

# MEDICARE A Bulletin

A NEWSLETTER FOR FLORIDA MEDICARE PART A 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 [www.fcso.com](http://www.fcso.com).

### Routing Suggestions :

- Medicare Manager
- Reimbursement Director
- Chief Financial Officer
- Compliance Officer
- DRG Coordinator
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



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**Medicare A Bulletin**

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**Publication Staff**

Millie C. Pérez  
Terri Drury  
Mark Willett  
Betty Alix

The *Medicare A Bulletin* is published monthly by First Coast Service Options Inc. Provider Outreach and Education division, to provide timely and useful information to Medicare Part A providers in Florida.

Questions concerning this publication or its contents may be faxed to:

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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 in accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters.

The Medicare Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. Important notifications requiring communication in between publications will be posted to the FCSO Medicare provider education Web site <http://www.floridamedicare.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 (please see the hardcopy registration form published in the May 2008 *Medicare A Bulletin*, page 4). 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:

- Some issues of the publication may start with an important message from our contractor medical director.
- Following are sections comprise of administrative and general information, processing guidelines, billing issues, and Medicare coverage guidelines applicable to all Medicare Part A providers and facilities.
- 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.)
- As needed, the *Bulletin* contains *Electronic Data Interchange* and *Fraud and Abuse* sections.
- 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.
- 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.

### Do you have comments?

The publications staff welcomes your comments and feedback on the *Bulletin* and appreciates your continued support. Please fax comments to:

Medicare Publications  
1-904-361-0723

## 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 listserv to ensure timely notification of all additions to the QPU. ❖

# GENERAL INFORMATION

## Update to the initial preventive physical examination benefit

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

### Provider types affected

Physicians and providers who submit claims to Medicare fiscal intermediaries (FIs), carriers and/or Part A/B Medicare administrative contractors (A/B MACs) for the initial preventive physical examination benefits (IPPE) provided to Medicare beneficiaries.

### What you need to know

This article is based on change request (CR) 6223, which announces that, effective January 1, 2009, the Centers for Medicare & Medicaid Services (CMS) is expanding coverage for the IPPE benefit.

This expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, no later than 12 months (rather than six months as previously required) after the date the individual's first coverage period begins under Medicare Part B. However, this expanded coverage only applies if the IPPE is performed on or after January 1, 2009.

The IPPE has been expanded to include measurement of an individual's body mass index, and end-of-life planning as mandatory services (upon an individual's consent). The screening electrocardiogram (EKG) is no longer a mandatory part of the IPPE, but it may be performed as an optional one-time service as a result of a referral arising out of the IPPE. Be sure your billing staff is aware of these changes.

### Background

Pursuant to Section 101 (b) of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), CMS is amending section 410.16 and related regulation provisions of the *Code of Federal Regulations*. Effective January 1, 2009, this expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, also known as the "Welcome to Medicare Visit", not later than 12 months after the date the individual's first coverage period begins under Medicare Part B.

### Changes to initial preventive physical examination

#### The initial preventive physical examination

- Effective for services performed on or after January 1, 2009, MIPPA changes the IPPE as follows:
  - Waives the deductible for the IPPE.
  - Adds the measurement of body mass index as part of the IPPE.
  - Adds end-of-life planning to the IPPE (upon an individual's consent).
  - Removes the mandatory requirement of the screening electrocardiogram (EKG). The screening EKG is optional and is permitted as a one-time

screening service as a result of a referral arising out of the IPPE.

### Eligibility

- Effective January 1, 2009, the MIPPA of 2008 extends the eligibility period from six months after Part B enrollment to 12 months after enrollment.
- Effective for IPPEs performed on or after January 1, 2009, a beneficiary is eligible for the extended IPPE benefits of MIPPA when he/she first enrolls in Medicare Part B and receives the IPPE benefit within the first 12 months of the effective date of the initial Part B coverage period.
- For IPPEs performed on or after January 1, 2009, the Medicare deductible does not apply to the IPPE.
- The waived deductible is applicable to the IPPE (code G0402) only, but the coinsurance still applies. Prior to January 1, 2009, the deductible was not waived.

### Billing Requirements

#### Codes used to bill the IPPE

- Effective January 1, 2005, the physician or qualified nonphysician practitioner will bill for IPPEs performed on or before December 31, 2008, using HCPCS code G0344 with one of the following HCPCS codes for the mandatory EKG: G0366, G0367, or G0368.
- Effective January 1, 2009, the screening EKG is billable with HCPCS code(s) G0403, G0404, or G0405, when it is a result of a referral from an IPPE.
- For an IPPE performed during the global period of surgery refer to Section 30.6.6, Chapter 12 of the *Medicare Claims Processing Manual* for reporting instructions on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>.

The following HCPCS codes have been developed for the IPPE benefit effective January 1, 2009:

#### HCPCS codes and short descriptors

- |       |   |
|-------|---|
| G0402 | Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment<br>Short Descriptor: Initial preventive exam                           |
| G0403 | Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report<br>Short Descriptor: EKG for initial prevent exam                   |
| G0404 | Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination<br>Short Descriptor: EKG tracing for initial prev |

**Update to the initial preventive physical examination benefit (continued)**

G0405 Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination  
Short Descriptor: EKG interpret & report preve

**Professional Claims Processed by carriers/ Medicare administrative contractors**

The type of service (TOS) for each of the new codes is as follows:

G0402: TOS = 1

G0403: TOS = 5

G0404: TOS = 5

G0405: TOS = 5

- The HCPCS codes for an IPPE and screening EKG are paid under the MPFS. The appropriate deductible and coinsurance applies to codes G0344, G0366, G0367, G0368, G0403, G0404, and G0405.
- The deductible is waived for code G0402 after January 1, 2009, but the coinsurance still applies.

**Institutional claims processed by fiscal intermediaries/Medicare administrative contractors**

- FIs/MACs will pay for code G0402 for the IPPE and code G0404 for the screening EKG, tracing only when those services are submitted on a type of bill (TOB) 12x or 13x for hospitals subject to the outpatient prospective payment system (OPPS). Codes G0403 and G0405 are not payable under the OPPS. Hospitals not subject to OPPS will be paid under current methodologies.
- For inpatient or outpatient services in hospitals in Maryland, payment is made according to the state cost containment system.
- For services performed on a 12x, Indian health services (IHS) hospitals, payment is made based on an all-inclusive ancillary per diem rate.
- For services performed on a 13x, IHS hospitals, payment is made based on the all-inclusive rate.
- For services performed on an 85x, IHS critical access hospitals (CAHs), payment is made based on an all inclusive facility specific per visit rate. For other CAHs billing on the 85x, payment is based on reasonable cost.
- For services billed by skilled nursing facilities (SNFs) on the 22x, payment for the technical component of the EKG is based on the MPFS.

**Note:** HCPC code G0405 is a professional component and is only allowable on 71x, 73x and 85x (CAH method II) TOBs. In addition, G0404 is a technical component HCPCS code that can only be submitted on 12x, 13x, 22x, or 85x (method I and II) TOBs.

**Rural health clinics/federally qualified health centers (RHCs/FQHCs) special billing instructions**

Payment for the professional services will be made under the all-inclusive rate. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location constitute a single visit.

**Outpatient prospective payment hospital billing**

Hospitals subject to outpatient prospective payment system (OPPS) (TOBs 12x and 13x) must use modifier 25 when billing the IPPE G0344 along with technical component of the EKG, G0367, on the same claim. The same is true when billing IPPE code G0402 along with the technical component of the screening EKG, code G0404.

**Reporting a medically necessary evaluation and management (E/M) at same IPPE visit**

When the physician or qualified NPP provides a medically necessary E/M service in the same visit as the IPPE, CPT codes 99201-99215 may be used depending on the clinical appropriateness of the circumstances. CPT modifier 25 will be appended to the medically necessary E/M service identifying this service as a significant, separately identifiable service from the IPPE code reported (G0344 or G0402, whichever applies based on the date of service).

**Documentation**

Physicians and qualified NPPs are required to use the 1995 and 1997 E/M documentation guidelines to document the medical record with the appropriate clinical information. The guidelines may be reviewed on the CMS Web site at [http://www.cms.hhs.gov/MLNEdWebGuide/25\\_EMDOC.asp](http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp).

**Medicare notices and messages****Remittance advice remark codes and claim adjustment reason codes**

- Your Medicare contractors will use the appropriate remittance advice remark code, i.e., N117 (This service is paid only once in a patient's lifetime) when denying additional claims for an IPPE and/or a screening EKG.
- Your Medicare contractors will use the appropriate claim adjustment reason code, i.e., 149 (Lifetime benefit maximum has been reached for this service/benefit category) when denying additional claims for an IPPE and/or a screening EKG.

**Advance beneficiary notice as applied to the IPPE**

- Effective for beneficiaries whose IPPE is provided on January 1, 2005, through December 31, 2008, an advance beneficiary notice (ABN) will be issued for all IPPEs conducted after the beneficiary's statutory six-month period has lapsed.
- Effective for IPPEs performed on or after January 1, 2009, an ABN will be issued for all IPPEs conducted after the beneficiary's statutory 12-month period has lapsed since based on Social Security Act Section 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the initial 12-month period under the MIPPA of 2008.

**Medicare summary notices**

- When denying additional claims for G0402, Medicare contractors will use Medicare summary notice (MSN) message 20.91 – This service was denied. Medicare covers a one-time initial preventive physical exam (Welcome to Medicare physical exam) if you get it within the first 12 months of the effective date of your Medicare Part B coverage.

**Update to the initial preventive physical examination benefit (continued)**

- When denying additional claims for screening EKG codes G0403, G0404 and G0405, contractors will use MSN message 20.12 – This service was denied because Medicare only covers this service once a lifetime.

**Additional information**

The official instruction (CR 6223) 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/R1615CP.pdf>.

If you have questions, please contact your Medicare 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>.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6223

Related Change Request (CR) Number: 6223

Related CR Release Date: October 24, 2008

Related CR Transmittal Number: R1615CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1615, CR 6223

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**Posting of 2009 HCPCS annual update**

The Centers for Medicare & Medicaid Services (CMS) has posted the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set to incorporate new changes for 2009. This annual update has been posted to the HCPCS Web site at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage>.

The latest version includes changes to the Current Dental Terminology (CDT) codes contributed by the American Dental Association (ADA) with their scheduled 2008 update.

In addition, the following changes have been made to the original posting:

E0764 – Language revised

E0770 – Coverage indicator changed

Q4114 – Language revised

All changes are effective January 1, 2009, unless otherwise indicated in the effective date column. ❖

Source: CMS PERL 200811-04 and 200811-23

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**Unsolicited/voluntary refunds**

All Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open accounts receivable). Intermediaries generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds. The Centers for Medicare & Medicaid Services reminds providers that:

“The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.” ❖

Source: CMS Pub 100-6 Transmittal 50, CR 3274

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**HCPCS coding decision for skin substitute products**

The 2009 HCPCS annual update includes a new code range, Q4100-Q4115, effective January 1, 2009, to identify skin substitute products. HCPCS codes J7340, J7341, J7342, J7343, J7344, J7346, J7347, J7348, J7349 and C9357 are discontinued effective December 31, 2008. For specific code language, please refer to the 2009 HCPCS annual update posted on CMS HCPCS Web site at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS>.

The coding decision was made based on programmatic reasons and to facilitate accurate coding of these products. Medicare Part B is not changing the way the payment amounts are determined for the products in the new codes. To the extent that single source drugs or biologicals were within the same billing and payment code as of October 1, 2003, Medicare Part B will continue to treat them as multiple source drugs for payment purposes as required by Section 1847A(c)(6)(C)(ii) of the Social Security Act. ❖

Source: CMS PERL 200811-04

## Update to Medicare deductible, coinsurance and premium rates for 2009

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

### Provider types affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], Medicare administrative contractors (A/B MAC), durable medical equipment Medicare administrative contractors [DME MAC] and carriers) for services provided to Medicare beneficiaries.

### Impact on providers

This article is based on change request (CR) 6258, which provides the Medicare rates for deductible, coinsurance and premium payment amounts for calendar year (CY) 2009.

### 2009 Part A – hospital insurance

A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode. When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Please note that an individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during an illness episode. The 2009 deductible and coinsurance amounts are in the following table.

**Table 1 – 2009 Part A – hospital insurance**

Deductible	\$1,068.00		
Coinsurance	Hospital		Skilled nursing facility
	Days 61-90	Days 91-150 (lifetime reserve days)	Days 21-100
	\$267.00	\$534.00	\$133.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for health insurance (HI) benefits without a premium payment. In addition, the Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium.

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a two-year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2009 Part A premiums are listed in table 2.

**Table 2 – 2009 Part A premiums**

Voluntary enrollees Part A premium schedule	
Base premium (BP)	\$443.00 per month
Base premium with 10 percent surcharge	\$487.30 per month
Base premium with 45 percent reduction	\$244.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45 percent reduction and 10 percent surcharge	\$268.40 per month

### 2009 Part B – supplementary medical insurance

Under Part B, the supplementary medical insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2009, the standard premium for SMI services is \$96.40 a month; the deductible is \$135.00 a year; and the coinsurance is 20 percent. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 6258, which is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R56GI.pdf>.

**Update to Medicare deductible, coinsurance and premium rates for 2009 (continued)****Additional information**

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6258

Related Change Request (CR) Number: 6258

Related CR Release Date: November 17, 2008

Related CR Transmittal Number: R56GI

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-01, Transmittal 56, CR 6258

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**2008-2009 influenza season resources for health care professionals**

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

**Provider types affected**

All Medicare fee-for-service (FFS) physicians, nonphysician practitioners, providers, suppliers, and other health care professionals who bill Medicare for flu vaccines and vaccine administration provided to Medicare beneficiaries.

**Provider action needed**

- Keep this special edition *MLN Matters* article and refer to it throughout the 2008-2009 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff – Get the Flu Shot – Not the Flu!

**Introduction**

Historically the flu vaccine has been an underutilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

All adults 65 and older should get flu and pneumococcal immunizations. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu shot.

**Prevention is key to public health!**

While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff. Protect yourself, your patients, your staff, and your family and friends. Get Your Flu Shot – Not the Flu!

**Note:** The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

**Educational products for health care professionals**

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for flu vaccines and their administration.

**1. MLN Matters articles**

- MM6153: Influenza Vaccine and the Pneumococcal Vaccine Payment Allowances Based on 95 Percent of the Average Wholesale Price (AWP) on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6153.pdf>.

**2008-2009 Influenza season resources for health care professionals (continued)**

- MM6121: 2008 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6121.pdf>.
  - MM6079: Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6079.pdf>.
  - MM5511: Update to Medicare Claims Processing Manual, Chapter 18, Section 10 for Part B Influenza Billing on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf>.
  - MM4240: Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf>.
  - MM5037: Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf>.
- 2. MLN influenza related products for health care professionals**
- Quick Reference Information: Medicare Part B Immunization Billing – This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF on the CMS Web site at [http://www.cms.hhs.gov/MLNProducts/downloads/qr\\_immun\\_bill.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf).
  - The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Second Edition – This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file on the CMS Web site at [http://www.cms.hhs.gov/MLNProducts/downloads/mps\\_guide\\_web-061305.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf).
  - Medicare Preventive Services Adult Immunizations Brochure – This two-sided tri-fold brochure provides health care professionals with an overview of Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file on the CMS Web site at [http://www.cms.hhs.gov/MLNProducts/downloads/Adult\\_Immunization.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf).
  - Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course – This WBT course contains four modules that include information about Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. To register, free of charge, to take this course go to the MLN Products Web page <http://www.cms.hhs.gov/MLNProducts/> and select “Web-Based Training Modules” from Related Links Inside CMS at the bottom of the Web page.
  - Quick Reference Information: Medicare Preventive Services – This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare’s preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B vaccines. Available in print or as a downloadable PDF file on the CMS Web site at [http://www.cms.hhs.gov/MLNProducts/downloads/MPS\\_QuickReferenceChart\\_1.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf).
  - Medicare Preventive Services Bookmark – This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder for health care professionals of the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file on the CMS Web site at <http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf>.
  - MLN Preventive Services Educational Products Web Page – This *Medicare Learning Network (MLN)* Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This Web page is updated as new product information becomes available. Bookmark this page for easy access ([http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage)).

*2008-2009 Influenza season resources for health care professionals (continued)***3. Other CMS resources**

- CMS Adult Immunizations Web Page is on the CMS Web site at <http://www.cms.hhs.gov/AdultImmunizations/>.
- CMS Frequently Asked Questions are available on the CMS Web site at [http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std\\_alp.php?p\\_sid=I3ALEdhi](http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEdhi).
- *Medicare Benefit Policy Manual* - Chapter 15, Section 50.4.4.2 – Immunizations available on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf>.
- *Medicare Claims Processing Manual* – Chapter 18, Preventive and Screening Services available on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf>.
- Medicare Part B Drug Average Sales Price Payment Amounts Influenza and Pneumococcal Vaccines Pricing found on the CMS Web site at [http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01\\_overview.asp](http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp).

**4. Other resources**

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2008 – 2009 flu season:

- Advisory Committee on Immunization Practices are on the Internet at <http://www.cdc.gov/vaccines/recs/acip/default.htm>.
- American Lung Association's Influenza (Flu) Center is on the Internet at <http://www.lungusa.org>. This Web site provides a flu clinic locator on the Internet at <http://www.flucliniclocator.org>. Individuals may enter their ZIP code to find a flu clinic in their area. Providers may also obtain information on how to add their flu clinic to this site.

Other sites with helpful information include:

- Centers for Disease Control and Prevention – <http://www.cdc.gov/flu>
- Food and Drug Administration – <http://www.fda.gov/>

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*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.*

- Immunization Action Coalition – <http://www.immunize.org>
- Immunization: Supporting a Healthy Life Throughout the Lifespan – <http://www.nfid.org/pdf/publications/naiaw08.pdf>
- Indian Health Services – <http://www.ihs.gov/>
- Medicare Quality Improvement Community – <http://www.QualityNet.org/MedQIC>
- National Alliance for Hispanic Health – <http://www.hispanichealth.org/>
- The National Center for Immunization and Respiratory Diseases (NCIRD) – <http://www.cdc.gov/ncird/default.htm>
- National Foundation For Infectious Diseases – <http://www.nfid.org/influenza>
- National Library of Medicine and NIH Medline Plus – <http://www.nlm.nih.gov/medlineplus/immunization.html>
- National Network for Immunization Information – <http://www.immunizationinfo.org>
- National Vaccine Program – <http://www.hhs.gov/nvpo>
- Office of Disease Prevention and Promotion – <http://odphp.osophs.dhhs.gov>
- Partnership for Prevention – <http://www.prevent.org>
- World Health Organization – <http://www.who.int/en/ on the Internet.>

**Beneficiary information**

For information to share with your Medicare patients, please visit the Internet at <http://www.medicare.gov>.

MLN Matters Number: SE0838

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 SE0838

## New 2008 payment rates effective for dates of service beginning July 1, 2008

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], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries and paid under the Medicare physician fee schedule (MPFS).

### Provider action needed

#### STOP – impact to You

This article is based on change request (CR) 6212, which announces the new 2008 MPFS payment rates effective for dates of service July 1, 2008, through December 31, 2008. Please note that Medicare contractors have already implemented the actions annotated in this article.

#### CAUTION – what you need to know

The Centers for Medicare & Medicaid Services (CMS) directed Medicare contractors to revert back to the 0.5 percent payment rates that were previously in place until June 30, 2008, and to use those rates through December 31, 2008. In addition, carriers/Part B MACs are using the same rates as used for January 1 through June 30, 2008, to make payments, where appropriate, to ambulatory surgical centers (ASCs) for services rendered from July 1 through December 31, 2008. This reflects a continuation of the payment policy for brachytherapy services at carrier/Part B MAC-priced amounts and the prospective rates for other ASC services. CMS also provided revised fees for selected mental health codes that had an increase in their fee schedule amounts. The effective date for the increase for the mental health codes was for dates of service on and after July 1, 2008.

#### GO – what you need to do

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

### Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. The 10.6 percent MPFS that took effect on July 1, 2008, was changed back to the January-June 2008 rates, which reflect an update of 0.5 percent. CMS directed Medicare contractors to revert back to the 0.5 percent payment files that were previously in place until June 30, 2008. The new MPFS rates are retroactive to July 1, 2008.

Consistent with the new legislation, carriers/Part B MACs are using the same fees as used for January 1 through June 30, 2008, to make payments to ambulatory surgical centers (ASCs) for July 1 through December 31, 2008. Those fees reflect the continuation of the payment policy for brachytherapy services at carrier/Part B MAC-priced amounts and the prospective rates for other ASC services.

Fiscal intermediaries/Part A MACs also have reverted back to the fees that were in effect from January 1, 2008, through June 30, 2008.

In addition, based on the new legislation, CMS provided Medicare contractors with new revised fees for selected mental health codes that had an increase in their fee schedule amounts. The effective date for the increase for the mental health codes was for dates of service on and after July 1, 2008, and Medicare contractors are currently paying the new fees.

After Medicare contractors began paying claims at the new rates, they began to identify any MPFS claims that were paid at the -10.6 percent rate for dates of service on and after July 1, 2008. Contractors are in the process of automatically adjusting those claims, and must complete the adjustments no later than September 30, 2008.

There may be some claims that cannot be automatically adjusted. Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1, 2008, and later billed with a submitted charge at least at the level of the January 1 through June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount requires providers to contact their local contractor for direction on obtaining adjustments. Nonparticipating physicians who submitted unassigned claims at the reduced non-participation amount also will need to request an adjustment.

Contractors are following the normal process for transmitting the adjusted claims to supplemental insurers, where appropriate. Contractors disclosed the new MPFS rates on their Web sites by July 23, 2008.

### Additional information

The official instruction, CR 6212, issued to your carrier, 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/R389OTN.pdf>.

If you have questions, please contact your Medicare 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>.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6212

Related Change Request (CR) Number: 6212

Related CR Release Date: October 24, 2008

Related CR Transmittal Number: R389OTN

Effective Date: July 1, 2008

Implementation Date: October 24, 2008, unless otherwise noted below

Source: CMS Pub. 100-20, Transmittal 389, CR 6212

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## Influenza vaccine and the pneumococcal vaccine payment allowances based on 95 percent of the average wholesale price

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

### Provider types affected

Physicians and providers 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.

### Provider action needed

This article is based on change request (CR) 6153 which provides the updated payment allowances, effective as of September 1, 2008, for influenza and pneumococcal vaccines when payment is based on 95 percent of the average wholesale price (AWP).

### Background

The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year. The payment allowances for pneumococcal vaccines are updated on a quarterly basis. CR 6153 provides the payment allowances for the following influenza virus vaccines: *Current Procedural Terminology (CPT)* codes 90655, 90656, 90657, 90658, and 90660 as well as the pneumococcal vaccines (*CPT* codes 90732 and 90669) when payment is based on 95 percent of the average wholesale price (AWP).

Effective September 1, 2008, these Medicare Part B payment allowances for influenza vaccines are as follows:

CPT code	Allowance
90655	\$16.879
90656	\$18.198
90657	\$6.609
90658	\$13.218

*CPT* code 90660 (*FluMist, a nasal influenza vaccine*) may be covered if the local Medicare claims processing contractor determines its use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for *CPT* code 90660 is \$22.316 (effective September 1, 2008).

The Medicare Part B payment allowance for the pneumococcal vaccine *CPT* code 90732 is \$32.703, and for *CPT* code 90669 is \$78.803. These payment allowances

were published as a part of the July 2008 quarterly average sales price (ASP) drug pricing files, as specified in CR 6049. See <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6049.pdf> on the CMS Web site to view the article related to CR 6049.

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic, or federally qualified health center, in which cases, payments for the vaccines are based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Medicare Contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR 6153. However, they will adjust such claims that you bring to their attention.

### Additional information

The official instruction, CR 6153, 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/R1623CP.pdf>.

If you have questions, please contact your Medicare 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>.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6153

Related Change Request (CR) Number: 6153

Related CR Release Date: October 31, 2008

Related CR Transmittal Number: R1623CP

Effective Date: September 1, 2008

Implementation Date: No later than December 1, 2008

Source: CMS Pub. 100-04, Transmittal 1623, CR 6153

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## Notice of home health prospective payment system update

The Centers for Medicare & Medicaid Services (CMS) issued a notice to update the home health prospective payment system (HH PPS) for calendar year (CY) 2009. Medicare payments to home health agencies will increase by an estimated additional \$30 million next year as a result of a 2.9 percent increase in the annual market basket calculation of the cost of goods and services included in providing services under the HH PPS.

The update also accounts for a 2.75 percent reduction to the HH PPS rates (the second year of a four-year phased in reduction) to account for the changes in case-mix that are unrelated to patient's health status, and an updated 2009 wage index.

A copy of the notice (CMS-1555-N) is available on the CMS Web site at <http://www.cms.hhs.gov/center/hha.asp>. ❖

Source: CMS PERL 200810-32

## Annual update of Healthcare Common Procedure Coding System codes used for home health consolidated billing enforcement

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

### Provider types affected

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

### Provider action needed

#### STOP – impact to you

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

#### CAUTION – what you need to know

This article is based on change request (CR) 6262 which provides the annual HH consolidated billing update effective January 1, 2009.

#### GO – what you need to do

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

### Background

The Social Security Act (Section 1842(b)(6); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1842.htm](http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see [http://edocket.access.gpo.gov/cfr\\_2005/octqtr/42cfr409.100.htm](http://edocket.access.gpo.gov/cfr_2005/octqtr/42cfr409.100.htm) on the Internet and in the *Medicare Claims Processing Manual* (Chapter 10, Section 20.1), available on the CMS Web site at <http://www.cms.hhs.gov/manuals/IOM/list.asp>.

The home health consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as

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frequently as quarterly in order to reflect the creation of temporary HCPCS codes (i.e., “K” codes) throughout the calendar year.

The following HCPCS code is **added** to the home health consolidated billing supply code list, and it is a new code that **does not replace** any prior HCPCS code on the list:

A6545 Gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each

The following HCPCS code is **deleted** from the home health consolidated billing supply code list, and this code is being removed because it is noncovered by Medicare statute.

A6413 Adhesive bandage, first-aid type, any size, each

### Additional information

The official instruction, CR 6262, 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/R1633CP.pdf>.

If you have questions, please contact your Medicare 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>.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6262

Related Change Request (CR) Number: 6262

Related CR Release Date: November 7, 2008

Related CR Transmittal Number: R1633CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1633, CR 6262

## E-prescribing information on the Medicare summary notice

The Centers for Medicare & Medicaid Services (CMS) has directed Medicare contractors to begin including messages regarding electronic prescribing and new services for caregivers on all Medicare summary notices (MSNs) generated and sent to Medicare beneficiaries on or after October 14, 2008, through February 28, 2009. Specifically, the MSN messages include the following statements:

- Electronic prescribing can save you time at the pharmacy, reduce the chance of getting the wrong medication or dose, and save money. When you go to the doctor, ask “Do you e-Prescribe?”
- Caring for someone with Medicare? We know it’s not easy. Visit “Ask Medicare” at <http://www.medicare.gov/Caregivers/> for up-to-the-minute information, resources, and tips on making the most of Medicare.

You may find additional information on the e-prescribing initiative on the CMS Web site at <http://www.cms.hhs.gov/EPrescribing/> and [http://www.cms.hhs.gov/PQRI/03\\_EPrescribingIncentiveProgram.asp](http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp). ❖

Source: CMS PERL 200810-39

## CMS announces the Medicare contractor provider satisfaction survey to begin December 2008

The Centers for Medicare & Medicaid Services (CMS) has announced that data collection for the 2009 Medicare Contractor Provider Satisfaction Survey (MCPSS) will begin in December 2008 and conclude in April 2009. The purpose of the annual MCPSS is to objectively measure (through the collection and analysis of quantifiable data) provider satisfaction levels with regard to the performance of the fee-for-service (FFS) contractors responsible for the processing and payment of more than \$280 billion in Medicare claims each year. All fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, Medicare administrative contractors (MACs), and durable medical equipment (DME) MACs will be included in the national administration of this important survey.

### Goals of the Medicare contractor provider satisfaction survey

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

### Contractor performance rated on seven key business functions

Of the 1.2 million Medicare providers (physicians, health care practitioners, and facilities) who provide service for Medicare beneficiaries, approximately 30,000 will be invited to participate in the 2009 MCPSS; the goal is to obtain approximately 400 completed surveys per contractor sample. Those surveyed will be asked to rate their FFS contractor(s) using a scale of one to six on each of the business functions listed below, with "one" representing "not at all satisfied" and "six" representing "completely satisfied."

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

1. Provider outreach and education
2. Provider inquiries
3. Claim processing
4. Appeals
5. Medical review
6. Provider enrollment
7. Provider audit and reimbursement (for Part A providers).

### Provider participation essential to success of the Medicare contractor provider satisfaction survey

CMS uses the findings of the annual MCPSS as a benchmark for monitoring future trends and to improve the oversight of contractor performance as well as the efficiency of Medicare program administration. Providers chosen to participate in the MCPSS also represent other organizations similar in size, practice type, and geographical location; therefore, the views of every respondent are critical to the success of this important study.

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

### How to obtain additional information and the Medicare contractor provider satisfaction survey updates

Data collection reports and study updates will be available beginning January 16, 2009, and the final results of the 2009 MCPSS will be accessible via an online reporting system in July of 2009. For further information about the survey, please visit the MCPSS Web page at <http://www.cms.hhs.gov/MCPSS/>.

The MCPSS home study page may be accessed at <https://www.mcpsstudy.org/>. ❖

Source: CMS JSM 09015, October 10, 2008

## Call for public comment to CMS on preliminary imaging efficiency measures

The Centers for Medicare & Medicaid Services (CMS) through The Lewin Group and its subcontractors, the National Imaging Associates Inc., (NIA) and Dobson/DaVanzo & Associates, LLC, is developing a preliminary set of outpatient imaging efficiency measures.

CMS would like to invite you to review and comment on these measures during the 30-day public comment period that begins on November 15, 2008, and will run through December 14, 2008. Please note that while the team will make every effort to consider and incorporate all comments, CMS will be making any and all determinations on the final measure set, including if or how they will be used in CMS program activities.

To review the measures and submit comments, please go to <http://www.imagingmeasures.com>.

CMS would also like to encourage you to forward this message and link to any colleagues or organizations you believe would be interested in reviewing and commenting on the measures.

Thank you in advance for your interest and contributions as CMS works to improve this preliminary measure set.

CMS is looking forward to hearing from you. ❖

Source: CMS PERL 200811-22

## Flu shot reminder

The flu season is here. The following are some of the many reasons Medicare patients give for not getting their annual flu shot:

- It causes the flu
- I don't need it
- It has side effects
- It's not effective
- I didn't think about it
- I don't like needles

Every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting an annual flu shot. Also, don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends.

### Get the flu shot, not the flu.

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

For information about Medicare's coverage of the 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 at [http://www.cms.hhs.gov/MLNProducts/Downloads/flu\\_products.pdf](http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf).

To download the Medicare Part B immunization billing quick reference chart, go to the CMS Web site [http://www.cms.hhs.gov/MLNProducts/downloads/qr\\_immun\\_bill.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf).

A copy of this chart can be ordered, free of charge, by going to the MLN Products Web page and clicking on MLN Product Ordering Page in the "Related Links Inside" CMS section of the Web page.

Visit the Medicare Learning Network – it's free! ❖

Source: CMS PERL 200811-05

## Gustav and Ike waivers expire

In September 2008, the Centers for Medicare & Medicaid Services (CMS) issued guidance that discussed the statutory requirement under the Medicare skilled nursing facility (SNF) benefit for a three-day prior hospital stay and the inability of beneficiaries, who were evacuated or transferred as a result of Hurricanes Gustav and Ike, to meet this requirement. This guidance provided temporary emergency coverage of SNF services that are not post-hospital SNF services under our authority in Section 1812(f) of the Social Security Act (the Act), for those beneficiaries who are evacuated, transferred, or otherwise dislocated as a result of the hurricanes.

In addition, for beneficiaries who (prior to the hurricanes) had been recently discharged from an SNF after utilizing some or all of their available SNF benefits, this guidance addressed the inability to meet the requirement to end an existing Medicare benefit period (or "spell of illness") before renewing SNF benefits.

Under the authority of Section 1812(f) of the Act, this policy enabled such beneficiaries to receive up to an additional 100 days of SNF Part A benefits for care needed as a result of the hurricanes, without first having to end a spell of illness by being discharged to custodial or noninstitutional care for a 60-day period.

Unlike the general waivers issued in response to the hurricanes under the authority of Section 1135 of the Act, these two SNF-related policies were not limited to states

designated as emergency areas. Rather, they would apply to all beneficiaries who were evacuated from an emergency area as a result of the hurricanes, regardless of where the "host" SNF providing post-hurricane care was located. In addition, these two SNF-related policies would remain in effect until such time as CMS issued a notification that normal procedures would resume.

We hereby announce the termination of these SNF-related policies concurrently with the 90-day expiration of the public health emergencies (PHEs) declared for Hurricanes Gustav and Ike. The waivers and modifications granted under the Section 1135 waiver authority also terminate concurrently with the expiration of the PHEs.

The expiration dates for the PHEs are shown below. Accordingly, effective with SNF admissions occurring on or after the termination dates listed below, the Internet-Only Manual instructions for determining compliance with the SNF benefit's prior hospitalization and benefit period requirements shall apply.

Finally, all program policies and questions and answers that implemented modifications to program requirements under the Section 1135 waiver authority for Hurricanes Gustav and Ike are no longer applicable on and after the dates stated below. Therefore, claims with dates of service on or after the termination dates cited below will follow all normal program requirements.

Hurricane(s)	State(s)	Section 1812(f)/1135 Waiver Termination Dates
Gustav	Mississippi, Alabama	November 29, 2008
Gustav and Ike	Texas	December 10, 2008
Gustav and Ike	Louisiana	December 12, 2008

Source: CMS PERL 200811-25

## Use of compendia as the authoritative sources for medically accepted indication

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

### Provider types affected

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

### Provider action needed

This article is based on change request (CR) 6191 which updates the list of compendia recognized as authoritative sources of information for the determination of drugs and biologicals used off-label in anti-cancer chemotherapeutic regimens.

### CAUTION – what you need to know

The Centers for Medicare & Medicaid Services (CMS) is recognizing the following as authoritative compendia and listing them in the *Medicare Benefit Policy Manual* (Chapter 15, Section 50.4.5) for use in the determination of a “medically-accepted indication” of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service-Drug Information (AHFS-DI), (existing)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (effective June 5, 2008)
- Thomson Micromedex DrugDex, (effective June 10, 2008)
- Clinical Pharmacology (effective July 2, 2008).

### GO – what you need to do

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

### Background

In the past, the following three compendia were recognized as authoritative sources for use in the determination of a “medically-accepted indication” of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen (unless the Secretary of the Department of Health & Human Services determined that the use was not medically appropriate or the use was identified as not indicated in one or more such compendia):

1. American Medical Association Drug Evaluations (AMA-DE)
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication
3. American Hospital Formulary Service-Drug Information (AHFS-DI).

Because the AMA-DE and the USP-DI are no longer published (due to changes in the pharmaceutical reference industry), the AHFS-DI became the only remaining statutorily-named compendia available for the CMS to use

as a reference. Consequently, CMS received requests from the stakeholder community for a process to revise the list of recognized authoritative compendia.

In the Medicare physician fee schedule final rule for calendar year 2008, CMS established:

1. A process for revising the list of compendia. (Section 1861(t)(2) of the Social Security Act; [[http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm)].
2. A definition for “compendium.” (72 FR 66222 [<http://edocket.access.gpo.gov/2007/07-5506.htm>], 72 FR 66303-66306 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiapreamble.pdf>], and 72 FR 66404 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf>].

A compendium is defined “as a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment.” (42 CFR 414.930(a) [<http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf>].

In addition, a compendium:

1. Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases.
2. Is indexed by drug or biological. (42 CFR 414.930(a) [<http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf>], 72 FR 66222 [<http://edocket.access.gpo.gov/2007/07-5506.htm>], and 72 FR 66404 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf>].

During a public meeting on March 30, 2006, the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) generated a list of desirable characteristics to use when reviewing a compendium. Subsequently, the MedCAC advised CMS of their findings and recommendations regarding the desirable characteristics of compendia for use in the determination of medically-accepted indications of drugs and biologicals in anti-cancer therapy.

After CMS conducted a review of specific compendia and compared their characteristics with the MedCAC list of desirable characteristics, CMS determined the following are recognized as authoritative compendia and is listing them in the *Medicare Benefit Policy Manual* (Chapter 15, Section 50.4.5) for use in the determination of a “medically-accepted indication” of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service - Drug Information (AHFS-DI)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Thomson Micromedex DrugDex

*Use of compendia as the authoritative sources for medically accepted indication (continued)*

- Clinical Pharmacology.

The above listed compendia employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium. In general, a use is identified by a compendium as medically accepted if the:

- Indication is a category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or,
- Narrative text in AHFS-DI or Clinical Pharmacology is supportive.

A use is not medically accepted by a compendium if the:

- Indication is a Category 3 in NCCN or a Class III in DrugDex; or,
- Narrative text in AHFS or Clinical Pharmacology is “not supportive.”

The complete absence of narrative text on a use is considered neither supportive nor nonsupportive.

Medicare contractors may also identify off-label uses that are supported by clinical research under the conditions identified in Section 50.4.5 of the *Medicare Benefits Policy Manual*, as amended by CR 6191. Peer-reviewed medical literature may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.

In-house publications of entities whose business relates to the manufacture, sale, or distribution of pharmaceutical products are excluded from consideration. Abstracts (including meeting abstracts) are excluded from consideration.

In determining whether an off-label use is supported, Medicare contractors will evaluate the evidence in published, peer-reviewed medical literature listed in the revised Section 50.4.5.C, which is attached to CR 6191. When evaluating this literature, Medicare contractors will consider (among other things) the following:

- Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
- Whether the administered chemotherapy regimen is adequately represented in the published evidence.
- Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
- Whether the study is appropriate to address the clinical question.

**Additional information**

The official instruction, CR 6191, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R96BP.pdf>.

The revised sections of the *Medicare Benefit Policy Manual* are attached to CR 6191.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

*MLN Matters* Number: MM6191

Related Change Request (CR) Number: 6191

Related CR Release Date: October 24, 2008

Related CR Transmittal Number: R96BP

Effective Date: June 5, June 10, and July 2, 2008 (see article)

Implementation Date: November 25, 2008

Source: CMS Pub. 100-02, Transmittal 96, CR 6191

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## Preparing for a transition from a fiscal intermediary/carrier to a Medicare administrative contractor

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

### Provider types affected

This article is relevant to all fee-for-service (FFS) physicians, providers, and suppliers that submit claims to fiscal intermediaries (FIs), carriers or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries. Providers already billing Medicare administrative contractors (MACs) have already transitioned and need not review this article.

### Impact on providers

This article is intended to assist all providers that will be affected by Medicare administrative contractor (MAC) implementations. The Centers for Medicare & Medicaid Services (CMS) is providing this information to make you aware of what to expect as your FI or carrier transitions its work to a MAC. Knowing what to expect and preparing as outlined in this article will minimize disruption in your Medicare business.

### Background

Medicare Contracting Reform (or section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B FFS programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new Medicare administrative contractor authority. Medicare Contracting Reform requires that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by FIs and carriers in administering the Medicare FFS program.

When completed, there will be 15 new MACs processing Part A and Part B claims. Each MAC will handle roughly the same volume of work. Because of this, the MACs will vary in geographic size but not necessarily in the amount of work they handle. This should result in greater consistency in the interpretation of Medicare policies.

### MAC implementation milestones definitions

There are specific milestones in the cutover from carrier or FI work to MAC. In this article, providers are advised to be aware of, and to take specific action, relative to the milestones defined below:

**Award** – this is the point at which a MAC is announced as having won the contract for specific FI or carrier work.

**Cutover** – This is the date on which carrier or FI work ceases and MAC work begins. Cutover is often done in phases by State-level jurisdictions.

### Pre-award

If you are in a jurisdiction where a new MAC has not yet been awarded, you can remain current with updates on Medicare contracting reform by visiting the CMS Web site <http://www.cms.hhs.gov/medicarecontractingreform/>.

### Post-award

Once the award to the MAC is made, you should immediately begin to prepare for the cutover. The following are recommendations to help you in this effort:

- **Pay attention** to the mail you receive from your outgoing Medicare contractor and your new MAC – you will be receiving letters and listserv messages about the cutover from both. These letters should include discussions on what, if any, impact the cutover will have on your payment schedule, issuance of checks, impact on paper and electronic claims processing, electronic fund transfers, etc.
- **Sign up for your new MAC's listserv.** While in many cases the list of providers that were in the jurisdiction of the outgoing Medicare contractor will be shared with the incoming MAC that may not always be the case. Getting on the MAC listserv distribution will ensure that you receive news as it happens concerning the implementation.
- **Access and bookmark the MAC's Web site and visit it regularly.** The MAC will have a new Web site that will have general information, news and updates, information on the MAC's requirements of providers, copies of newsletters and information on meetings and conference calls that are being conducted by the MAC.
- **Review the frequently-asked questions (FAQs) on the MAC's Web site.**
- **Participate in the MAC's advisory groups and "Ask the Contractor" meetings.** Every MAC will be conducting conference calls to give providers the opportunity to ask questions and have open discussion. Take advantage of the opportunity to communicate with the new MAC.
- **Review the MAC's local coverage determinations (LCDs)** as they may be different from the outgoing contractor LCDs. The MAC must provide education on LCDs. Providers should monitor MAC communications and Web site for information regarding potential changes to the LCDs.

### One Month Prior to Cutover

- **Complete and return your electronic funds transfer (EFT) agreements.** CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC. (If your new MAC is the same entity as your current FI/carrier, then a new EFT agreement is not needed.) This form is a legal agreement between you and the MAC that allows funds to be deposited into your bank account. It is critical for the MAC to receive these forms before any payments are issued. Complete the CMS-588 and get it to the MAC to ensure that there is no delay or disruption in payment. We encourage you to do this no later than 60 days prior to cutover. Contact your MAC with any questions concerning the agreement.
- The CMS-588 form can be found on the CMS Web site at <http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf>.

*Preparing for a transition from a fiscal intermediary/carrier to a Medicare administrative contractor (continued)*

- You are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, you will need to note the mailing address for the form, which is available on the MAC's Web site. Your contractor may also provide instructions on its Web site on accurately completing the form.
- Your new MAC may also request you to execute a new Electronic Data Interchange (EDI) Trading Partner Agreement as well. If so, be sure to complete that agreement timely. Some helpful information on such agreements is available on the CMS Web site at <http://www.cms.hhs.gov/EducationMaterials/downloads/TradingPartner-8.pdf>.
- Some (not all) MAC contractors may assign you a new EDI submitter/receiver and logon IDs as the cutover date approaches. Review your mailings from the MAC and/or their Web site for information about assignment of new IDs and whether you have to do anything to get those IDs. The MAC EDI staff will send these Submitter IDs and passwords to you in hardcopy or electronically. You don't need to do anything to get the new IDs, however, if you do receive a new ID and password, CMS strongly suggests that you contact the incoming MAC to test these IDs. Since there may be a different EDI platform, it is critical to consider testing to minimize any disruption to your business at cutover.
- Contact your claims processing vendor and clearinghouse to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. Ask your vendor, "Are you using the new contractor number or ID of the new MAC, submitter number and logon ID?" "Have you tested with the MAC?"
- Because the contractor number is changing, your EDI submissions need to reflect the new MAC number at cutover.
- Be aware that some MACs may offer participation in an "early boarding" process for electronic claims submission and/or electronic remittance advice (ERA). This will enable submitters the ability to convert to the new MAC prior to cutover. If you are currently receiving ERAs, you will continue to do so after cutover. As mentioned previously, some MACs may assign a new submitter/receiver ID and password – watch for and document them for use after cutover to the MAC.

**Cutover weekend**

- Be aware that in certain situations, CMS will have the outgoing Medicare contractor release claims payments a few days early in preparation for implementation weekend. Providers will be notified prior to the cutover date if they will receive such payments. While the net payments are the same, providers will experience increased total payments followed by no payments for a two-week period.
- Be aware that providers may also experience system "dark days" around cutover weekends. Providers will be notified by the MAC or outgoing contractor if a dark

day(s) is planned for the MAC implementation. During a dark day, the Part A provider will have limited EDI processing and no access to the fiscal intermediary standard system (FISS) to conduct claim entry or claim correction, verify beneficiary eligibility and claim status. Those providers who currently bill carriers may also experience some limited access to certain functions, such as beneficiary eligibility and claims status on dark days.

- Be aware that some interactive voice response (IVR) functionality may also be unavailable during a dark day.

**Post-cutover**

- The first one-two weeks may be extremely busy at the MAC. The outgoing Medicare contractor will have the "in-process" work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.
- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll free number for use.
- Be prepared that you may experience longer than normal wait times for customer service representatives and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC's staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.
- **Learn how to use the MAC's IVR.** The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If users are unfamiliar and resort to calling the contact center representative (CSR) line, the result is a spike in volume of calls to (CSRs) that are difficult to accommodate.
- Check the MAC's outreach and education event schedule on the MAC's and outgoing contractor's Web sites. It is recommended that you have staff attend some of the education courses that may be offered by the MAC.
- Be aware that there may be changes in faxing policies (e.g., for medical records).
- Be aware that you may experience changes in remittance advice (RA) coding. While the combination of codes used on the remittance advice (RA) is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

**CMS post-cutover monitoring**

Post-cutover is the CMS-designated period of time beginning with the MAC's operational date. During the post-cutover period, CMS will monitor the MAC's operations and performance closely to ensure the timely and correct processing of the workload that was transferred.

*Preparing for a transition from a fiscal intermediary/carrier to a Medicare administrative contractor (continued)*

The post-cutover period is generally three months, but it may vary in length depending on the progress of the implementation.

**Additional Assistance**

There are three attachments at the end of this article to assist you in keeping informed of the progress of the cutover as well as documenting important information:

- Attachment A is a summary of what you need to do and information you will need.
- Attachment B may be used to track communications offered by the MAC, such as training classes and conferences, and your staff participation.
- Attachment C may be used to assist you in tracking major MAC milestones.

**Additional information**

The following *MLN Matters* article provides additional information about the MAC implementation process:

- MM5979: “Assignment of Providers to Medicare Administrative Contractors” located on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5979.pdf>.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

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**Attachment A**

**Timeline and checklist for preparing for MAC implementation**

Checklist item	Input
Scheduled Award Date:	
Actual Award Date:	
MAC Contractor:	
MAC Contractor Number:	
MAC Mailing Address:	
MAC Scheduled Dark Days:	
MAC Web site:	
MAC Contact Center Number:	1-800-
MAC EDI Mailing Address:	

**90 days before cutover**

1. Visit MAC Web site and bookmark for future use
2. Join the MAC Listserv
3. **Monitor:**
  - LCDs Published by the new MAC; compare current LCD’s that affect your practice’s services.
4. Review:
  - Provider enrollment status for all providers, update as needed.
  - Pay-to address information for practice/providers, update as needed.
5. Contact:
  1. Your practice management/billing software vendor to determine if your system will be able to send and receive data to/from the new MAC.
  2. Claims Clearinghouse (if used) to confirm they are or will be able to send and receive data to/from the new MAC.

**75 days before cutover**

1. Continue to check the MAC’s Web site and/or Listserv for outreach programs, educational and informational events, and conference calls.

*Preparing for a transition from a fiscal intermediary/carrier to a Medicare administrative contractor (continued)*

2. Check your state’s Medical Society or local provider organization Web site for MAC transition information, MAC Coordinators.

**60 days before cutover**

1. If needed, submit CMS Form 588 – EDI form(s) to the new MAC.
2. Consider registering for Electronic Remittance Advice (ERA) enrollment, if you are not already enrolled.
3. Download or request a sample Remittance Advice (RA). RA codes are standard but use of codes may vary across contractors.

**45 days before cutover**

1. Monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. Begin staff training on the MAC transition, covering locations, LCDs, telephone and fax numbers and other changes.
3. Verify readiness of software vendor, clearinghouse(s) and other trading partners.

**30 days before cutover**

1. Continue to monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. New EDI Submitter ID number and password should be received.
3. New ERA enrollment confirmation should be received.

4. Submit test electronic claims.
5. Address and resolve any electronic claim issues within 10 business days.
6. Begin daily monitoring of e-mail from the MAC Listserv.

**15 days before cutover**

1. Continue to monitor current carrier/FI claim submissions.
2. Verify EDI and ERA connections are operational.
3. Collect and record all MAC telephone and fax numbers for: General Inquiry Customer Service, Provider Enrollment, Provider Relations, EDI and ERA.
4. Place test calls and become familiar with the MAC IVR query system.
5. Continue daily monitoring of the MAC listserv.

**10 days before cutover**

1. Address any existing open items.
2. Continue daily monitoring of the MAC listserv.

**5-10 days after cutover**

1. Begin submitting claims to the new MAC.
2. Continue daily monitoring of the MAC listserv.
3. Monitor and follow up on the MAC Open Item list.

**30 days after cutover**

1. Electronic payments should be arriving by now.
2. Payments for paper claims may be arriving by now.

**Attachment B**

**Schedule of MAC contractor training classes**

Scheduled date	Title of class	Attendee(s)

**Schedule of MAC conferences**

Scheduled date	Conference subject	Attendee(s)

## Attachment C

### Important MAC implementation dates

Event	Date
MAC dark days	
Cutoff date for claims submissions	
Last date for outgoing contractor will make payment	
Last date outgoing contractor will have telephone/customer service	
Last day outgoing contractor will send file to bank	
Date MAC will accept electronic claims	
Date MAC will accept paper claims	
Date bill/claim cycle begins	
First anticipated MAC payment date	
Date MAC begins customer service	

## Fee schedule update for 2009 for durable medical equipment, prosthetics, orthotics, and supplies

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

### Provider types affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 6270 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). Be sure your billing staffs are aware of these changes.

### Background

The update process for the DMEPOS fee schedule is contained in section 60, Chapter 23 of the *Medicare Claims Processing Manual*, which is located on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>.

Other information on the fee schedule, including access to the DMEPOS fee schedules is at [http://www.cms.hhs.gov/DMEPOSFeeSched/01\\_overview.asp](http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp) on the CMS Web site. The key points of CR 6270 are as follows:

- For gap-filling purposes, the 2008 deflation factors by payment category are:
  - 0.500 for oxygen
  - 0.504 for capped rental
  - 0.505 for prosthetics and orthotics
  - 0.641 for surgical dressings
  - 0.697 for parental and enteral nutrition
- The fee schedule amounts for HCPCS code K0672 (Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each) are added to the fee schedule file on January 1, 2009, and are effective for claims submitted with dates of service on or after January 1, 2009.
- HCPCS code E2295 (Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features) is added to the HCPCS file on January 1, 2009. Due to low claims volumes expected, your Medicare contractor will establish local fee schedule amounts to pay claims for E2295.
- Fee schedule amounts for L3905, L3806, and L3808 were revised in the July 2008 quarterly update. However, CMS has determined that the gap-filled fees originally established for these three codes were correct and the fee amounts will revert back to what was in place prior to the July update. Claims already processed for dates of service on or after July 1, 2008, through December 31, 2008, will not be adjusted.

- The following codes are being deleted from the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2009, and are therefore being removed from the DMEPOS fee schedule files:

L5993   L5994   L5995   L7611   L7612  
L7613   L7614   L7621   L7622

*Fee schedule update for 2009 for durable medical equipment, prosthetics, orthotics, and supplies (continued)***2009 fee schedule updates following the enactment of the Medicare Improvements for Patients and Providers Act**

- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandates a fee schedule covered item update of 9.5 percent for 2009 for items included in round one of the DMEPOS Competitive Bidding program. The reduction applies to items furnished on or after January 1, 2009, in any geographical area.
- Items selected for competitive bidding in 2008 will receive a 9.5 percent update for 2009 with the exception of HCPCS codes E1392, K0738, E0441, E0442, E0443 and E0444. These six oxygen generating portable equipment (OGPE) and oxygen contents codes will receive a zero percent update for 2009 as the fees for these items are not adjusted by the covered item update specified in 1834(a)(14), and are not reduced by the 9.5 percent, even though they are competitive bid items.
- Noncompetitive bid items will receive a 5.0 percent covered item update for 2009.

**New modifier KE and modifier KL**

A new HCPCS modifier was added to the HCPCS on January 1, 2009, and is effective for claims with dates of service on or after January 1, 2009. The new modifier is KE (Bid under round one of the DMEPOS Competitive Bidding program for use with noncompetitive bid base equipment).

To accommodate the fee schedule updates required per the MIPPA, CMS is adding modifier KE to the fee schedule for all power mobility device (PMD) accessory items selected for competitive bidding in 2008 as part of this update. Modifier KE is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and noncompetitive bidding product categories. For example, HCPCS code E0981 (Wheelchair accessory, seat upholstery, replacement only, each) may be used with both competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with noncompetitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898).

All fee schedules for PMD accessory codes with modifier KE will receive a five percent covered item update for 2009, whereas the fee schedules for the PMD accessory codes without modifier KE will receive the MIPPA-required 9.5 percent reduction for 2009. Suppliers need to know that if a competitively bid PMD accessory code is used with a competitively bid standard PMD base code (K0813 thru K0829) or complex rehabilitative PMD base code (K0835 thru K0864), claims for the PMD accessory code should be submitted without modifier KE. If such claims are submitted with modifier KE, they will be rejected with message M78 (Missing/incomplete/invalid HCPCS modifier) and 125 (Submission/billing error (s)).

Suppliers should bill the accessory code with modifier KE when the accessory is used in conjunction with a noncompetitively bid manual wheelchair (K0001 through K0009) or a miscellaneous PMD (K0898). In the case

of the complex rehabilitative only PMD accessory code E2373 KC, suppliers should bill for the replacement only of E2373 without modifier KE, but with modifier KC when the accessory is used with a competitively bid complex rehabilitative PMD base code (K0835 thru K0864). When the replacement only code E2373 is used with a noncompetitively bid manual or miscellaneous wheelchair, suppliers should bill code E2373 without modifier KC, but with modifier KE.

For the aforementioned reasons, CMS is also adding modifier KE to the fee schedule for the following competitively bid HCPCS codes: A4636, A4637, A7000, and E0776. If codes A4636 and A4637 are used in conjunction with a competitively bid walker code (E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, and E0149), claims for the replacement handgrip (A4636) or tip (A4637) should be submitted without modifier KE. Suppliers should bill codes A4636 and A4637 with modifier KE when the codes are used with non-competitively bid cane or crutch codes. Likewise, suppliers should bill the disposable canister code A7000 without modifier KE when this code is used in conjunction with the competitively bid negative pressure wound therapy pump code E2402. When code A7000 is used with a noncompetitively bid respiratory or gastric suction pump, suppliers should bill code A7000 with the KE modifier. Similarly when an IV pole (E0776) is used in conjunction with competitively bid enteral nutrient codes (B4149, B4150, and B4152 thru B4155), suppliers should bill code E0776 with modifier BA, but without modifier KE. When code E0776 is used with noncompetitively bid parenteral nutrient codes, suppliers should bill code E0776 without modifier BA, but with modifier KE.

Further instruction on the use of modifier KE with codes competitively bid in 2008 is available in Attachment B of CR 6270, which is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf>.

**Note:** Suppliers should not use modifier KE on any claims for payment for items that were included under Round 1 such as an accessory for a standard power wheelchair.

With CR 6270, CMS is also adding modifier KL to the fee schedule for the following diabetic supply HCPCS codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259. As indicated in CR 5641 (July Quarterly Update for 2007 DMEPOS Fee Schedule, discussed in *MLN Matters* article MM5641 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5641.pdf>), suppliers began using modifier KL as an informational modifier to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258 and A4259) furnished via mail order on or after July 1, 2007. Effective January 1, 2009, modifier KL has been changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers must use modifier KL on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. Modifier KL is not used with diabetic supply codes that are not delivered to the beneficiary's residence and are obtained from local supplier storefronts.

*Fee schedule update for 2009 for durable medical equipment, prosthetics, orthotics, and supplies (continued)*

**Note:** Inappropriate use of a competitive bidding modifier on a competitive bidding claim is in violation of the law and may lead to claims denial and/or other corrective actions. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

**Competitive bidding items from 2008 impacted by 2009 pricing**

The following product lists of the HCPCS codes that were selected for competitive bidding in 2008 are subject to the 9.5 percent covered item update for 2009. The detailed descriptions of the listed HCPCS codes (for product categories 1-10) are not repeated in this article, but are available in attachment A of CR 6270, which is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf>.

**Product category 1** – Oxygen, supplies and equipment (for the detailed product description of each HCPCS code see attachment A)

E1390	E1391	E0424	E0439	E0431
E0434	A4608	A4615	A4616	A4617
A4620	E0560	E0580	E1353	E1355

As part of this update, CMS is implementing the 2009 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2009. CMS is revising the fee schedule file to include the new national 2009 monthly payment rate of \$175.79 for stationary oxygen equipment. This revised 2009 monthly payment rate of \$175.79 is reduced by 11.8 percent from the 2008 monthly payment rate. This reduction includes the 9.5 percent covered item reduction ascribed to items selected for competitive bidding in 2008 as required by section 154(a)(2)(A) of MIPPA and the 2.53 percent budget neutrality reduction as required by section 1834(a)(9)(D)(ii) of the Social Security Act and discussed in a final rule published in the *Federal Register* on November 9, 2006. The previously announced payment amount for 2009 of \$193.21 did not include the 9.5 percent reduction and assumed a higher shift to oxygen generating portable equipment (OGPE).

As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

**Product category 2** – Standard power wheelchairs, scooters, and related accessories (for the detailed product description of each HCPCS code see Attachment A)

E0950	E0951	E0952	E0955	E0956
E0957	E0960	E0973	E0978	E0981
E0982	E0990	E0995	E1016	E1020
E1028	E2208	E2209	E2210	E2361
E2363	E2365	E2366	E2367	E2368
E2369	E2370	E2371	E2381	E2382
E2383	E2384	E2385	E2386	E2387

E2388	E2389	E2390	E2391	E2392
E2394	E2395	E2396	E2601	E2602
E2603	E2604	E2605	E2606	E2607
E2608	E2611	E2612	E2613	E2614
E2615	E2616	E2619	E2620	E2621
K0015	K0017	K0018	K0019	K0020
K0037	K0038	K0039	K0040	K0041
K0042	K0043	K0044	K0045	K0046
K0047	K0050	K0051	K0052	K0053
K0098	K0195	K0733	K0734	K0735
K0736	K0737	K0800	K0801	K0802
K0806	K0807	K0808	K0813	K0814
K0815	K0816	K0820	K0821	K0822
K0823	K0824	K0825	K0826	K0827
K0828	K0829			

**Product category 3** – Complex rehabilitative power wheelchairs and related accessories (for the detailed product description of each HCPCS code see Attachment A)

E0950	E0951	E0952	E0955	E0956
E0957	E0960	E0973	E0978	E0981
E0982	E0990	E0995	E1002	E1003
E1004	E1005	E1006	E1007	E1008
E1010	E1016	E1020	E1028	E1029
E1030	E2208	E2209	E2210	E2310
E2311	E2321	E2322	E2323	E2324
E2325	E2326	E2327	E2328	E2329
E2330	E2351	E2361	E2363	E2365
E2366	E2367	E2368	E2369	E2370
E2371	E2373 KC	E2374	E2375	E2376
E2377	E2381	E2382	E2383	E2384
E2385	E2386	E2387	E2388	E2389
E2390	E2391	E2392	E2394	E2395
E2396	E2601	E2602	E2603	E2604
E2605	E2606	E2607	E2608	E2611
E2612	E2613	E2614	E2615	E2616
E2619	E2620	E2621	K0015	K0017
K0018	K0019	K0020	K0037	K0038
K0039	K0040	K0041	K0042	K0043
K0044	K0045	K0046	K0047	K0050
K0051	K0052	K0053	K0098	K0195
K0733	K0734	K0735	K0736	K0737
K0835	K0836	K0837	K0838	K0839
K0840	K0841	K0842	K0843	K0848
K0849	K0850	K0851	K0852	K0853
K0854	K0855	K0856	K0857	K0858
K0859	K0860	K0861	K0862	K0863
K0864				

**Product category 4** – Mail-order diabetic supplies (for the detailed product description of each HCPCS code see Attachment A)

A4233 KL	A4234 KL	A4235 KL	A4236 KL
A4253 KL	A4256 KL	A4258 KL	A4259 KL

**Product category 5** – Enteral nutrients, equipment, and supplies (for the detailed product description of each HCPCS code see Attachment A)

B4034	B4035	B4036	B4081	B4082
B4083	B4087	B4088	B4149	B4150
B4152	B4153	B4154	B4155	B9000
B9002	E0776			

**Fee schedule update for 2009 for durable medical equipment, prosthetics, orthotics, and supplies (continued)**

**Product category 6** – Continuous positive airway pressure devices, respiratory assist devices, and related supplies and accessories (for the detailed product description of each HCPCS code see Attachment A)

A4604	A7030	A7031	A7032	A7033
A7034	A7035	A7036	A7037	A7038
A7039	A7044	A7045	A7046	E0470
E0471	E0472	E0561	E0562	E0601

**Product category 7** – Hospital beds and related supplies (for the detailed product description of each HCPCS code see Attachment A)

E0250	E0251	E0255	E0256	E0260
E0261	E0265	E0266	E0271	E0272
E0280	E0290	E0291	E0292	E0293
E0294	E0295	E0296	E0297	E0300
E0301	E0302	E0303	E0304	E0305
E0310	E0316	E0910	E0911	E0912
E0940				

**Product category 8** – Negative pressure wound therapy pumps and related supplies and accessories (for the detailed product description of each HCPCS code see Attachment A)

A6550	A7000	E2402
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**Product category 9** – Walkers and related supplies (for the detailed product description of each HCPCS code see Attachment A)

A4636	A4637	E0130	E0135	E0140
E0141	E0143	E0144	E0147	E0148
E0149	E0154	E0155	E0156	E0157
E0158	E0159			

**Product category 10** – Support surfaces (for the detailed product description of each HCPCS code see Attachment A)

E0193	E0277	E0371	E0372	E0373
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#### **Billing instructions for power wheelchair harness (HCPCS code E2313)**

The April quarterly update for the 2007 DMEPOS fee schedule included instructions for suppliers to submit claims for the electronics necessary to upgrade from a nonexpandable controller to an expandable controller at initial issue using HCPCS code E2399. This instruction was intended as a temporary measure until a new code could be added to describe the electronics/cables/junction boxes used when upgrading from a non-expandable controller at initial issue.

- HCPCS code E2313 (Power wheelchair accessory, harness for upgrade to expandable controller, including

all fasteners, connectors and mounting hardware, each) was added to the HCPCS effective January 1, 2008, for use in paying claims for the electronics furnished when upgrading from a non-expandable controller at initial issue.

- Suppliers may submit claims for the electronics provided at initial issue using HCPCS code E2313 for dates of service on or after January 1, 2008, and must no longer use code E2399 for submission of such items.
- Claims submitted for the electronics necessary to upgrade from a non-expandable controller to an expandable controller using HCPCS code E2399 are invalid and will be denied as contractor/supplier responsibility. When such claims are denied, CMS will use message codes of M20 (Missing/incomplete/invalid HCPCS), 189 (Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.), N211 (Alert: You may not appeal this decision.), and MA13 (You may be subject to penalties if you bill the patient for amount not reported with the PR (patient responsibility) group code.). These denials are made as CO-contractual obligation denials.

#### **Additional information**

For complete details regarding this CR please see the official instruction (CR 6270) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf>.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6270

Related Change Request (CR) Number: 6270

Related CR Release Date: November 7, 2008

Related CR Transmittal Number: R1630CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1630, CR 6270

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.

Fee schedule update for 2009 for durable medical equipment, prosthetics, orthotics, and supplies (continued)

2009 DMEPOS fee schedule

HCPCS Code	Fee
A4561	\$21.62
A4562	\$53.74
A7040	\$42.71
A7041	\$80.25
A7042	\$190.66
A7043	\$30.37
E0749	\$253.80
E0782	\$4508.08
E0783	\$8596.26
E0785	\$496.13
E0786	\$8385.13
L8600	\$563.24
L8603	\$395.57
L8606	\$207.65
L8609	\$5943.03
L8610	\$577.75
L8612	\$609.36
L8613	\$272.82

HCPCS Code	Fee
L8614	\$17,268.34
L8615	\$411.39
L8616	\$95.82
L8617	\$83.70
L8618	\$23.90
L8619	\$7,407.48
L8621	\$0.56
L8622	\$0.30
L8623	\$59.01
L8624	\$147.06
L8630	\$303.88
L8631	\$2,039.39
L8641	\$329.82
L8642	\$270.73
L8658	\$282.94
L8659	\$1,760.14
L8670	\$502.09
L8680	\$418.98

HCPCS Code	Fee
L8681	\$1,030.25
L8682	\$5,437.91
L8683	\$4,786.58
L8684	\$628.58
L8685	\$11,927.92
L8686	\$7,610.99
L8687	\$15,522.99
L8688	\$9,904.93
L8689	\$1,573.38
L8690	\$4,339.22
L8691	\$2,432.27
L8695	\$15.20
Q0480	\$82,151.87
Q0481	\$13,254.26
Q0482	\$4,151.48
Q0483	\$17,102.23
Q0484	\$3,321.20
Q0485	\$320.66

HCPCS Code	Fee
Q0486	\$266.88
Q0487	\$311.37
Q0489	\$14,826.70
Q0490	\$641.33
Q0491	\$1,008.22
Q0492	\$81.25
Q0493	\$231.27
Q0494	\$195.71
Q0495	\$3,810.12
Q0496	\$1,367.52
Q0497	\$427.01
Q0498	\$468.53
Q0499	\$152.22
Q0500	\$27.85
Q0501	\$465.83
Q0502	\$593.05
Q0503	\$1,186.13
Q0504	\$625.88

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# AMBULANCE SERVICES

## 2009 ambulance fee schedule

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, fiscal intermediaries, and Part A/B Medicare administrative contractors use to determine how much to pay for the claims submitted for ambulance services. Specifically, this section of the Act provides for a 2009 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF). Change request (CR) 6113 furnished the calendar year 2009 AIF, which is 5.0 percent. The revised fees are effective for dates of service January 1, 2009, and after.

**Note:** For ground ambulance trips of over 50 miles that you furnish on or after July 1, 2004, and before January 1, 2009 (regardless of where the transportation originates); a 25 percent bonus “per mile” payment will be added to the existing “per mile” reimbursement rate for all miles above the initial 50 miles. This 25 percent increase in the “per mile” payment rate for trips of 51 miles or greater will stop on December 31, 2008; and effective for dates of service of January 1, 2009, and later, services paid under the ambulance fee schedule will not include this temporary increase.

The *MLN Matters* article is on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6113.pdf>.

The official issued instruction (CR 6113), is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1607CP.pdf>.

Code	Loc 01/02	Loc 03	Loc 04	
A0425	\$6.87	\$6.87	\$6.87	
A0425	\$6.94	\$6.94	\$6.94	*
A0426	\$245.65	\$259.84	\$269.01	
A0426	\$248.06	\$262.39	\$271.64	*
A0427	\$388.95	\$411.42	\$425.93	
A0427	\$392.77	\$415.45	\$430.10	*
A0428	\$204.71	\$216.54	\$224.17	
A0428	\$206.72	\$218.66	\$226.37	*
A0429	\$327.54	\$346.46	\$358.67	
A0429	\$330.75	\$349.86	\$362.19	*
A0430	\$2,758.36	\$2,870.75	\$2,943.30	
A0430	\$4,137.54	\$4,306.12	\$4,414.95	*
A0431	\$3,207.00	\$3,337.66	\$3,422.01	
A0431	\$4,810.50	\$5,006.49	\$5,133.02	*
A0432	\$358.25	\$378.94	\$392.30	
A0432	\$361.76	\$382.66	\$396.15	*
A0433	\$562.96	\$595.48	\$616.47	
A0433	\$568.48	\$601.32	\$622.52	*
A0434	\$665.31	\$703.75	\$728.56	
A0434	\$671.84	\$710.65	\$735.70	*
A0435	\$8.07	\$8.07	\$8.07	
A0435	\$12.11	\$12.11	\$12.11	*
A0436	\$21.53	\$21.53	\$21.53	
A0436	\$32.30	\$32.30	\$32.30	*

\* Rural rate

Source: CMS Pub. 100-04, Transmittal 1607, CR 6113

# GENERAL COVERAGE

## Adding certain entities as originating sites for payment of telehealth services

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

### Provider types affected

Hospital-based or critical access hospital-based renal dialysis centers (including satellites); skilled nursing facilities (SNFs); and/or community mental health centers (CMHCs) submitting claims to Medicare contractors (fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for telehealth services provided to Medicare beneficiaries. Eligible distant site physicians and practitioners may now be paid for qualifying telehealth services provided to beneficiaries who are located at these new sites.

### Provider action needed

This article is based on change request (CR) 6215 which announces that the Centers for Medicare & Medicaid Services (CMS) is adding entities as originating sites for payment of telehealth services for dates of service on or after January 1, 2009. Those added entities are:

- Hospital-based or critical access hospital-based renal dialysis centers (including satellites)
- Skilled nursing facilities
- Community mental health centers (CMHCs).

**Note: Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) did not add independent renal dialysis facilities as originating sites for payment of telehealth services.**

Consistent with existing requirements, in order to be eligible to serve as an originating site, entities must be located in either a non-metropolitan statistical area (non-MSA) county or rural health professional shortage area (HPSA).

Be sure your billing staff is aware of these changes.

### Background

Section 149 of the MIPPA amended Section 1834(m) of the Social Security Act (“the Act”) to add certain entities as originating sites for payment of telehealth services. Effective for services furnished on or after January 1, 2009, eligible originating sites include a hospital-based or critical access hospital-based renal dialysis center (including satellites); a skilled nursing facility (as defined in Section 1819(a) of the Act); and a community mental health center (as defined in Section 1861(ff)(3)(B) of the Act). MIPPA also amended Section 1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under Section 1834(m)(4)(C)(ii)(VII) from the consolidated billing provisions of the skilled nursing facility prospective payment system (SNF PPS).

This article provides you with updated instructions for billing the originating site facility fee. Providers are also subject to existing payment policy and claim processing

instructions applicable to Medicare telehealth services that are not included in this change request, as set forth in the CMS *Medicare Benefit Policy Manual*, Chapter 15, Section 270 and the CMS *Medicare Claims Processing Manual*, Chapter 12, Section 190. These manuals are available on the CMS Web site at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

### Key Points of CR6215

- The originating site facility fee is a separately billable Part B payment. Your Medicare contractor pays it outside of other payment methodologies. This fee is subject to post payment verification.
- The originating site facility fee is updated annually by the Medicare economic index. The updated fee is included in the Medicare physician fee schedule (MPFS) final rule, which is issued by November 1 prior to the start of the calendar year for which it is effective.
- An interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used.

### Hospital-based or critical access hospital-based renal dialysis centers

For dates of service on or after January 1, 2009, hospital-based and critical access hospital (CAH)-based renal dialysis centers (including satellites) are eligible for Medicare payment when they serve as originating sites for telehealth services.

- When a hospital-based or critical access hospital-based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or monthly capitation payment (MCP) amount.
- With respect to the originating site facility fee, hospital-based and CAH-based renal dialysis centers should bill their regular FI or MAC for the originating site facility fee on **type of bill (TOB) 72x using revenue code 078x and Healthcare Common Procedure Coding System (HCPCS) code Q3014** on a separate revenue line from any other services provided to the beneficiary. Note that the originating site facility fees (Q3014)

**Adding certain entities as originating sites for payment of telehealth services (continued)**

are not ESRD services and do not count towards the number of services used to determine payment for ESRD services.

**Skilled nursing facilities**

For dates of service on or after January 1, 2009, SNFs as defined in 1819(a) of the Act are eligible for Medicare payment when they serve as originating sites for telehealth services.

- The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. The originating site facility fee is a separately billable Part B payment.
- With respect to the originating site facility fee, SNFs will bill their regular FI or MAC for the originating site facility fee on **TOBs 22x or 23x**. For SNF inpatients in a covered Part A stay, SNFs will bill their regular FI or MAC for the originating site facility fee on **TOB 22x**. All SNFs will bill **using revenue code 078x and HCPCS code Q3014** on a separate revenue line from any other services provided to the beneficiary.

**Community mental health centers**

For dates of service on or after January 1, 2009, community mental health centers (CMHCs) as defined in 1861(ff)(3)(B) of the Act are eligible for Medicare payment when they provide telehealth originating site services.

- When a CMHC serves as an originating site, the originating site facility fee is not a partial hospitalization service. The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization services. The originating site facility fee is not bundled in the per diem payment for partial hospitalization. The

originating site facility fee is a separately billable Part B payment.

- With respect to the originating site facility fee, CMHCs will bill their regular FI or MAC for the originating site facility fee on **TOB 76x using revenue code 078x and HCPCS code Q3014** on a separate revenue line from any other services provided to the beneficiary. Note that **Q3014 does not count towards the number of services used to determine per diem payments for partial hospitalization services**.

**Additional information**

The official instruction (CR 6215) issued to your Medicare FI or MAC consists of two transmittals. One transmittal revises the *Medicare Claims Processing Manual*, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1635CP.pdf>, and the other revises the *Medicare Benefit Policy Manual*, which is available on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/R97BP.pdf>.

If you have questions, please contact your Medicare 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>.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6215

Related Change Request (CR) Number: 6215

Related CR Release Date: November 14, 2008

Related CR Transmittal Number: R1635CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1635, CR 6215

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**Sign up to our eNews electronic mailing list**

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

## November is American Diabetes Month®

The American Diabetes Association (ADA) has designated American Diabetes Month® as a time to communicate the seriousness of diabetes and the importance of proper diabetes control. Left undiagnosed, diabetes can lead to serious complications such as heart disease, stroke, blindness, kidney damage, lower-limb amputations, and premature death. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes. Medicare also provides coverage for services to help beneficiaries effectively manage their diabetes. Coverage of these services is subject to certain eligibility and other limitations.

### Diabetes screening tests

Medicare provides coverage of the following diabetes screening tests for eligible beneficiaries:

- A fasting blood glucose test
- A post-glucose challenge test (not limited to an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults)
- A two-hour post-glucose challenge test alone.

For beneficiaries diagnosed with diabetes, Medicare provides coverage of diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services to help beneficiaries learn to effectively manage their condition.

### Diabetes self-management training

DSMT services are intended to educate beneficiaries in the successful self-management of diabetes. Medicare provides coverage of DSMT services for beneficiaries who have been recently diagnosed with diabetes, determined to be at risk for complications from diabetes, or were previously diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible for coverage under the Medicare program. Eligible Medicare beneficiaries must receive a referral from a physician or qualified nonphysician practitioner certifying that DSMT services are needed to treat their diabetic condition.

### Medical nutrition therapy

MNT provided by a registered dietitian or a qualified nutrition professional may result in improved diabetes and renal disease management and other health outcomes and

may help delay disease progression. Medicare provides coverage of MNT services for beneficiaries diagnosed with diabetes or renal disease (except for those receiving dialysis). Eligible beneficiaries must receive a referral from the treating physician, the primary care physician, or specialist coordinating care for the beneficiary with diabetes or renal disease. Qualified nonphysician practitioners cannot make referrals for MNT.

**Note:** MNT is a separate billable benefit from DSMT services. Eligible beneficiaries may receive referrals for both services, but both services cannot be received on the same day.

### Your help is needed

Your help is needed to ensure people with Medicare are assessed for and informed about their risk factors for diabetes or pre-diabetes and that those who are eligible take advantage of the diabetes screening tests. And, when appropriate, you can provide referrals for DSMT and MNT. These services can help beneficiaries learn to manage their disease and may help lower the risk of serious complications.

### For more information

- For more information about Medicare's coverage of diabetes screening services, DSMT, and MNT services (including coverage, coding, billing, and reimbursement guidelines), please visit the CMS *Medicare Learning Network (MLN) Preventive Services Educational Products Web page* [http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp).
- For literature to share with your Medicare patients, please visit <http://www.medicare.gov>.
- To locate recognized diabetes education programs in your local area, please visit the ADA Web site <http://www.diabetes.org/education/edustate2.asp>.
- To locate registered dietitians or qualified nutrition professionals in your local area, please visit the ADA Web site at <http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/index.html>.
- For more information about American Diabetes Month®, please visit the ADA Web site <http://www.diabetes.org/communityprograms-and-localevents/americanmonth.jsp>. ❖

Source: CMS PERL 200811-06

# 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://www.fcso.com>.

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 Web site <http://www.fcso.com>, Florida Providers, 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

## Local Coverage Determination Table of Contents

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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://www.fcso.com>.**

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## ADDITIONAL MEDICAL INFORMATION

### C9399: Triesence™ (triamcinolone acetonide injectable suspension)

Triesence™ (triamcinolone acetonide injectable suspension), a synthetic corticosteroid, received approval from the Food and Drug Administration (FDA) on November 29, 2007, for intraocular (intravitreal) use in the conditions listed below. First Coast Service Options Inc. (FCSO) will consider Triesence™ medically reasonable and necessary for services rendered on or after the FDA-approval date for the following FDA-approved conditions:

- Sympathetic ophthalmia (diagnosis code 360.11)
- Temporal arteritis (diagnosis code 446.5)
- Uveitis (diagnosis codes include 360.11, 363.20, 364.00 and 364.3)
- Ocular inflammatory conditions unresponsive to topical corticosteroids (many diagnosis codes would apply to this condition)
- Visualization during a vitrectomy procedure

Triesence™ should be reported with HCPCS code C9399 (unclassified drugs or biologicals) and CPT code 67028 (*Intravitreal injection of a pharmacologic agent [separate procedure]*).

The administration for the intravitreal injection of Triesence™ must be billed on the same claim as the drug, with CPT code 67028. When performing an injection on both eyes, modifier 50 should be used and modifier RT or LT should be used for unilateral services.

The initial recommended dose of Triesence™ for the treatment of ophthalmic diseases is 4 mg (100 microliters of 40 mg/mL suspension) with subsequent dosage as needed over the course of treatment.

The recommended dose of Triesence™ for visualization during vitrectomy is 1 to 4 mg (25 to 100 microliters of 40 mg/mL suspension) administered intravitreally.

Triesence™ is supplied in a single-use 1 mL vial containing 40 mg/mL of sterile triamcinolone acetonide suspension.

**Note:** The Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals and other providers to schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner. However, if a physician, hospital or other provider must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded along with the amount administered, up to the amount of the drug or biological as indicated on the vial or package label (CMS Internet-only Manual System, Pub 100-04, *Medicare Claims Processing Manual*, Chapter 17, Section 40).

**Medical record documentation maintained by the performing provider should be available upon request, and must include the following:**

- The clinical indication/medical necessity for the Triesence™ injection
- Name of the drug administered
- Dosage of drug administered
- Route of administration
- Topical corticosteroid(s) given to patient for ocular inflammatory condition prior to treating with Triesence™.

**Note:** HCPCS code J3301 (Injection, triamcinolone acetonide, per 10 mg) is used to report Kenalog-10, Kenalog-40, Tri-Kort, Kenaject-40, Cenacort A-40, Triam-A or Triolog and the drugs represented by this HCPCS code have different indications, pricing, dosages, routes, etc than Triesence™. Therefore, claim processing methods used (e.g., indications, pricing, etc.) for the drugs represented by HCPCS code J3301 would not apply to Triesence™ (triamcinolone acetonide injectable suspension). ❖

### J2357: Xolair and administration CPT code 96401—correct billing clarification

First Coast Service Options Inc. (FCSO) and providers have had a discussion recently regarding Omalizumab (Xolair®) and chemotherapy administration CPT code 96401 (*Chemotherapy administration, subcutaneous or intramuscular; nonhormonal*). Xolair® is indicated for adults and adolescents (12 years of age and above) with moderate to severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids. Xolair® is administered subcutaneously. For administrations of Xolair® where the dose is greater than 150 mg, the dose should be divided among more than one injection site to limit injections to not more than 150 mg per site. Because Xolair is a monoclonal antibody, the use of CPT code 96401 is permitted. The intent of the RVU weighting of CPT code 96401 was for the patient risk for the “single dose” not the syringes used to deliver a split dose. Providers are paid extra for chemotherapy administration (as opposed to other drug administration) given the risk and side effects associated with these drugs and the associated overhead to monitor. The additional cost for the syringe and nurse work is not a major factor since the code is weighted three times a therapeutic injection. Therefore, FCSO would not expect to see more than 1 unit of CPT code 96401 billed for the administration of Xolair®. ❖

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# HOSPITAL SERVICES

## New HCPCS code for billing hemophilia clotting factor

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

### Provider types affected

Hospital providers submitting claims to Medicare fiscal intermediaries (FIs) and/or Part A/B Medicare administrative contractors (A/B MACs) for inpatient services provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 6268 which announces that, effective for inpatient claims with dates of discharge on or after January 1, 2009, Healthcare Common Procedure Coding System (HCPCS) code J7186 **will be payable** by Medicare.

HCPCS code Q4096 **will not be payable** by Medicare for claims with dates of discharge on or after January 1, 2009.

### Background

CR 6268 instructs that Healthcare Common Procedure Coding System (HCPCS) code J7186 will be payable by Medicare for inpatient claims with dates of discharge on or after January 1, 2009, and HCPCS code Q4096 will not be payable by Medicare for claims with dates of services after January 1, 2009.

See CR 6006, transmittal 1564, dated July 25, 2008, titled, "New Hemophilia Clotting Factor and HCPCS Code," on the Center for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1564CP.pdf> for more information, regarding payment for Q4096, prior to January 1, 2009.

An *MLN Matters* article related to that transmittal is also available on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6006.pdf>.

Effective for inpatient claims with dates of discharge on or after January 1, 2009, the following HCPCS code will be payable by Medicare:

HCPCS	Short descriptor	Long description	Effective dates
J7186	Antihemophilic VIII/VWF comp	injection, antihemophilic factor VIII/von Willebrand factor complex,(human), per factor VIII I.U.	January 1, 2009

Effective for inpatient claims with dates of discharge on or after January 1, 2009, the following HCPCS code will no longer be payable by Medicare:

HCPCS	Short descriptor	Long description	Effective dates
Q4096	VWF complex, not humate-P (NOS)	Injection, von Willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per I.U. vWF:RCO vWF complex, NOS	April 1, 2008 (Terminated effective January 1, 2009)

Appropriate systems changes for editing HCPCS codes J7186 and Q4096 on inpatient claims will be made by the fiscal intermediary standard system (FISS) and the common working file (CWF) in the April 2009 release.

During the period between January 1, 2009, and April 5, 2009 (date of the FISS and CWF implementation of the hemophilia inpatient edit changes in the April 2009 release), CR 6268 instructs that the following procedures are to be followed for inpatient claims:

1. Providers will submit claims for hospital inpatient care, omitting J7186. This includes the following hospitals:

- Hospitals paid under the inpatient prospective payment system (IPPS).
- Hospitals paid under the long term care hospital prospective payment system (LTCH PPS).
- Hospitals paid under the inpatient rehabilitation facility prospective payment system (IRF PPS).
- Hospitals paid on the basis of reasonable cost (TEFRA hospitals, critical access hospitals (CAHs).
- Indian health service (IHS) hospital inpatient services (actually paid on a DRG basis)] omitting J7186.

This does not apply to claims from inpatient psychiatric facilities (IPFs) paid under IPF PPS. IPFs receive a comorbidity adjustment under IPF PPS based on the presence of a hemophilia diagnosis on the claim. IPFs should refrain from including J7186 on their inpatient claims.

2. Once the provider has received PPS payment for the inpatient claim, the provider will immediately submit an adjustment request (Type of Bill (TOB) = 117), this time including J7186.

**New HCPCS code for billing hemophilia clotting factor (continued)**

3. Medicare contractors will hook and hold any provider initiated adjustment requests containing J7186 with discharge dates between January 1, 2009, and April 5, 2009.
4. Medicare contractors will return to provider (RTP) any initial inpatient claims (TOB 11x) containing J7186 with discharge dates on or after January 1, 2009 but prior to April 1, 2009.
5. Once FISS and CWF have been updated for the clotting factor edits to include J7186, Medicare contractors will release all held adjustment requests.

**Note:** There is no impact on outpatient hospital claims or on any skilled nursing facility (SNF) claims as payment is made under different methodologies. HCPCS code J7186 is payable in those settings effective January 1, 2009.

**Implementation**

The implementation date is April 6, 2009.

**Additional information**

The official instruction, CR 6268, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R394OTN.pdf>.

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>.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6268

Related Change Request (CR) Number: 6268

Related CR Release Date: October 24, 2008

Related CR Transmittal Number: R394OTN

Effective Date: January 1, 2009

Implementation Date: April 6, 2009

Source: CMS Pub. 100-20, Transmittal 394, CR 6268

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**New institutional National Correct Coding Initiative edits**

The National Correct Coding Initiative (NCCI) edits are updated quarterly and the institutional version is one calendar quarter behind the physician version. In the past, the outpatient code editor (OCE) has not applied the NCCI edits for the following categories of services: Anesthesiology, evaluation and management, and mental health services.

**Effective January 1, 2009**, these categorical exclusions will be removed, and there will be a large number of new institutional NCCI edits applied to claims. These institutional NCCI edits will be available on or about January 1, 2009, on the CMS Web site at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage>.

To review the types of NCCI edits that were previously excluded from the institutional version but are currently included in the physician version for these categories, refer to the NCCI files on the following Web site at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage>.

You may use anesthesiology, evaluation and management, or mental health services CPT or Level II HCPCS codes to search these files. A subset of the corresponding edits in the physician version is being added to the institutional version. Consistent with longstanding practice, CMS makes specific decisions about NCCI edits that are appropriate for facilities, incorporating comments on potential edits from relevant professional associations. Therefore, the institutional NCCI edits may differ from the physician NCCI edits.

Affected providers should begin immediately to educate their staff about the application of the additional categories of NCCI edits to their claims. Note that at this time, no additional providers will be subject to NCCI edits. ❖

Source: CMS PERL 200811-30

**Fiscal year 2009 inpatient psychiatric facility PPS PRICER is now available**

The Centers for Medicare & Medicaid Services (CMS) has updated the inpatient psychiatric facility (IPF) prospective payment system (PPS) PRICER for fiscal year (FY) 2009. If you use the IPF PC PRICER, please go to the Web page at [http://www.cms.hhs.gov/PCPricer/09\\_inppsy.asp#TopOfPage](http://www.cms.hhs.gov/PCPricer/09_inppsy.asp#TopOfPage) and download the FY 2009 version posted on November 5, 2008. ❖

Source: CMS PERL 200811-12

## Application of the hospital outpatient quality data reporting program under the hospital outpatient prospective payment system

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

### Provider types affected

Hospitals submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part 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) 6072 regarding application of the hospital outpatient quality data reporting program to services paid under the hospital outpatient prospective payment system (OPPS), effective for services provided **on or after January 1, 2009**.

### CAUTION – what you need to know

Effective for OPPS services furnished on or after January 1, 2009, ‘subsection (d) hospitals’ that have failed to submit timely outpatient hospital quality data as required in the Social Security Act (Section 1833(t)(17) (A)) will receive payment under the OPPS that **reflects a two percent deduction from the annual OPPS update** for failure to submit quality data in a timely manner or for failure to submit quality data that passes validation edits. Hospitals that are not required to submit quality data (i.e. that are not ‘subsection (d) hospitals’) will receive the full update. Similarly, the reduction will not apply to subpart (d) hospitals that are not paid under the OPPS (e.g. Indian health service hospitals).

### GO – what you need to do

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

### Background

As a condition for receiving the full market basket update on their inpatient prospective payment system (IPPS) payments, all hospitals defined as ‘subsection (d) hospitals’, are required to report hospital quality data:

- In a timely manner
- In a way that passes the Centers for Medicare & Medicaid Services (CMS) validation edits for inpatients receiving services in the hospital.

Effective for services furnished on or after January 1, 2009, this policy will also apply to services paid under OPPS to ‘subsection (d) hospitals’.

‘Subsection (d) hospitals’ have the same definition for hospitals paid under the OPPS as for hospitals paid under the inpatient PPS. Specifically, ‘subsection (d) hospitals’ are defined in the Social Security Act (Section 1886(d)(1)(B); [http://www.ssa.gov/OP\\_Home/ssact/title18/1886.htm](http://www.ssa.gov/OP_Home/ssact/title18/1886.htm) on the Internet) as hospitals that are located in the fifty states or the District of Columbia other than those categories of hospitals or hospital units that are specifically excluded from the IPPS, including psychiatric, rehabilitation, long-term care, children’s and cancer hospitals or hospital units. In other

words, the provision does not apply to hospitals and hospital units excluded from the IPPS, or to hospitals located in Maryland, Puerto Rico, or the U.S. territories.

CR 6072 announces that, effective for OPPS services furnished on or after January 1, 2009, **‘subsection (d) hospitals’ that have failed to submit timely outpatient hospital quality data** as required in the Social Security Act (Section 1833(t)(17)(A); [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) on the Internet) **will receive payment under the OPPS that reflects a two percent deduction from the annual OPPS update for failure to submit quality data in a timely manner or for failure to submit quality data that passes validation edit. Where hospitals are required to report the quality data and fail to do so, the OPPS Pricer will assign a new return code of 11 (Reduced for absent quality reporting) when a payment APC on a line has a status indicator equal to P, S (if APC is not 1491-1537), T (if APC is not 1539-1574), V, or X.**

Hospitals that are not required to submit quality data (i.e. that are not ‘subsection (d) hospitals’) will receive the full update. Similarly, the reduction will not apply to subpart (d) hospitals that are not paid under the OPPS (e.g. Indian health service hospitals).

CMS will send your FI or MAC a file of hospitals to which the reduction will apply as soon as the list is available. This is expected to be on or about December 1 of each year. Should a ‘subsection (d) hospital’ later be determined to have met the criteria after publication of this list, their status will be changed and FIs/MACs will be notified.

For new hospitals, FIs/MACs will provide information to CMS (or a CMS-designated contractor) to allow contact with the new facilities to inform them of the Hospital Quality Initiative.

### Additional information

The official instruction, CR 6072, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R368OTN.pdf>.

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>.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6072  
 Related Change Request (CR) Number: 6072  
 Related CR Release Date: August 15, 2008  
 Related CR Transmittal Number: R368OTN  
 Effective Date: January 1, 2009  
 Implementation Date: January 5, 2009

Source: CMS Pub. 100-20, Transmittal 368, CR 6072

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## Announcing plans to bolster quality of care in hospital outpatient departments

The Centers for Medicare & Medicaid Services (CMS) recently announced plans to strengthen the tie between the quality of care furnished to people with Medicare in hospital outpatient departments (HOPDs) and the payments hospitals receive for those services. In a final rule establishing Medicare payment and policy changes for services in HOPDs and ambulatory surgical centers (ASCs) for calendar year (CY) 2009, CMS reiterates its commitment to implementing value based purchasing (VBP) initiatives across the continuum of beneficiaries' care and transforming Medicare from a passive payer to a prudent purchaser of health care.

The final outpatient prospective payment system (OPPS) ASC payment system rule also includes a 3.6 percent annual inflation update for HOPDs and adopts changes to payment policies for HOPDs and ASCs beginning on January 1, 2009.

The law sets the ASC update for CY 2009 at zero percent.

To view the entire press release, go to [http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp).

A copy of the final rule (CMS-1404-FC) is available at <http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1216689&intNumPerPage=10>. ❖

Source: CMS PERL 200810-37

## CMS releases fiscal year 2009 inpatient rehabilitation facility PPS PC PRICER

The Centers for Medicare & Medicaid Services (CMS) has released the fiscal year (FY) 2009 inpatient rehabilitation facility (IRF) prospective payment system (PPS) PC PRICER. If you use the IRF PPS PC PRICER, please go to the Web page at [http://www.cms.hhs.gov/PCPricer/06\\_IRF.asp#TopOfPage](http://www.cms.hhs.gov/PCPricer/06_IRF.asp#TopOfPage) and download the FY 2009 version posted on December 29, 2008. ❖

Source: CMS PERL 200811-01

## Payment for implanted prosthetic devices for Medicare Part B inpatients

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

**Note:** CMS has revised this *MLN Matters* article on November 4, 2008, to reflect revisions made to change request (CR) 6050, addressing the new C-code indicated in CR 6050 is HCPCS code C9899. This article was revised accordingly. The CR release date, transmittal number, and the Web address for accessing CR 6050 were revised. All other information remains the same. The *MLN Matters* article MM6050 was published in the September 2008 *Medicare A Bulletin* (pages 57-58).

### Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), and/or Part A/B Medicare administrative contractors (A/B MACs) for implanted prosthetic devices provided to Medicare beneficiaries under Part B.

### Provider action needed STOP – impact to you

This article is based on change request (CR) 6050, which clarifies payment for implanted prosthetic devices for Medicare Part B inpatients.

### CAUTION – what you need to know

CR 6050 revises the *Medicare Claims Processing Manual* (Chapter 4, Section 240) to provide instructions regarding how contractors are to establish the payment to be made under the outpatient prospective payment system (OPPS) for implanted prosthetic devices that are furnished to Medicare beneficiaries who, on the date that the device is implanted, are hospital inpatients without Part A coverage of services, but with Part B coverage.

### GO – what you need to do

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

### Background

The Centers for Medicare & Medicaid Services (CMS) can designate medical and other health services (that are payable under the Medicare OPPS) for beneficiaries who are hospital inpatients with Medicare Part B benefits, but who do not have Part A benefits. See the Social Security Act (Section 1833(t)(2)(A)) on the Internet at [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm).

The *Medicare Benefits Policy Manual*, Chapter 2, Section 10, includes implanted prosthetic devices in the list of designated services for which payment may be made under the OPPS for Medicare beneficiaries who are inpatients of a hospital but who are not covered under Medicare Part A at the time of implantation, but who do have Part B coverage, on the day that they receive an implanted prosthetic device. The processing of claims for these services is discussed in the *Medicare Claims Processing Manual*, Chapter 4, Section 240. Under Medicare PPS, reimbursement for these items is packaged into payment for the procedure in which they are implanted.

CR 6050 revises the *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 240 (Inpatient Part B Hospital Services) to provide instructions regarding how Medicare contractors are to establish payment for providers subject to the OPPS for implanted prosthetic devices that

**Payment for implanted prosthetic devices for Medicare Part B inpatients (continued)**

are furnished to Medicare beneficiaries who are hospital inpatients not having Part A coverage of services on the date that the device is implanted.

Specifically, the manual is revised to specify that **providers must submit these services on a type of bill 12x, reporting the new HCPCS code C9899** that will be effective for services furnished on and after January 1, 2009, **when they furnish an implanted prosthetic device** to a Medicare beneficiary:

- Who is a hospital inpatient, but
- Who does not have Part A coverage of inpatient services on the date that the implanted prosthetic device is furnished.

By reporting the new HCPCS C-code, the hospital is reporting that all of the criteria for payment under Part B are met as specified in the Chapter 6, Section 10 of the *Medicare Benefits Policy Manual*.

The manual is also revised to specify that Medicare contractors will:

- Determine if the device meets the definition for an implanted prosthetic device.
- Establish the payment to be made for the device.

Medicare contractors will first determine that the item furnished meets the Medicare criteria for coverage as an implantable prosthetic device as specified in Chapter 6, Section 10, of the *Medicare Benefits Policy Manual*. If the item does not meet the criteria for coverage as an implantable prosthetic device, the Medicare contractor will deny payment on the basis that the item is outside the scope of the benefits for which there is coverage for Part B inpatients. The beneficiary is liable for the charges for the noncovered item when the item does not meet the criteria for coverage as an implanted prosthetic device as specified in Chapter 6, Section 10 of the *Medicare Benefits Policy Manual*.

Once the Medicare contractor determines that the device is covered, it will then determine the appropriate payment amount for the device.

The contractor shall begin this process by determining if the device has pass through status under the OPSS. If so, the contractor will establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio.

Where the device does not have pass through status under the OPSS, the contractor will set the payment amount for the device at the lesser of the amount for the device, in the DMEPOS fee schedule, where there is such an amount or the actual charge for the device. Where there is no amount for the device in the durable medical equipment prosthetic orthotics supply (DMEPOS) fee schedule, the contractor shall establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. Payment would be made at the lesser of the contractor established payment rate for the specific device or the actual charge for the device.

In setting a Medicare contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established. This information may include, but is not

limited to, the amount of device cost that would be removed from an applicable ambulatory payment classification (APC) payment for implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

See <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp> for the amount of reduction to the APC payment that would apply in these cases. From this OPSS Web page, select "Device, Radiopharmaceutical and Procedure Edits" from the list on the left side of the page. Open the file "Procedure to Device Edits" to determine the HCPCS code that best describes the procedure in which the device would be used. Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPSS Web page and open the file "APC Adjustments in Cases of Full Credit/No Cost or Partial Credit for Replaced Devices." Select the "Full offset reduction amount" that pertains to the APC that is most applicable to the device described by the new HCPCS C code. It would be reasonable to set this amount as the payment for a device furnished to a Part B inpatient.

For example, if the new HCPCS C-code is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description on the claim in "remarks") the file of procedure to device edits shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes and therefore would not apply if electrodes are not also billed). The table of offset reduction amounts for calendar year 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is \$4,881.77. It would therefore be reasonable for the FI or MAC to set the payment rate for a single chamber pacemaker furnished to a Part B inpatient to \$48,81.77. In this case the coinsurance would be \$936.75 (20 percent of \$4,881.77, which is less than the inpatient deductible).

The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e. the pass through payment amount, the DMEPOS fee schedule amount or the contractor established amount, or the actual charge where applicable), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

Note that Medicare contractors will deny payment for an item reported with the new HCPCS code C9899 if they determine that it does not meet the definition of an implanted prosthetic device that is implanted in the body at least temporarily. On such denials, the remittance advice remark code will show N180 (This item or service does not meet the criteria for the category under which it was billed.) with a group code or PR (Patient responsibility) and a claim adjustment reason code of 96 (Noncovered charges).

Medicare contractors will also deny payment if they or Medicare systems determine that the beneficiary was in a covered Part A stay on the date of service of the item reported with the new HCPCS code C9899. Such denials will contain a remittance advice remark code of M2 (Not paid separately when the patient is an inpatient), a group code of CO (Contract obligation) and a claim adjustment reason code of 96 (Noncovered charges).

### **Payment for implanted prosthetic devices for Medicare Part B inpatients (continued)**

**Note:** The revised *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 240 (Inpatient Part B Hospital Services)) is included as an attachment to CR 6050.

### **Additional information**

The official instruction, CR 6050, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1628CP.pdf>.

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>.

The toll-free number for First Coast Service Options Inc. Medicare Part A Customer Service Center is 888-664-4112.

*MLN Matters* Number: MM6050 – Revised  
Related Change Request (CR) Number: 6050  
Related CR Release Date: November 3, 2008  
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# CRITICAL ACCESS HOSPITAL SERVICES

## Payment of assistant at surgery services in a critical access hospital method II

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

### Provider types affected

Method II critical access hospitals (CAHs) (to whom physicians and nonphysician practitioners rendering assistant in surgery services have reassigned their billing rights) who bill Medicare fiscal intermediaries (FI) or Part A/B Medicare administrative contractors A/B MAC for such assistant at surgery services.

### What you need to know

Change request (CR) 6123, from which this article is taken, implements the amount Medicare pays to providers who (having reassigned their billing rights to method II CAHs render assistance at surgery services in that hospital.

The payment amount for a physician assisting at surgery is calculated as follows:

The facility specific Medicare physician fee schedule (MPFS) amount **multiplied by** a 16 percent assistant at surgery reduction amount minus the deductible and coinsurance, then **multiplied by** 115 percent,

or

$((\text{MPFS} \times .16) - (\text{deductible and coinsurance})) \times 1.15$ .

The payment amount for a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) assisting at surgery is calculated as follows:

The facility specific MPFS amount **multiplied by** a 16 percent assistant at surgery reduction amount **multiplied by** an 85 percent nonphysician practitioner reduction **minus** the deductible and coinsurance, then **multiplied by** 115 percent,

or

$((\text{MPFS} \times .16 \times .85) - (\text{deductible and coinsurance})) \times 1.15$ .

Make sure that your billing staffs are aware of this method of calculating payment for assistance in surgery services.

### Background

Physicians and nonphysician practitioners billing on type of bill (TOB) 85x for professional services rendered in a method II CAH have the option of reassigning their billing rights to that CAH. When they elect to reassign these billing rights, payment is made to the CAH for professional services (revenue codes [RC] 96x, 97x or 98x).

CR 6123, from which this article is taken, implements the payment amount for providers who (having reassigned their billing rights to method II CAH render assistance at surgery services.

CR 6123 also updates *Medicare Claims Processing Manual* Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPSS)) by adding the following new sections:

- 250.9 (Coding Assistant at Surgery Services Rendered in a Method II CAH)
  - 250.9.1 (Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Assistants at Surgery)
  - 250.9.2 (Payment of Assistant at Surgery Services Rendered in a Method II CAH)
  - 250.9.3 (Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages)
  - 250.9.4 (Assistant at Surgery Services in a Method II CAH Teaching Hospital)
- 1.1.5 (Review of Supporting Documentation for Assistant at Surgery Services in a Method II CAH).

### CAH impact summary

Assistant at surgery services are those services rendered by physicians or nonphysician practitioners who actively assist the physician in charge of performing a surgical procedure. When a method II CAH bills for a surgical procedure on TOB 85x with RC 96x, 97x or 98x, and an appropriate assistant at surgery modifier (explained below), Medicare will pay the CAH for the assistant at surgery services it provides (if the rendering a physician or nonphysician practitioner has reassigned their billing rights to the CAH).

You should be aware that Section 1862 of the Social Security Act (the Act) stipulates that payment can only be made for care that is reasonable and necessary; and specifically, Section 1862(15)(A) of the Act addresses the services of an assistant at surgery and when those services are statutorily excluded. In conformance with this stipulation, Medicare uses the payment policy indicators on the Medicare physician fee schedule database (MPFSDB) to determine if assistant at surgery services are reasonable and necessary for a specific HCPCS/CPT code. You may find the MPFSDB on the Centers for Medicare & Medicaid Services (CMS) Web site at [http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02\\_PFSsearch.asp](http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp).

### Payment

Medicare pays for a surgical assistant when the procedure is authorized for an assistant and the person performing the service is a physician, PA, NP or a CNS.

**Payment of assistant at surgery services in a critical access hospital method II (continued)**

To facilitate payment, CMS (under authority of 42 CFR Section 414.40) has established uniform national definitions of services, codes to represent services, and payment modifiers to the codes, to include the use of payment modifiers for assistant at surgery services.

To bill for these services, you should use **modifier 80** (assistant surgeon), **81** (minimum assistant surgeon), or **82** (when qualified resident surgeon not available). You should also use **modifier AS** when you need to indicate that a PA, NP or CNS served as the assistant at surgery. Be aware that when you use modifier AS, you must also use modifier 80, 81, or 82 because using these modifiers without modifier AS indicates that a physician served as the surgical assistant. Claims that you submit with modifier AS and without modifier 80, 81 or 82 will be returned to you.

**Payment amount calculation**

Section 1834(g)(2)(B) of the Social Security Act (the Act) requires that professional services included within outpatient CAH services be paid at 115 percent of the amount that would otherwise be paid if such services were not included in the outpatient CAH services.

Other sections of the Act address the specific payment for surgical assistance:

- Section 1848(i)(2)(B) stipulates that if, for a physician-furnished surgery service, a separate payment is made to a physician providing surgical assistance, the fee schedule amount will not exceed 16 percent of the fee schedule amount.
- Section 1833(a)(1)(O)(ii) states that when the surgical assistance is provided by a PA, NP or CNS, payment is the lesser of the actual charge, or 85 percent of the amount that would otherwise be paid to a physician serving as an assistant at surgery.

The payment amount for a physician assisting at surgery is calculated as follows:

The facility specific MPFS amount **multiplied by** a 16 percent assistant at surgery reduction amount **minus** the deductible and coinsurance, **then multiplied by** 115 percent,

**or**

**((MPFS x .16) – (deductible and coinsurance)) x 1.15.**

The payment amount for a PA, NP, or CNS assisting at surgery is calculated as follows:

The facility specific MPFS amount **multiplied by** a 16 percent assistant at surgery reduction amount **multiplied by** an 85 percent nonphysician practitioner reduction **minus** the deductible and coinsurance, and **then multiplied by** times 115 percent,

**or**

**((MPFS x .16 x .85) – (deductible and coinsurance)) x 1.15).**

You should be aware that FIs and A/B MACs will suspend and assign a unique reason code in the 5xxxx series to assistant at surgery services on TOB 85x with RC 96x, 97x or 98x and modifier AS, 80, 81 or 82 when the HCPCS/CPT code has a payment policy indicator of '0' (Payment

restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity). They will pay for these services when medical necessity has been established. Such payment will be based on the lesser of actual charges or the reduced MPFS amount determined by the formulas listed above.

FIs and A/B MACs will return to provider (RTP) claims for assistant at surgery services that you submit on TOB 85x with RC 96x, 97x or 98x and modifier AS, 80, 81 or 82 when the HCPCS/CPT code billed with the modifier has a payment policy indicator of '9' (concept does not apply).

**Medicare summary notice (MSN) and remittance advice (RA) messages**

When denying noncovered assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '0' (Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity) or '2' (Payment restrictions for assistants at surgery does not apply to this procedure. Assistant surgery may be paid) when an advance beneficiary notice (ABN) was issued, FIs and A/B MACs will use the following MSN and RA messages:

**MSN messages to the beneficiary**

- 36.1 Our records show you were informed in writing, before receiving the service, Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.

**RA remark code**

- M38 The patient is liable for charges for this service as you informed the patient in writing before the service was furnished that we could not pay for it, and the patient agreed to pay.

**RA group code**

- PR Patient responsibility

**RA claim adjustment reason code**

- 54 Multiple physicians/assistants are not covered in this case.

Unless you issue an appropriate ABN, you are liable for noncovered assistant at surgery services with a payment policy indicator of '0' or '2'. When denying non-covered assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '0' or '2' and an ABN was not issued, FIs and A/B MACs will use the following MSN and RA messages:

**MSN messages to the beneficiary**

- 36.2 It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.

**Payment of assistant at surgery services in a critical access hospital method II (continued)****RA remark code**

**M27** The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.

**RA group code**

**CO** Contractual obligation

**RA claim adjustment reason code**

**54** Multiple physicians/assistants are not covered in this case.

When denying medically unnecessary assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '1' (Statutory payment restrictions for assistants at surgery applies to this procedure. Assistant at surgery may not be paid), FIs and A/B MACs will use the following MSN and RA messages:

**MSN message**

**15.11** Medicare does not pay for an assistant surgeon for this procedure/surgery.

**RA remark code**

**N425** Statutorily excluded service

**RA group code**

**PR** Patient responsibility

**RA Claim adjustment reason code**

**54** Multiple physicians/assistants are not covered in this case.

**Teaching hospitals impact summary**

Providing assistant in surgery services in teaching has some specific requirements. In general, if a hospital has a training program relating to the medical specialty required for the surgical procedure, and a qualified resident is available to provide surgical assistance for a procedure, Section 1842(b)(7)(D) of the Social Security Act stipulates that no payment will be made for the services of a surgical assistant for the procedure. FIs and A/B MACs will process assistant at surgery services furnished in method II teaching CAHs through the use of **modifier 82**, which indicates that a qualified resident surgeon was not available.

However, such payments can be made in teaching hospitals under certain circumstances such as exceptional medical circumstances (emergency, life threatening situations such as multiple traumatic injuries), which require immediate treatment; situations in which the medical staff may find that exceptional medical circumstances justify the

services of a physician or nonphysician provider to assist at surgery even though a qualified resident is available; or if the primary surgeon has an across-the board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

Claims will be suspended and developed when billed by method II teaching CAHs with **modifiers AS, 80 or 81** to determine if exceptional medical circumstances existed or the primary surgeon has an across-the board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

Given the absence of national policy on this provision, FIs and A/B MACs have the authority to establish procedures to define the appropriate supporting documentation needed to establish medical necessity, the existence of exceptional medical circumstances or to determine if the primary surgeon has an across the board policy of never involving residents in the preoperative, operative or postoperative care of his patients for assistant at surgery services. FIs and A/B MACs will also determine if a clinician or non-clinician medical reviewer will review assistant at surgery services.

Also, keep in mind that FIs and A/B MACs:

- Process assistant at surgery claims for services furnished in a teaching hospital through the use of **modifier 82** to indicate that a qualified resident was not available. Modifier 82 is for use only when the basis for payment is the unavailability of qualified residents.
- Will suspend for review and assign a unique reason code in the 5xxxx series to claims that you submit on type of bill 85x with RC 96x, 97x or 98x and **modifier AS, 80 or 81**, when the HCPCS/CPT code has a payment policy indicator of '0' (Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity) or '2' (Payment restrictions for assistants at surgery does not apply to this procedure. Assistant surgery may be paid) and the intern to bed ratio is greater than 0 (teaching hospital). Once supporting documentation justifies the services of the assistant at surgery, the FI or A/B MAC will make payment on the claim.

Finally, you should know that FIs and A/B MACs will not search for, and adjust claims that have been paid prior to the implementation date, but will adjust claims that you bring to their attention.

**Additional information**

You may find more information about the payment of assistant at surgery services in a method II CAH by going to CR 6123, located on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1620CP.pdf>.

You will find the updated updates *Medicare Claims Processing Manual* Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPSS)) Sections 250.9 (Coding Assistant at Surgery Services Rendered in a Method II CAH), 250.9.1 (Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Assistants at Surgery), 250.9.2 (Payment of Assistant at Surgery)

**Payment of assistant at surgery services in a critical access hospital method II (continued)**

Services Rendered in a Method II CAH), 250.9.3 (Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages), and 250.9.4 (Assistant at Surgery Services in a Method II CAH Teaching Hospital).

As mentioned earlier, you may find the assistant at surgery payment policy indicators for HCPCS/CPT on the MPFSD on the CMS Web site at [http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02\\_PFSsearch.asp](http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp).

You might also want to look at CR 6013 – Physician Fee Schedule Payment Policy Indicator File Record Layout for Use in Processing Method II CAH Claims for Professional Services), released May 16, 2008, for more information about the file layout used in processing CAH professional service claims.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6123

Related Change Request (CR) Number: 6123

Related CR Release Date: October 24, 2008

Related CR Transmittal Number: R1620CP

Effective Date: January 1, 2009

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Source: CMS Pub. 100-04, Transmittal 1620, CR 6123

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# ESRD SERVICES

## Discarded erythropoietin stimulating agents for home dialysis method I

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

### Provider types affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for erythropoietin stimulating agents (ESA) services provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 6133 which updates the *Medicare Claims Processing Manual*, Publication 100-04, Chapters 8, Sections 60.4.4.1 (Self Administered EPO Supply) and 60.7.4 (Darbepoetin Alfa [Aranesp<sup>®</sup>] Furnished to Home Patients) and Chapter 17, Section 40.1 (Discarded Erythropoietin Stimulating Agents for Home Dialysis) for discarded drugs and biologicals and CR 6133 includes specific instructions regarding appropriately discarded self-administered erythropoietin stimulating agents for method I home dialysis patients. Be sure billing staff is aware of these changes.

### Background

Supplies of ESAs for self administration are billed according to the pre-determined plan of care schedule provided to home dialysis patients that meet the criteria for self-administered ESAs as discussed in the *Medicare Claims Processing Manual* (Chapter 8, Sections 60.4 and 60.7. (See revised Chapter 8, Sections 60.4.4.1 and 60.7.4 which are Attachments of CR 6133.) The renal facility, through the amounts prescribed in the plan of care, shall ensure the patient's ESAs on hand at any time does not exceed a two-month supply. The Centers for Medicare & Medicaid Services (CMS) expects the facility to minimize excess dispensing of the ESAs for self-administration based on the patient's plan of care.

Multiuse vials are generally not subject to payment for discarded amounts of drugs or biologicals. An exception is applied specifically to self administered erythropoietin stimulating agents (ESAs) by method I home dialysis patients.

Providers may bill the Medicare program using the modifier JW for the amount of ESAs appropriately discarded, if the home dialysis patient must discard a portion of the ESA supply due to:

- Expiration of a vial because of interruption in the patient's plan of care, or
- Unused ESAs on hand after a patient's death.

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**Note:** In these situations, the maximum numbers of administrations generally allowed per month (i.e., 13 to 14 administrations) are not expected to all be administered to a patient.

This applies only to home dialysis patients who meet the method I conditions described in the *Medicare Benefits Policy Manual* (Chapter 11, Section 90 (Epoetin (EPO))), and does not apply to method II home dialysis patients. See on the CMS Web site <http://www.cms.hhs.gov/manuals/Downloads/bp102c11.pdf>.

When billing for discarded ESAs for method I patients in accordance with the policy in the *Medicare Claims Processing Manual* (Chapter 17, Section 40.1; see to CR 6133), the provider must show the amount discarded on a separate line item with the modifier JW, and the line item date of service should be:

- The date of the last covered administration according to the plan of care, or
- The date of death, if the patient dies.

### Additional information

The official instruction, CR 6133, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1581CP.pdf>.

If you have questions, please contact your Medicare 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>.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6133  
 Related Change Request (CR) Number: 6133  
 Related CR Release Date: August 29, 2008  
 Related CR Transmittal Number: R1581CP  
 Effective Date: December 1, 2008  
 Implementation Date: December 1, 2008

Source: CMS Pub. 100-04, Transmittal 1581, CR 6133

# SKILLED NURSING FACILITY SERVICES

## Revision to the reporting requirements of qualifying hospital stays on inpatient skilled nursing facility and swing bed claims

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

### Provider types affected

Skilled nursing facilities (SNFs) and swing bed facilities (SBs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 6233 which updates the requirement for reporting prior qualifying hospital stay dates on inpatient SNF and SB claims. Be sure billing staff are aware of these requirements.

### Background

SNF and SB providers must submit a qualifying hospital stay, or an appropriate condition code for bypassing the qualifying stay, if applicable, on all claims, including initial and subsequent claims that are submitted as covered. This is applicable for submitted bill types 21x (SNF inpatient) and 18x (SB inpatient). This also includes all covered claims, including claims submitted for benefits exhaust denials.

Covered claims submitted on 21x and 18x bill types that do not contain a qualifying hospital stay (using occurrence span code 70 with the qualifying hospital stay dates) or an appropriate condition code indicating why a qualifying hospital stay is not applicable will be denied.

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### Additional information

The official instruction, CR 6233, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1618CP.pdf>.

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>.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6233

Related Change Request (CR) Number: 6233

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Related CR Transmittal Number: R1618CP

Effective Date: April 1, 2009

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Source: CMS Pub. 100-04, Transmittal 1618, CR 6233

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# CORF/ORF SERVICES

## 2009 annual update to the therapy code list

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

### Provider types affected

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

### What providers need to know

This article is based on change request (CR) 6254 and alerts providers to updates to Medicare's therapy code list with two "sometimes" therapy codes for calendar year (CY 2009). Note that these codes always represent therapy services and require the use of a therapy modifier when performed by therapists. The two codes added are:

- 95992 *Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day*
- 0183T *Low frequency, non-contact, non-thermal ultrasound, including topical applications(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*

**Note:** If billed by a hospital subject to outpatient prospective payment system (OPPS) for an outpatient service, CPT code 0183T will be paid under the OPPS when the service is not performed by a qualified therapist and it is inappropriate to bill the service under a therapy plan of care. In addition, no Medicare physician fee schedule (MPFS) amount exists for this code. Since the local carrier (or A/B MAC) determines the coverage and pricing for this code, the FI or A/B MAC contacts the local contractor to obtain the appropriate fee schedule amount.

### Background

This instruction updates the list of codes that sometimes or always describe therapy services. The additions, changes,

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**Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2007 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.**

and deletions to the therapy code list reflect those made in the CY 2008 and 2009 HCPCS/CPT-4.

Therapy services, including "always therapy" services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, Chapter 5 which is available on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf> and the *Medicare Benefit Policy Manual*, Chapter 12, which is available on the CMS Web site at <http://www.cms.hhs.gov/manuals/Downloads/bp102c12.pdf>.

### Additional information

The official instruction (CR 6254) issued to your Medicare FI, A/B MAC, carrier or RHHI, which is on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1625CP.pdf>.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6254  
 Related Change Request (CR) Number: 6254  
 Related CR Release Date: October 31, 2008  
 Related CR Transmittal Number: R1625CP  
 Effective Date: January 1, 2009  
 Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1625, CR 6254

## RURAL HEALTH CLINIC SERVICES

### Medicare rural health clinics and federally qualified health centers payment rate increases

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

#### Provider types affected

Rural health clinics (RHCs) and federally qualified health centers (FQHCs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

#### Provider action needed

This article is based on change request (CR) 6218 which provides instructions for the calendar year (CY) 2009 payment rate increases for RHC and FQHC services.

#### Background

In accordance with the Social Security Act (Section 1833(f)); (see on the Internet [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm)) the Centers for Medicare & Medicaid Services (CMS) is increasing the calendar year (CY) payment rates for RHCs and FQHCs effective for services on or after January 1, 2009, through December 31, 2009 (i.e., CY 2009), as follows:

- The RHC upper payment limit per visit is increased from \$75.63 to \$76.84 effective January 1, 2009, through December 31, 2009 (i.e., CY 2009). The 2009 rate reflects a 1.6 percent increase over the 2008 payment limit in accordance with the rate of increase in the Medicare economic index (MEI) as authorized by the Social Security Act (Section 1833(f)).
- The FQHC upper payment limit per visit for urban FQHCs is increased from \$117.41 to \$119.29 effective January 1, 2009, through December 31, 2009 (i.e., CY 2009), and the maximum Medicare payment limit per visit for rural FQHCs is increased from \$100.96 to

\$102.58 effective January 1, 2009, through December 31, 2009 (i.e. CY 2009). The 2009 FQHC rates reflect a 1.6 percent increase over the 2008 rates, in accordance with the rate of increase in the MEI.

To avoid any unnecessary administrative burden, Medicare contractors will **not** retroactively adjust individual RHC/FQHC bills paid at previous upper payment limits. However, they retain the discretion to make adjustments to the interim payment rate or a lump sum adjustment to total payments already made to take into account any excess or deficiency in payments to date.

#### Additional information

The official instruction, CR 6218, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1626CP.pdf>.

If you have questions, please contact your Medicare 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>.

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6218  
 Related Change Request (CR) Number: 6218  
 Related CR Release Date: October 31, 2008  
 Related CR Transmittal Number: R1626CP  
 Effective Date: January 1, 2009  
 Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1626, CR 6218

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### Medicare billing information for rural providers, suppliers, and physicians

The revised publication titled Medicare *Billing Information for Rural Providers, Suppliers, and Physicians* (October 2008), which consists of charts that provide Medicare billing information for rural health clinics, federally qualified health centers, skilled nursing facilities, home health agencies, critical access hospitals, and swing beds, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf>. ❖

Source: CMS PERL 200811-29

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# HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## Archiving and retrieving of the integrated outpatient code editor and the Medicare code editor for processing claims

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

### Provider types affected

Providers submitting claims to Medicare fiscal intermediaries (FIs), 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) 6177 and assures providers that Medicare contractors will have the ability to process claims and apply edits correctly. The Centers for Medicare & Medicaid Services (CMS) requires Medicare contractors to establish a mechanism to retrieve outpatient code editor (OCE) versions, effective for a date of service (DOS) prior to the most recent iteration (minus seven years), and establish a mechanism to retrieve Medicare code editor (MCE) versions effective for discharges prior to the most recent iteration (minus ten years).

### Background

Currently the fiscal intermediary shared system (FISS) includes one copy of the integrated outpatient code editor (IOCE) software, which is supplied by 3M and replaced each quarter. However, to maintain a reasonable size for the software, there is a need to archive versions of the OCE greater than seven years (28 versions) within the shared system so contractors can have the capability to process claims with dates of service prior to the single copy FISS currently maintains. For instance, if a contractor is required to process an OPSS claim on June 1, 2009, and the claim has a DOS of April 2, 2002, the contractor should be able to process the claim without special handling. However, if the OPSS claim had a DOS of March 30, 2002, the contractor must have the capacity to retrieve the archived January 2002 version of the OCE to correctly process the claim.

This is also true for the MCE. There is a complete replacement product each year which includes all versions.

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.

Because it is not possible to use the same archiving and calling conventions used for the inpatient PRICERS, CR 6177 directs Medicare contractors to develop a new archiving and call process for FISS to use in accessing archived OCEs and MCEs.

CR 6177 instructs FIs, A/B MACs and RHHIs to be able to:

- Process claims, with DOS prior to the most recent 28 versions of the OCE, with the appropriate corresponding archived version.
- Process claims, with discharges prior to the most recent iteration of the MCE, with the appropriate corresponding archived version.

### Additional information

The official instruction (CR 6177) issued to your Medicare A/B MAC, FI, and/or RHHI is available on the CMS Web site at <http://www.cms.hhs.gov/transmittals/downloads/R391OTN.pdf>.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part A Customer Service Center is 888-664-4112.

MLN Matters Number: MM6177

Related Change Request (CR) Number: 6177

Related CR Release Date: October 24, 2008

Related CR Transmittal Number: R391OTN

Effective Date: April 1, 2009

Implementation Date: April 6, 2009

Source: CMS Pub. 100-20, Transmittal 368, CR 6177

## Medicare hospital outpatient prospective payment system PRICER file update

The fourth quarter 2008 hospital outpatient prospective payment system (OPPS) PRICER downloads have been updated to include the outpatient provider specific file update. You may go to [http://www.cms.hhs.gov/PCPricer/08\\_OPSS.asp#TopOfPage](http://www.cms.hhs.gov/PCPricer/08_OPSS.asp#TopOfPage) to view the latest update.

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

Source: CMS PERL 200811-09

## EDUCATIONAL EVENTS

### Upcoming provider outreach and educational events December 2008 – February 2009

#### Ask the contractor – Topic: Jurisdiction 9 – Important transition updates

When: Tuesday, December 16, 2008  
 Time: 2:00 p.m. – 3:30 p.m. Eastern Standard Time  
 Type of Event: Webcast

#### Hot topics – Medicare updates, coverage determinations, and tips to avoid claim denials and returns

When: Wednesday, January 14, 2009  
 Time: 11:30 a.m. – 12:30 p.m. Eastern Standard Time  
 Type of Event: Webcast

#### Ask the contractor – Topic: To be determined

When: Wednesday, February 11, 2009  
 Time: 11:30 a.m. – 1:00 p.m. Eastern Standard Time  
 Type of Event: Webcast

#### Two easy ways to register

**Online** – Log on to your account on our provider training Web site at [www.fcsomedicaretraining.com](http://www.fcsomedicaretraining.com) 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 using the instructions at [www.floridamedicare.com/Education/108651.asp](http://www.floridamedicare.com/Education/108651.asp) to register for a class and obtain materials.

**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.

Keep checking our Web site, [www.floridamedicare.com](http://www.floridamedicare.com), or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled educational events (teleconferences, webcasts, etc.).

#### Tips for using the FCSO provider training Web site

To search and register for Florida events on [www.fcsomedicaretraining.com](http://www.fcsomedicaretraining.com) click on the following links:

- “Course Catalog” from top navigation bar
- “Catalog” in the middle of the page
- “Browse Catalog” on the right of the search box
- “FL – Part B or FL – Part A” from list in the middle of the page.

Select the specific session you’re interested in, click the “Preview Schedule” button at the bottom of the page. On the Instructor-Led Training (ILT) Schedule page, locate the line that has the course you are interested in and click the “Register” link in the Options column.

If you need assistance, please contact our FCSO Medicare training help desk by calling 866-756-9160 or sending an email to [fcsohelp@geolearning.com](mailto:fcsohelp@geolearning.com).

#### 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: \_\_\_\_\_

More educational events (teleconferences, webcasts, etc.) are being planned to help providers with hot issues. Keep checking our Web site <http://www.floridamedicare.com> or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events. ❖

## OTHER EDUCATIONAL RESOURCES

### The Medicare Learning Network

The *Medicare Learning Network (MLN)* is the brand name for the official Centers for Medicare & Medicaid Services (CMS) national fee-for-service (FFS) health care professional education products. The *MLN* is designed to promote national consistency of Medicare information developed for CMS initiatives. Most importantly, it is available to help you.

Each quarter the *MLN* will send out information on the latest products available to order. Please be on the lookout for those updates. For more information on the *Medicare Learning Network*, please visit on the Internet <http://www.cms.hhs.gov/MLNGenInfo>.

### Revised Medicare Physician Guide

The revised *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (October 2008), which offers general information about the Medicare program, becoming a Medicare provider or supplier, Medicare reimbursement, Medicare payment policies, evaluation and management services, protecting the Medicare trust fund, inquiries, overpayments, and appeals, is now to download from the CMS *Medicare Learning Network* at <http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf>.

### The MLN product catalog

The *MLN* products catalog is now an interactive downloadable document that lists all *MLN* products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document. All products indicate the available formats as follows:

- Title product and downloadable -- will link you to the online version of the product.
- Hard copy and CD-ROM -- will automatically link you to the *MLN* product ordering page.

The catalog is updated quarterly and the latest version is now available for download on the CMS Web site at <http://www.cms.hhs.gov/MLNProducts/downloads/MLNCatalog.pdf>.

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

Source: CMS PERL 200810-29

### ICD-10-CM/PCS national provider conference call for hospital staff transcript

The transcript of the Centers for Medicare & Medicaid Services (CMS) International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) national provider conference call for hospital staff that was held on October 14, 2008, is now available at [http://www.cms.hhs.gov/ContractorLearningResources/Downloads/ICD-10\\_October14calltranscript.pdf](http://www.cms.hhs.gov/ContractorLearningResources/Downloads/ICD-10_October14calltranscript.pdf).

If you are unable to access any of the hyperlinks in this message, please copy and paste the URL into your Internet browser. Visit the *Medicare Learning Network*. It's free. ❖

Source: CMS PERL 200810-31

### Guidelines for teaching physicians, interns, and residents booklet now available

The revised publication, *Guidelines for Teaching Physicians, Interns, and Residents* (July 2008), which provides information about payment for physician services in teaching settings, general documentation guidelines and evaluation and management documentation guidelines, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit [http://www.cms.hhs.gov/MLNProducts/01\\_Overview.asp](http://www.cms.hhs.gov/MLNProducts/01_Overview.asp), scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS PERL 200811-18 and 200811-24

### Adult immunizations brochure for health care providers now available

The *Adult Immunizations* (October 2008) brochure for health care providers has been updated and is now available in downloadable portable document format (PDF) from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. This brochure provides an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. To view, download, and print, please go to the CMS Web site [http://www.cms.hhs.gov/MLNProducts/downloads/Adult\\_Immunization.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf). ❖

Source: CMS PERL 200811-27

### Order Form – Medicare Part A Materials

The following materials are available for purchase. To order, please complete and submit this form along with your check/ money order payable to: FCSO – account number 40-500-150.

Number Ordered	Item	Account Number	Cost per Item
_____	<p><b>Medicare A Bulletin Subscriptions</b> – The <i>Medicare A Bulletin</i> is available free of charge online at <a href="http://www.fcsso.com">http://www.fcsso.com</a>. Hardcopy or CD-ROM distribution is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida for processing during the twelve months prior to the release of each issue.</p> <p><b>Beginning with publications issued after June 1, 2003,</b> providers that meet the above criteria must register with our office (see May 2008 <i>Medicare A Bulletin</i> page 4) to receive the <i>Bulletin</i> in hardcopy or CD-ROM format. Qualifying providers will be eligible to receive one hardcopy or CD-ROM of each issue, if a valid reason is given indicating why the electronic publication available free-of-charge on the Internet cannot be used.</p> <p>Non-Medicare providers (e.g., billing agencies, consultants, software vendors, etc.) or providers that need additional copies at other office-facility locations may purchase an annual subscription. This subscription includes all Medicare bulletins published from October 2008 through September 2009 (back issues sent upon receipt of the order). Please check here if this will be a:</p> <p><input type="checkbox"/> Subscription renewal or  <input type="checkbox"/> New subscription</p>	40-500-150	<p>\$33.00 (Hardcopy)</p> <p>\$55.00 (CD-ROM)</p>

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**P.O. Box 406443**  
**Atlanta, GA 30384-6443**

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**Note:** The *Medicare A Bulletin* is available free of charge online at [www.fcsso.com](http://www.fcsso.com).

## Addresses

### CLAIMS STATUS

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 (MSP)

Information on Hospital Protocols  
Admission Questionnaires  
Audits

Medicare Secondary Payer  
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

### Automobile Accident Cases Settlements/Lawsuits Other Liabilities

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

### PROVIDER EDUCATION

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

### Seminar Registration Hotline

1-904-791-8103

### Seminar Registration Fax Number

1-904-361-0407

## Other Important Addresses

### REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY

Home Health Agency Claims  
Hospice Claims

Palmetto Government Benefit  
Administrators – Gulf Coast  
34650 US Highway 19 North,  
Suite 202  
Palm Harbour, FL 34684-2156

### RAILROAD MEDICARE

Railroad Retiree Medical Claims

Palmetto Government Benefit  
Administrators  
P. O. Box 10066  
Augusta, GA 30999-0001

### ELECTRONIC CLAIM FILING “DDE Startup”

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

### FRAUD AND ABUSE

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

### PART A RECONSIDERATION Claims Denied at Redetermination Level

MAXIMUS  
QIC Part A East Project  
Eastgate Square  
50 Square Drive  
Victor, NY 14564-1099

### OVERPAYMENT COLLECTIONS Repayment Plans for Part A Participating Providers Cost Reports (original and amend- ed)

Receipts and Acceptances  
Tentative Settlement Determinations  
Provider Statistical and Reimburse-  
ment (PS&R) Reports  
Cost Report Settlement (payments  
due to provider or program)  
Interim Rate Determinations  
TEFRA Target Limit and Skilled  
Nursing Facility Routine Cost Limit  
Exceptions  
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 American Diabetes Association

Certificates

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

### 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

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 MEDIA CLAIMS

EMC Start-Up

1-904-791-8767, option 4

Electronic Eligibility

1-904-791-8131

Electronic Remittance Advice

1-904-791-6865

Direct Data Entry (DDE) Support

1-904-791-8131

PC-ACE Support

1-904-355-0313

Testing

1-904-791-6865

Help Desk

(Confirmation/Transmission)

1-904-905-8880

## Medicare Web sites

### PROVIDERS

Florida Medicare Contractor

[www.floridamedicare.com](http://www.floridamedicare.com)

Centers for Medicare & Medicaid  
Services

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

### BENEFICIARIES

Centers for Medicare & Medicaid  
Services

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



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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***MEDICARE A BULLETIN***

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

**♦ ATTENTION BILLING MANAGER ♦**

