related to voluntary uses of advance beneficiary notices of noncoverage by going to CR 6563, located on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1894CP.pdf>.

You will find the updated Medicare Claims Processing Manual, Chapter 1 (General Billing Requirements), Section 60 (Provider Billing of Noncovered Charges) as an attachment to that CR.

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

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 Related Change Request (CR) Number: 6563
 Related CR Release Date: January 15, 2010
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 Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1894, CR 6563

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Processing claims rejecting for gender/procedure conflict

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article MM6638 to reflect revisions to change request (CR) 6638. The CR release date, transmittal number, and the Web address for accessing CR 6638 were revised. All other information remains the same. The *MLN Matters* article MM6638 was published in the November 2009 *Medicare A Bulletin* (pages 7-8).

Provider types affected

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

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

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

Caution – what you need to know

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

*Processing claims rejecting for gender/procedure conflict (continued)***Go – what you need to do**

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

Background

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

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

CR 6638 instructs institutional providers submitting Part A claims to report **condition code 45** (ambiguous gender category) on inpatient or outpatient services for affected beneficiaries where the service performed is gender specific (i.e., services that are considered female or male only). Providers should use this claim-level condition code to identify these unique claims and to allow the sex related edits to be processed correctly by Medicare systems and allow the service to continue normal processing.

The **modifier KX**, which is defined as “Requirements specified in the medical policy have been met”, is a multipurpose informational modifier for Part B professional claims. In addition to its other existing uses, the **modifier KX** should also be used to identify services that are gender

specific (i.e., services that are considered female or male only) for affected beneficiaries on claims submitted by physicians and nonphysician practitioners to Medicare carriers and MACs. Use of the **modifier KX** will alert the carrier/MAC that the physician/practitioner is performing a service on a patient for whom gender specific editing may apply, and that the service should be allowed to continue with normal processing. Payment will be made if the coverage and reporting criteria have been met for the service.

Additional information

The official instruction, CR 6638, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1877CP.pdf>.

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

MLN Matters® Number: MM6638 – Revised
Related Change Request (CR) Number: 6638
Related CR Release Date: December 18, 2009
Related CR Transmittal Number: R1877CP
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1877, CR 6638

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Implementation of home health agency program safeguard provisions

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

Provider types affected

Home health agencies (HHAs) submitting claims to Medicare contractors (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

This article is based on change request (CR) 6750, which implements two provisions from the home health agency (HHA) prospective payment system final rule (CMS-1560-F). The first provision requires an HHA whose Medicare billing privileges have been deactivated to undergo a state survey or obtain accreditation from a CMS-approved accrediting organization prior to having its billing privileges reactivated. The second provision holds that an HHA may not undergo a change of ownership or transfer of ownership if the effective date of the change or transfer occurs within 36 months of: (1) the effective date of the provider’s enrollment in Medicare, or (2) the effective date of the last ownership change or transfer for the HHA. The provider must instead enroll as a new HHA, undergo a state survey or obtain accreditation from a CMS-approved accrediting organization, and sign a new provider agreement.

Background

An “ownership change” includes any of the following:

- Change of ownership (CHOW)
- Acquisition/merger
- Consolidation
- Change request reporting a five percent or greater ownership change (including , stock transfer or asset sale), or
- Change request reporting a change in partners, regardless of the percentage of ownership involved.

If a Medicare contractor receives an application for an ownership change from an HHA, it will determine whether the effective date of the transfer is within 36 months of either the effective date of the provider’s initial enrollment in Medicare or last ownership change. The Medicare contractor will verify the effective date of the ownership transfer by requesting a copy of the transfer agreement, sales agreement, bill of sale, etc., rather than relying upon the projected date of the sale listed on the application.

If the transfer date falls within the 36-month period after the effective date of the provider’s enrollment in

Implementation of home health agency program safeguard provisions (continued)

Medicare or last ownership change, the Medicare contractor will return the application and notify the provider that, per 42 CFR 424.550(b), the HHA must:

- Enroll as an initial applicant
- Obtain a new state survey or accreditation from a CMS-approved accrediting organization after it has submitted its initial enrollment application and the Medicare contractor has made a recommendation for approval to the state
- Sign a new provider agreement as part of the initial enrollment.

As the new owner must enroll as a new provider, the Medicare contractor will also deactivate the HHA's billing privileges if the sale has already occurred. If the sale has not occurred, the contractor will alert the HHA that it must submit a CMS-855A voluntary termination application (see on the CMS Web site <http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf>).

If the transfer date is more than 36 months after the effective date of the provider's enrollment in Medicare or most recent ownership change, the application may be processed normally, without the need for a new state survey or an approval from an approved accreditation organization.

Additional information

The official instruction, CR 6750, issued to your FI, A/B MAC, and RHHI regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R318PI.pdf>.

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

MLN Matters® Number: MM6750

Related Change Request (CR) Number: 6750

Related CR Release Date: December 18, 2009

Related CR Transmittal Number: R318PI

Effective Date: January 1, 2010

Implementation Date: January 1, 2010

Source: CMS Pub. 100-08, Transmittal 318, CR 6750

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AMBULANCE SERVICES

MIPPA ambulance provisions expired December 31

Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided for an increase in the ambulance fee schedule amounts for covered ground ambulance transport. For transports that originated in urban areas, the increase was two percent. For transports that originated in rural areas, the increase was three percent. The increases were applicable only for claims with dates of service July 1, 2008, through December 31, 2009.

Further, Section 146(b)(1) of MIPPA amended the designation of rural areas for air ambulance services. The statute specified that any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services should continue to be treated as a rural area for purposes of making air ambulance service payments under the ambulance fee schedule. This statute was also applicable only for claims with dates of service July 1, 2008, through December 31, 2009.

As such, as of January 1, 2010, for ground and air ambulance claims received with dates of service on this date and beyond, Medicare will no longer be paying ground and air ambulance service providers based on these two expired provisions. ❖

PROVIDER SATISFACTION SURVEY

Providers randomly selected to participate in the Medicare contractor provider satisfaction survey urged to respond

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

Provider types affected

Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care practitioners that received a letter indicating they were randomly selected to participate in the 2010 Medicare contractor provider satisfaction survey (MCPSS) should review this article.

Provider action needed

This special edition article alerts providers that the Centers for Medicare & Medicaid Services (CMS) has launched the fifth annual national administration of the MCPSS. If you received a letter indicating you were randomly selected to participate in the 2010 MCPSS, CMS urges you to take a few minutes to go online and complete this important survey via a secure Internet website. Responding online is a convenient, easy, and quick way to provide CMS with your feedback on the performance of your FFS contractor. Survey questionnaires can also be submitted by mail, secure fax, and over the telephone.

Background

CMS is responsible for the administration of the Medicare FFS program and does so primarily through its Medicare FFS contractors. As Medicare's agents, these contractors are responsible for executing the daily operational aspects of the Medicare FFS program by processing and paying the more than \$370 billion in Medicare claims each year and performing other related business functions that support regular daily interactions with Medicare FFS providers.

The MCPSS that is conducted annually by CMS is designed to collect quantifiable data on provider satisfaction with the performance of Medicare FFS contractors. The MCPSS offers Medicare FFS providers an opportunity to give CMS valuable feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. Survey questions focus on seven key business functions of the provider-contractor relationship:

- Provider inquires
- Provider outreach & education
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit & reimbursement

The MCPSS is a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which mandated CMS to develop contract performance requirements, including measuring health care provider

satisfaction with Medicare contractors. The MCPSS enables CMS to hear provider concerns, monitor trends, improve contractor oversight, and increase efficiency of the Medicare program. The MCPSS provides contractors with more insight into their provider communities and allows them to make process improvements based on provider feedback.

The 2010 MCPSS study

Sample selection

Each year, a new random sample of Medicare FFS providers is selected to participate in the MCPSS. For the 2010 MCPSS study, CMS will ask approximately 30,000 Medicare FFS providers and suppliers to participate in the MCPSS. The sample is scientifically designed, and then randomly selected, to represent the community of more than 1.5 million Medicare providers nationwide who serve Medicare beneficiaries across the country. The sample includes:

- Medicare FFS physicians
- limited licensed practitioners (LLP)
- laboratories
- hospitals
- skilled nursing facilities (SNF)
- rural health clinics (RHC)
- home health agencies (HHA)
- federally qualified health centers (FQHC)
- hospice facilities
- end-stage renal disease (ESRD) facilities
- durable medical equipment (DME) suppliers
- ambulance service providers
- other Part A institutional facilities
- Part B health care practitioners.

Those health care providers randomly selected to participate in the 2010 MCPSS were notified in January.

Web-based survey questionnaire

CMS continues to make completing and returning the survey simple by migrating to an easy to use Web-based survey. Providers selected to participate in the 2010 study will have access to an online Web-based survey tool where they can rate their contractor's performance and complete and submit their survey questionnaire over a secure Internet website. The Internet is a quick, convenient, and environmentally friendly way for providers to contribute directly to CMS' understanding of contractor performance. CMS encourages all participants with Internet access to submit their completed survey online. Participants may

Providers randomly selected to participate in the MCPSS urged to respond (continued)

also submit their completed survey questionnaire via mail, secure fax, and over the telephone. The 2010 MCPSS takes approximately 20 minutes to complete.

New satisfaction rating scale

The 2010 survey questions use a fully-labeled five-point Likert response scale with “1” representing “Very Dissatisfied” and “5” representing “Very Satisfied”. In contrast to previous years’ surveys which used a six-point scale, where only the end-points were labeled, this new scale assigns words to every answer category and includes a neutral category. The change will allow CMS to communicate a well-defined message about the performance of the Medicare contractors. While only health care providers selected to participate in the 2010 MCPSS may complete and return the survey questionnaire, a sample of the 2010 MCPSS questionnaire is available for viewing for informational purposes at <http://www.cms.hhs.gov/mcpss>.

Reporting results

CMS will analyze the 2010 MCPSS data and release a summary report on the CMS website in the summer of 2010. The report prepared for this study will summarize findings across the sample and will not associate responses with a specific individual, practice, or facility. CMS has contracted with SciMetrika, a public health consulting firm, to administer this important survey and report statistical data to CMS.

Provider participation key to success of study

Participation in the MCPSS is voluntary, however, the

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survey offers providers the opportunity to contribute directly to CMS’ understanding of Medicare contractor performance, as well as aid future process improvement efforts at the contractor level. The views of every health care provider asked to participate in the 2010 study are very important to the success of this study, as each one represents many other organizations that are similar in size, practice type, and geographical location.

The feedback captured through the MCPSS is important. CMS urges all providers selected to participate in the 2010 study to take this opportunity to provide CMS with their feedback on the performance of the Medicare FFS contractor that processes and pays their Medicare claims. CMS requests that you complete your survey questionnaire as quickly as possible when you receive it.

CMS is listening and wants to hear from you.

Additional information

For more information about the MCPSS, including results of the 2009 MCPSS, please visit the CMS Web site at <http://www.cms.hhs.gov/mcpss>.

MLN Matters® Number: SE1005

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Related CR Transmittal Number: N/A

Effective Date: N/A

Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE1005

CMS launches fifth annual Medicare contractor provider satisfaction survey

The Centers for Medicare & Medicaid Services (CMS) is listening and wants to hear from you about your satisfaction with the services provided by Medicare fee-for-service (FFS) contractors that process and pay Medicare claims. CMS has launched the fifth annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers the opportunity to give CMS feedback on their interactions with Medicare FFS contractors.

Approximately 30,000 randomly selected providers will be notified in January that they have been selected to participate in the survey. CMS urges all health care providers that are selected to participate in the 2010 survey to take a few minutes to complete and return this important survey. To read the CMS press release announcing the launch of the 2010 MCPSS, go to http://www.cms.hhs.gov/MCPSS/Downloads/2010_MCPSS_contractor_survey.pdf.

CMS is listening and wants to hear from you. ❖

Source: CMS PERL 201001-04

New feedback page

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

ELECTRONIC HEALTH RECORDS

Setting regulations and standards for electronic health record incentive program

Public encouraged to comment on new regulations

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) for Health Information Technology encourage public comment on two regulations that lay a foundation for improving quality, efficiency, and safety through meaningful use of certified electronic health record (EHR) technology. The regulations will help implement the EHR incentive programs enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act).

A proposed rule issued by CMS outlines proposed provisions governing the EHR incentive programs, including defining the central concept of “meaningful use” of EHR technology. An interim final regulation (IFR) issued by ONC sets initial standards, implementation specifications, and certification criteria for EHR technology. Both regulations are open to public comment.

“Widespread adoption of electronic health records holds great promise for improving health care quality, efficiency, and patient safety,” said, National Coordinator for Health Information Technology David Blumenthal, M.D., M.P.P. “The Recovery Act’s financial incentives demonstrate Congress’ and the Administration’s commitment to help providers adopt and make meaningful use of EHR technology so they can give better care and their patients’ experience of care will improve. Over time, we believe the EHR incentive program under Medicare and Medicaid will accelerate and facilitate health information technology adoption by more individual providers and organizations throughout the health care system.”

“These regulations are closely linked,” said Charlene Frizzera, CMS Acting Administrator. “CMS’s proposed regulation would define and specify how to demonstrate ‘meaningful use’ of EHR technology, which is a prerequisite for receiving the Medicare incentive payments. Our rule also outlines the proposed payment methodologies for the Medicare and Medicaid EHR incentive programs. ONC’s regulation sets forth the standards and specifications that will enhance the interoperability, functionality, utility and security of health information technology.”

CMS and ONC worked closely to develop the two rules and received input from hundreds of technical subject matters experts, health care providers, and other key stakeholders. Numerous public meetings to solicit public comment were held by three federal advisory committees: the National Committee on Vital and Health Statistics (NCVHS), the Health IT Policy Committee (HITPC), and the Health IT Standards Committee (HITSC). HITSC presented its final recommendations to the National Coordinator in August 2009.

These recommendations, along with all other input, were considered to help inform the development of the regulations announced today.

The IFR issued by ONC describes the standards that must be met by certified EHR technology to exchange healthcare information among providers and between providers and patients. This initial set of standards begins to define a common language to ensure accurate and secure health information exchange across different EHR systems. The IFR describes standard formats for clinical summaries and prescriptions; standard terms to describe clinical problems, procedures, laboratory tests, medications and allergies; and standards for the secure transportation of this information using the Internet.

The IFR calls for the industry to standardize the way in which EHR information is exchanged between organizations, and sets forth criteria required for an EHR technology to be certified. These standards will support meaningful use and data exchange among providers who must use certified EHR technology to qualify for the Medicare and Medicaid incentives.

Under the statute, HHS is required to adopt an initial set of standards for EHR technology by Dec. 31, 2009. The IFR will go into effect 30 days after publication, with an opportunity for public comment and refinement over the next 60 days. A final rule will be issued in 2010. “We strongly encourage stakeholders to provide comments on these standards and specifications,” Dr. Blumenthal said.

The Recovery Act established programs to provide incentive payments to those eligible professionals and hospitals that not only participate in Medicare and Medicaid but also adopt and make “meaningful use” of certified EHR technology.

Incentive payments may begin as soon as October 2010 to eligible hospitals. Incentive payments to other eligible providers may begin in January 2011.

The proposed rule would define the term “meaningful EHR user” as an eligible professional or eligible hospital that, during the specified reporting period, demonstrates meaningful use of certified EHR technology in a form and manner consistent with certain objectives and measures presented in the regulation. These objectives and measures would include use of certified EHR technology in a manner that improves quality, safety, and efficiency of health care delivery; reduces health care disparities; engages patients and families; improves care coordination; improves population and public health; and ensures adequate privacy and security protections for personal health information.

The proposed rule would define meaningful use for the Medicare EHR incentive programs. It proposes one definition that would apply to eligible professionals participating in the Medicare fee-for-service and the Medicare Advantage EHR incentive programs as well as a proposed definition that would apply to eligible hospitals and critical access hospitals. These definitions also would

Setting regulations and standards for electronic health record incentive program (continued)

serve as the minimum standard for eligible professionals and eligible hospitals participating in the Medicaid EHR incentive program. The rule proposes that states could request CMS approval to implement additional meaningful use measures, as appropriate, but could not request approval of fewer or less rigorous meaningful use measures than required by the rule.

This rule proposes a phased approach to implement the proposed requirements for demonstrating meaningful use. This approach would initially establish reasonable criteria for meaningful use based on currently available technological capabilities and providers' practice experience. CMS will establish stricter and more extensive criteria for demonstrating meaningful use over time, as anticipated developments in technology and providers' capabilities occur.

CMS provides a 60-day comment period on the proposed rule. "The definition and requirements for demonstrating meaningful use of EHR technology are proposals. CMS welcomes and will give serious consideration to comments that improve our proposal while achieving the goals Congress established for the EHR incentive programs," Frizzera said.

The CMS proposed rule and fact sheets may be viewed at http://www.cms.hhs.gov/Recovery/11_HealthIT.asp.

ONC's interim final rule may be viewed at <http://healthit.hhs.gov/standardsandcertification>.

In early 2010, ONC intends to issue a notice of proposed rulemaking related to the certification of health information technology.

Additional Web site resources:

- The Recovery Act Health IT page is:
http://www.cms.hhs.gov/Recovery/11_HealthIT.asp.
- Direct link to CMS regulation:
<http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf>.
- A copy of the ONC regulation is available at:
<http://healthit.hhs.gov/standardsandcertification>.
- The HHS press release is available at:
https://www.cms.hhs.gov/apps/media/press_releases.asp.
- The CMS fact sheets are available at:
https://www.cms.hhs.gov/apps/media/fact_sheets.asp. ❖

Source: CMS PERL 200912-34

Use the PDS report to improve your Medicare billing operations

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

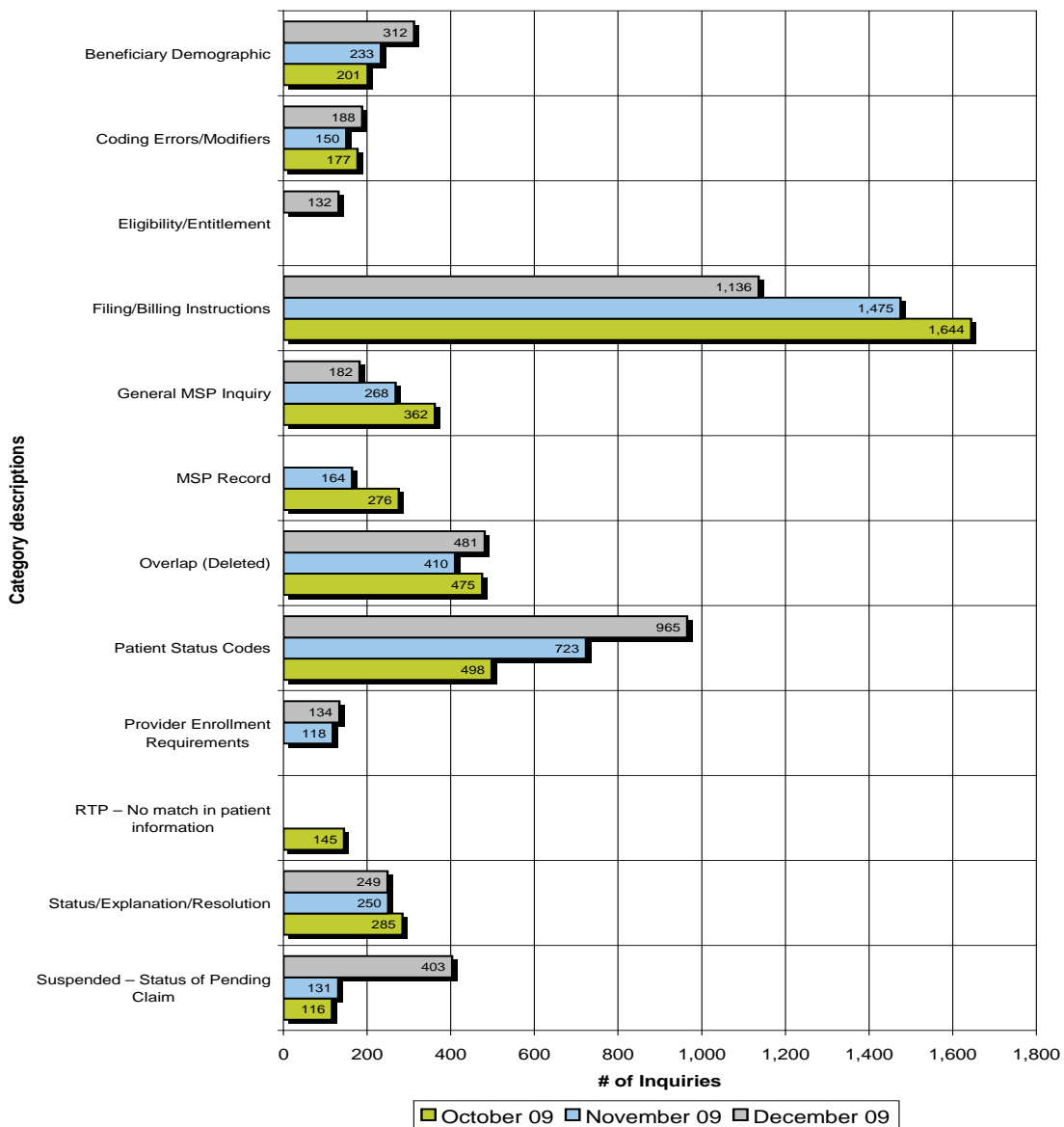
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims for October-December 2009

The following charts demonstrate the available top number of inquiries, the top reason codes for return to providers (RTPs), and reject claims submitted to First Coast Service Options Inc. (FCSO), by Florida, and U.S. Virgin Islands providers during October-December 2009.

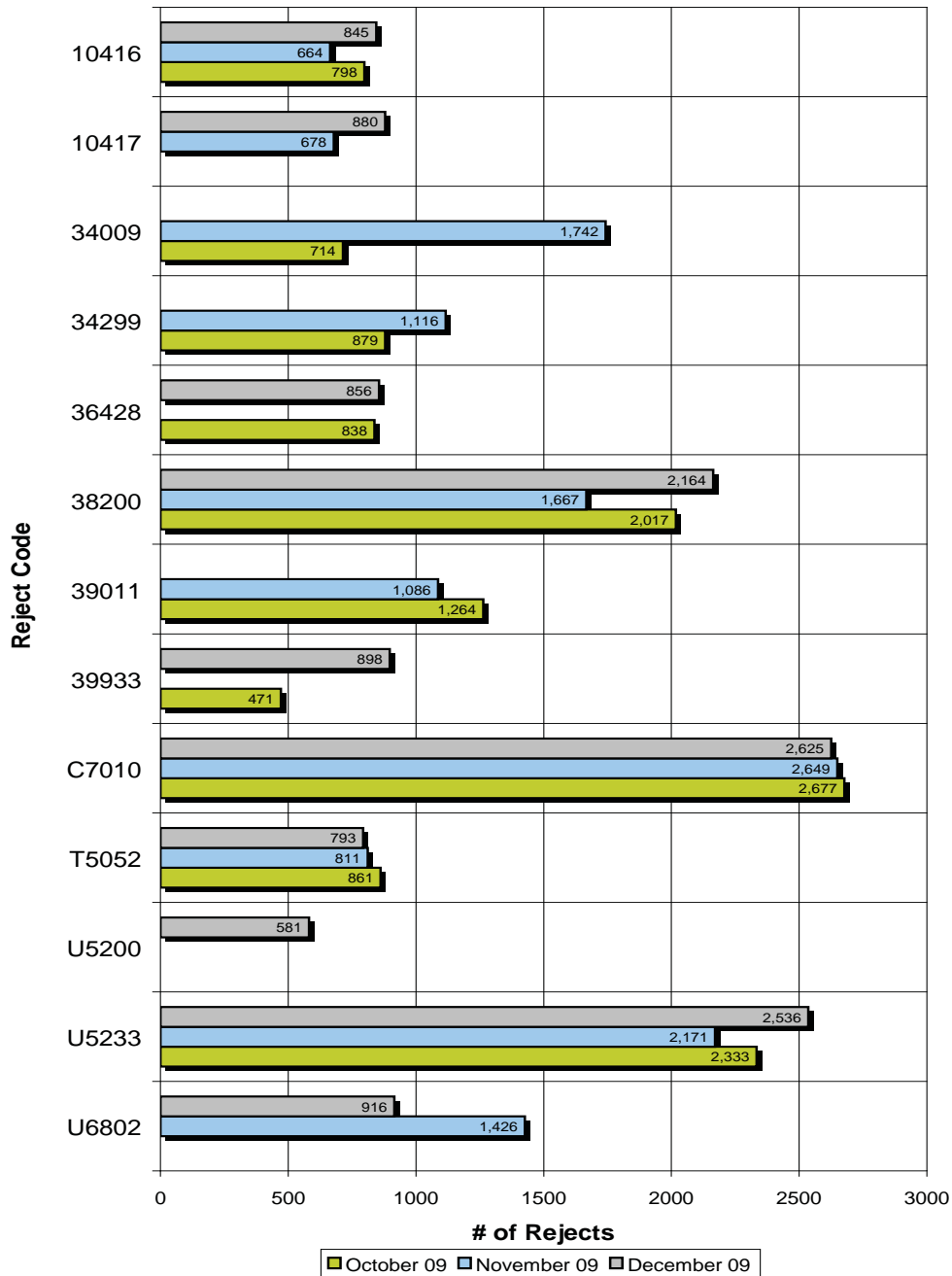
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our Web site at http://medicare.fcso.com/Inquiries_and_denials/index.asp.

Florida Part A top inquiries for October-December 2009



Top inquiries, return to provider, and reject claims for October-December 2009 (continued)

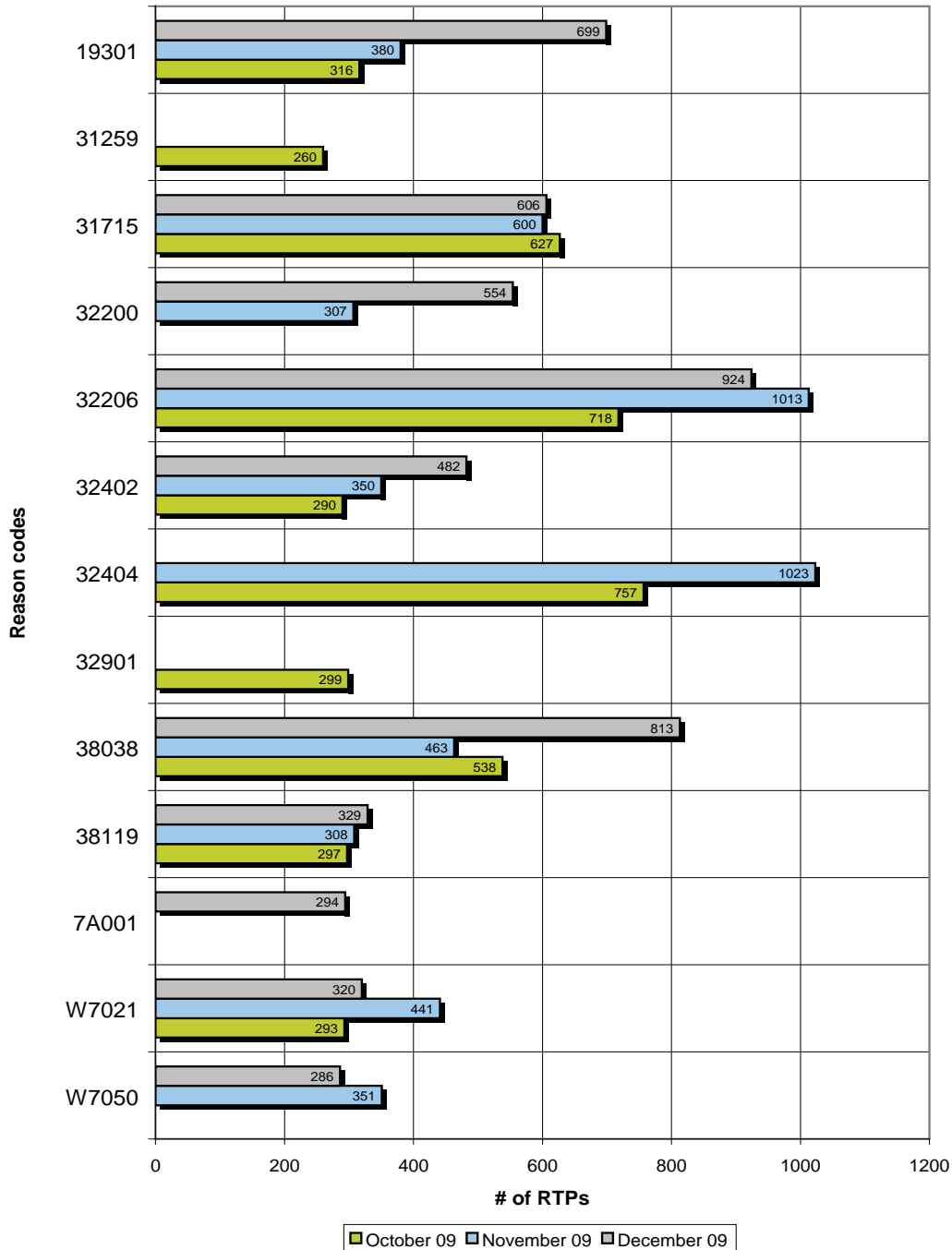
Florida Part A top rejects for October-December 2009



Find your favorites fast – use Quick Find
 Looking for the fastest way to find your favorite sections of our Web site? It's easy – just use the Quick Find navigational tool. Located on the left-hand side of every page, this convenient drop-down menu allows you to jump to the most popular pages on the site – with just one click. You'll find links to the Part A and Part B homepages as well as quick links to the procedure-diagnosis lookup tool, local coverage determinations (LCDs), fee schedules, publications, and more. Find out how easy is to find what you need fast – use Quick Find.

Top inquiries, return to provider, and reject claims for October-December 2009 (continued)

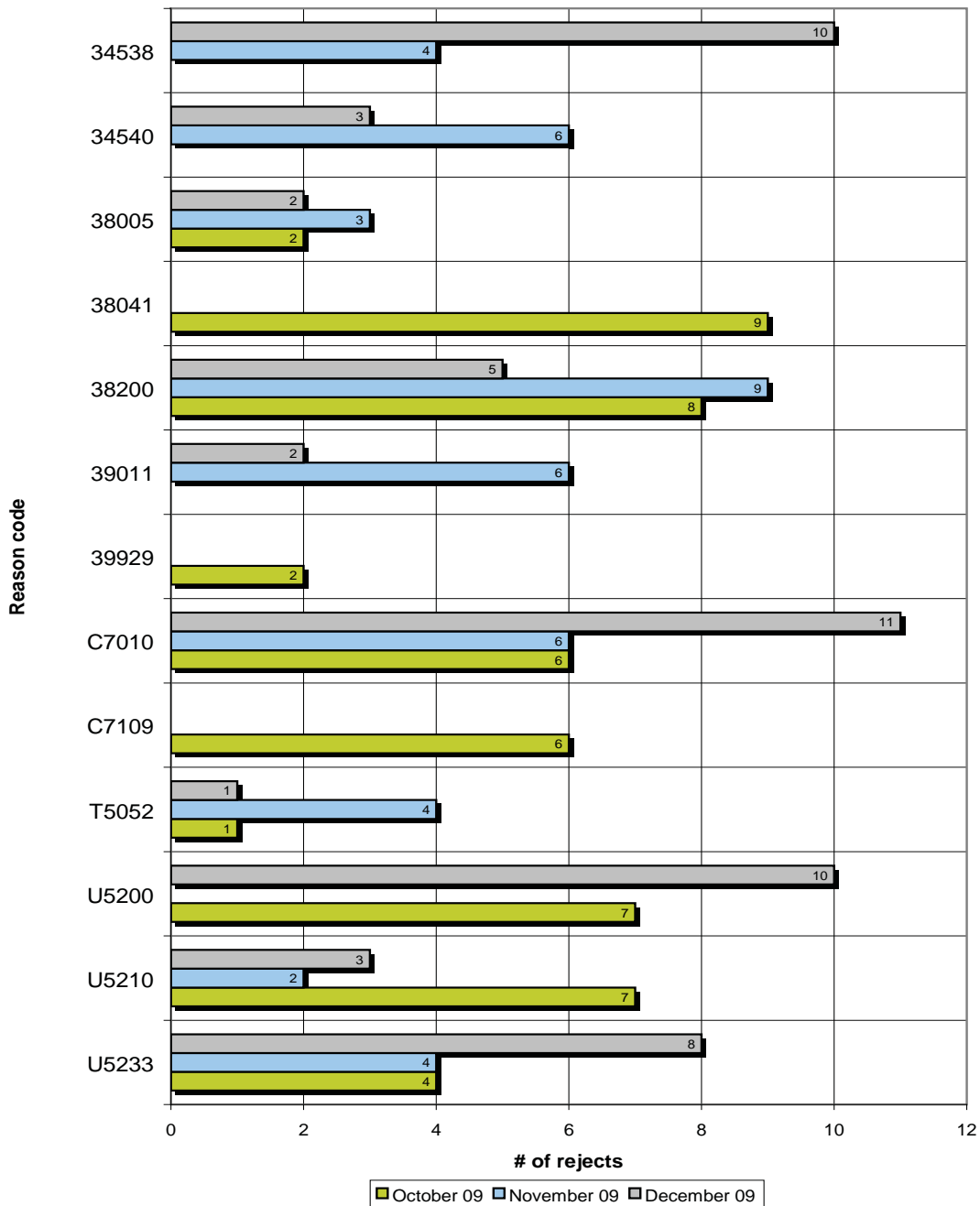
Florida Part A top RTPs for October-December 2009



Keep Informed
 Join *e-News*, FCSO e-mailing list to receive the most current revisions and updates. Check our upcoming provider events calendar and learn how to register for free teleconferences and webcasts that will help you increase your knowledge of the Medicare program and find ways to improve Medicare billing and payment efficiency.

Top inquiries, return to provider, and reject claims for October-December 2009 (continued)

U.S. Virgin Islands Part A top rejects for October-December 2009

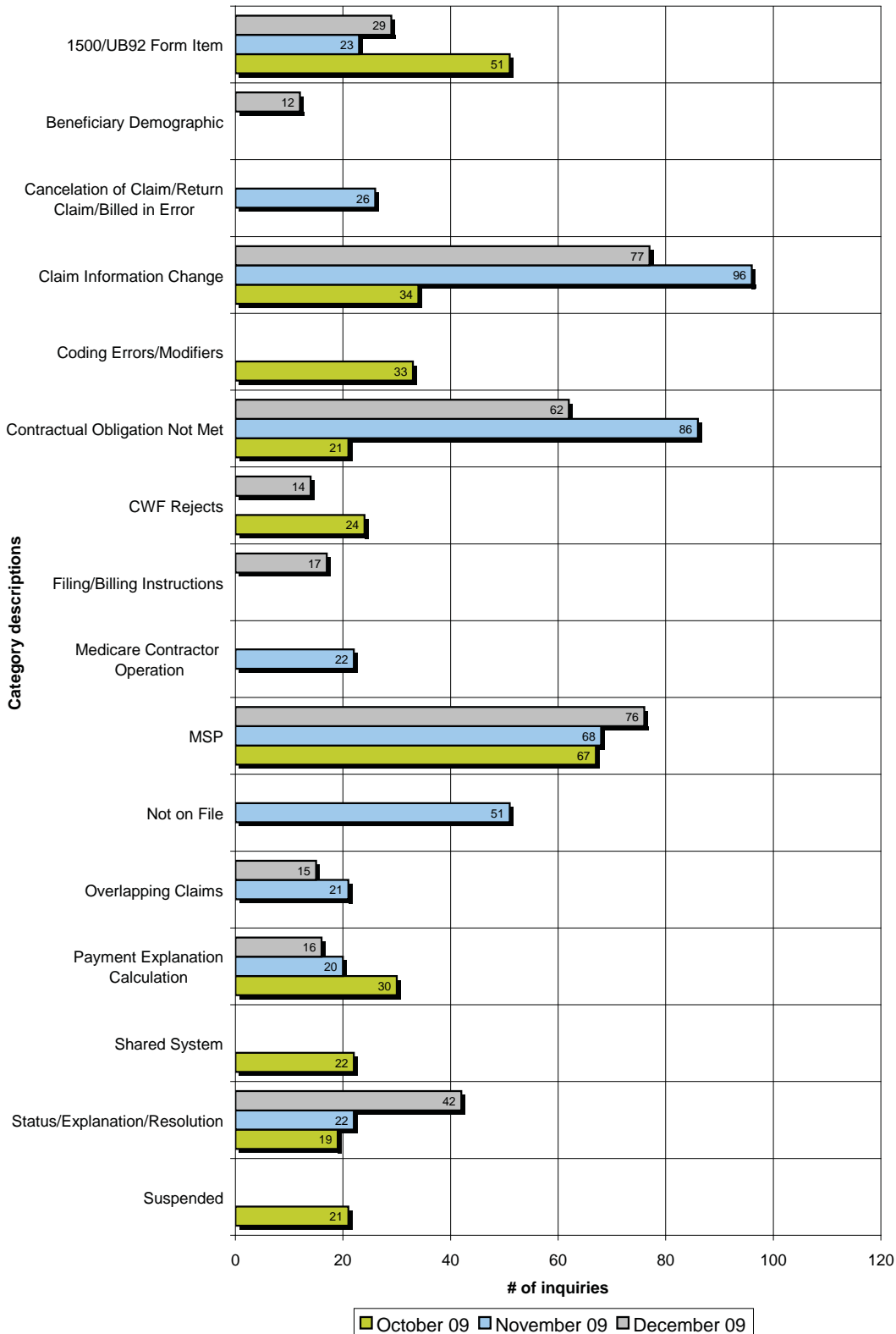


Educational Resources

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

Top inquiries, return to provider, and reject claims for October-December 2009 (continued)

Puerto Rico and U.S. Virgin Islands Part A top inquiries for October-December 2009



GENERAL COVERAGE

Pharmacogenomic testing for warfarin response

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

Provider types affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare administrative contractors [A/B MAC]) for providing pharmacogenomic testing to predict warfarin (Coumadin®) responsiveness to Medicare beneficiaries should be aware of this article.

What you need to know

Change request (CR) 6715, from which this article is taken, announces that effective August 3, 2009, pharmacogenomic testing to predict warfarin responsiveness is covered only when provided to Medicare beneficiaries in the context of a prospective randomized, controlled clinical study when that study meets certain criteria as outlined in the Medicare *National Coverage Determinations (NCD) Manual*, Chapter 1, Section 90.1 (Pharmacogenomic Testing to Predict Warfarin Responsiveness), which you may find as an attachment to CR 6715. Pharmacogenomic testing for warfarin responsiveness is limited to testing for CYP2C9 or VKORC1 alleles. Testing is covered for Medicare beneficiaries who: 1) Are candidates for anticoagulation therapy with warfarin, 2) Have not been previously tested for CYP2C9 or VKORC1 alleles, and 3) Have received fewer than five days of warfarin in the anticoagulation regimen for which the testing is ordered. Pharmacogenomic testing for the presence of the CYP2C9 and VKORC1 alleles to predict warfarin responsiveness is covered only once in a patient's lifetime.

Background

There has been considerable public interest in the use of pharmacogenomic testing (testing of how an individual's genetic makeup, or genotype, affects the body's response to drugs) to predict a patient's response to warfarin sodium (an orally administered anticoagulant drug marketed most commonly as Coumadin®). Warfarin affects the vitamin K-dependent clotting factors II, VII, IX, and X, and is thought to interfere with clotting factor synthesis.

The elimination of warfarin is almost entirely by metabolic conversion to inactive metabolites by cytochrome P450 (CYP) enzymes in liver cells. CYP2C9 is the principal cytochrome P450 enzyme that modulates the anticoagulant activity of warfarin. From results of clinical studies, genetic variation in the CYP2C9 and/or VKORC1 genes can, in concert with clinical factors, predict how each individual responds to warfarin.

On August 4, 2008, the Centers for Medicare & Medicaid Services (CMS) opened a national coverage analysis (NCA) to determine if the use of pharmacogenomic testing for warfarin responsiveness is reasonable and necessary under the Medicare program. On August 3, 2009, CMS issued a final decision stating that the available evidence does not demonstrate that pharmacogenomic

testing to predict warfarin responsiveness improves health outcomes in Medicare beneficiaries, and is therefore not reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act (the Act).

However, the CMS decision also states that the available evidence does support pharmacogenomic testing for warfarin responsiveness under coverage with evidence development (CED). CR 6715 announces that, effective August 3, 2009, the available evidence supports that CED under Section 1862(a)(1)(E) of the Act is appropriate for pharmacogenomic testing of CYP2C9 or VKORC1 alleles to predict warfarin responsiveness by any method, and is therefore covered when provided to Medicare beneficiaries who are candidates for anticoagulation therapy with warfarin only if they have not been previously tested for CYP2C9 or VKORC1 alleles; and have received fewer than five days of warfarin in the anticoagulation regimen for which the testing is ordered.

Further, such patients must be enrolled in a prospective, randomized, controlled clinical study that addresses one or more aspects of the specific research questions, and the study must adhere to standards of scientific integrity and relevance to the Medicare population. See Publication 100-03, *NCD Manual*, Chapter 1, Section 90.1, for detailed study requirements/criteria.

Note: This NCD does not determine coverage to identify CYP2C9 or VKORC1 alleles for other purposes, nor does it determine national coverage to identify other alleles to predict warfarin responsiveness. Further, CMS believes that the available evidence does not demonstrate that pharmacogenomic testing of CYP2C9 or VKORC1 alleles to predict warfarin responsiveness improves health outcomes in Medicare beneficiaries outside the context of CED, and is therefore not reasonable and necessary under Section 1862(a)(1)(A) of the Act.

Billing requirements

A new temporary Healthcare Common Procedure Coding System (HCPCS) Level II code effective August 3, 2009, G9143 (warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)), has been developed to enable the implementation of pharmacogenomic testing under CED.

Please note that this would be a once-in-a-lifetime test unless there is a reason to believe that the patient's personal genetic characteristics would change over time.

Institutional clinical trial claims for pharmacogenomic testing for warfarin response are identified through the presence of all of the following elements:

- Value code D4 and eight-digit clinical trial number (when present on the claim)

Pharmacogenomic testing for warfarin response (continued)

- ICD-9 diagnosis code V70.7
- Condition code 30

(For these three elements, please see MM5790 – Use of an 8-Digit Registry Number on Clinical Trial Claims on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5790.pdf>.)

- **HCPCS modifier Q0:** outpatient claims only (please see MM5805 – New Healthcare Common Procedure Coding System (HCPCS) Modifiers when Billing for Patient Care in Clinical Research Studies at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5805.pdf>.)
- **HCPCS code G9143** (mandatory with the April 2010 integrated outpatient code editor and the January 2011 clinical laboratory fee schedule (CLFS) updates). Prior to these times, clinical studies should bill Medicare contractors for this test as they currently do absent these instructions, and the Medicare contractors should process and pay those claims accordingly.

Practitioner clinical trial claims for pharmacogenomic testing for warfarin response are identified through the presence of all of the following elements:

- ICD-9 diagnosis code V70.7
- Eight-digit clinical trial number (when present on the claim)
- HCPCS modifier Q0
- HCPCS code G9143 (to be carrier-priced for claims with dates of service on and after August 3, 2009, processed prior to the January 2011 CLFS update).

Payment requirements

You should be aware that Medicare will track whether a beneficiary receives once-in-a-lifetime pharmacogenomic testing for warfarin response and will generate a Medicare line-item denial if a subsequent test is submitted for payment. Your carrier, FI, or MAC will provide the following messages to enforce the one-time limitation for the test:

Claim adjustment reason code (CARC) 50: These are noncovered services because this is not deemed a ‘medical necessity’ by the payer. Note: Refer to the 835 Healthcare policy identification segment, if present. (The aforementioned note is a revision to CARC 50 effective 04/01/2010.)

Remittance advice remark code (RARC) N362: The number of days or units of service exceeds our acceptable maximum.

Group code CO: contractual obligation

Medicare summary notice (MSN) 16.76: This service/item was not covered because you have exceeded the lifetime limit for getting this service/item. (Este servicio/artículo no fue cubierto porque usted ya se ha pasado del límite permitido de por vida para recibirlo.) (MSN 16.76 is effective for dates of service on and after August 3, 2009.)

Additionally, Medicare will return to provider/return as unprocessable claims for pharmacogenomic testing for warfarin response when not billed with HCPCS modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study) on the same line with HCPCS code G9143 using the following messages:

CARC 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.

Group code CO: contractual obligation

MSN 16.77 – This service/item was not covered because it was not provided as part of a qualifying trial/study. (Este servicio/artículo no fue cubierto porque no estaba incluido como parte de un ensayo clínico/estudio calificado.) (MSN 16.77 is effective for dates of service on and after August 3, 2009.)

If your claim contains **modifier Q0** and HCPCS code G9143 but does not contain the V70.7 diagnosis code, those claim lines will generate a return to provider/return as unprocessable with the following messages:

CARC 16: Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)

RARC 64: Missing/incomplete/invalid other diagnosis.

Group code CO: contractual obligation

MSN 16.77: This service/item was not covered because it was not provided as part of a qualifying trial/study. (Este servicio/artículo no fue cubierto porque no estaba incluido como parte de un ensayo clínico/estudio calificado.) (MSN 16.77 is effective for dates of service on and after August 3, 2009.)

Please note that effective for claims with dates of service August 3, 2009, through April 4, 2010, your contractors will not search their files to adjust previously processed claims, but will adjust any claims that you bring to their attention.

Additional information

You may find more information about pharmacogenomic testing for warfarin response by going to CR 6715, which was issued in two transmittals. The first transmittal updates the *Medicare National Coverage Determinations Manual*, Chapter 1, Section 90.1 (Pharmacogenomic Testing to Predict Warfarin Responsiveness) and that transmittal is on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R111NCD.pdf>.

The second transmittal, <http://www.cms.hhs.gov/Transmittals/downloads/R1889CP.pdf>, updates the *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 240 (Pharmacogenomic Testing for Warfarin Response).

Pharmacogenomic testing for warfarin response (continued)

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

MLN Matters® Number: MM6715

Related Change Request (CR) Number: 6715

Related CR Release Date: January 8, 2010

Related CR Transmittal Number: R1889CP and R111NCD

Effective Date: August 3, 2009

Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1889, CR 6715

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Expansion of Medicare telehealth services for calendar year 2010

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

Provider types affected

Physicians, hospitals, and skilled nursing facilities (SNFs) submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for telehealth services provided to Medicare beneficiaries are affected by this article.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) added three Healthcare Common Procedure Coding System (HCPCS) codes, 96150-96152, to the list of Medicare distant site telehealth services for individual health and behavior assessment and intervention (HBAI) services. CMS also added three new HCPCS codes, G0425-G0427, for initial inpatient telehealth consultations and expanded coverage of HCPCS codes G0406-G0408, for follow-up inpatient telehealth consultations, to include telehealth services furnished to beneficiaries in a skilled nursing facility (SNF).

These changes are discussed in the calendar year (CY) 2010 physician fee schedule final rule (with comment period [CMS-1413-FC]). This article highlights the related policy instructions. Be sure your billing staff is aware of these changes.

Background

As noted in the calendar year 2010 physician fee schedule final rule with comment period (CMS-1413-FC; see <http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf>), CMS did the following:

- Added three codes to the list of Medicare distant site telehealth services for **individual health and behavior assessment and intervention (HBAI) services**
- Added three codes for **initial inpatient telehealth consultations**
- Expanded the definition of **follow-up inpatient telehealth consultations** to include consultative visits furnished via telehealth to beneficiaries in SNFs as well as hospitals).

These codes are included in the calendar year (CY) 2010 HCPCS annual update. Change request (CR) 6705 adds the relevant policy instructions to the manuals, as finalized in the regulations.

The list of Medicare telehealth services was expanded to include:

- **Individual HBAI**, as described by:
 - ♦ **CPT code 96150** (initial assessment): Practitioners conducting the initial assessment of the patient to determine the biological, psychological, and social factors affecting the patient's physical health and any treatment problems
 - ♦ **CPT code 96151** (re-assessment): Practitioners conducting a re-assessment of the patient to evaluate the patient's condition and determine the need for further treatment. A re-assessment may be performed by a clinician other than the one who conducted the patient's initial assessment
 - ♦ **CPT code 96152** (intervention-individual): Practitioners conducting intervention services provided to an individual to modify the psychological, behavioral, cognitive, and social factors affecting the patient's physical health and well-being. Examples include increasing the patient's awareness about his or her disease and using cognitive and behavioral approaches to initiate physician prescribed diet and exercise regimens
- **Initial inpatient telehealth consultations** provided at various levels of complexity as described by:
 - ♦ **HCPCS G0425** (problem focused): Practitioners taking a problem focused history, conducting a problem focused examination, and engaging in medical decision making that is straightforward. At this level of service, practitioners would typically spend 30 minutes communicating with the patient via telehealth
 - ♦ **HCPCS G0426** (detailed): Practitioners taking a detailed history, conducting a detailed examination, and engaging in medical decision making that is of moderate complexity. At this level of service, practitioners would typically spend 50 minutes communicating with the patient via telehealth

Expansion of Medicare telehealth services for calendar year 2010 (continued)

- ♦ **HCPCS G0427** (comprehensive): Practitioners taking a comprehensive history, conducting a comprehensive examination, and engaging in medical decision making that is of high complexity. At this level of service, practitioners would typically spend 70 minutes or more communicating with the patient via telehealth.

In addition, effective January 1, 2010, the following is valid when billed for telehealth services furnished to beneficiaries in hospitals or SNFs:

- **Follow-up inpatient telehealth consultations**, as described by:
 - ♦ **HCPCS G0406**: Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
 - ♦ **HCPCS G0407**: Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth, and
 - ♦ **HCPCS G0408**: Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth.

Note: HCPCS codes G0406-G0408 have been effective since January 1, 2009, but were only valid for telehealth services provided to a beneficiary in an inpatient hospital. As of January 1, 2010, these three codes are also billable for telehealth services furnished to beneficiaries in an SNF.

The following telehealth modifiers are required when billing for telehealth services with codes 96150-96152, G0406-G0408, and G0425-G0427:

GT Via interactive audio and video telecommunications system

GQ Via asynchronous telecommunications system

Note: Consistent with existing telehealth policy, all telehealth services must be billed with either modifier GT or GQ to identify the telehealth technology used to provide the service.

Effective January 1, 2010, CMS eliminated the use of all AMA *Current Procedural Terminology* (CPT) consultation codes. (See the *MLN Matters*[®] article for full details at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf>.)

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Because revisions in consultation services payment policy affect telehealth policy, CR 6705 includes references to the revisions relevant to professional consultations furnished via telehealth.

Effective January 1, 2010:

- CMS will no longer recognize office/outpatient consultation CPT codes 99241-99245.
 - ♦ Instead, physicians and practitioners are instructed to bill a new or established patient visit CPT code in the range of CPT codes 99201-99215, as appropriate to the particular patient, for all office/outpatient visits furnished via telehealth; and
- CMS will no longer recognize initial inpatient consultation CPT codes 99251-99255.
 - ♦ Instead, CMS created HCPCS codes G0425-G0427 specific to the telehealth delivery of initial inpatient consultations to retain the ability for practitioners to furnish and bill for initial inpatient consultations delivered via telehealth.

This expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment or billing methodology applicable to Medicare telehealth services as set forth in the *Medicare Benefit Policy Manual* (Chapter 15, Section 270) and the *Medicare Claims Processing Manual* (Chapter 12, Section 190). These manuals are available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

Additional information

The official instruction, CR 6705, was issued in two transmittals to your carrier, FI, and A/B MAC. The first transmittal revises the *Medicare Benefit Policy Manual* and is available at <http://www.cms.hhs.gov/Transmittals/downloads/R118BP.pdf>.

The second transmittal, which modifies the *Medicare Claims Processing Manual*, is at <http://www.cms.hhs.gov/Transmittals/downloads/R1881CP.pdf>.

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

MLN Matters[®] Number: MM6705

Related Change Request (CR) Number: 6705

Related CR Release Date: December 18, 2009

Related CR Transmittal Number: R1881CP and R118BP

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1881, CR 6705

2010 MPFS policies and telehealth originating site facility fee payment amount

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

Provider types affected

This article is for physicians, other practitioners, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries and paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 6756, which provides a summary of the policies in the 2010 MPFS and announces the telehealth originating site facility fee payment amount. Be sure billing staff are aware of these Medicare changes.

Background

The Social Security Act (Section 1848(b)(1) at http://www.ssa.gov/OP_Home/ssact/title18/1848.htm requires the Centers for Medicare & Medicaid Services (CMS) to provide (by regulation before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year. CMS published a document that will affect payments to physicians effective January 1, 2010.

The Social Security Act (Section 1834(m) at http://www.ssa.gov/OP_Home/ssact/title18/1834.htm established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 21, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare economic index (MEI) as defined in Section 1842(i)(3) of the Social Security Act (or the ACT). The MEI increase for calendar year (CY) 2010 is 1.2 percent. **The telehealth originating site facility fee (HCPCS code Q3014) for 2010 is 80 percent of the lesser of the actual charge or \$24.00.**

Summary of other key changes discussed by CR 6756

Practice expense (PE) issues

The two primary data sources used to calculate practice expense (PE) relative value units (RVUs) are:

1. Specialty-specific survey data on indirect practice expenses
2. Procedure specific data on direct practice expenses, based primarily on American Medical Association (AMA) recommendations reviewed by CMS

Recently, the AMA conducted a new physician practice information survey (PPIS) and expanded it to include nonphysician practitioners paid under the MPFS. The incorporation of the AMA's contemporaneous, consistently collected, multi-specialty PPIS data into the calculation of the resource-based practice expense (PE) RVUs ensures that the practice expense RVUs reflect the best and most current data available. In the CY 2010 MPFS proposed rule, CMS proposed to include the data collected by the

AMA's PPIS into the calculation of resource-based practice expense RVUs. In the 2010 MPFS final rule, CMS finalized its proposal to use the PPIS survey date to calculate PE RVUs. CMS believes the impact of using the new PPIS data warrants a four-year transition for existing 2009 CPT codes from the current PE RVUs to the PE RVUs developed using the new PPIS data. New and substantially revised CPT codes will not be subject to a transition. CMS will also continue using the oncology supplemental survey data for the drug administration codes.

Equipment utilization rate

In the CY 2010 MPFS proposed rule, CMS proposed to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for expensive equipment (purchase price over \$1 million). Many of these high cost diagnostic imaging services are currently subject to a statutory payment limit based on the outpatient prospective payment system rates (OPPS cap). In the MPFS final rule, CMS finalized the proposal to increase the equipment utilization rate to 90 percent for expensive diagnostic equipment priced at more than \$1 million. This change will be transitioned over a four-year period. CMS is not finalizing the proposal to increase the utilization rate assumption for expensive therapeutic equipment.

Geographic practice cost indices: locality discussion

In the CY 2010 MPFS proposed rule, CMS noted that the legislative 1.0 work geographic practice cost indices (GPCIs) floor established by section 134 of the Medicare Improvements for Patients and Providers Act (MIPPA) expires December 31, 2009. The proposed CY 2010 GPCIs did not include the 1.0 floor. In the MPFS final rule, CMS summarized comments received on their report on potential alternative locality configurations. Also in the final rule, CMS reiterated that they are not proposing any changes in the PFS locality structure but will continue to review the options available. A final report will be posted to the CMS Web site after further review of the studied alternative locality approaches.

Malpractice RVUs

Section 1848(c) of the Act required the implementation of resource-based malpractice (MP) RVUs for services furnished beginning January 1, 2000. Section 1848(c) (2) (B) (i) of the Act requires that CMS review and, if necessary, adjust RVUs no less often than every five years. The law requires that the updates to the MP RVUs are budget neutral overall. In 2005, CMS implemented the results of the first comprehensive review of the MP RVUs. The second update must be implemented for CY 2010. In the past, the MP RVUs for technical component (TC) services (for example diagnostic tests) and the TC portion of global services were based on historical allowed charges and were not resource based due to a lack of available malpractice premium data for nonphysician suppliers. In the CY 2010 PFS proposed rule, CMS discussed the proposed methodology and updated premium data for the second

2010 MPFS policies and telehealth originating site facility fee payment amount (continued)

update of malpractice RVUs. CMS proposed to use medical physicist premium data as a proxy for the malpractice premiums paid by all entities providing TC services; primarily independent diagnostic testing facility (IDTFs). Other than this TC change, the proposed rule methodology conceptually followed the same approach, with some minor refinements, used to originally develop the resource based MP RVUs.

In the CY 2010 MPFS final rule, CMS finalized the updated malpractice RVUs. Due to newly available data, CMS will use malpractice premium data for IDTFs instead of medical physicist premium data to determine the malpractice premiums paid by technical component suppliers.

Specific coding issues related to physician fee schedule**Consultation services**

In the CY 2010 MPFS proposed rule, CMS proposed to eliminate the use of all consultation codes (inpatient and office/outpatient consultation codes used for various places of service) except telehealth consultation G codes. CMS justified this proposal on the grounds that, in light of recent reductions in the documentation requirements for consultation services, the resources involved in doing an inpatient or office consultation are not sufficiently different than the resources required for an inpatient or office visit to justify the existing differences in payment levels. Eliminating the consultation codes would have the effect of increasing payments for the office visit codes that are billed by most physicians, and most commonly by primary care physicians. Although all physicians would gain from the increased payment for office visits, the net result would be a reallocation of payments from specialists (who bill consultation codes much more frequently) to primary care physicians.

In the CY 2010 MPFS final rule, CMS finalized the proposal to eliminate the use of all consultation codes (inpatient and office/outpatient consultation codes used for various places of service) except telehealth consultation G codes. As requested by the surgical specialties, CMS increased the surgical global period RVUs to reflect the resulting increases in the RVUs for the visit codes.

For more information on revisions to consultation services please see transmittal 1875, CR 6740, dated December 14, 2009. A related *MLN Matters*® article, MM6740, is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf>.

Initial preventive physical exam

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provides for coverage under Part B for the initial preventive physical exam (IPPE), also known as the “Welcome to Medicare” visit. MIPPA made several changes to the IPPE including expanding the benefit period to not later than 12 months after an individual’s first coverage period begins under Medicare Part B. Last year CMS implemented the MIPPA revisions to the benefit, but retained the existing value, and requested comments

on whether it should be revalued. In the CY 2010 PFS proposed rule, CMS proposed to increase the work RVUs to the same level as a level four new patient office visit. In the CY 2010 MPFS final rule, CMS adopted this proposal. Consequently, the work RVU for the IPPE will increase from 1.34 to 2.30.

Canalith repositioning

In the CY 2009 MPFS final rule, a new *CPT* code 95992 for canalith repositioning procedure(s) was bundled with E/M codes. After the final rule was published, CMS recognized that physical therapists that had previously been performing this service now had no way to bill for it since they cannot bill for E/M services. In the 2010 MPFS proposed rule, CMS proposed to change the indicator to I (invalid). In the CY 2010 MPFS final rule, CMS finalized the proposal to make the *CPT* code for canalith repositioning invalid. Physicians will continue to be paid for this service as part of an E/M service. Physical therapists will continue to use one of the more generally defined “always therapy” *CPT* codes.

Clarification concerning certain audiology codes

In the CY 2010 MPFS final rule, CMS is clarifying that therapeutic and/or management activities are not payable to audiologists because they do not fall under the diagnostic tests benefit category designation.

MIPPA provisions**Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services**

By statute, Medicare pays 50 percent of the approved amount for outpatient mental health treatment services, while paying 80 percent of the approved amount for outpatient physical health services. Section 102 of the MIPPA gradually phases out the limitation by 2014. When the provision is fully implemented, CMS will pay outpatient mental health services at the same level as other Part B services. For 2010, CMS will pay 55 percent of the approved amount for outpatient psychiatric services.

Section 139: Improvements for Medicare Anesthesia Teaching Programs

Section 139 of MIPPA establishes a special payment rule for teaching anesthesiologists and provides a directive to the Secretary of Health and Human Services (HHS) regarding payments for the services of teaching certified registered nurse anesthetists (CRNAs). It also specifies the periods when the teaching anesthesiologist must be present during the procedure in order to receive payment for the case at 100 percent of the fee schedule amount. These provisions are effective for services furnished on or after January 1, 2010.

- The special payment rule for teaching anesthesiologists allows payment to be made at the regular fee schedule rate for the teaching anesthesiologist’s involvement in the training of residents in either a single case or in two concurrent anesthesia cases. In the CY 2010 MPFS final rule, CMS will apply the special payment rule to teaching anesthesiologists in the following three cases:

2010 MPFS policies and telehealth originating site facility fee payment amount (continued)

- ♦ The teaching anesthesiologist is involved in one resident case (which is not concurrent to any other anesthesia case)
- ♦ The teaching anesthesiologist is involved in each of two concurrent resident cases (which are not concurrent to any other anesthesia case)
- ♦ The teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under medical direction payment rules

Anesthesia handoff

MIPPA Section 139 requires the teaching anesthesiologist to be present at the key or critical portions of an anesthesia procedure. It also specifies that the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure. However, in the proposed rule CMS proposed that the teaching anesthesiologist must be present during key or critical portions of a procedure. Anesthesiologists advised CMS that it may be common practice for different members of a teaching anesthesia group to provide a service instead of a single teaching anesthesiologist. This practice is referred to as an anesthesia handoff.

In the 2010 MPFS final rule, CMS finalized an alternative option that permits handoffs between members of the same anesthesia group for key or critical portions of a procedure. This option is consistent with current anesthesia practice and it is less disruptive to current anesthesia practice arrangements.

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CMS may propose to standardize protocols and quality rules for handoffs in the future.

Certified registered nurse anesthetist (CRNA) teaching payment policy

Section 139(b) of the MIPPA instructs the HHS Secretary to make appropriate adjustments to Medicare teaching CRNA payment policy so that it is consistent with the adjustments made by the special payment rule for teaching anesthesiologists under section 139(a) of the MIPPA.

In the 2010 MPFS final rule, CMS allows the teaching CRNA, who is not medically directed, to be paid the full fee for his/her involvement in two concurrent cases with student nurse anesthetists. Other payment policies would remain unchanged.

Additional information

The official instruction, CR 6756, issued to your Medicare MAC, carrier, or FI regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R615OTN.pdf>.

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

MLN Matters® Number: MM6756

Related Change Request (CR) Number: 6756

Related CR Release Date: December 29, 2009

Related CR Transmittal Number: R615OTN

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

Source: CMS Pub. 100-20, Transmittal 615, CR 6756

Web site survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by LCMS, Medicare contractors no longer distribute full-text local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LCDs from our provider education Web site <http://medicare.fcso.com> through the CMS Medicare Coverage Database.

Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part A section under the Part A Medical Coverage section.

This section of the *Medicare A Bulletin* features summaries of new and revised 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 fiscal intermediary's LCDs and review guidelines are consistent with accepted standards of medical practice.

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 provider education Web site is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the Web site, subscribe to the FCSO *eNews* mailing list. It is very easy to do. Simply go to our educational Web site <http://medicare.fcso.com>, click on the "eNews" link located on the upper-right-hand corner of the page and follow the prompts.

More information

If you do not have Internet access, contact the Medical Policy and Procedures department at:

Medical Policy and Procedures – 19T
 First Coast Service Options, Inc.
 P.O. Box 2078
 Jacksonville, FL 32231-0048

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Advance beneficiary notice

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

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our provider education Web site at <http://medicare.fcso.com>.

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ADDITIONS/REVISIONS TO EXISTING LCDs

A17311: Mohs micrographic surgery (MMS) – revision to the LCD

LCD ID Number: L28932 (Florida)

LCD ID Number: L28953 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Mohs micrographic surgery (MMS) was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, a revision was made to the LCD based on the annual 2010 ICD-9-CM update for Merkel cell carcinoma.

Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, diagnosis code range 209.31-209.36 was added for Merkel cell carcinoma.

Effective date

This LCD revision is effective for claims processed **on or after January 28, 2010**, for services provided **on or after October 1, 2009**.

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

Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. ❖

AJ3487: Zoledronic acid – revision to the LCD

LCD ID Number: L29009 (Florida)

LCD ID Number: L29041 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for zoledronic acid was most recently revised on November 5, 2009. Since that time, it has been updated. On October 19, 2009, First Coast Service Options Inc. (FCSO) added the Food and Drug Administration (FDA) approved indication for prevention of osteoporosis in postmenopausal women as medically reasonable and necessary for HCPCS code J3488 (Injection, zoledronic acid [Reclast[®]], 1 mg) under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD. Since that time, further correspondence and research has shown that this FDA approved indication is not covered by Medicare as it is not medically reasonable and necessary in the diagnosis and treatment of a specific illness or injury as defined under section 1862 (a)(1)(A) and as stated in Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 50.4. Therefore, this FDA approved indication has been moved to the “Limitations” section of the LCD.

In addition to the above revisions, for HCPCS code J3488, the “Utilization Guidelines” section of the LCD and the “Coding Guidelines” attachment have been revised to remove all language referencing coverage for this indication. This revision also requires the removal of ICD-9-CM diagnosis code V49.81 (Asymptomatic postmenopausal status [age related] [natural]), as a covered diagnosis code for HCPCS code J3488. FCSO will no longer accept diagnosis code V49.81 as an allowable code for the prevention of osteoporosis in postmenopausal women, as this indication is not medically reasonable and necessary for the diagnosis and treatment of a specific illness or injury. All other indications listed for HCPCS code J3488 will remain covered per the guidelines outlined in this LCD.

Effective date

This revision is effective for claims processed **on or after February 11, 2010**, for services provided **on or after May 29, 2009**.

FCSO LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/overview.asp>.

Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. ❖

AJ9045: Carboplatin (Paraplatin[®], Paraplatin-AQ[®]) – revision to the LCD

LCD ID Number: L28791 (Florida)

LCD ID Number: L28796 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for carboplatin (Paraplatin[®], Paraplatin-AQ[®]) was most recently revised on April 2, 2009. Since that time, a revision was made to the LCD based on the annual 2010 ICD-9-CM Update for Merkel cell carcinoma.

Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, diagnosis code range 173.0-173.9 was deleted and replaced with diagnosis code range 209.31-209.36 to be used for Merkel cell carcinoma.

Effective date

This LCD revision is effective for claims processed **on or after January 28, 2010**, for services provided **on or after October 1, 2009**.

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

Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. ❖

ATHERSVCS: Therapy and rehabilitation services – revision to the LCD

LCD ID Number: L28992 (Florida)

LCD ID Number: L29024 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for therapy and rehabilitation services was most recently revised on October 5, 2009. Since that time, language has been revised regarding a change in the dollar amount of the therapy cap in the financial limitation for therapy caps section of the LCD in accordance with the Centers for Medicare & Medicaid Services (CMS) change request 6660, transmittal 1851, dated November 13, 2009. In addition, the therapy cap dollar amount was revised in accordance with change request 6719, transmittal 1851, dated November 13, 2009, to the following specific limitations:

For 2010, the annual limit on the allowed amount for outpatient physical therapy and speech language pathology combined is \$1860; the limit for occupational therapy is \$1860.

The following language has been added to the coding guidelines attachment in accordance with change request 6719: Effective January 1, 2010, CPT code 95992 – *Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day*, is removed from the online therapy code list, which is available at <http://www.cms.hhs.gov/TherapyServices/05AnnualTherapyUpdate.asp#TopOfPage>.

Effective January 1, 2010, CPT code 92520 – *Laryngeal function studies (ie, aerodynamic testing and acoustic testing)* – which is considered a “sometimes therapy” code, is added to the online therapy code list. The online therapy code list includes all of the “always” and “sometimes” therapy procedure codes. (Pub. 100-04, Chapter 5, Section 20.B)

Effective date

This LCD revision is effective for services provided **on or after January 1, 2010**.

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

Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. ❖

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Find LCDs faster on our new medical coverage page

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

HOSPITAL SERVICES

Processing of noncovered ICD-9-CM procedure codes on inpatient hospital claims

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article MM6547 to reflect revisions to change request (CR) 6547. The CR release date, transmittal number, and the Web address for accessing CR 6547 were revised. All other information remains the same. The *MLN Matters* article MM6547 was published in the November 2009 *Medicare A Bulletin* (page 28).

Provider types affected

Hospitals submitting claims to Medicare administrative contractors (MAC) or fiscal intermediaries (FI) for procedures performed for Medicare beneficiaries are affected.

Provider action needed

Effective for inpatient discharges on or after April 1, 2010, hospitals must submit ICD-9-CM codes for noncovered procedures performed in the same inpatient stay with covered procedures on a separate claim. This article is based on CR 6547, which provides instructions to Medicare contractors for processing these claims for noncovered services, also referred to as no-pay claims. Be sure billing staffs are aware of these changes.

Background

Medicare uses ICD-9-CM codes to identify diagnoses and procedures in the hospital inpatient setting. Hospitals must report the principal diagnosis using the appropriate ICD-9-CM code, as well as any secondary diagnoses – some of which may be considered complications or comorbidities (CCs) or major complications or comorbidities (MCCs) for Medicare severity-diagnosis related group (MS-DRG) assignment. The circumstances of inpatient admission always govern selection of the principal diagnosis. Diagnosis codes should be reported to the highest level of specificity available – a code is invalid if it has not been coded to the full number of digits required for that code. For inpatient admissions involving procedures, hospitals must also report ICD-9-CM procedure codes for surgical and other procedures, up to six procedures on a claim.

Effective for inpatient discharges on or after April 1, 2010, hospitals must separate a hospital stay into two claims where both covered and noncovered ICD-9-CM procedure codes are reported:

- One claim with covered services/procedures unrelated to the noncovered ICD-9-CM procedures on a type of bill (TOB) 11x (with the exception of TOB 110), and

- The other claim with the noncovered services/procedures on a TOB 110 (no-pay claim).

Note that the statement covers period should match on both the covered and the noncovered claim.

No-pay claims submitted will be denied as noncovered, using the following on the remittance advice:

Claim adjustment reason code

50 – These are noncovered services because this is not deemed a ‘medical necessity’ by the payer.

Group code used when a hospital issued notice of noncoverage (HINN) was not issued

CO – Contractual obligation

Group code used when a HINN was issued

PR – Patient responsibility

Additional information

The official instruction (CR 6547) issued to your MAC regarding this change, may be viewed on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1895CP.pdf>.

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

MLN Matters® Number: MM6547 – Revised
Related Change Request (CR) Number: 6547
Related CR Release Date: January 15, 2010
Related CR Transmittal Number: R1895CP
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1895, CR 6547

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Wrong surgical/other invasive procedure performed on a patient and/or body part

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article MM6405 to correct the references to the *Medicare Benefit Policy Manual*. The reference for the revised manual should have stated Chapter 1, Sections 10 and 120, and Chapter 16, Section 180. All other information is unchanged. The *MLN Matters* article MM6405 was last published in the October 2009 *Medicare A Bulletin* (pages 55-57).

Note: Additional information on the use of modifiers PA, PB, and PC discussed in this article is available in the *MLN Matters*® article on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6718.pdf>.

Provider types affected

Physicians, other practitioners, and providers billing Medicare contractors (carriers, fiscal intermediaries [FIs] or Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Effective January 15, 2009, the Centers for Medicare & Medicaid Services (CMS) does not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient.

Medicare will also **not** cover hospitalizations and other services related to these noncovered procedures as defined in the *Medicare Benefit Policy Manual* (BPM) Chapter 1, Sections 10 and 120 and Chapter 16, Section 180. This is pursuant to the national coverage determinations (NCDs) made as part of CR 6405.

Caution – what you need to know

For inpatient claims, hospitals are required to bill a no-pay claim (type of bill 110) when the erroneous surgery related to the NCD is reported. If there are covered services/procedures provided during the same stay as the erroneous surgery, hospitals are then required to submit two claims, one claim with covered services or procedures unrelated to the erroneous surgery, the other noncovered services/procedures as a no-pay claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery/procedure.

Go – what you need to do

Make sure that your billing staff are aware of these new billing and claim requirements.

Background

In 2002, the National Quality Forum (NQF) published “*Serious Reportable Events in Healthcare: A Consensus Report*,” which listed 27 adverse events that were “serious, largely preventable and of concern to both the public and health care providers.” (That report is available on the Internet at <http://www.qualityforum.org/pdf/reports/sre.pdf>.)

These events and subsequent revisions to the list became known as “never events.” This concept and need for the proposed reporting led to NQF’s “Consensus Standards Maintenance Committee on Serious Reportable Events,” which maintains and updates the list that currently contains 28 items.

In order to address and reduce the occurrence of these surgeries, CR 6405 establishes three new NCDs that nationally noncover the three surgical errors and sets billing policy to implement appropriate claims processing.

Effective January 15, 2009, CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs:

- 1) a different procedure altogether;
- 2) the correct procedure but on the wrong body part; or
- 3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these noncovered procedures as defined in the *Medicare Benefit Policy Manual* (BPM) Chapter 1, Sections 10 and 120, and Chapter 16, Section 180. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

Note: Related services do not include performance of the correct procedure.

Definitions

- Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the *Current Procedural Terminology* (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.
- A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that patient.

Wrong surgical/other invasive procedure performed on a patient and/or body part (continued)

- A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

Note: Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).

- A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient.

Beneficiary liability

Generally, a beneficiary liability notice such as an advance beneficiary notice of noncoverage (ABN) or a hospital issued notice of noncoverage (HINN) is appropriate when a provider is furnishing an item/service that the provider reasonably believes Medicare will not cover on the basis of Section 1862(a)(1) of the Social Security Act.

- An ABN must include all of the elements described in the *Medicare Claims Processing Manual*, Chapter 30, Section 50.6.3, in order to be considered valid. For example, the ABN must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include a cost estimate for the noncovered item/service. (The *Medicare Claims Processing Manual* is available on the CMS Web site at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.)
- Similarly, HINNs must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include all of the elements described in the instructions found in the *Medicare Claims Processing Manual*, Chapter 30, Section 200.

Thus, a provider cannot shift financial liability for the noncovered services to the beneficiary, unless the ABN or the HINN satisfies all of the applicable requirements in Chapter 30, Sections 50.6.3 and 200, respectively, of the *Medicare Claims Processing Manual*.

Given these requirements, CMS cannot envision a scenario in which HINNs or ABNs could be validly delivered in these NCD cases. However, an ABN or a HINN could be validly delivered prior to furnishing follow-up care for the noncovered surgical error that would not be considered a related service to the noncovered surgical error (see Chapter 1, Sections 10 and 120, and Chapter 16, Section 180, of the *Benefit Policy Manual*).

Implementation**Inpatient claims**

Effective for inpatient discharges on or after January 15, 2009, hospitals are required to submit a no-pay claim (TOB 110) when the erroneous surgery related to the NCD is reported. If there are covered services/procedures provided during the same stay as the erroneous surgery, hospitals are then required to submit two claims:

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a type of bill (TOB) 11x (with the exception of 110), and,
- The other claim with the noncovered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim).

Note: Both the covered and noncovered claim must have a matching “Statement Covers Period.”

For discharges on or after January 15, 2008, and before October 1, 2009, the noncovered TOB 110 will be required to be submitted via the UB-04 (hard copy) claim form, clearly indicating in form locator (FL) 80 (remarks), or the 837I (electronic) claim form, loop 2300, one of the applicable two-digit surgical error codes as follows:

- MX – for a wrong surgery on patient
- MY – for surgery on the wrong body part
- MZ – for surgery on the wrong patient.

For discharges on or after October 1, 2009, hospitals will refer to *MLN Matters*[®] article MM6634 for how to submit an erroneous surgery claim. MM6634 may be found on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6634.pdf>.

The claim for the noncovered services will be denied using:

- **Claim adjustment reason code (CARC) 50** – These are noncovered services because this is not deemed a ‘medical necessity’ by the payer.
- **Group code CO** – contractual obligation.

Outpatient, ambulatory surgical centers, other appropriate bill types and practitioner claims

Hospital outpatient departments, ambulatory surgical centers (ASCs), practitioners and those submitting other appropriate TOBs are required to append one of the following applicable NCD modifiers to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009:

- **PA:** Surgical or other invasive procedure on wrong body part
- **PB:** Surgical or other invasive procedure on wrong patient
- **PC:** Wrong surgery or other invasive procedure on patient

Contractors shall suspend claims with dates of service on and after January 15, 2009, with surgical errors identified by one of the above HCPCS modifiers.

Wrong surgical/other invasive procedure performed on a patient and/or body part (continued)

Contractors shall create/maintain a list that includes the beneficiary health information code and the surgical error date of service. Each new surgical error occurrence shall be added to the list, and an MPP event or a system control facility (SCF) rule will be implemented so that all claims for that beneficiary for that date of service will be suspended. Contractors shall then continue to process the claim.

Claim lines submitted with one of the above HCPCS modifiers will be line-item denied using the following:

- **CARC 50** – these are noncovered services because this is not deemed a “medical necessity” by the payer.
- **Group code – CO** – contractual obligation

Related claims

Within **five** days of receiving a claim for a surgical error, contractors shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, contractors shall review any claims applied to SCF rules and MPP events to identify incoming claims that have the potential to be related. When Medicare identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, contractors shall continue to review beneficiary history for related claims and take appropriate action as necessary.

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INPATIENT REHABILITATION SERVICES

Coverage of inpatient rehabilitation services

Note: The Centers for Medicare & Medicaid Services (CMS) has revised change request 6699, and rescinded transmittal 112, issued on October 23, 2009, and replaced with transmittal 119. Sections 110.3.1 through 110.5 have been deleted from the manual as this information was updated and incorporated into Sections 110 through 110.3. All other information remains the same. This information was published through the *MLN Matters* article MM6699 in the October 2009 *Medicare A Bulletin* (pages 34-39).

The Centers for Medicare & Medicaid Services (CMS) has adopted new inpatient rehabilitation facility (IRF) coverage requirements and technical revisions to certain other IRF requirements to reflect changes that have occurred in medical practice during the past 25 years and the implementation of the IRF prospective payment system (PPS). In light of adopting new coverage requirements that will be effective for IRF discharges occurring on or after January 1, 2010, a notice has been issued to rescind HCFAR 85-2 when the new coverage requirements take effect. CMS Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110 was originally based upon the provisions found in HCFAR 85-2. Therefore, the purpose of this change request is to issue new instructions to replace the existing instructions found in Section 110 consistent with the new IRF coverage requirements adopted in the fiscal year (FY) 2010 final rule (74 FR 39762 (August 7, 2009)).

The new IRF coverage requirements are effective for IRF discharges occurring on or after January 1, 2010. These requirements form the basis for the new instructions in Pub. 100-02, Chapter 1, Section 110. Under the new coverage policy, the decision to admit the patient to the IRF is the key to determining whether the admission is reasonable and necessary. Thus, these manual revisions include the following subjects:

Additional information

For complete details regarding this change request (CR) please see the official instruction (CR 6405) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction was issued in two transmittals. The first transmittal presents the national coverage determination related to this issue and that transmittal is on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R102NCD.pdf>.

The other transmittal presents claim processing manual revision and instructions. That transmittal is on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1819CP.pdf>.

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

MLN Matters® Number: MM6405 – Revised
 Related Change Request (CR) Number: 6405
 Related CR Release Date: September 25, 2009
 Related CR Transmittal Number: R1819CP and R102NCD
 Effective Date: January 15, 2009
 Implementation Date: July 6, 2009, for those billing carriers and Part B MACs; October 5, 2009, for FIs and Part A MACs

Source: CMS Pub. 100-04, Transmittal 1819, CR 6405

Coverage of inpatient rehabilitation services (continued)

- Documentation Requirements
- Required Preadmission Screening
- Required Post-Admission Physician Evaluation
- Required Individualized Overall Plan of Care
- Required Admission Orders
- Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- Inpatient Rehabilitation Facility Medical Necessity Criteria
- Multiple Therapy Disciplines
- Intensive Level of Rehabilitation Services
- Ability to Actively Participate in Intensive Rehabilitation Therapy Program
- Physician Supervision
- Interdisciplinary Team Approach to the Delivery of Care
- Definition of Measurable Improvement.

110 – Inpatient Rehabilitation Facility Services

The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

The IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRF, patients must be able to fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order to be transferred to an IRF. IRF admissions for patients who are still completing their course of treatment in the referring hospital and who therefore are not able to participate in and benefit from the intensive rehabilitation therapy services provided in IRFs will not be considered reasonable and necessary.

Conversely, the IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting.

IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) of the Social Security Act if the patient meets all of the requirements outlined in 42 CFR Sections 412.622(a)(3), (4), and (5), as interpreted in this section. This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR Section 412.23(b)(2)

(ii) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs.

For detailed guidance on the required qualifications of a therapist, required skills of a therapist, and medically necessary and appropriately documented therapy services, see Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Sections 220 and 230. The policies in those sections describe a standard of care that should be consistent throughout the therapy disciplines, regardless of the setting of care.

110.1 – Documentation Requirements

Medicare contractors must consider the documentation contained in a patient's IRF medical record when determining whether an IRF admission was reasonable and necessary, specifically focusing on the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders.

110.1.1 – Required Preadmission Screening

A preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to document the patient's medical and functional status within the 48 hours immediately preceding the IRF admission in the patient's medical record at the IRF. The preadmission screening in the patient's IRF medical record serves as the primary documentation by the IRF clinical staff of the patient's status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive.

The preadmission screening documentation must indicate the patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy), expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.

If the patient is being transferred from a referring hospital, the preadmission screening may be done in person or through a review of the patient's medical records from the referring hospital (either paper or electronic format), as long as those medical records contain the necessary assessments to make a reasonable determination. However, a preadmission screening conducted entirely by telephone will not be accepted without transmission of the patient's

Coverage of inpatient rehabilitation services (continued)

medical records from the referring hospital to the IRF and a review of those records by licensed or certified clinical staff in the IRF.

The IRF is responsible for developing a thorough preadmission screening process for patients admitted to the IRF from the home or community-based environment, which is expected to include all of the required elements described in this section. However, such admissions may not necessarily involve the use of medical records from a prior hospital stay in another inpatient hospital setting unless such records are pertinent to the individual patient's situation.

Individual elements of the preadmission screening may be evaluated by any clinician or group of clinicians designated by a rehabilitation physician, as long as the clinicians are licensed or certified and qualified to perform the evaluation within their scopes of practice and training. Although clinical personnel are required to evaluate the preadmission screening information, each IRF may determine its own processes for collecting and compiling the preadmission screening information. The focus of the review of the preadmission screening information will be on its completeness, accuracy, and the extent to which it supports the appropriateness of the IRF admission decision, not on how the process is organized.

The "rehabilitation physician" need not be a salaried employee of the IRF but must be a licensed physician with specialized training and experience in rehabilitation. For ease of exposition throughout this document, this physician will be referred to as a "rehabilitation physician".

All findings of the preadmission screening must be conveyed to a rehabilitation physician prior to the IRF admission. In addition, the rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the preadmission screening prior to the IRF admission.

All preadmission screening documentation (including documents transmitted from the referring hospital or other prior inpatient hospital stay, if applicable) must be retained in the patient's medical record at the IRF.

"Trial" IRF admissions, during which patients were sometimes admitted to IRFs for 3 to 10 days to assess whether the patients would benefit significantly from treatment in the IRF or other settings, are no longer considered reasonable and necessary. Such determination must be made through a careful preadmission screening prior to the patient's admission to the IRF.

110.1.2 – Required Post-Admission Physician Evaluation

A post-admission physician evaluation of the patient must be performed by a rehabilitation physician. The purpose of the post-admission physician evaluation is to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin development of the patient's expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care (as discussed in Section 110.1.3). The post-admission physician evaluation must identify any relevant changes that may have occurred since the preadmission screening and must include a documented

history and physical exam, as well as a review of the patient's prior and current medical and functional conditions and comorbidities.

In order for the IRF stay to be considered reasonable and necessary, the post-admission physician evaluation must be completed within the first 24 hours of admission to the IRF and must support the medical necessity of the IRF admission. The post-admission physician evaluation documentation must be retained in the patient's medical record at the IRF.

What to do if there are differences between the preadmission screening and the post-admission physician evaluation (within the first 24 hours of admission to the IRF):

In most cases, the clinical picture of the patient that emerges from the post-admission physician evaluation will closely resemble the information documented in the preadmission screening. However, for a variety of reasons, the patient's condition at the time of admission may occasionally not match the description of the patient's condition on the preadmission screening. This could occur, for example, if the patient's condition changes after the preadmission screening is completed. In these cases, it is important for a rehabilitation physician to note the discrepancy and to document any deviations from the preadmission screening as a result. For example, if the patient's preadmission screening indicated an expectation that the patient would actively participate in an intensive rehabilitation therapy program on admission to the IRF, but the patient is only able to tolerate a less intensive therapy program on the first day due to an increase in pain secondary to a long ambulance trip to the IRF, the IRF does not have to discharge the patient since the clinicians fully expect the patient to be able to participate in the intensive rehabilitation program the next day. Instead, the reason for the temporary change must be noted in the patient's medical record at the IRF.

In addition, the preadmission screening and the post-admission physician evaluation could differ in rare cases when a patient's preadmission screening indicates that the patient is an appropriate candidate for IRF care but this turns out not to be the case, either, for example, due to a marked improvement in the patient's functional ability since the time of the preadmission screening or an inability to meet the demands of the IRF rehabilitation program. If this occurs, the IRF must immediately begin the process of discharging the patient to another setting of care. It might take a day or more for the IRF to find placement for the patient in another setting of care. Medicare contractors will therefore allow the patient to continue to receive treatment in the IRF until placement in another setting can be found. However, in these particular cases, any IRF services provided after the third day following the patient's admission to the IRF (considering the day of admission to be the first day) are not considered reasonable and necessary. In these particular cases, instead of denying the entire IRF claim for not meeting the criteria in Section 110.2 of this chapter, Medicare authorizes its contractors to permit the IRF claim to be paid at the appropriate case-mix group (CMG) for IRF patient stays of three days or less.

*Coverage of inpatient rehabilitation services (continued)***110.1.3 – Required Individualized Overall Plan of Care**

Information from the preadmission screening and the post-admission physician evaluation, together with other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, will be synthesized by a rehabilitation physician to support a documented overall plan of care, including an estimated length of stay. The overall plan of care must detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission.

The anticipated interventions detailed in the overall plan of care must include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning the total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay. These expectations for the patient's course of treatment must be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

Whereas the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, it is the sole responsibility of a rehabilitation physician to integrate the information that is required in the overall plan of care and to document it in the patient's medical record at the IRF.

In the unlikely event that the patient's actual length of stay and/or the expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies in the IRF differ significantly from the expectations indicated in the overall plan of care, then the reasons for the discrepancies must be documented in detail in the patient's medical record at the IRF.

In order for the IRF admission to be considered reasonable and necessary, the overall plan of care must be completed within the first four days of the IRF admission; it must support the determination that the IRF admission is reasonable and necessary; and it must be retained in the patient's medical record at the IRF.

While CMS believes that it may be good practice to conduct the first interdisciplinary team meeting within the first 4 days of admission to develop the overall individualized plan of care, CMS believes that there may be other ways of developing the overall individualized plan of care. Thus, IRFs may develop this required documentation using whatever internal processes they believe are most appropriate.

110.1.4 – Required Admission Orders

At the time that each Medicare Part A fee-for-service patient is admitted to an IRF, a physician must generate admission orders for the patient's care. These admission orders must be retained in the patient's medical record at the IRF.

110.1.5 – Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

Medicare now requires that the IRF patient assessment instrument (IRF-PAI) forms be included in the patient's medical record at the IRF (either in electronic or paper format). The information in the IRF-PAIs must correspond with all of the information provided in the patient's IRF medical record.

110.2 – Inpatient Rehabilitation Facility Medical Necessity Criteria

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening described in section 110.1.1, the post-admission physician evaluation described in section 110.1.2, the overall plan of care described in section 110.1.3, and the admission orders described in section 110.1.4) must demonstrate a reasonable expectation that the following criteria were met **at the time of admission** to the IRF:

1. The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.
2. The patient must generally require an intensive rehabilitation therapy program, as defined in section 110.2.2. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least three hours of therapy per day at least five days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a seven consecutive day period, beginning with the date of admission to the IRF.
3. The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program that is defined in section 110.2.2 at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, as defined in section 110.3, and if such improvement can be expected to be made within a prescribed period of time.
4. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least three days per week throughout the patient's stay in the IRF to

Coverage of inpatient rehabilitation services (continued)

assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation, as defined in Section 110.2.5.

110.2.1 – Multiple Therapy Disciplines

A primary distinction between the IRF environment and other rehabilitation settings is the interdisciplinary approach to providing rehabilitation therapy services in an IRF. Patients requiring only one discipline of therapy would not need this interdisciplinary approach to care. For this reason, the information in the patient's IRF medical record (especially the required documentation described in Section 110.1) must document a reasonable expectation that, at the time of admission to the IRF, the patient required the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.

110.2.2 – Intensive Level of Rehabilitation Services

A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs. Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least three hours per day at least five days per week. However, this is not the only way that such intensity of services can be demonstrated (that is, CMS does not intend for this measure to be used as a "rule of thumb" for determining whether a particular IRF claim is reasonable and necessary).

The intensity of therapy services provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a seven-consecutive day period starting from the date of admission). For example, if a hypothetical IRF patient was admitted to an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of four hours of therapy 3 days per week and 1 ½ hours of therapy on two (or more) other days per week in order to accommodate his or her chemotherapy schedule. Thus, IRFs may also demonstrate a patient's need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a 7-consecutive day period starting from the date of admission), as long as the reasons for the patient's

need for this program of intensive rehabilitation are well-documented in the patient's IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient. Many IRF patients will medically benefit from more than three hours of therapy per day or more than 15 hours of therapy per week, when all types of therapy are considered. However, the intensity of therapy provided must be reasonable and necessary under section 1862(a)(1)(A) of the Act and must never exceed the patient's level of need or tolerance, or compromise the patient's safety. See below for a brief exceptions policy for temporary and unexpected events.

The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services. As such, they are included in the total daily/weekly provision of therapies used to demonstrate the intensity of therapy services provided in an IRF.

The standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group therapies serve as an adjunct to individual therapies. In those instances in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record at the IRF.

Brief Exceptions Policy

While patients requiring an IRF stay are expected to need and receive an intensive rehabilitation therapy program, as described above, this may not be true for a limited number of days during a patient's IRF stay because patients' needs vary over time. For example, if an unexpected clinical event occurs during the course of a patient's IRF stay that limits the patient's ability to participate in the intensive therapy program for a brief period not to exceed 3 consecutive days (e.g., extensive diagnostic tests off premises, prolonged intravenous infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services must be documented in the patient's IRF medical record. If these reasons are appropriately documented in the patient's IRF medical record, such a break in service (of limited duration) will not affect the determination of the medical necessity of the IRF admission. Thus, Medicare contractors may approve brief exceptions to the intensity of therapy requirement in these particular cases if they determine that the initial expectation of the patient's active participation in intensive therapy during the IRF stay was based on a diligent preadmission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.

110.2.3 – Ability to Actively Participate in Intensive Rehabilitation Therapy Program

The information in the patient's IRF medical record (especially the required documentation described in Section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient's condition is such that the patient can reasonably be expected to actively

Coverage of inpatient rehabilitation services (continued)

participate in, and significantly benefit from, the intensive rehabilitation therapy program that is defined in Section 110.2.2.

110.2.4 – Physician Supervision

A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services. For this reason, the information in the patient's IRF medical record (especially the required documentation described in Section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient's medical management and rehabilitation needs require an inpatient stay and close physician involvement. Close physician involvement in the patient's care is demonstrated by documented face-to-face visits from a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least three days per week throughout the patient's IRF stay. The purpose of the face-to-face visits is to assess the patient both medically and functionally (with an emphasis on the important interactions between the patient's medical and functional goals and progress), as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Other physician specialties may treat and visit the patient, as needed, more often than three days per week. However, the requirement for IRF physician supervision is intended to ensure that IRF patients receive more comprehensive assessments of their functional goals and progress, in light of their medical conditions, by a rehabilitation physician with the necessary training and experience to make these assessments at least three times per week. The required rehabilitation physician visits must be documented in the patient's medical record at the IRF.

110.2.5 – Interdisciplinary Team Approach to the Delivery of Care

An IRF stay will only be considered reasonable and necessary if at the time of admission to the IRF the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. That is, the complexity of the patient's condition must be such that the rehabilitation goals indicated in the preadmission screening, the post-admission physician evaluation, and the overall plan of care can only be achieved through periodic team conferences—at least once a week—of an interdisciplinary team of medical professionals (as defined below).

Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured,

and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the medical record at the IRF):

- A rehabilitation physician with specialized training and experience in rehabilitation services
- A registered nurse with specialized training or experience in rehabilitation
- A social worker or a case manager (or both)
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

The interdisciplinary team must be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment in the IRF. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting.

The periodic team conferences—held a minimum of once per week—must focus on:

- Assessing the individual's progress towards the rehabilitation goals
- Considering possible resolutions to any problems that could impede progress towards the goals
- Reassessing the validity of the rehabilitation goals previously established
- Monitoring and revising the treatment plan, as needed.

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. It is expected that all treating professionals from the required disciplines will be at every meeting or, in the infrequent case of an absence, be represented by another person of the same discipline who has current knowledge of the patient. Documentation of each team conference must include the names and professional designations of the participants in the team conference. The occurrence of the team conferences and the decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the patient's medical record in the IRF. The focus of the review of this requirement will be on the accuracy and quality of the information and decision-making, not on the internal processes used by the IRF in conducting the team conferences.

110.3 – Definition of Measurable Improvement

A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, as required in Section 110.2.3, if the patient's IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient's safe

Coverage of inpatient rehabilitation services (continued)

return to the home or community-based environment upon discharge from the IRF. The patient's IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient's admission to the IRF, an extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.

For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care. However, to justify the need for a continued IRF stay, the documentation in the IRF medical record must demonstrate the patient's ongoing requirement for an intensive level of rehabilitation services (as defined in Section 110.2.1) and an inter-disciplinary team approach to care (as defined in Section 110.2.2). Further, the IRF medical record must

also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment. Since in most instances the goal of an IRF stay is to enable a patient's safe return to the home or community-based environment upon discharge, the patient's treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result. During most IRF stays, therefore, the emphasis of therapies would generally shift from traditional, patient-centered therapeutic services to patient/caregiver education, durable medical equipment training, and other similar therapies that prepare the patient for a safe discharge to the home or community-based environment.

Change Request (CR) Number: 6699

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CR Transmittal Number: R119BP

Effective Date: IRF discharges on or after January 1, 2010

Implementation Date: January 4, 2010

Source: CMS Pub. 100-02, Transmittal 119, CR 6699

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ESRD SERVICES

Coverage of kidney disease patient education services

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

Provider types affected

This article affects physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for kidney disease education services provided to Medicare beneficiaries diagnosed with stage IV chronic kidney disease (CKD).

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6557, which implements kidney disease education (KDE) services as a Medicare Part B covered benefit for Medicare beneficiaries diagnosed with stage IV CKD.

Caution – what you need to know

KDE services are designed to provide beneficiaries with comprehensive information regarding the management of comorbidities, including for purposes of delaying the need for dialysis; prevention of uremic complications; and each option for renal replacement therapy. This benefit is also designed to be tailored to individual needs and provide the beneficiary with the opportunity to actively participate in his/her choice of therapy. The Centers for Medicare & Medicaid Services (CMS) issued two new Healthcare Common Procedure Coding System (HCPCS) codes to be used to report covered KDE services:

- G0420** Face-to-face educational services related to the care of chronic kidney disease; individual, per session; per one hour
- G0421** Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour

Go – what you need to do

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

Background

By definition, CKD is kidney damage for three months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Complications can develop from kidneys that do not function properly, such as high blood pressure, anemia, and weak bones. When chronic kidney disease progresses, it may lead to kidney failure, which requires artificial means to perform kidney functions (dialysis) or a kidney transplant to maintain life.

Individuals with CKD may benefit from KDE interventions due to the large amount of medical information that could affect patient outcomes, including the increasing emphasis on self-care and patients' desire for informed, autonomous decision-making. Pre-dialysis education can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. Education interventions should be patient-centered, encourage collaboration, offer support to the patient, and be delivered consistently.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA Section 152(b)); see <http://waysandmeans.house.gov/MoreInfo.asp?section=45>) added KDE services as a Medicare Part B covered benefit for Medicare beneficiaries diagnosed with stage IV CKD who have received a referral from the physician managing the beneficiary's kidney condition.

KDE content requirements

CMS published regulations implementing this provision at 42 CFR 410.48. Medicare Part B covers KDE services, provided by a qualified person, who provides:

- Comprehensive information regarding the management of comorbidities, including for the purpose of delaying the need for dialysis
- Prevention of uremic complications
- Therapeutic options, treatment modalities, and settings, including a discussion of the advantages and disadvantages of each treatment option, and how the treatments replace the kidney
- Opportunities for beneficiaries to participate actively in the choice of therapy, tailored to meet the needs of the individual beneficiary involved.

KDE outcomes assessments

Qualified persons that provide KDE services will develop outcomes assessments that are designed to measure beneficiary knowledge about CKD and its treatment. It also serves to assist KDE educators and CMS in improving subsequent KDE programs and patient understanding and assessing program effectiveness. The assessment will be administered to the beneficiary during a KDE session, and will be made available to CMS upon request.

KDE billing instructions

Change request (CR) 6557 instructs Medicare contractors to pay for KDE services that meet the following conditions:

- No more than six sessions of KDE services are provided in a beneficiary's lifetime

Coverage of kidney disease patient education services (continued)

- Sessions billed in increments of one hour (if the session is less than one hour, it must last at least 31 minutes in order to be billed, in which case a session less than one hour and longer than 31 minutes is billable as one session)
- Sessions furnished either individually or in a group setting of 2 to 20 individuals (who need not all be Medicare beneficiaries)
- Furnished, upon the referral of the physician managing the beneficiary's kidney condition, by a qualified person meaning a:
 - ♦ Physician, physician's assistant, nurse practitioner, or clinical nurse specialist
 - ♦ Hospital, critical access hospital (CAH), skilled nursing facility (SNF) comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, that is located in a rural area; or
 - ♦ Hospital or CAH that is paid as if it were located in a rural area (hospitals and CAHs reclassified as rural under Section 42 CFR 412.103).

The following providers are not "qualified persons" and are excluded from furnishing KDE services:

- A hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice located outside of a rural area (using the actual geographic location core-based statistical area [CBSA] to identify facilities located outside of a rural area under the Medicare physician fee schedule [MPFS], unless the services are furnished by a hospital or CAH that is treated as being in a rural area (such claims are denied with claims adjustment reason code [CARC] 170 – Payment is denied when performed/billed by this type of provider) and Medicare summary notice (MSN) 21.6 – This item or service is not covered when performed, referred, or ordered by this provider)
- Renal dialysis facilities (type of bill (TOB) 72x).

CMS issued two new HCPCS codes G0420 and G0421 to be used to report covered KDE services in the January 2010 integrated outpatient code editor (IOCE) and MPFS database and identified the payment amounts in the final 2010 MPFS. One of these HCPCS codes must be present, along with ICD-9-CM code 585.4 (chronic kidney disease, stage IV [severe]), in order for a claim to be processed and paid correctly.

Medicare contractors will deny claims for KDE services billed without ICD-9-CM code 585.4 using CARC 167 (This (these) diagnosis(es) is(are) not covered.)

Medicare contractors will deny claims with HCPCS G0420 or G0421 and ICD-9-CM 585.4 for more than six sessions using claim adjustment reason code (CARC) 119 (Benefit maximum for this time period or occurrence has been reached).

Medicare will not pay a professional claim and an institutional claim for HCPCS G0420 or G0421 and ICD-9-CM 585.4 where both claims contain the same date of service. If such claims are received, the initial claim is paid and subsequent claims are denied using CARC 18 (Duplicate claim/service).

Note: If a signed advance beneficiary notice (ABN) was provided, Medicare contractors will use group code PR (patient responsibility), and the liability falls to the beneficiary. If an ABN was not provided, contractors use group code CO (contractual obligation) and the liability falls to the provider.

The following additional billing requirements are applicable to KDE claims submitted by institutional providers to MACs or FIs:

- MACs/FIs will reimburse for KDE services when rendered in a rural area and submitted on the following TOBs: 12x, 13x, 22x, 23x, 34x, 75x, 81x, and 82x.

Note: TOB 85x is reimbursable for KDE services regardless of the provider's geographical location.

- MACs/FIs will use the actual geographic location CBSA to identify facilities located in rural areas under the MPFS.
- KDE services are covered when claims containing the above-mentioned TOBs are received from section 401 hospitals (the provider is found on the annually updated Table 9C of the inpatient prospective payment system final rule).
- Revenue code 0942 (Other therapeutic services; education/training) should be reported when billing for KDE services on TOBs 22x, 23x, 34x, 75x, 81x, 82x, and 85x.
- Medicare will return to provider hospice claims, TOBs 81x and 82x, billing for KDE services with revenue code 0942 when any other services are also included.
- Hospices must include value code 61 or G8 when billing for G0420 or G0421.
- Hospital outpatient departments should bill for KDE services under any valid/appropriate revenue code, and they are not required to report revenue code 0942. Maryland hospitals under jurisdiction of the Health Services Cost Review Commission, TOBs 12x and 13x, are paid on an inpatient Part B basis in accordance with the terms of the Maryland waiver.

Additional information

Be aware that Medicare contractors will not search their files for claims with service dates on or after January 1, 2010, that are processed prior to the implementation of CR 6557. However, if you identify such claims to your Medicare contractor, they will adjust them.

Coverage of kidney disease patient education services (continued)

The official instruction, CR 6557, was issued via two transmittals, one revising the *Medicare Claims Processing Manual*, Chapter 32, Section 20, and one for revisions to the *Medicare Benefit Policy Manual*, Chapter 15, Section 310. These transmittals are available, respectively, on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1876CP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R117BP.pdf>.

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

MLN Matters® Number: MM6557

Related Change Request (CR) Number: 6557

Related CR Release Date: December 18, 2009

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Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1876, CR 6557

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.

Web site survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

SKILLED NURSING FACILITY SERVICES

Five-star quality rating system – January news

1. The five-star provider preview reports was available on Tuesday, January 19, 2010. Providers may access the report from the minimum data set (MDS) state welcome pages available at the state servers for submission of minimum data set.

Provider preview access information:

- Visit the MDS state welcome page available on the state servers where you submit MDS data to review your results.
 - To access these reports, select the certification and survey provider enhanced reports (CASPER) reporting link located at the bottom of the login page.
 - Once in the CASPER reporting system:
 - i. Click on the “folders” button and access the five-star report in your “st LTC facid” folder
 - ii. Where st is the two-digit postal code of the state in which your facility is located
 - iii. “Facid” is the state assigned “facid” of your facility.
2. The helpline will remain open until Wednesday, February 3, 2010. BetterCare@cms.hhs.gov is also available to address any five-start rating questions and concerns.
 3. *Nursing Home Compare* was update with January five-star data on Thursday, January 28, 2010.
 4. For the latest five-star quality rating system information, please visit http://www.cms.hhs.gov/CertificationandComplianc/13_FSQRS.asp. ❖

Source: CMS PERL 201001-13

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OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

January 2010 integrated outpatient code editor specifications version 11.0

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

Provider types affected

This article is for providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency not under the home health prospective payment system, or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider action needed

This article is based on change request (CR) 6761, which describes changes to the I/OCE and OPPS to be implemented in the January 2010 OPPS and I/OCE updates. Be sure billing staffs are aware of these changes.

Background

CR 6761 describes changes to billing instructions for various payment policies implemented in the January 2010 OPPS update. The January 2010 integrated outpatient code editor (I/OCE) changes are also discussed in CR 6761. Attached to CR 6761 are lengthy specifications for the I/OCE. A summary of the changes for January 2010 is within Appendix M of Attachment A of CR 6761 and that summary is captured in the following key points:

- For calendar year (CY) 2010, Medicare is modifying edit 74 for type of bills (TOB) 85x to apply edit 74 to conditional or independently bilateral codes (indicator 1 or 3) with modifier 50 and more than one unit of service on the same or multiple lines on the same day, with the same revenue code. Medicare will exclude any bilateral lines with any other modifier present. This applies to type of bill 85x with revenue code 96x, 97x or 98x.
- For CY 2010, Medicare will bypass diagnosis edits (1-5) for types of bill 322 and 332 if the FROM date is on/after September 26 and on or before September 30.
- Effective August 3, 2009, Medicare will apply a mid-quarter national coverage determination (NCD) date for HCPCS code G9143.
- Effective September 1, 2009, Medicare will apply a mid-quarter approval date for HCPCS codes G9141 and G9142.
- Effective September 28, 2009, Medicare will add new CPT code 90470 retroactively.

- Effective September 28, 2009, Medicare will apply a mid-quarter NCD approval date for CPT codes 75558, 75560, 75562, and 75564.

For CY 2010, Medicare will:

- Add CPT code 92520 to the ‘Sometimes Therapy’ list and logic.
- Update composite ambulatory payment classification (APC) requirements (add/delete codes as specified in the preliminary summary of data changes document attached to CR6761).
- Change the status indicator (SI) for ‘blank’ revenue code 657, from ‘M’ to ‘A’, when submitted on types of bill 81x and 82x.
- Make Healthcare Common Procedure Coding System (HCPCS) /APC/SI changes as specified by the Centers for Medicare & Medicaid Services (CMS) in the preliminary summary of data changes attached to CR 6751.
- Implement version 15.3 of the National Correct Coding Initiative (as modified for hospitals/OPPS).
- Add new modifiers as specified in CR 6751.
- Update procedure/device and device/procedure edit requirements.
- Update FB/FC device reduction amounts and crosswalk.
- Make SI assignment changes for blank revenue codes as specified by CR 6751.
- Revise the description for payment method flag #1 as follows – From: “Based on OPPS coverage or billing rules, the service is not paid”
To: “Service not paid based on coverage or billing rules.”
- Change descriptive references for HCPCS code G0379 from ‘Direct admission...’ to ‘Direct referral...’.
- Create 508-compliant versions of the specifications and summary of data changes documents for publication on the CMS Web site.

Additional information

The official instruction (CR 6761) issued to your Medicare MAC and/or FI is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/RI872CP.pdf>.

January 2010 integrated outpatient code editor specifications version 11.0 (continued)

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

MLN Matters® Number: MM6761

Related Change Request (CR) Number: 6761

Related CR Release Date: December 11, 2009

Related CR Transmittal Number: R1872

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1872, CR 6761

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Use the PDS report to improve your Medicare billing operations

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

ELECTRONIC DATA INTERCHANGE

Implementation of the HIPAA version 5010 in jurisdiction 9

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

Provider types affected

All physicians, providers and suppliers who bill the Parts A and B (A/B) Medicare administrative contractor (A/B MAC) only in jurisdiction 9 (Florida, Puerto Rico, and U.S. Virgin Islands) for services provided to Medicare beneficiaries are affected by change request (CR) 6745. Providers in other jurisdictions should look for articles concerning their readiness and the readiness of their MACs for version 5010. Providers in jurisdictions 10 and 14 were previously informed of this activity in *MLN Matters*[®] article MM6595, released on August 28, 2009, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6595.pdf>.

Provider action needed

Stop – impact to you

If you submit claims to the A/B MAC in jurisdiction 9, you need to be aware that CR 6745 directs the A/B MAC in this jurisdiction to begin implementing HIPAA version 5010. Implementation of HIPAA 5010 will require changes to software, systems and perhaps procedures that you use for billing Medicare and other payers. So it is extremely important that you and your staff are aware of this HIPAA change being implemented by your MAC and be alert to future directions for this implementation.

Caution – what you need to know

Effective January 1, 2012, you must be ready to submit your claims electronically using the X12 version 5010. CMS will provide additional information to assist you and keep you informed of progress on Medicare's implementation of HIPAA 5010 through a variety of communication vehicles. This article explains what your A/B MAC must do to begin the process of implementing the HIPAA 5010 standard transaction.

Go – what you need to do

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

Background

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The Centers for Medicare & Medicaid Services (CMS) is now implementing the next version of the HIPAA transactions. The purpose of CR 6745 is to instruct the A/B MAC for jurisdiction 9 to prepare their systems to process ASC X12 version 005010 transaction. The Secretary of the Department of Health & Human Services (DHHS) adopted Accredited Standards Committee (ASC) X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version D.0 as the next HIPAA transaction standards for covered entities to exchange HIPAA transactions. The final rule was published on January 16, 2009. All covered entities have to be fully compliant on January 1, 2012.

Additional information

The official instruction, CR 6745, issued to your Medicare A/B MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R621OTN.pdf>.

You may find more information about HIPAA 5010 by going to the Electronic Billing & EDI Transactions page http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010DO.asp.

Medicare has prepared a comparison of the current X12 HIPAA EDI standards (version 4010/4010A1) with version 5010, and has made the side-by-side comparison available at this Web site.

MLN Matters[®] Number: MM6745
 Related Change Request (CR) Number: 6745
 Related CR Release Date: January 15, 2010
 Related CR Transmittal Number: R621OTN
 Effective Date: March 1, 2010
 Implementation Date: March 1, 2010

Source: CMS Pub. 100-20, Transmittal 621, CR 6745

Implementation of HIPAA version 5010 276/277 claim status second phase

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], DME Medicare administrative contractors [DME MACs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries should be aware of this issue.

Provider action needed

This article is based on change request (CR) 6721, which provides technical directions to Medicare shared system maintainers and Medicare contractors regarding the implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for the Accredited Standards Committee (ASC) X12 version 005010 health care claim status request and response (276/277) transaction sets. Providers need to be aware of their own requirements to be fully compliant with the X12 5010 standards by January 1, 2012. Extensive information regarding the standards, along with helpful guidance for providers, is available at <http://www.cms.hhs.gov/Versions5010andD0/>.

Note: The above implementation dates relate only to Medicare contractors completion of work on this particular phase of the implementation.

Background

CR 6721 provides technical direction to the following Medicare shared system maintainers and Medicare contractors for implementing the second phase of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for the Accredited Standards Committee (ASC) X12 version 005010 health care claim status request and response (276/277) transaction sets. The CR also contains details on the common edits and enhancement module (CEM) software for the inbound claim status inquiry process.

CMS has prepared a comparison of the current X12 HIPAA electronic data interchange (EDI) standards (version 4010/4010A1) with version 5010 and the National Council for Prescription Drug Programs (NCPDP) EDI standards

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version 5.1 to version D.0. The 4010A1 implementation guides and the 5010 technical report 3 (TR3) documents served as reference materials during the preparation of the comparison excel spreadsheets. CMS is making the side-by-side comparison documents available for download in both Microsoft Excel and portable document format (PDF). The comparisons were performed for Medicare fee-for-service business use and while they may serve other uses, CMS does not offer to maintain this product for purposes other than Medicare fee-for-service. You may find these documents at http://www.cms.hhs.gov/MF5010D0/20_Technical%20Documentation.asp#TopOfPage.

Additional information

The official instruction, CR 6721, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R623OTN.pdf>.

You may also review the final rule as published in the *Federal Register* on January 16, 2009 by the Department of Health and Human Services 45 CFR Part 162, Subpart N—Health Care Claim Status at <http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf>.

You may find more information about HIPAA version 5010 and NCPDP version D.0. at http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp.

A special edition *MLN Matters*® article, SE0832, on the ICD-10 code set is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf>.

MLN Matters® Number: MM6721

Related Change Request (CR) Number: 6721

Related CR Release Date: January 15, 2010

Related CR Transmittal Number: R623OTN

Effective Date: April 1, 2010 (**except July 1, 2010 for Jurisdiction 9 MAC**)

Implementation Date: April 5, 2010 (**except July 6, 2010 for Jurisdiction 9 MAC**)

Source: CMS Pub. 100-20, Transmittal 623, CR 6721

Find out first: Subscribe to FCSO eNews

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

FRAUD AND ABUSE

OIG reports \$20.97 billion in savings and recoveries in fiscal year 2009

In its *Semiannual Report to Congress*, the Department of Health & Human Services (HHS) Office of Inspector General (OIG) announced significant audit, investigation, and evaluation accomplishments for the second half of fiscal year (FY) 2009 (April 1, 2009-September 30, 2009) and for FY 2009 in total. OIG reported savings and expected recoveries of \$20.97 billion for all of FY 2009.

Specifically, OIG's \$20.97 billion in savings and expected recoveries includes \$16.48 billion in implemented recommendations to put funds to better use, \$4 billion in investigative receivables, and \$492 million in audit receivables.

"We continue to make significant progress in our fight against fraud, waste, and abuse in HHS programs, particularly Medicaid and Medicare," said Inspector General Daniel R. Levinson. "We're doing this by leveraging our audit, legal, evaluation, and investigative tools, as well as employing the latest in data analysis technology. But the results we've achieved are due primarily to the hard work of our professional staff and effective collaboration with our government partners. We will remain aggressive in our mission to protect the integrity of these vital programs."

Additionally, in FY 2009, OIG excluded 2,556 individuals and organizations from participation in federal health care programs. OIG also reported 671 criminal actions against individuals or organizations that engaged in crimes against HHS programs and 394 civil actions, including False Claims Act and unjust enrichment suits filed in federal district court, Civil Monetary Penalties Law (CMPL) settlements, and administrative recoveries related to provider self-disclosure matters.

Significant OIG accomplishments during the semiannual reporting period include the following:

Medicare Fraud Strike Force operations lead to sentencing of seven Miami-area residents in Medicare infusion fraud scheme

Seven employees of a Miami infusion clinic were ordered to pay \$19.8 million in restitution and sentenced to prison terms ranging from 37 to 97 months. In their guilty pleas, the individuals admitted to activities including manipulating patients' blood samples to generate false medical records, ordering and administering medications to treat conditions that were falsely documented with fraudulent test results, and billing Medicare for services that were medically unnecessary or never provided.

This operation was conducted by the Medicare Fraud Strike Force, a key component of the joint HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team, known as HEAT. During the reporting period, Medicare Fraud Strike Force investigations resulted in the filing of charges against 138 individuals or entities, 44 convictions, and \$40.7 million in investigative receivables.

State and local pandemic influenza preparedness

During this semiannual period, we issued two reports related to states' and localities' pandemic influenza preparedness. Our key findings include the following:

- In one review we found that although the majority of selected localities had begun planning to distribute and dispense vaccines and antiviral drugs, more needs to be done to improve localities' ability to respond to an influenza pandemic. Specifically, in their preparedness plans, selected localities had not addressed most of the vaccine and antiviral drug distribution and dispensing preparedness items identified in HHS guidance. Further, although all of the selected localities conducted exercises related to vaccine and antiviral drug distribution and dispensing, most did not create after-action reports and improvement plans for these exercises. (OEI-04-08-00260)
- In a second review, we found that although selected states and localities are making progress in preparing for a medical surge, they need to do more to improve their ability to respond to an influenza pandemic. Specifically, fewer than half of the selected localities had started to recruit the medical volunteers required to respond to a medical surge, and none of the states reviewed had implemented electronic systems to manage volunteers. Moreover, although all of the selected localities had acquired limited medical equipment for a pandemic, only three of the five states had electronic systems to track beds and equipment. Also, most of the selected localities had not identified guidelines for altering triage, admission, and patient care during a pandemic. (OEI-02-08-00210)

Pfizer Inc. enters into settlement for marketing and promotion practices

Pfizer Inc. entered into a \$1 billion civil False Claims Act settlement with the United States in connection with Pfizer's marketing and promotion practices associated with the anti-inflammatory drug Bextra and several other drugs. The settlement agreement is part of a global criminal, civil, and administrative settlement with Pfizer and its subsidiary, Pharmacia & Upjohn Company, Inc., which also includes a comprehensive five-year corporate integrity agreement (CIA) between Pfizer and OIG.

[**Note to editors:** Pfizer and Pharmacia & Upjohn agreed to pay a total of \$2.3 billion in this case, the largest health care fraud settlement in history, to resolve both the civil and criminal liability arising from the illegal promotion of certain pharmaceutical products. The criminal portion of the settlement is not included in this semiannual report because it became effective after September 30, 2009.]

OIG reports \$20.97 billion in savings and recoveries in fiscal year 2009 (continued)

Medicaid personal care claims made by providers in New York City

We estimated that New York State improperly claimed \$275.3 million in federal Medicaid reimbursement for some personal care claims submitted by providers in New York City during calendar years 2004 through 2006. The improper claims occurred because the state did not adequately monitor New York City’s personal care services program for compliance with federal and state requirements. We recommended that the state refund \$275.3 million, work with the Centers for Medicare & Medicaid Services to resolve two Consumer Directed Personal Assistance Program (CDPAP) claims, improve its monitoring of New York City’s personal care services program, and promulgate specific regulations related to CDPAP claims. The state disagreed with our first recommendation and with several of our findings. (A-02-07-01054)

Barriers to the Food and Drug Administration’s response to food emergencies

In two reviews, we addressed the Food and Drug Administration’s (FDA) responsibilities for overseeing the safety of food in both the human and pet food supply.

- In one review, OIG found that in the event of a food emergency, FDA would likely have difficulty tracing food products through the food supply chain. We were able to trace only five of the 40 products reviewed through each stage of the food supply chain. For 31 of the 40 products, we could identify the facilities that likely handled the products, and for the remaining four products, we could not identify the facilities. Furthermore, 59 percent of the facilities reviewed did not meet FDA’s requirements to maintain records about their sources, recipients, and transporters, and 25 percent were not aware of these requirements.

We recommended, among other things, that FDA consider seeking additional statutory authority to strengthen its lot-specific information requirements and to request facilities’ records at any time. We

also recommended that FDA work with the industry to develop needed guidance and that FDA address issues related to mixing raw food products from a large number of farms. FDA agreed to consider these recommendations. (OEI-02-06-00210)

- In the second review, we found that FDA did not have statutory authority to require pet food manufacturers or importers to initiate recalls of contaminated food or to assess penalties for recall violations. Furthermore, FDA’s existing regulations were issued as nonbinding recall guidance for firms. We found that FDA’s lack of authority, coupled with its sometimes-lax adherence to its recall guidance and internal procedures, limited FDA’s ability to ensure that contaminated pet food was promptly removed from retailers’ shelves. Our report contained detailed recommendations for strengthening FDA’s recall authority and improving its monitoring of recalls. FDA agreed or agreed in principle with all of our recommendations. (A-01-07-01503)

Nursing home executive agrees to permanent exclusion

The President and Chairman of the Board of Pleasant Care Corporation (Pleasant Care), Emmanuel Bernabe, agreed to be permanently excluded from federal health care programs following an investigation of substandard care at nursing homes formerly operated by Pleasant Care. OIG alleged that Bernabe, through his management and oversight of Pleasant Care, caused services to be furnished to Pleasant Care residents that substantially departed from the professional standard of care. For example, Pleasant Care failed to maintain adequate staffing levels, properly administer medication, provide adequate hydration and nutrition, and prevent accidents.

To read the full *Semiannual Report to Congress*, go to the following link: http://oig.hhs.gov/publications/docs/semiannual/2009/semiannual_fall2009.pdf. ❖

Source: Office of Inspector General Press Release, December 3, 2009

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HHS employs new tougher standards in calculation of improper Medicare payment rates for 2009

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

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

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

The Medicare, Medicaid and Children's Health Insurance Program (CHIP) improper payment rates are issued annually as part of the U.S. Department of Health and Human Services (HHS) Agency Financial Report.

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

"If we aren't honest about the problem, there is no way we can get to a solution. Through a more stringent

review of Medicare claims, we've been able to establish a more complete accounting of errors, enabling CMS to take more actionable steps to further reduce the error rate and identify abusive or potentially fraudulent actions before they become problems," said Sebelius. "This change in calculating the error rate is just one part of our larger Administration-wide effort to reduce waste, fraud and abuse in health care. In addition to the establishment of HEAT, the joint task force that was established earlier this year with the Department of Justice, we've taken aggressive steps at HHS and CMS to improve our oversight of the Medicare trust funds and the taxpayer dollars that pay for the health care of millions of older and vulnerable Americans."

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

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

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

Source: CMS Press Release, November 18, 2009

Timely claim filing guidelines

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

Dates of Service

Last Filing Date

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

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

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

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events February 2010 – May 2010

Topic – Reject/Return to Provider (RTP) reason codes

When: Tuesday, February 9, 2010
 Time: 10:00 a.m. – 11:30 a.m. ET **Delivery language:** English
 Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Recovery audit contractor (RAC)

When: Wednesday, February 10, 2010
 Time: 1:00 p.m. – 2:30 p.m. ET **Delivery language:** Spanish
 Type of Event: Webcast **Focus:** Puerto Rico

Topic – Hot Topics

When: Tuesday, March 9, 2010
 Time: 10:30 a.m. – 12:00 noon ET **Delivery language:** English
 Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Hot Topics

When: Tuesday, May 11, 2010
 Time: 11:30 a.m. – 1:00 p.m., ET **Delivery language:** English
 Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Two easy ways to register

Online – Visit our provider training Web site at www.fcsomedicaretraining.com, log on to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event. **First-time User?** Set up an account by completing [Request User Account Form](#) online. Providers who do not have yet a national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

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

Please Note:

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

Registrant’s Name: _____
 Registrant’s Title: _____
 Provider’s Name: _____
 Telephone Number: _____ Fax Number: _____
 E-mail Address: _____
 Provider Address: _____
 City, State, ZIP Code: _____

Keep checking our Web site, www.medicare.fcsso.com, 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 Web site, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

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

PREVENTIVE SERVICES

January is National Glaucoma Awareness Month

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of a comprehensive annual glaucoma-screening exam for Medicare beneficiaries at high risk for developing glaucoma.

Medicare coverage

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high-risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older
- A covered glaucoma screening includes both of the following:
 - A dilated eye examination with an intraocular pressure (IOP) measurement
 - A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination

What you can do

As a health care professional who provides care to seniors and others with Medicare, you can help protect the vision of your Medicare patients who may be at high risk for glaucoma by educating them about their risk factors and reminding them of the importance of getting an annual glaucoma-screening exam.

For more information

CMS has developed several educational products related to Medicare-covered preventive services, including glaucoma screenings:

The Glaucoma Screening brochure – provides information on risk factors, coverage, and documentation for Medicare-covered Glaucoma screenings.

The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for Medicare Learning Network (MLN) preventive services educational products and resources for health care professionals and their staff, including products related to Medicare-covered glaucoma screening.

Quick Reference Information: Medicare Preventive Services – this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including Medicare-covered glaucoma screenings.

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – this comprehensive resource provides in-depth information about the many preventive services Medicare covers, including glaucoma screenings.

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products.

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate beneficiaries at high risk for developing glaucoma about the importance of getting a Medicare-covered glaucoma screening. ❖

Source: CMS PERL 201001-02

Adult Immunizations brochure

The Adult Immunizations brochure, which provides an overview of Medicare's coverage of seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration, is now available in print format.

To place your order for the print version, select MLN Product Ordering Page in the Related Links Inside CMS section on the *Medicare Learning Network* homepage at http://www.cms.hhs.gov/MLNGenInfo/01_Overview.asp.

You may also download at the following address:

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

For more products related to Medicare-covered preventive services, please visit the Centers for Medicare & Medicaid Services (CMS) Preventive Services Educational Products page at:

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

Source: CMS PERL 201001-06

National Influenza Vaccination Week

National Influenza Vaccination Week was January 10-16, 2010. The Centers for Disease Control and Prevention (CDC) has announced the week of January 10-16, 2010, as National Influenza Vaccination Week. This weeklong event is designed to raise awareness of the importance of continuing influenza (flu) vaccinations, as well as foster greater use of flu vaccine in January, February, and beyond. Since flu activity typically does not peak until February or later, January and February still provide good opportunities to offer flu shots.

This year, Thursday, January 15 is designated as Seniors' Vaccination Day. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare get their flu shots. Please use this weeklong event as an opportunity to place greater emphasis on flu prevention.

If you have Medicare patients who have not yet received their annual flu shots, CMS asks that you encourage these patients to protect themselves from the seasonal flu and serious complications arising from the flu virus by recommending that they take advantage of the flu shot benefit covered by Medicare. And remember, health care professionals and their staff are also at risk for contracting and spreading the flu virus, so don't forget to immunize yourself and your staff.

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

Note: Influenza vaccine plus its administration are covered Part B benefits. Influenza vaccine is not a Part D covered drug.

For information about Medicare coverage of the seasonal influenza virus vaccine and its administration, as well as related educational resources for health care professionals and their staff, please go to the CMS Web site http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf.

You will find a variety of resources that explain Medicare coverage and claim submission policies related to the seasonal influenza vaccine.

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

For more information about National Influenza Vaccination Week, please visit the Centers for Disease Control and Prevention Web site at <http://www.cdc.gov/flu/nivw/index.htm>. ❖

Source: CMS PERL 201001-06

MLN educational products related to Medicare-covered preventive services

Help keep your Medicare patients healthy in the New Year. The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to encourage their patients with Medicare to take advantage of Medicare-covered preventive services. Medicare covers a wide array of preventive services for eligible beneficiaries, including cancer screenings, glaucoma screenings, an initial preventive physical examination, and certain immunizations.

What you can do

As a health care professional who provides care to seniors and others with Medicare, you can help protect the health of your Medicare patients by educating them about their risk factors and reminding them of the importance of getting the preventive screenings covered by Medicare.

For more information

CMS has developed the following educational products related to Medicare-covered preventive services:

- The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for *Medicare Learning Network (MLN)* preventive services educational products and resources for health care professionals and their staff.

- Quick Reference Information: Medicare Preventive Services – this double-sided chart provides coverage and coding information on Medicare-covered preventive services.
- Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination (IPPE) – this double-sided chart provides a checklist of services included in the IPPE, as well as additional information on the IPPE benefit.
- Quick Reference Information: Medicare Part B Immunization Billing – this double-sided chart provides coverage and coding information on Medicare-covered immunizations.

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products.

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

Source: CMS PERL 200912-39

OTHER EDUCATIONAL RESOURCES

The Medicare Learning Network celebrates its 10th anniversary The Medicare Learning Network – Celebrating 10 years as your Medicare educational resource

This year marks the 10th anniversary for the *Medicare Learning Network (MLN)* – the home for official information for Medicare fee-for-service (FFS) providers. We're located within the Centers for Medicare & Medicaid Services (CMS) and over the past decade, we've been very busy:

- Producing quality educational products designed to meet the needs and learning styles of busy health-care professionals
- Adding continuing education credits to many of our online courses
- Developing new and different ways to make our products accessible and available to the FFS provider community.

Whether you're familiar with the *Medicare Learning Network* or just curious about us, our upcoming marketing campaign will help you to discover or re-discover the features and benefits that so many members of the FFS provider community turn to on a daily basis. So, check your e-mails and join us as we enter our second decade of dedication to providing the Medicare FFS provider community with the education and information resources it needs.

Learn more about the Medicare Learning Network right now Download the Medicare Learning Network marketing brochure

View our new marketing brochure online to learn what the *Medicare Learning Network* has to offer – print copies of this brochure will soon be available on our product ordering system.

Order The Medicare Learning Network DVD– A good place to start

This DVD contains quick and basic information about the *Medicare Learning Network* and its benefits to providers. The DVD is suitable for self instruction, as well as exhibits and training events. National and local provider associations are encouraged to post this product on their Web sites and/or distribute via electronic newsletters or mailing lists. Run time is 7 minutes, 7 seconds.

Visit the *Medicare Learning Network* Product Ordering page and scroll down to the “Educational Tool” topic category to find the DVD and place your order. You can also view the video online.

Stay tuned for more. ❖

Source: CMS PERL 201001-11

Message from the MLN – did you resolve to learn something new this year? New information is just a click away

The *Medicare Learning Network (MLN)* Web-based training courses are the perfect way to make good on that resolution. You may choose from a variety of courses that cover the Medicare program policy topics, ranging from general overviews to specific billing and coding information, as well as important education on new initiatives from the Centers for Medicare & Medicaid Services (CMS).

You do not have to miss a moment in the office because you can access any course 24 hours a day, 7 days a week – and it is easy to complete the courses at your own pace. Each course is a compact learning opportunity; you gain a significant amount of information in just a short period.

Stay on track with CMS' learning management system. The system charts your completed courses and evaluations and even remembers the chapters you have completed if you are not able to finish in one sitting.

Many of the courses offer the benefit of continuing education credits to help you meet academic requirements to obtain or maintain your license or certification. And, remember – like all *Medicare Learning Network* products – our Web-based training courses are free-of-charge.

Resolve to visit the MLN Products page today. Find out more information and click on Web-Based Training to get started. ❖

Source: CMS PERL 201001-20

Revised Medicare Physician Guide

The revised *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (Oct 2009), which offers general information about the Medicare program, how to become a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management services, protecting the Medicare trust fund, inquiries, overpayments, and fee-for-service appeals, is now available in CD-ROM format from the *Centers for Medicare & Medicaid Services Medicare Learning Network*.

To place your order, visit <http://www.cms.hhs.gov/MLNGenInfo/>, scroll down to Related Links Inside CMS and select MLN Product Ordering Page. ❖

Source: CMS PERL 201001-10

New Medicare Learning Network quick reference charts

The *Medicare Learning Network (MLN)* has produced the following quick reference charts that provide information on frequently used Centers for Medicare & Medicaid Services (CMS) Web pages:

The Quick Reference: All Medicare Providers (December 2009) – chart includes a list of CMS Web pages that all Medicare providers use most frequently.

The Quick Reference: New Medicare Provider (December 2009) – chart includes a list of CMS Web pages that new Medicare providers use most frequently.

These charts may be bookmarked and viewed online or printed and used as references. Both charts may be located at <http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp> on the MLN Publications page. Use search key word “quick” to locate these publications.

Quick reference charts can be handy lists for looking up information. ❖

Source: CMS PERL 201001-17

New World of Medicare Web-based training course

Looking for help with the fundamentals of the Medicare program? This new Web-based training (WBT) course from the *Medicare Learning Network (MLN)* can help.

The World of Medicare WBT is designed for health care professionals who want to understand the fundamentals of the Medicare program. After completing this course, participants should be able to differentiate between Medicare Part A, Part B, Part C, and Part D and identify Medicare beneficiary health insurance options, eligibility, and enrollment, as well as recognizing how Medigap and Medicaid work with the Medicare program.

This WBT course offers continuing education credits, please see the course description for details. This training may be accessed by visiting <http://www.cms.hhs.gov/MLNgeninfo/>.

Scroll down to the Related Links Inside CMS section, select Web Based Training (WBT) modules, and then select World of Medicare (January 2010) from the list of training courses provided. ❖

Source: CMS PERL 201001-18

Revised remittance advice WBT now available from Medicare Learning Network

The revised Understanding the Remittance Advice (RA) for Professional Providers Web-based training (WBT) course is now available from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network*. Available for continuing education credit, this course provides instructions to help Medicare fee-for-service providers and their billing staffs interpret the RA received from Medicare and reconcile it against submitted claims.

In addition, it provides guidance on how to read electronic remittance advices (ERAs) and standard paper remittance advices (SPRs), and it offers instructions for balancing an RA. This course also presents an overview of software that Medicare provides free to providers in order to view ERAs. This training may be accessed by visiting <http://www.cms.hhs.gov/MLNgeninfo/>.

Scroll down to the Related Links Inside CMS section, select Web-Based Training (WBT) modules, and then select Understanding the Remittance Advice for Professional Providers from the list of training courses provided. ❖

Source: CMS PERL 200912-38

Revised Hospice Payment System fact sheet now available in print

The revised *Hospice Payment System* fact sheet (November 2009) is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. This fact sheet provides general information about the Medicare hospice benefit including coverage of hospice services, certification requirements, election periods, how payment rates are set, patient coinsurance payments, caps on hospice payments, and additional reporting required on hospice claims.

To place your order, visit <http://www.cms.hhs.gov/MLNGenInfo/>, under Related Links Inside CMS, select MLN Product Ordering Page.” ❖

Source: CMS PERL 201001-16

Educational Resources

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

Order form for Medicare Part A 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)

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
Part A subscription – The Medicare Part A jurisdiction 9 publications, in both Spanish and English, are available free of charge online at http://medicare.fcso.com/Publications/ (English) or http://medicareespanol.fcso.com/Publicaciones/ (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2009 through September 2010.	40-500-150	Hardcopy \$33		
		CD-ROM \$55		
Language preference for subscription: English [<input type="checkbox"/>] Español [<input type="checkbox"/>]				
<i>Please write legibly</i>			Subtotal	\$
			Tax (<i>add % for your area</i>)	\$
			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: _____

Telephone Number (include area code): _____

Mailing Address: _____

City: _____

State, ZIP Code: _____

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

Addresses

CLAIMS/CORRESPONDENCE

Claim Status
Additional Development
General Correspondence
Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
 Medicare Part A Customer Service
 P. O. Box 2711
 Jacksonville, FL 32231-0021

PART A REDETERMINATION

Medicare Part A Redetermination
 and Appeals
 P. O. Box 45053
 Jacksonville, FL 32232-5053

MEDICARE SECONDARY PAYER Information on Hospital Protocols Admission Questionnaires, Audits

MSP – Hospital Review
 P. O. Box 45267
 Jacksonville, FL 32232-5267

General MSP Information Completion of UB-04 (MSP Related) Conditional Payment

Medicare Secondary Payer
 P. O. Box 2711
 Jacksonville, FL 32231-0021

MSPRC DPP Debt Recovery Automobile Accident Cases Settlements/Lawsuits

Other Liabilities
 Auto/Liability Department – 17T
 P. O. Box 44179
 Jacksonville, FL 32231-4179

ELECTRONIC CLAIM FILING Direct Data Entry (DDE) Startup

Direct Data Entry
 P. O. Box 44071
 Jacksonville, FL 32231-4071

FRAUD AND ABUSE

Complaint Processing Unit
 P. O. Box 45087
 Jacksonville, FL 32232-5087

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY Home Health Agency Claims Hospice Claims

Palmetto Government Benefit
 Administrators
 Medicare Part A
 P.O. Box 100238
 Columbia, SC 29202-3238

RAILROAD MEDICARE

Railroad Retiree Medical Claims
 Palmetto Government Benefit
 Administrators
 P. O. Box 10066
 Augusta, GA 30999-0001

POST-PAY MEDICAL REVIEW

First Coast Service Options Inc.
 P. O. Box 44159
 Jacksonville, FL 32231-4159

OVERPAYMENT COLLECTIONS

**Repayment Plans for Part A
 Participating Providers**
**Cost Reports (original and amended)
 Receipts and Acceptances**
Tentative Settlement Determinations
**Provider Statistical and
 Reimbursement (PS&R) Reports**
**Cost Report Settlement (payments
 due to provider or program)**
Interim Rate Determinations
**TEFRA Target Limit and SNF Routine
 Cost Limit Exceptions**
 Provider Audit and Reimbursement
 Department (PARD)
 P. O. Box 45268
 Jacksonville, FL 32232-5268
 1-904-791-8430

Freedom of Information Act Requests (relative to cost reports and audits)

Provider Audit and Reimbursement
 Department (PARD)
 Attn: FOIA PARD – 16T
 P. O. Box 45268
 Jacksonville, FL 32232-5268
 1-904-791-8430

PROVIDER ENROLLMENT

CMS-855 Applications
 P. O. Box 44021
 Jacksonville, FL 32231-4021

PROVIDER ENROLLMENT American Diabetes Association Certificates

Medicare Provider Enrollment – ADA
 P. O. Box 2078
 Jacksonville, FL 32231-0048

SPECIAL DELIVERY

**Overnight Mail and/or other
 Special Courier Services**
 First Coast Service Options Inc.
 532 Riverside Av.
 Jacksonville, FL 32202-4914

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

Durable Medical Equipment Claims
**Orthotic and Prosthetic Device
 Claims**
Take Home Supplies
Oral Anti-Cancer Drugs
 CIGNA Government Services
 P. O. Box 20010
 Nashville, Tennessee 37202

Telephone Numbers

PROVIDERS

Customer Service Center Toll-Free
 1-888-664-4112

Interactive voice response (IVR)
 1-888-664-4112

Speech and Hearing Impaired
 1-877-660-1759

BENEFICIARY

Customer Service Center Toll-Free
 1-800-MEDICARE
 1-800-633-4227
Speech and Hearing Impaired
 1-800-754-7820

ELECTRONIC DATA INTERCHANGE 1-888-670-0940

Option 1
Transaction Support

Option 2
PC-ACE Support

Option 3
Direct Data Entry (DDE) Support

Option 4
Enrollment Support

Option 5
Electronic Funds
 (check return assistance only)

Option 6
Automated Response Line

PROVIDER EDUCATION & OUTREACH

Seminar Registration Hotline
 1-904-791-8103

Seminar Registration Fax Number
 1-904-361-0407

PROVIDER ENROLLMENT 1-877-602-8816

CREDIT BALANCE REPORT Debt Recovery

1-904-791-6281

Fax
 1-9043610359

Medicare Web sites

PROVIDERS

Florida Medicare Contractor
medicare.fcso.com

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REDETERMINATION and REDETERMINATION OVERPAYMENTS

First Coast Service Options Inc
 P. O. Box 45097
 Jacksonville, FL 32232-5097

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Centers for Medicare & Medicaid
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www.medicare.gov



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦

