

# 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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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:

**Medicare Publications  
1-904-361-0723**

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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

### Electronic mailbox for submitting requests to add or delete telehealth services

The Centers for Medicare & Medicaid Services (CMS) makes any additions or deletions to the services defined as Medicare telehealth services effective on a January 1st basis. Any interested parties from either the public or private sectors may submit requests for adding services to the list of Medicare telehealth services.

Requests for adding services to the list of Medicare telehealth services may be submitted on an ongoing basis. Requests must be submitted and received no later than December 31 of each calendar year to be considered for the following year proposed rule (i.e., requests must be received by December 31, 2008, to be considered during the 2009 rulemaking cycle that establishes physician fee schedule rates for 2010).

Requests to add or delete services may be mailed to:

Attention: Telehealth Review Process  
 Division of Practitioner Services  
 Mail Stop: C4-03-06  
 Centers for Medicare & Medicaid Services  
 7500 Security Boulevard  
 Baltimore, MD 21244-1850

As an alternative to regular mail, requests may be submitted electronically to the telehealth requests resource mailbox [CMS\\_Telehealth\\_Review\\_Process@cms.hhs.gov](mailto:CMS_Telehealth_Review_Process@cms.hhs.gov)

For information on submitting a request to add or delete telehealth services, visit the CMS Web site at <http://www.cms.hhs.gov/telehealth/>. ❖

Source: CMS PERL 200812-15

### CMS issues news release on improper payment rates for Medicare, Medicaid, and SCHIP

The Center for Medicare & Medicaid Services has reported it protected roughly \$400 million of taxpayer dollars. Improper payments for Medicare fee-for-service (FFS) decreased from 3.9 percent in fiscal year (FY) 2007 to 3.6 percent (or \$10.4 billion) in FY 2008. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) improper payment rates are issued annually as part of the U.S. Department of Health & Human Services (HHS) agency financial report.

In addition to improved Medicare FFS payments for FY 2008, CMS reports its first Medicare Advantage improper payment rate of 10.6 percent (or \$6.8 billion) in payments made in calendar year 2006. Also being reported for the first time are the FY 2007 national composite error rates for Medicaid and SCHIP. The Medicaid composite error rate is 10.5 percent (or \$32.7 billion) of which the federal share is \$18.6 billion. The SCHIP composite error rate is 14.7 percent (or \$1.2 billion) with a federal share of \$0.8 billion.

To read the complete CMS press release issued November 7, 2008, click here: [http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp). ❖

Source: CMS PERL 200811-32

### New informational message on the Medicare summary notice

Beginning January 9, 2009, through September 30, 2009, First Coast Service Options Inc. will print the general message number 24.15 on all Medicare summary notices (MSNs) issued to beneficiaries in Florida. This message will be placed on the first page in the fraud section:

#### English version

Report items and services that you did not receive to Medicare's Fraud Hotline at 1-866-417-2078.

#### Spanish version

Reporte los servicios y artículos que no recibió a la línea gratuita para Fraude de Medicare al 1-866-417-2078. ❖

Source: CMS JSM 09111, December 31, 2008



## Flu shot reminder

**I**t's not too late to get the flu shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. Re-vaccination is necessary each year because flu viruses change each year. So please encourage your Medicare patients who haven't already done so to get their annual flu shot. Medicare patients give many reasons for not getting their annual flu shot, including:

- 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.

The fact is that 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, your family and friends.

### Get your 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.

## Educational resources

Health care professionals and their staff may learn more about Medicare's coverage of the influenza vaccine and its administration, and other Medicare Part B covered vaccines and related provider education resources created by the CMS *Medicare Learning Network (MLN)*, by reviewing special edition *MLN Matters* article SE0838 on the CMS Web site <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf>.

Additional information is available on 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 at [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 quick reference chart may be ordered at no 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. ❖

Source: CMS PERL 200811-36, 200812-02, 200812-47

## National Influenza Vaccination Week

**T**he Centers for Disease Control and Prevention (CDC) announced the week of December 8-14, 2008, as National Influenza Vaccination Week. This week-long event is designed to raise awareness of the importance of continuing influenza (flu) vaccination, as well as foster greater use of flu vaccine in December, January, and beyond. Since flu activity typically does not peak until February or later, December and January still provide good opportunities to offer flu shots.

The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare get their flu shots. If you have Medicare patients who have not yet received their annual flu shots, we ask that you encourage your patients to protect themselves from the seasonal flu and serious complications arising from the flu virus by recommending that they take advantage of the flu shot benefit covered by Medicare.

**Remember:** Health care professionals and their staff are also at risk for contracting and spreading the flu virus, so don't forget to immunize yourself and your staff. Protect yourself, patients, family and friends.

### Get your flu shot – not the flu.

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

## For more information

Learn more about Medicare's coverage of the flu vaccine and other Medicare Part B covered vaccines and related provider education resources created by CMS, by reviewing special edition *MLN Matters* article SE0838 located on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf>.

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

Source: CMS PERL 200812-19

## A CMS quick reference information resource for flu season

**F**lu season is here! Medicare provides coverage of the flu vaccine without any out-of-pocket costs to Medicare patients. No deductible or copayment/coinsurance applies. For quick information to assist with filing claims for the influenza vaccine and its administration, the Centers for Medicare & Medicaid Services (CMS) has prepared the *Quick Reference Information: Medicare Part B Immunization Billing chart (Feb. 2008)*. This two-sided laminated reference chart gives Medicare fee-for-service providers, a quick reference to coding and billing information. To view, download, and print the 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). To order a copy, free of charge, go to the MLN Products Ordering Web page at [http://cms.meridianksi.com/kc/pfs/pfs\\_lnkfrm\\_fl.asp?lgnfrm=reqprod&function=pfs](http://cms.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs). ❖

Source: CMS PERL 200811-41

## Understanding new workload and roll-up numbers for all Medicare administrative contractors

**Effective date: January 1, 2006**

**Implementation date: December 29, 2008**

Change request (CR) 6259 replaces previously issued CR 5651. The information outlined below provides details related to changes for providers and contractors as they move toward the Medicare administrative contractor (MAC) environment. Information includes:

- explanation of the numbering scheme of the MAC workload number
- explanation and use of the “roll-up numbers”
- chart outlining all numbers that may be utilized for all MAC jurisdictions

### Background

The Centers for Medicare & Medicaid Services (CMS) assigns new workload numbers for MAC jurisdictions. Medicare contracting reform requires that CMS use competitive procedures to replace its current fiscal intermediaries and carriers with a uniform type of administrative entity, referred to as Medicare administrative contractor (MAC). As such, new numbers are required to identify the work being performed by the new MAC contractors. Previous instructions were issued in CR 5651. New numbers have been issued for the state of North Carolina Part A and Part B due to the previous numbers utilized by another CMS component. For ease of reference and to reduce duplication, CR 5651 has been withdrawn and its pertinent sections combined with CR 6259.

The numbering scheme allows for three tiers of MAC numbers to meet the current and future needs of CMS and its contractors.

**The bottom tier** is the **workload number**, which uniquely identifies each MAC workload by claim type and state as described below.

**The second tier** number is the **Part A number, Part B number, durable medical equipment (DME) number, or home health and hospice (HHH) number**. This number is the aggregate for each of the claim types processed within each MAC jurisdiction and is commonly referred to as the “roll-up” number.

**The top tier** consists of a single jurisdiction number which uniquely identifies each MAC and includes all claim types processed by that jurisdiction.

As the MAC implementations move forward, it is imperative that all:

- CMS components and contractors understand the numbering convention and what it represents
- claim processing and financial system applications recognize/process the appropriate numbers, and
- components use the appropriate number that best meets their needs within the overall MAC numbering scheme as described below.

When each jurisdiction is awarded and cutover dates are finalized, a change request will be issued with the appropriate MAC numbers for that jurisdiction.

### Workload number

**For Part A and Part B, there will be a unique workload number for each state within the 15 MAC jurisdictions.** That number may be appended with a unique business segment identifier (BSI), which also represents the state and is used in certain applications and workload reporting. The following shows an example for the state of Kansas in jurisdiction 5.

#### Workload number

0 5 2 0 1

05 = jurisdiction indicator

2 = state indicator by state alphabetical order within the jurisdiction

0 = for future use to indicate a change of MAC contractor

1 = claim type\*

KSA - business segment identifier

\*Claim type designations: Part A = 1; Part B = 2; DME = 3; RHHI = 4

#### Business segment identifier

K S A

### Part A, Part B, DME, or HHH number (a.k.a. roll-up number)

This number is for components requiring a roll-up number for Part A and Part B for the 15 A/B MACs (e.g., financial reporting) or a DME or HHH number. There will be no BSI or state indicator for these numbers. The Part A and Part B examples are shown for the state of Kansas.

The four DME jurisdictions (jurisdictions A, B, C, and D) are identified for numbering purposes as jurisdictions 16, 17, 18, and 19 respectively.

Four A/B MACs (jurisdictions 6, 11, 14, and 15) will be responsible for processing HHH claims. Each of those MACs will process HHH claims for a designated HHH jurisdiction, configured in the same manner as the DME jurisdictions. The following four examples illustrate the application of the roll-up number for each of the different claim types.

#### Part A (roll-up) number

0 5 0 0 1\*

#### Part B (roll-up) number

0 5 0 0 2\*

#### DME number

1 8 0 0 3\*

**Understanding new workload and roll-up numbers for all Medicare administrative contractors (continued)**

**HHH Number**

0 6 0 0 4\*

First two numbers = jurisdiction indicator

Last number = claim type\*

\* Claim type designations: Part A = 1; Part B = 2; DME = 3; RHHI = 4

**Jurisdiction number**

This would be the number representing the entire MAC jurisdiction. This would be used by an application desiring an all-inclusive jurisdiction number.

**Jurisdiction number**

0 5 0 0 0

The following chart shows all numbers that may be utilized for all MAC jurisdictions.

Jurisdiction	Workload Type	Workload Number	State	Roll- up
1	A	01101 01201 01301	CA HI NV	01001
	B	01192 01102 01202 01302	CA S CAN HI NV	01002
2	A	02101 02201 02301 02401	AK ID OR WA	02001
	B	02102 02202 02302 02402	AK ID OR WA	02002
3	A	03101 03201 03301 03401 03501 03601	AZ MT ND SD UT WY	03001
	B	03102 03202 03302 03402 03502 03602	AZ MT ND SD UT WY	03002
4	A	04101 04201 04301 04401	CO NM OK TX	04001
	B	04102 04202 04302 04402	CO NM OK TX	04002

**GENERAL INFORMATION**

**Understanding new workload and roll-up numbers for all Medicare administrative contractors (continued)**

Jurisdiction	Workload Type	Workload Number	State	Roll- up
5	A	05101 05201 05301 05401	IA KS MO NE	05001
	B	05102 05202 05302 05392 05402	IA KS MO W. MO E. NE	05002
6	A	06101 06201 06301	IL MN WI	06001
	B	06102 06202 06302	IL MN WI	06002
7	A	07101 07201 07301	AR LA MS	07001
	B	07102 07202 07302	AR LA MS	07002
8	A	08101 08201	IN MI	08001
	B	08102 08202	IN MI	08002
9	A	09101 09201	FL PR/VI	09001
	B	09102 09202 09302	FL PR VI	09002
10	A	10101 10201 10301	AL GA TN	10001
	B	10102 10202 10302	AL GA TN	10002
11	A	11501 11201 11301 11401	NC SC VA WV	11001
	B	11502 11202 11302 11402	NC SC VA WV	11002



## Understanding new workload and roll-up numbers for all Medicare administrative contractors (continued)

Jurisdiction	Workload Type	Workload Number	State	Roll- up
12	A	12101 12201 12301 12401 12501	DE DC MD NJ PA	12001
	B	12102 12202 12302 12402 12502	DE DC MD NJ PA	12002
13	A	13101 13201	CT NY	13001
	B	13102 13292 13282 13202	CT NY (GHI NY (HealthNow) NY (Empire)	13002
14	A	14101 14201 14301 14401 14501	ME MA NH RI VT	14001
	B	14102 14202 14302 14402 14502	ME MA NH RI VT	14002
15	A	15101 15201	KY OH	15001
	B	15102 15202	KY OH	15002
DMAC A		16003	RAD	00811
DMAC B		17003	RBD	00635
DMAC C		18003	RCD	00885
DMAC D		19003	RDD	05655
<b>Home Health and Hospice</b>				
6	HHH D	06004	AKR	
11	HHH C	11004	ALR	
14	HHH A	14004	CTR	
15	HHH B	15004	ILR	

**Understanding new workload and roll-up numbers for all Medicare administrative contractors (continued)**

The following systems shall reflect the new contractor number: BESS, CAFM, CERT, CMIS, COBA, the CMS HDC, CROWD, CSAMS, CWF, DCS, ECRS, FISS, HCIS, HIGLAS, IRIS, LOLA, MPaRTS, MCS, National Claims History, NGD, the NPI crosswalk, OSCAR, PECOS, PIMR, PORS, PS&R, the PSC, PSOR, PULSE, REMAS, REMIS, STAR, and the Expert Claims Processing System or ECPS (which was formerly known as SuperOP).

Finally, the CMS is studying how and when to transition to the applicable MACs the workload covered by contractor workload number 52280, which was formerly processed by Mutual of Omaha and is currently processed by Wisconsin Physicians Service (WPS) in its capacity as a legacy Title XVIII fiscal intermediary. The CMS will notify all parties as soon as its instructions are final.

Source: CMS Pub. 100-20, Transmittal 405, CR 6259

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.

**Written clarification on the DMEPOS accreditation deadline**

Medicare for Patients and Providers Act of 2008 (MIPPA) section 154(b) added a new subparagraph (F) to section 1834(a)(20) of the Social Security Act. This subparagraph states that eligible professionals and other persons are exempt from meeting the September 30, 2009, accreditation deadline that generally applies to other durable medical equipment prosthetics orthotics and supplies (DMEPOS) suppliers unless the Centers for Medicare & Medicaid Services (CMS) determines that the quality standards are specifically designed to apply to such professionals and persons.

The eligible professionals to whom this exemption applies are set out at sections 1848(k)(3)(B) and 1861(r) of the Act, and include physicians, physical therapists, occupational therapists, qualified speech-language pathologists, physician assistants, and nurse practitioners.

Additionally, section 154(b) of MIPPA allows the Secretary to specify “other persons” that, like the eligible professionals described above, are exempt from meeting the accreditation requirements unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, we are defining “such other persons” as orthotists, prosthetists, opticians, and audiologists.

CMS will define how the quality standards apply to these eligible professionals and other persons by rulemaking in 2009.

Individuals not included in this exemption list, such as pedorthotists, mastectomy fitters, orthopedic fitters/technicians or athletic trainers applying for Medicare enrollment in order to bill for Medicare Part B services are not exempt from meeting the September 30, 2009, deadline for DMEPOS accreditation. ❖

Source: CMS PERL 200812-27

**News on the ICD-10-Clinical Modification/Procedure Coding System initiative****Transcript from the national provider conference call for physicians now available**

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 physicians that was held on November 17, 2008, is now available at <http://www.cms.hhs.gov/ICD10/Downloads/November17calltranscript.pdf>.

**ICD-10 2009 files**

CMS has updated the ICD-10 download files by posting the 2009 version of the following documents at [http://www.cms.hhs.gov/ICD10/01m\\_2009\\_ICD-10-PCS.asp#TopOfPage](http://www.cms.hhs.gov/ICD10/01m_2009_ICD-10-PCS.asp#TopOfPage):

- ICD-10 General equivalence mappings (these refer to procedure codes)
- Reimbursement mappings and guides for the use of the mappings
- 2009 version of ICD-10-procedure coding system (PCS)
- ICD-10 version of the digestive Medicare severity-diagnosis related groups (MS-DRG)

The 2009 ICD-10-CM (diagnosis codes) general equivalence mappings have been posted at [http://www.cms.hhs.gov/ICD10/03\\_ICD\\_10\\_CM.asp](http://www.cms.hhs.gov/ICD10/03_ICD_10_CM.asp).

The 2009 version of ICD-10-Clinical Modifications (CM), diagnoses, will be posted by the end of December 2008 on the following sites:

- <http://www.cdc.gov/nchs/icd9.htm>
- [http://www.cms.hhs.gov/ICD10/02m\\_2009\\_ICD\\_10\\_CM.asp](http://www.cms.hhs.gov/ICD10/02m_2009_ICD_10_CM.asp). ❖

Source: CMS PERL 200812-38

## ICD-10-Clinical Modification/Procedure Coding System fact sheet

The ICD-10-Clinical Modification/Procedure Coding System Fact Sheet, which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9CM and ICD-10-CM/PCS, and implementation planning recommendations, is 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 200812-06

## ICD-10 national conference call for other Part A and Part B providers transcript

The transcript of the Centers for Medicare & Medicaid Services ICD-10-CM/PCS national provider conference call for other Part A and Part B providers that was held on November 12, 2008, is now available at <http://www.cms.hhs.gov/icd10/Downloads/Nov12calltranscript.pdf>. ❖

Source: CMS PERL 200812-14

## What's new for Medicare fee-for-service providers on the CMS Web site

The Centers for Medicare & Medicaid Services (CMS) is continually updating and improving the fee-for-service (FFS) provider Web pages to make it easier for FFS providers to find important information on the CMS Web site. CMS notifies interested parties via the FFS provider listserv periodically when those revisions are made. Most of the Medicare FFS provider Web pages may be found on the Medicare page at <http://www.cms.hhs.gov/home/medicare.asp>.

The following Medicare FFS provider Web pages are a sample of what's been updated:

- These sections have been improved by adding dynamic lists for provider specific regulations and notices and transmittals for inpatient psychiatric facilities (<http://www.cms.hhs.gov/InpatientPsychFacilPPS/>) and hospice (<http://www.cms.hhs.gov/Hospice/>) providers.
- The Educational Resources section of the Hospital-Acquired Conditions (HAC) & Present on Admission (POA) Indicator Reporting Web page (<http://www.cms.hhs.gov/HospitalAcqCond/>) has recently been updated to include the agenda for the hospital-acquired conditions and hospital outpatient health care-associated conditions listening session scheduled for Thursday, December 18, 2008.
- Effective for dates of service on or after January 1, 2009, the National Correct Coding Initiative (NCCI) edits will not categorically exclude any types of services. For more information, go to the Hospital Outpatient PPS and Therapy NCCI Web page at ([http://www.cms.hhs.gov/NationalCorrectCodInitEd/02\\_hoppscciedits.asp](http://www.cms.hhs.gov/NationalCorrectCodInitEd/02_hoppscciedits.asp)). These institutional NCCI edits will be available on or about January 1, 2009 at (<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp>). 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 <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp>.
- See the updates to the Competitive Acquisition for Part B Drugs & Biologicals (<http://www.cms.hhs.gov/CompetitiveAcquisforBios/>) Web pages which reflect the major changes to this program.

Check out what's new for you. ❖

Source: CMS PERL 200812-31

### 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.

## Online Medicare self-enrollment now available for physician and nonphysician practitioners

Internet-based Medicare enrollment is available for Medicare physician and nonphysician practitioners (NPPs) in 44 states and the District of Columbia. **It's fast, secure, and easy.**

Now there is a better way for physicians and NPPs to enroll or make a change in their Medicare enrollment information. The Internet-based provider enrollment, chain, and ownership system (PECOS) will allow physicians and NPPs to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on the status of a Medicare enrollment application via the Internet.

The Centers for Medicare & Medicaid Services (CMS) announced that Internet-based PECOS is available to physicians and NPPs in the District of Columbia and the following states:

Alabama	Alaska	Arizona	Arkansas	Connecticut	Delaware	Florida	Georgia
Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky	
Louisiana	Maine	Maryland	Massachusetts	Michigan	Minnesota	Mississippi	
Missouri	Montana	Nebraska	Nevada	New Hampshire	New Jersey	New York	
North Carolina	North Dakota	Ohio	Oregon	Pennsylvania	Rhode Island	South Carolina	
South Dakota	Tennessee	Utah	Vermont	Washington	West Virginia	Wisconsin	
Wyoming							

Physicians and NPPs (located in the District of Columbia and in the states shown above) who wish to access Internet-based PECOS, may go to <https://pecos.cms.hhs.gov>.

CMS will expand the availability of Internet-based PECOS for physicians and NPPs to all states over the next two months. In addition, CMS will make Internet-based PECOS available next year to all providers and suppliers (except those who supply durable medical equipment, prosthetics, orthotics, and supplies).

### Fast

By submitting the initial Medicare enrollment application through Internet-based PECOS, a physician or NPP's enrollment application can be processed as much as 50 percent faster than by paper. This means that it will take less time to enroll.

Physicians and NPPs are required by regulation to report certain changes in their enrollment information within specified timeframes. Internet-based PECOS will allow them to update, make corrections, and check on the status of their Medicare enrollment applications as much as 50 percent faster than by paper. Changes include a change in practice location, ownership, or final adverse action (medical license suspension or revocation). For additional information about the types of changes that must be reported, go to the download section of <http://www.cms.hhs.gov/MedicareProviderSupEnroll>.

### Secure

Internet-based PECOS meets all required Government security standards in terms of data entry, data transmission, and the electronic storage of Medicare enrollment information. Only authorized individuals can enter enrollment information into PECOS or view PECOS data from the Internet.

Authorized individuals include physicians and NPPs. Their user IDs and passwords protect the access to their enrollment information. After physicians or NPPs create user IDs and passwords (or change their passwords), they should keep this information secure and not share it with anyone. By safeguarding their user IDs and passwords, they are taking an important step in protecting their enrollment information. CMS does not disclose Medicare enrollment information to anyone except when authorized or required to do so by law.

### Easy

Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The scenario-driven application process will ensure that physicians and NPPs complete and submit only the information necessary to enroll or make a change in their Medicare enrollment record. In contrast to the information collected on the CMS-855I, physicians and NPPs will no longer see questions that are not applicable to their enrollment scenarios when using Internet-based PECOS.

**Note:** Physicians and NPPs are still required to sign and date the certification statement and to mail the certification statement and all supporting paper documentation to the Medicare contractor.

A Medicare contractor will not process an Internet enrollment application without the signed and dated certification statement and the required supporting documentation. In addition, the effective date of filing an enrollment application is the date the Medicare contractor receives the signed certification statement that is associated with the Internet submission.

### Additional information

For information about Internet-based PECOS, including important information that physicians and NPPs should know before submitting a Medicare enrollment application via Internet-based PECOS, go to <http://www.cms.hhs.gov/MedicareProviderSupEnroll>. ❖

Source: CMS PERL 200812-13, 200812-25, 200812-34, 200812-45

## Method of payment for extended stay services under the frontier extended stay clinic demonstration

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

### Provider types affected

Specific rural health clinics (RHC), federally qualified health centers (FQHC), or tribally owned clinics that are part of the frontier extended stay clinic (FESC) demonstration project and billing Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs) for extended stay services rendered to Medicare beneficiaries in remote frontier areas.

### Impact on provider

This article is based on change request (CR) 6057 and outlines the payment instructions and policy rules for the FESC demonstration project, which impacts a very limited number of providers as identified in this article.

### Background

Section 434 of the MMA established the Frontier Extended Stay Clinic (FESC) Demonstration project to test the feasibility of providing extended stay services to remote frontier areas under Medicare payment and regulations. A FESC must be located in a community which is:

1. At least 75 miles away from the nearest acute care hospital or critical access hospital, or
2. Is inaccessible by public road.

FESCs are designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care hospitals, or patients who do not meet CMS inpatient hospital admission criteria and who need monitoring and observation for a limited period of time.

Under rules established for the demonstration, clinics participating under the FESC demonstration will be allowed to keep patients for extended stays in situations where weather or other circumstances prevent transfer. Extended stays up to 48 hours are permitted for patients who do not meet the CMS inpatient hospital admission criteria but who need monitoring and observation for a limited period of time. According to the rules, there can be no more than four patients under this criterion at any one time at any single facility and the FESC demonstration will last for three years.

The following six clinics/tribal facilities are eligible for the demonstration

Clinic	Town	Clinic type
Inter-island Medical Center	Friday Harbor, WA	RHC
Powder River Medical Clinic	Broadus, MT	RHC
Cross Road Medical Center	Glenallen, AK	FQHC
Iliuliuk Family & Health Services	Unalaska, AK	FQHC
Alicia Roberts Medical Center	Prince of Wales Island, AK	Tribal facility
Haines Health Center	Haines, AK	Tribal facility

A listed clinic must receive certification from CMS before it can bill for services to the MAC. Certification signifies a clinic's adherence to the requirements for services, staffing, life safety codes and other factors.

### Key points

For each chosen clinic:

- The clinic will be paid for extended stays in four hour increments after an initial four hour stay. Subject to a screening for medical necessity, Medicare payment will only occur for stays that last at least four hours. For these stays that equal or exceed four hours, demonstration payment will also apply to the first four hours of the stay.
- The clinic may provide services to:
  - Patients with an emergency medical condition who require an extended stay due to weather or other conditions that preclude transport to an acute care hospital.
  - Ill or injured patients who receive an extended stay because a physician, nurse practitioner or physician assistant determines that they do not meet Medicare inpatient hospital admission criteria but do need monitoring and observation, and determines that they can be discharged within 48 hours.
- The HCPCS code G9140 will indicate the length of stay for each Medicare patient from the point of time that he/she is seen by the clinic. This code will measure four hour units of time.
- The FI and/or A/B MAC will calculate Medicare payment specific to the demonstration from the G-code. Payment will be made through the same mechanism for RHC and FQHC payments, but the demonstration payment will be separable for accounting purposes.



**Method of payment for extended stay services under the frontier extended stay clinic demonstration (continued)**

- A claim that can be distinctly measured as greater than the four hour unit will be either rounded up or down to the closer four hour multiple, (i.e., a claim that reads 300 minutes should reflect one four hour unit; a claim of 420 minutes should reflect two, four hour units)
- The revenue codes are 516, 519, 0529 and 0510 and the applicable bill types are 13x, 71x, and 73x.
- The FI and/or AB MAC will conduct a medical necessity screening of each Medicare patient who equals or exceeds four hours from the time he/she is originally seen by the clinic.
- The FI and/or AB MAC will make a Medicare payment under the demonstration if:
  - The patient’s stay equals or exceeds four hours, and
  - There is no documentation of weather or transportation issues, and
  - The FI and/or A/B MAC determines under its medical review that the patient’s condition has been evaluated by a physician, physician assistant, or nurse practitioner and is of sufficient risk to warrant continued observation in the clinic. Or
  - There is documentation of a transfer or weather or transportation conditions preventing transfer, and
  - The patient’s stay equals or exceeds four hours.
- There is a four hour payment rate for each FESC selected for the demonstration. These rates are based on the 2007 ambulatory payment classification for observation services, and they incorporate wage and cost-of-living adjustments. The four hour payment rates for the clinics for 2009 are:

Tribal Clinics	Alicia Roberts Medical Center (Prince of Wales Island, Alaska)	\$541.24
	Haines Health Center (Haines, Alaska)	\$541.24
Federally Qualified Health Centers	Cross Road Medical Center (Glenallen, Alaska)	\$541.24
	Iliuliuk Family and Health Services (Unalaska, Alaska)	\$541.24
Rural Health Clinics	Inter-island Medical Center (Friday Harbor, Washington)	\$479.74
	Powder River Medical Clinic(Broadus, Montana)	\$435.64

For subsequent years of the demonstration, these payment amounts will be updated by the market basket adjustment, which is applicable to the outpatient prospective payment system.

- The FI and/or MAC will use the following instructions to conduct the medical necessity screening to determine whether the patient meets these requirements:
  - All medical conditions will be eligible.
  - The patient’s time from the point when he/she is seen by the clinic staff must be documented on the medical record.
  - A beneficiary’s observation time must be documented on the medical record.
  - The beneficiary must be in the care of a physician, physician assistant, or nurse practitioner during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician, physician assistant, or nurse practitioner.
  - The medical record must include documentation that the physician, physician assistant, or nurse practitioner explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.
- For those claims designated for payment under the demonstration the FI and/or A/B MAC will make a demonstration payment specific to each provider. This payment will be the rate of payment per time unit multiplied by the number of time units (four hour units) in the stay.
- Except for Indian health service and tribally owned and operated clinics, the FI and/or AB/MAC will apply a 20 percent coinsurance on Medicare beneficiaries receiving the extended stay services (i.e., services in the clinic beyond the first four hours).
- For Indian Health Service and tribally owned and operated clinics, there will be no coinsurance.
- There will be no deductible for extended stay services.
- The Centers for Medicare & Medicaid Services (CMS) will design a form that each participating clinic will use to document weather conditions or other circumstances that prevent a transfer will conduct additional retrospective reviews of two circumstances pertaining to patient stays:
  1. CMS will verify the weather conditions for stays longer than 12 time units by retrospectively assessing documentation provided by clinics.

**Method of payment for extended stay services under the frontier extended stay clinic demonstration (continued)**

2. The clinic should report to CMS at any time when there are more than four Medicare patients who are each in the clinic for more than four hours. If the clinic reports there are more than four patients at one time, it must complete the form documenting weather or other conditions that prevent transfer. CMS will conduct audits of these records at least once every three months and determine whether the clinic is in compliance with the rule. Neither the FI nor the A/B MAC has responsibility for monitoring these records.
- The FI and/or A/B MAC will pay claims on an automated basis, and post-payment review will occur as is standard for RHCs and FQHCs.

**Additional Information**

To see the official instruction (CR 6057) issued to your Medicare FI or A/B MAC visit on the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R59DEMO.pdf>.

If you have any questions, please contact your carrier, FI, or 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6057

Related Change Request (CR) Number: 6057

Related CR Release Date: December 12, 2008

Related CR Transmittal Number: R59DEMO

Effective Date: January 1, 2009

Implementation Date: January 12, 2009

Source: CMS Pub. 100-19, Transmittal 59, CR 6057

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.

## National Heritage Insurance Corporation awarded the jurisdiction 14 contract

### National Heritage Insurance Corporation (NHIC) will administer Medicare claim payments in Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

The Centers for Medicare & Medicaid Services (CMS) recently announced that National Heritage Insurance Corporation (NHIC) has been awarded a contract of up to five years for the combined administration of Part A and Part B Medicare claim payment in Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

NHIC will serve as the first point of contact for the processing and payment of Medicare fee-for-service claims from hospitals, skilled nursing facilities, physicians and other health care practitioners in this jurisdiction. The new Part A/Part B Medicare administrative contractor (A/B MAC) was selected using competitive procedures in accordance with federal procurement rules.

The new contractor will take claim payment work currently performed by three fiscal intermediaries and two carriers in this jurisdiction. The A/B MAC contract, which has an approximate value of \$176 million over five years, will fulfill the requirements of the Medicare Modernization Act (MMA) contracting reform provisions.

As the A/B MAC contractor, NHIC will immediately begin implementation activities and will assume full responsibility for the claim processing work in its five-state jurisdiction no later than May 2009. NHIC will be reaching out to providers and state medical associations to provide education and information about the implementation. For more details, visit NHIC's Web site at <http://www.medicarenhic.com/>.

CMS awarded the first A/B MAC contract in July 2006 to Noridian Administrative Services, LLC, headquartered in Fargo, N.D. The list of new contractors and the states they cover, along with other information, may be found at <http://www.cms.hhs.gov/MedicareContractingReform/>.

To read the related CMS press release issued on November 19, 2008, click here: [http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp). ❖

Source: CMS PERL 200811-31

## Influenza pandemic emergency: The Medicare program prepares

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised this *MLN Matters* article on December 8, 2008, to include a Web link to change request (CR) 6209, which was recently issued by CMS. All other information remains the same. The *MLN Matters* article SE0836 was published in the October 2008 *Medicare A Bulletin* (page 13).

### Provider types affected

In the event of a pandemic flu, all physicians and providers who submit claims to Medicare Part C or Part D plans or to Medicare contractors (Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), durable medical equipment Medicare administrative contractors (DME MACs), carriers or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

### Impact on providers

This article is informational only and is alerting providers that the CMS has begun preparing emergency policies and procedures that may be implemented in the event of a pandemic or national emergency.

### Background

As part of its preparedness efforts for influenza pandemic, CMS has begun developing certain emergency policies and procedures that **may** be implemented for the Medicare program in the event of a pandemic or other emergency.

Decision to implement would occur if:

1. The President declares an emergency or disaster under the National Emergencies Act or the Stafford Act.
2. The Secretary of the Department of Health and Human Services declares – under Section 319 of the Public Health Service Act – that a public health emergency exists.
3. The Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act (Act) pursuant to Section 1135 of such Act.

In the event of a pandemic or other national emergency, CMS will issue communications to Medicare providers to specify which policies and procedures will be implemented and other relevant information.

This article includes links to policy documents that have been released by CMS. As additional policy becomes available, CMS will revise this article to include links to all available influenza pandemic policy documents.

### Dedicated CMS Web page now available

Providers should be aware that all relevant materials will be posted on a CMS dedicated “Pandemic Flu” Web page at [http://www.cms.hhs.gov/Emergency/10\\_PandemicFlu.asp](http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp).

That page will contain all important information providers need to know in the event of an influenza pandemic, including the policy documents discussed above.

### Additional information

Additional CMS influenza pandemic policy documents include:

- CR 6146, which may be found on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R404OTN.pdf>.
- CR 6164, which may be found on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R402OTN.pdf>.
- CR 6174, which may be found on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R403OTN.pdf>.
- CR 6209, which is available on the CMS Web site at <http://cms.hhs.gov/Transmittals/downloads/R411OTN.pdf>.

If you have questions, please contact your Medicare FI, A/B MAC, DME 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: SE0836 – Revised  
 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 SE0836

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## Medicare's practical guide to the e-prescribing incentive program

The guide explains the e-prescribing incentive program, how eligible professionals can participate, and how to choose a qualified e-prescribing system. To read or print the guide, visit <http://www.cms.hhs.gov/partnerships/downloads/11399.pdf>.

By adopting e-prescribing through Medicare's program, eligible professionals can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care, while earning incentives from Medicare.

### Continuing education credits available

On October 6-7, 2008, CMS and 34 partner organizations hosted the National E-Prescribing Conference to promote and explain the potential of e-prescribing to improve health care in the United States. Sessions included the e-prescribing incentive payment program; strategies and tools for integrating e-prescribing with current health care delivery practices; and privacy, security, and risk management implications.

The Massachusetts Medical Society and the American Pharmacists Association will provide continuing education for selected presentations from the conference through an online education portal. Available credits are a maximum

of 22.5 AMA PRA Category 1 Credits™, and continuing education for pharmacists (up to 13.25 hours of continuing education credit [1.325 CEUs]). To view or listen to the presentations, and complete an online test on each segment, go to [http://www.massmed.org/cme/CMS\\_eprescribing](http://www.massmed.org/cme/CMS_eprescribing).

### Additional information

For additional information about e-prescribing, you may also visit <http://www.cms.hhs.gov/PQRI>.

Select "E-prescribing Incentive Program;" <http://www.cms.hhs.gov/eprescribing> for information on Part D e-prescribing standards that will be effective April 1, 2009; and <http://www.ehealthinitiative.org> to download "A Clinician's Guide to Electronic Prescribing."

Additional information is available on the National E-Prescribing Conference Web site at <http://www.epsilonregistration.com/er/EventHomePage/CustomPage.jsp?ActivityID=378&ItemID=1117>.

The Centers for Medicare & Medicaid Services looks forward to working with you on the adoption of e-prescribing and implementation of the incentive program. ❖

Source: CMS PERL 200811-35

## Electronic-prescribing incentive program update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the specifications for the e-prescribing measure, which will be used to determine whether an eligible professional is a successful e-prescriber and may qualify for a two percent incentive payment for the 2009 reporting period, has been posted to the CMS Web site. The measure specifications may be found in the Downloads section of the E-Prescribing Incentive Program Web page on the CMS Web site at [http://www.cms.hhs.gov/PQRI/03\\_EPrescribingIncentiveProgram.asp#TopOfPage](http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp#TopOfPage).

An eligible professional does not have to enroll to participate in the e-prescribing incentive program. Furthermore, an eligible professional does not need to participate in the physician quality reporting incentive (PQRI) to participate in this incentive program.

Beginning January 1, 2009, eligible professionals may participate in the e-prescribing incentive program by submitting information required by the e-prescribing measure on their Medicare Part B claims.

Detailed information on the implementation of the e-prescribing incentive program for 2009 may be found in the final 2009 Medicare physician fee schedule final rule with comment period that was published in the *Federal Register* on November 19, 2008. A copy of the final rule with comment period is on display at the *Federal Register* and may be viewed on the CMS Web site at <http://www.cms.hhs.gov/center/physician.asp>. ❖

Source: CMS PERL 200812-01

## Facilitator's Guide: Companion to Medicare Physician Guide

The revised Facilitator's Guide – Companion to Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals (October 2008) is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at <http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp>.

This publication includes all the following information and instructions necessary to prepare for and present a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program:

- instructions for facilitators
- customization guide
- PowerPoint presentation with speaker notes
- pre- and post-assessments
- master assessment answer keys, and
- evaluation tools. ❖

Source: CMS PERL 200812-10



# AMBULANCE SERVICES

## Payment rate increase for covered ground ambulance services

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

### Provider types affected

Ambulance providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Medicare administrative contractors [MACs]) for ambulance services provided to Medicare beneficiaries.

### What you need to know

Change request (CR) 6206, from which this article is taken announces an increase in payment for ground ambulance transports. Effective July 1, 2008, through December 31, 2009, the ambulance fee schedule amounts for covered ground ambulance transports which originate in rural areas are increased by three percent, and for covered ground ambulance transports which originate non-rural areas, they are increased by two percent. You should ensure that your billing staffs are aware of these ambulance fee schedule increases.

### Background

Section 146(a) of Medicare Improvements for Patients and Providers Act of 2008 (MIPAA) amends Section 1834(1)(13) of the Social Security Act to provide an increase in payment for ground transports, effective for claims with dates of service on or after July 1, 2008, and before January 1, 2010. It increases the ambulance fee schedule amounts for:

- Covered ground ambulance transports which originate in a rural area by three percent.
- Covered ground ambulance transports which originate in a non-rural area by two percent.

Until the new fee schedule files have been tested and implemented, your carrier, FI, MAC will hold all of your ground ambulance claims affected by these changes and release them for processing when the files are implemented.

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.

They will also identify ambulance claims (with dates of service on or after July 1, 2008) that were not paid at the rates that CR 6206 provides; and (to the extent possible) automatically reprocess them within 30 days of the release date of CR 6206. In addition, they will adjust claims that cannot be automatically identified and adjusted, if you bring such claims to their attention. Finally, you should be aware that your carrier, FI, or MAC will follow their normal processes for transmitting the adjusted claims to supplemental insurers, where appropriate.

### Additional information

The official instruction, CR 6206, issued to your carrier, FI, or MAC is available on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R414OTN.pdf>.

If you have any questions, please contact your carrier, FI, or 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6206  
 Related Change Request (CR) Number: 6206  
 Related CR Release Date: December 12, 2008  
 Related CR Transmittal Number: R414OTN  
 Effective Date: July 1, 2008  
 Implementation Date: January 12, 2009

Source: CMS Pub. 100-20, Transmittal 414, CR 6206

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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.fcsoc.com>, select Florida Providers, click on the "eNews" link located on the upper-right-hand corner of the page and follow the prompts.



## GENERAL COVERAGE

### Medicare proposes revised coverage policy for bariatric surgery

The Center for Medicare & Medicaid Services (CMS) seeks comments from public on proposal to limit coverage to morbidly obese patients

CMS announced a proposal to clarify its policies for Medicare coverage of bariatric surgery as a treatment for beneficiaries with type 2 (or noninsulin-dependent) diabetes.

Following an extensive evidence review, CMS proposes to revise its existing coverage policy for bariatric surgery. The proposed decision notes that type 2 diabetes is one of the co-morbidities CMS would consider in determining whether bariatric surgery would be covered for a Medicare beneficiary who is morbidly obese. An individual with a body-mass index (BMI) of at least 35 is considered morbidly obese.

To read the CMS press release issued November 7, 2008, click here:

[http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp).

The proposed decision memorandum is available on CMS' Coverage Web site at

<http://www.cms.hhs.gov/center/coverage.asp>. ❖

Source: CMS PERL 200811-33

### Thermal intradiscal procedures

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

#### Provider types affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (MAC) for providing thermal intradiscal procedures (TIP) to Medicare beneficiaries.

#### What you need to know

Change request (CR) 6291, from which this article is taken, communicates the findings of a new national coverage determination (NCD) regarding thermal intradiscal procedures (TIPs), including billing requirements.

Effective for services performed on or after September 29, 2008, the Centers for Medicare & Medicaid Services (CMS) has concluded that the evidence does not demonstrate that TIPs improve health outcomes; and has therefore determined that TIPs are not reasonable and necessary for the treatment of low back pain.

Effective September 29, 2008, TIPs are **noncovered** for Medicare beneficiaries.

Specifically, CR 6291:

- Announces the relevant *Current Procedural Terminology (CPT)* codes that (effective September 29, 2008) will be denied when submitted, and also the codes that will be denied when identified as a TIP.
- Instructs Medicare contractors to deny claims for radiologic or fluoroscopic guidance when performed in conjunction with a TIP.
- Urges physicians, ambulatory surgical centers (ASC), and hospitals to provide appropriate liability notices to beneficiaries.

You should make sure that your billing staffs are aware of this NCD regarding TIPs, the details of which may be found in the *Background* section that follows.

#### Background

Percutaneous thermal intradiscal procedures (TIPs) involve the insertion a catheter(s)/probe(s) into the spinal disc under fluoroscopic guidance in order to produce, or apply, heat and/or disruption within the disc to relieve low back pain.

On January 15, 2008, CMS initiated a national coverage analysis (NCA) on TIPs. CR 6291 communicates the findings of this NCA, and the resultant NCD. Please note that this is the first NCD to address thermal intradiscal procedures (TIPs).

The NCA addressed the use of TIPs to: 1) treat symptomatic patients with annular disruption of a contained herniated disc, 2) to seal annular tears or fissures, or 3) to destroy nociceptors for the purpose of relieving pain. It included the use of percutaneous intradiscal techniques that utilize devices employing a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc for coagulation and/or decompression of disc material. Further, it included techniques that use single or multiple probes/catheters which: 1) utilize a resistance coil or other thermal intradiscal technology; 2) are flexible or rigid; and 3) are placed within the nucleus, the nuclear-annular junction, or the annulus.

Although not meant to be a complete list, TIPs are commonly identified as:

- Intradiscal electrothermal therapy (IDET)
- Intradiscal thermal annuloplasty (IDTA)
- Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT)
- Radiofrequency annuloplasty (RA)
- Intradiscal biacuplasty (IDB)

**Thermal intradiscal procedures (continued)**

- Percutaneous (or plasma) disc decompression (PDD) or ablation
- Targeted disc decompression (TDD).

At times, TIPs are identified, or labeled, based on the name of the catheter(s)/probe(s) that are used (e.g. SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes); and each technique or device has its own protocol for application of the therapy.

**Note:** Percutaneous disc decompression or nucleoplasty procedures that do not utilize a radiofrequency energy source or electrothermal energy (such as the disc decompressor procedure or laser procedure) are not within this NCD's scope.

**National coverage determination requirements for thermal intradiscal procedures**

CR 6291 announces that CMS has concluded that the evidence does not demonstrate that TIPs improve health outcomes; and has therefore determined that TIPs are not reasonable and necessary for the treatment of low back pain.

Therefore, effective September 29, 2008, TIPs are noncovered for Medicare beneficiaries; and for services on and after that date, your carriers, FIs, and MACs will deny any claims that you submit for TIPs.

The following table displays the CPT/HCPCS codes that are identified for TIPs procedures performed within the annulus of the intervertebral disc. On, or after, September 29, 2008, your Medicare contractors will deny claims that you submit for TIPs procedures with any of these noncovered codes.

CPT Code	Description
22526	<i>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level</i>
22527	<i>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels</i>
0062T	<i>Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level</i>
0063T	<i>Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; one or more additional levels</i>

**CPT codes identified for TIPs procedures performed within the annulus of the intervertebral disc\***

\*The change to add the noncovered indicator for these codes will be part of the January 2009 Medicare physician fee schedule update and the change to the status indicator to noncovered for the above HCPCS is part of the integrated outpatient code editor (IOCE) update for January 2009.

**Note:** The following CPT codes, which may be used for TIPs procedures performed within the nucleus of the disc (e.g., PDD or TDD procedures), may also be used for procedures that are not within the scope of this NCD:

- 62287 *Aspiration procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar*
- 22899 *Unlisted procedure, spine*
- 64999 *Unlisted procedure, nervous system*

Please note that since CPT codes 22899 or 64999 do suspend for review, when you submit them for TIPs procedures performed within the nucleus, you should submit a clear description of the procedure in the narrative section of the claim. Contractors may also be advising providers to submit intervertebral disc nucleus procedures that are considered TIPs under codes 22899 or 64999 in order to avoid improper payment for a TIP under code 62287. Providers are also advised to submit the biacuplasty procedure under code 0062T (currently some providers are submitting this procedure under code 64999).

In addition, as all TIPs procedures are performed with radiologic or fluoroscopic guidance, this ancillary service would be directly related to a noncovered service and would itself, therefore, also be noncovered. CR 6291 instructs your carrier, FI, or A/B MAC to deny claims for the radiologic or fluoroscopic guidance when performed in conjunction with a TIP.

When denying your TIPs claims, Medicare contractors will use:

- Medicare summary notice (MSN) 21.11 – “This service was not covered by Medicare at the time you received it;”
- Claim adjustment reason code (CARC) 96 – “Noncovered charge(s)”
- Remittance advise remark code N386, “This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have access, you may contact the contractor to request a copy of the NCD.”

**Note:** Carriers, FIs, and A/B MACs do not need to search their files to recoup payment for claims already paid, however they will adjust claims that are brought to their attention.

**Thermal intradiscal procedures (continued)**

CR 6291 further advises physicians and hospitals to give beneficiaries, who choose to have this procedure, an advance beneficiary notice (ABN), consistent with the *Medicare Claims Processing Manual*, Chapter 30, (Financial Liability Protections). This ABN, which you must issue prior to the procedure, should indicate that, after an NCA, Medicare issued a national coverage determination (NCD) (*Medicare National Coverage Determinations (NCD) Manual*, Section 150.11 (Thermal Intradiscal Procedures [TIPs] [effective September 29, 2008]) which states that TIPs are not reasonable and necessary for Medicare beneficiaries. Therefore, Medicare never pays for this service and the beneficiary would be held financially responsible if they decide to have this procedure.

You should be aware that unless the beneficiary was informed via the ABN prior to performance of the procedure that he/she would be financially responsible, you are liable for charges for TIPs.

You should also be aware that beginning March 1, 2009, the ABN-G will no longer be valid and you must issue the revised ABN (CMS-R-131).

**Additional information**

You may find the official instruction, CR 6291, was issued to your carrier, FI or MAC in two transmittals. You will find revised *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 2 (Sections 90 – 160.26) (Coverage Determinations), Section 150.11 (Thermal Intradiscal Procedures [TIPs] [Effective

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September 29, 2008] is a national coverage determination [NCD]) at <http://www.cms.hhs.gov/Transmittals/downloads/R97NCD.pdf> on the CMS Web site. The transmittal that revises the *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 220 (Billing Requirements for Thermal Intradiscal Procedures [TIPs] Claims), 220.1 (General), 220.2 (Contractor A/B MAC), 220.3 (Medicare Summary Notice [MSN], Claim Adjustment Reason Code [CARC] and Remittance Advise Remark Code [RARC]), and 220.4 (Advance Beneficiary Notice [ABN]) is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1646CP.pdf>.

If you have any questions, please contact your carrier, FI, or 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6291

Related Change Request (CR) Number: 6291

Related CR Release Date: December 9, 2008

Related CR Transmittal Number R1646CP and R97NCD

Effective Date: September 29, 2008

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1646, CR 6291

**Changes to the laboratory national coverage determination edit software**

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

**What you need to know**

This article is based on change request (CR) 6304 which announces the changes that will be included in the January 2009 release of the edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in October 2008.

**Background**

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2 (see <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf> on the Centers for Medicare & Medicaid Services [CMS] Web site), the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

Change request (CR) 6304 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for January 2009 as described below. These changes become effective for services furnished on or after January 1, 2009, and are as follows:

**HIV testing**

Add ICD-9-CM code 482.42 to the list of ICD-9-CM codes covered by Medicare for the HIV testing (diagnosis) (190.14) NCD.

**Phromboplastin time (PTT)**

Add ICD-9-CM code range 249.40-249.41 to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.

**Changes to the laboratory national coverage determination edit software (continued)**

**Prothrombin time (PT)**

- Add ICD-9-CM code range 249.40-249.41 and the ICD-9-CM codes 197.7, V15.21, V15.22, and V15.29 to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- Delete ICD-9-CM code V15.2 from the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.

**Serum iron studies**

Add ICD-9-CM code ranges to the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD:

249.00-249.01	249.10-249.11	249.20-249.21
249.30-249.31	249.40-249.41	249.50-249.51
249.60-249.61	249.70-249.71	249.80-249.81
249.90-249.91	285.22, 285.29	V15.21
V15.22	V15.29.	

**Blood glucose testing**

Add ICD-9-CM diagnosis code and ranges to the list of ICD-9-CM codes covered by Medicare for the blood glucose testing (190.20) NCD:

482.42	249.00-249.01	249.10-249.11
249.20-249.21	249.30-249.31	249.40-249.41
249.50-249.51	249.60-249.61	249.70-249.71
249.80-249.81	249.90-249.91.	

**Glycated hemoglobin/glycated protein**

Add ICD-9-CM code ranges to the list of ICD-9-CM codes covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD:

249.00-249.01	249.10-249.11	249.20-249.21
249.30-249.31	249.40-249.41	249.50-249.51
249.60-249.61	249.70-249.71	249.80-249.81
249.90-249.91.		

**Thyroid testing**

Add ICD-9-CM code ranges to the list of ICD-9-CM codes covered by Medicare for the thyroid testing (190.22) NCD:

249.00-249.01	249.10-249.11	249.20-249.21
249.30-249.31	249.40-249.41	249.50-249.51
249.60-249.61	249.70-249.71	249.80-249.81
249.90-249.91.		

**Lipid testing**

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

249.00-249.01	249.10-249.11	249.20-249.21
249.30-249.31	249.40-249.41	249.50-249.51
249.60-249.61	249.70-249.71	249.80-249.81
249.90-249.91.		

**Gamma glutamyl transferase**

Add ICD-9-CM code 275.2 to the list of ICD-9-CM codes covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

**Fecal occult blood test (FOBT)**

- Add ICD-9-CM codes 530.86 and 530.87 to the list of ICD-9-CM codes covered by Medicare for the fecal occult blood test (FOBT) (190.34) NCD.
- For All 23 NCDs (190.12-190.34):
- Add ICD-9-CM codes V16.52 and V73.81 to the list of denied ICD-9-CM codes for all 23 Lab NCDs.

**Additional information**

The official instruction, CR 6304, issued to your carrier, FI, or A/B MAC regarding this change may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R1645CP.pdf>.

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

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6304  
 Related change Request (CR) Number: 6304  
 Related CR Release Date: December 9, 2008  
 Related CR Transmittal Number: R1645CP  
 Effective Date: January 1, 2009  
 Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1645, CR 6304

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# 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

### AJ0881: Erythropoiesis stimulating agents – clarification on correct use of modifiers

**LCD ID Number: L895**

Providers are applying the incorrect modifiers when billing erythropoiesis stimulating agents (ESAs), HCPCS code J0881 (Injection, darbepoetin alfa, 1 mcg [non-ESRD use]) and HCPCS code J0885 (Injection, epoetin alfa, [for non-ESRD use], 1000 units). In this article, First Coast Service Options Inc. (FCSO) outlines the appropriate use of the modifiers for non-ESRD ESA administration and the appropriate ICD-9-CM diagnosis codes for each modifier.

Effective January 1, 2008, all claims reporting non-ESRD ESAs (HCPCS codes J0881 and J0885) are required to report one of the following modifiers:

**EA** ESA, anemia, chemo induced

**EB** ESA anemia, radio-induced

**EC** ESA anemia, non-chemo/radio

**Modifier EA** must only be reported when the ESA is being given for anemia resulting from myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. The corresponding covered ICD-9-CM codes that would apply to modifier EA are as follows:

140.0-149.9	150.0-159.9	160.0-165.9
170.0-176.9	179-189.9	190.0-199.1
200.00-200.88	201.00-201.98	202.00-202.98
203.00-203.81	204.00-204.91	230.0-234.9
235.0-235.9	236.0-236.99	237.0-237.9
238.0	238.1	238.2
238.3	238.4	238.5
238.6	238.8	238.9
239.0-239.9	273.3.	

The corresponding anemia code must also be billed. The dual diagnosis rule is outlined in the local coverage determination (LCD). Any other covered diagnosis code listed in the LCD for HCPCS codes J0881 or J0885 will be denied if billed with modifier EA.

**Modifier EC** must only be reported for those covered indications outlined in the LCD for HCPCS codes J0881 and J0885 where the anemia being treated is non-chemo/radio induced. FCSO has discovered that providers are billing modifier EC for one of the covered cancer diagnosis codes listed above under the modifier EA instructions. By appending modifier EC to a cancer diagnosis code, the provider is stating that the anemia for that cancer condition is not related to chemotherapy. Anemia of cancer not related to cancer treatment is a nationally **noncovered** condition per the national coverage determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS) for non-ESRD ESA use. The following are the appropriate ICD-9-CM diagnosis codes that would apply when billing modifier EC:

**For HCPCS code J0881:**

238.71	238.72	238.73	238.74	238.75	238.76
273.3	585.1	585.2	585.3	585.4	585.5
585.9					

**For HCPCS code J0885:**

042	070.54	070.70	238.71	238.72	238.73
238.74	238.75	238.76	273.3	585.1	585.2
585.3	585.4	585.5	585.9	714.0	V07.8

The corresponding anemia code must also be billed. The dual diagnosis rule is outlined in the LCD.

**Modifier EB is noncovered.** If billed with an ESA the claim will be denied.

All other conditions of coverage are outlined in the LCD and corresponding coding guideline.

First Coast Service Options Inc. (FCSO) LCDs and coding guidelines are available through the CMS Medicare Coverage Database ([List of LCDs for FCSO Inc. \(00090, Intermediary\)](#)).

If providers have questions regarding coverage of ESAs, please send correspondence to [medical.policy@fcs.com](mailto:medical.policy@fcs.com). ❖

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## AJ0881: Erythropoiesis stimulating agents – revision to the coding guidelines

LCD ID Number: L895

The “coding guidelines” attachment for erythropoiesis stimulating agents was last revised on October 1, 2008. Since that time, the “coding guidelines” attachment has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) change request 6133, transmittal 1581, dated August 29, 2008, “Discarded Erythropoietin Stimulating Agents for Home Dialysis.”

The following language has been added:

Multiuse vials are not subject to payment for discarded amounts of drug or biological, with the exception of self administered erythropoietin stimulating agents (ESAs) by Method I home dialysis patients. The renal facility must bill the 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. This applies only to home dialysis patients who meet the Method I conditions described in Pub 100-02, *Medicare Benefit Policy Manual*, chapter 11, section 90 “Epoetin (EPO)”, and does not apply to Method II home dialysis patients. When billing for drug wastage for Method I patients in accordance with the policy in Chapter 17 of this manual, section 40.1 the provider must show the wastage on a separate line item with the modifier JW. The line item date of service should be the date of the last covered administration according to the plan of care or if the patient dies, use the date of death.

### Effective date

This revision to the “Coding Guidelines” attachment is effective for services provided **on or after December 1, 2008**. First Coast Service Options Inc. (FCSO) local coverage determinations (LCDs) and coding guidelines are available through the CMS Medicare Coverage Database ([List of LCDs for FCSO Inc. \(00090, Intermediary\)](#)).

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

## Clarification on correct administration of Neupogen® and Neulasta®

First Coast Service Options Inc. (FCSO) has discovered, through subsequent data analysis, that providers continue to inappropriately administer Neupogen® (J1440 and J1441) and Neulasta® (J2505) to patients who are receiving a chemotherapeutic agent.

Neupogen is a class II hematopoietic growth factor that acts on progenitor cells. Because Neupogen acts only on progenitor cells that are already committed to one pathway, it increases only the neutrophil count. The local coverage determination (LCD) for Neupogen outlines the Food and Drug Administration (FDA) approved indications as well as the off-label indications FCSO will cover when the medical necessity criteria are met. Under the “Limitations” section of the G-CSF (Filgrastim®, Neupogen®) LCD, it is outlined that Neupogen should not be given within 24 hours before or 24 hours after a dose of a chemotherapeutic agent, as rapidly dividing myeloid cells are potentially sensitive to these agents. This instruction follows the FDA approved label. This rule applies to any indication in the LCD that requires the administration of a chemotherapeutic agent.

Neulasta is a colony stimulating factor (CSF) that acts on hematopoietic cells by binding to specific cell surface receptors thereby, stimulating proliferation, differentiation, commitment, and end cell functional activation. The LCD for Neulasta outlines the FDA approved indications as well as the off-label indication FCSO will cover when the medical necessity criteria are met. Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the Pegfilgrastim (Neulasta®) LCD, it is outlined that Neulasta administration should not occur within 14 days before and 24 hours after administration of cytotoxic chemotherapy.

The continued practice of inappropriate administration of Neupogen and Neulasta may prompt medical review of documentation to ensure the appropriate FDA labeling is followed.

FCSO strongly encourages providers to review the current LCDs for Neupogen and Neulasta to ensure their patients meet the coverage criteria outlined for each indication and that all other documentation and utilization requirements are met. LCDs may be located on our Web site at [http://www.floridamedicare.com/Part\\_A/Local\\_Medical\\_Coverage/Final\\_LCDs/index.asp](http://www.floridamedicare.com/Part_A/Local_Medical_Coverage/Final_LCDs/index.asp).

Questions regarding coverage or the appropriate administration of Neupogen or Neulasta can be forwarded to [medical.policy@fcs.com](mailto:medical.policy@fcs.com).

FCSO also has a process in place that providers can follow when they feel LCD reconsideration may be appropriate. The LCD reconsideration process is outlined at [http://www.floridamedicare.com/Part\\_A/Local\\_Medical\\_Coverage/108773.asp](http://www.floridamedicare.com/Part_A/Local_Medical_Coverage/108773.asp).

For reconsideration of this issue, then the appropriate clinical literature supporting administration outside the FDA approved indications must be submitted to the medical policy department for review and consideration. If you find that your facility has been reimbursed for services that are outside Medicare coverage guidelines, you may find information regarding an overpayment refund at [http://www.floridamedicare.com/Part\\_A/Forms/105559.pdf](http://www.floridamedicare.com/Part_A/Forms/105559.pdf). ❖

**2009 HCPCS local coverage determination changes**

Florida Medicare has revised local coverage determinations (LCDs) impacted by the 2009 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and removed accordingly.

LCD Title	2009 Changes
AALEFACEPT – Alefacept (Coding Guidelines only)	<ul style="list-style-type: none"> <li>Deleted CPT code 90772</li> <li>Added CPT code 96372</li> </ul>
AAPBI – Accelerated Partial Breast Irradiation (APBI)	<ul style="list-style-type: none"> <li>Descriptor change for CPT codes 19296 and 19297</li> <li>Retired “Coding Guidelines” attachment</li> </ul>
AJ1561 – Intravenous Immune Globulin	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J1572</li> <li>Deleted HCPCS code Q4097</li> <li>Added HCPCS code J1459</li> <li>Deleted HCPCS code G0332 from the “Coding Guidelines” attachment</li> <li>Changed Contractor’s Determination Number to AJ1459</li> </ul>
AJ2792 – Rho (D) Immune Globulin Intravenous	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS codes J2788 and J2790</li> </ul>
AJ7187 – Hemophilia Clotting Factors	<ul style="list-style-type: none"> <li>Deleted HCPCS code Q4096</li> <li>Added HCPCS code J7186</li> <li>Changed Contractor’s Determination Number to AJ7186</li> </ul>
AJ9000 – Doxorubicin HCl	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9000</li> </ul>
AJ9001 – Doxorubicin, Liposomal (Doxil)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9001</li> </ul>
AJ9010 – Alemtuzumab (Campath®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9010</li> </ul>
AJ9015 – Aldesleukin (Proleukin®, Interleukin-2, Recombinant, and RIL-2)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9015</li> </ul>
AJ9045 – Carboplatin (Paraplatin®, Paraplatin-AQ®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9045</li> </ul>
AJ9160 – Denileukin Diftitox (Ontak®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9160</li> </ul>
AJ9170 – Docetaxel (Taxotere®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9170</li> </ul>
AJ9181 – Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9181</li> <li>Deleted HCPCS code J9182</li> </ul>
AJ9185 – Fludarabine (Fludara®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9185</li> </ul>
AJ9200 – Floxuridine (FUDR)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9200</li> </ul>
AJ9201 – Gemcitabine (Gemzar®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9201</li> </ul>
AJ9206 – Irinotecan (Camptosar®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9206</li> </ul>
AJ9213 – Interferon, alfa-2a (Roferon®-A)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9213</li> </ul>
AJ9265 – Paclitaxel (Taxol®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9265</li> </ul>
AJ9300 – Gemtuzumab Ozogamicin (Mylotarg™)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9300</li> </ul>
AJ9310 – Rituximab (Rituxan®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9310</li> </ul>
AJ9350 – Topotecan Hydrochloride (Hycamtin®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9350</li> </ul>
AJ9355 – Trastuzumab (Herceptin®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9355</li> </ul>
AJ9390 – Vinorelbine Tartrate (Navelbine®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9390</li> </ul>
AJ9600 – Porfimer (Photofrin®)	<ul style="list-style-type: none"> <li>Descriptor change for HCPCS code J9600</li> </ul>

2009 HCPCS local coverage determination changes (continued)

LCD Title	2009 Changes
ANCSVCS – The List of Medicare Noncovered Services	<ul style="list-style-type: none"> <li>• Descriptor change for CPT codes 20985* and 34806* (*investigational)</li> <li>• Changed CPT code 53899* to CPT code 0193T*</li> <li>• Deleted CPT codes 0088T*, 20986*, and 20987*</li> <li>• Added CPT codes 0054T*, 0055T*, 0194T*, 0195T*, 0196T*, 0198T*, and 41530* to the “Local Noncoverage Decisions” section of the LCD</li> <li>• Added CPT codes 90650 and 90681 to the “Local Noncoverage Decisions” section of the LCD</li> </ul>
APPHPROG – Psychiatric Partial Hospitalization Program	<ul style="list-style-type: none"> <li>• Descriptor change for HCPCS code G0129</li> <li>• Added HCPCS codes G0410 and G0411</li> </ul>
ASKINSUB – Skin Substitutes	<ul style="list-style-type: none"> <li>• Deleted HCPCS codes J7340, J7341, J7342, J7343, and J7344</li> <li>• Added HCPCS codes Q4100, Q4101, Q4102, Q4105, and Q4106</li> <li>• Added Modifiers JC and JD to the “Coding Guidelines” attachment</li> </ul>
A11000 – Debridement Services	<ul style="list-style-type: none"> <li>• Descriptor change for CPT code 11001</li> </ul>
A93224 – Electrocardiographic Monitoring for 24 Hours (Holter Monitoring)	<ul style="list-style-type: none"> <li>• Descriptor change for CPT codes 93224, 93225, 93226, 93227, 93230, 93231, 93232, 93233, 93235, 93236, and 93237</li> </ul>
A93303 – Transthoracic Echocardiography (TTE)	<ul style="list-style-type: none"> <li>• Descriptor change for CPT codes 93307 and 93308</li> <li>• Added CPT code 93306</li> </ul>
A93350 – Stress Echocardiography	<ul style="list-style-type: none"> <li>• Descriptor change for CPT code 93350</li> <li>• Added CPT codes 93351 and 93352</li> </ul>

\* = Investigational

First Coast Service Options Inc. (FCSO) LCDs and coding guidelines are available through the CMS Medicare Coverage Database ([List of LCDs for FCSO Inc. \(00090, Intermediary\)](#)). ❖

Source: Maggie Puskas, Medical Policy & Procedures

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# HOSPITAL SERVICES

## Present on admission indicator payment implications

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

### Provider types affected

Hospitals that submit claims to fiscal intermediaries (FI) or Part A/B Medicare Administrative Contractors (MACs) for Medicare beneficiary inpatient services.

### Provider action needed

While this article is informational in nature, it is very important that hospitals properly report the present on admission (POA) indicator for all claims involving inpatient admissions to general acute care hospitals. In order to group claims into the proper Medicare severity-diagnosis related group (MS-DRG) and pay claims appropriately based on the hospital acquired conditions (HAC) regulations, the Centers for Medicare & Medicaid Services (CMS) must capture the POA indicator for all claims involving inpatient admissions to general acute care hospitals. Use the **UB-04 Data Specifications** manual and the ICD-9-CM *ICD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the POA indicator for each “principal” diagnosis and “other” diagnosis codes reported on claim forms UB-04 and 837 institutional. Information regarding the UB-04 data specifications may be found on the Internet at <http://www.nubc.org/become.html>.

Information regarding the ICD-9-CM guidelines is available on the CMS Web site at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01\\_overview.asp](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp).

### Background

This article is not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines*

### CMS POA indicator options and definitions

*for Coding and Reporting*. The POA indicator guidelines are not intended to provide guidance on when a condition should be coded, but rather to provide guidance on how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should be assigned to all diagnoses that have been coded.

**Note:** Critical access hospitals, Maryland waiver hospitals, long term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, cancer hospitals, and children’s inpatient facilities are exempt from this requirement.

As stated in the Introduction to the *ICD-9-CM Official Guidelines for Coding and Reporting*, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnosis and procedure codes. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis.

The provider, a provider’s billing office, third party billing agents and anyone else involved in the transmission of this data shall insure that any resequencing of diagnosis codes prior to transmission to CMS also includes a resequencing of the POA indicators. The table below outlines the payment implications for each of the different POA indicator reporting options.

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission. CMS will pay the complicating condition/major complicating condition (CC/MCC) DRG for those selected HACs that are coded as “Y” for the POA indicator.
N	Diagnosis was not present at time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “N” for the POA indicator.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “U” for the POA indicator.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as “W” for the POA indicator.
1	Unreported/not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as “1” for the POA indicator. The “1” POA indicator should not be applied to any codes on the HAC list. These claims will be returned to the provider for correction. For a complete list of codes on the POA exempt list, see page 110 of the <i>Official Coding Guidelines for ICD-9-CM</i> . <a href="http://www.cdc.gov/nchs/dataawh/ftp/ftp9/ftpicd9/icdguide08.pdf">http://www.cdc.gov/nchs/dataawh/ftp/ftp9/ftpicd9/icdguide08.pdf</a> .



**Present on admission indicator payment implications (continued)****Additional information**

Providers may find further information concerning HACs and POAs on the CMS Web site at <http://www.cms.hhs.gov/HospitalAcqCond/>.

You may also want to review related *MLN Matters* articles MM5499 and MM6086, which are respectively at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5499.pdf> and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6086.pdf>.

If you have any questions, please contact your FI or 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

*MLN Matters* Number: SE0841

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 SE0841

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**Long-term care hospital special project**

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), Pub L. 110-173, and specifically section 114(f), provides for expanded review of medical necessity for admission and continued stay at long-term care hospitals (LTCHs).

The Centers for Medicare & Medicaid Services (CMS) has awarded contracts for this project. CMS has awarded contracts to AdvanceMed to perform LTCH sampling and validation, and to Wisconsin Physician Services (WPS) to perform medical review of LTCH claims to determine a national error rate for LTCHs.

The WPS contractor will use existing inpatient hospital review criteria in order to determine the medical necessity of admission.

CMS expects the medical reviews to begin in January 2009. The information gathered as a result of these activities will be useful for allowing contractors to recover overpayments and will serve as a benchmark, which will help CMS contractors determine if future/additional review is necessary.

If you have any questions or need additional information, please contact the Medicare contractor within your claim payment jurisdiction.

The toll-free number for First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112. ❖

Source: CMS PERL 200812-42

**Fiscal year 2009 inpatient prospective payment system PC PRICER**

The Centers for Medicare & Medicaid Services (CMS) has updated the fiscal year (FY) 2009 inpatient prospective payment system (IPPS) PC PRICER with the October 2008 provider data. If you use the IPPS PC PRICER, visit the CMS Web page at [http://www.cms.hhs.gov/PCPricer/03\\_inpatient.asp#TopOfPage](http://www.cms.hhs.gov/PCPricer/03_inpatient.asp#TopOfPage) and download the FY 2009 version of the PC PRICER posted on November 26, 2008. ❖

Source: CMS PERL 200811-42

**Fiscal year 2009 inpatient rehabilitation facility PPS PC PRICER updated**

The Centers for Medicare & Medicaid Services (CMS) has updated the fiscal year (FY) 2009 inpatient rehabilitation facility (IRF) PC PRICER. If you use the IRF 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 5, 2008. ❖

Source: CMS PERL 200812-20

# CRITICAL ACCESS HOSPITAL SERVICES

## Health professional shortage area bonus payment policy changes

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 carriers, Medicare administrative contractors (A/B MACs), and/or fiscal intermediaries (FIs) for services provided to Medicare beneficiaries in areas designated as geographic HPSAs.

### Provider action needed

This article is based on change request (CR) 6106 and informs providers who are serving Medicare beneficiaries in areas that were eligible on December 31 of the prior year for the health professional shortage area (HPSA) bonus but not on the automated ZIP code list to use the modifier AQ to receive the HPSA bonus payment. Make sure billing staff are aware of the clarified criteria for proper use of the modifier AQ.

### Background

The Section 1833(m) of the Social Security Act provides for an additional ten percent bonus payment for physicians' services furnished to a covered individual in an area that is designated as a geographic HPSA prior to the beginning of the year in which the services were provided. Such HPSA areas are identified by the Secretary of the Department of Health & Human Services prior to the beginning of such year. The Centers for Medicare & Medicaid Services (CMS) posts a file annually of ZIP codes within which the HPSA bonus payment should be made automatically. Physicians furnishing services in areas that were eligible for the HPSA bonus prior to the beginning of the year but not on the automated list have been instructed to use the modifier AQ to receive the HPSA bonus payment.

### Key points

- Effective for claims with dates of service on or after January 1, 2009, only services furnished in areas that are designated as geographic HPSAs as of December 31 of the prior year are eligible for the HPSA bonus payment.

- Services furnished in areas that are designated at any time during the current year will not be eligible for the HPSA bonus payment until the following year, provided they are still designated on December 31.
- If you are providing services to Medicare beneficiaries in areas that are designated on December 31 of the prior year but not included on the list of ZIP codes eligible for automated HPSA bonus payments make certain you use the modifier AQ to receive the HPSA bonus payment.
- Remember, your Medicare contractor will automatically make a HPSA bonus payment to physicians providing eligible services in a ZIP code included in the annual file.

### Additional information

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

For complete details regarding this change request (CR) please see the official instruction (CR 6106) issued to your Medicare A/B MAC, carrier or FI. That instruction may be viewed by going to the CMS Web site <http://www.cms.hhs.gov/Transmittals/downloads/R1639CP.pdf>.

The toll-free number for the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6106

Related Change Request (CR) Number: 6106

Related CR Release Date: November 21, 2008

Related CR Transmittal Number: R1639CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1639, CR 6106

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# ESRD SERVICES

## Implementation of changes in end-stage renal disease payment for calendar year 2009 services

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 (fiscal intermediaries [FIs] and/or Medicare administrative contractors [MACs]) for ESRD services provided to Medicare beneficiaries.

### Provider action needed stop – impact to you

This article is based on change request (CR) 6216 which provides payment updates for end-stage renal disease (ESRD) facilities for calendar year (CY) 2009.

### Caution – what you need to know

The Medicare Improvements for Patient and Providers Act of 2008 (MIPPA; Section 153) amended the Social Security Act (Section 1881(b)(12)) to require a one percent increase to the ESRD composite payment rate and that hospital-based dialysis facilities are paid the same composite payment rate as independent dialysis facilities. Other changes include: 1) an update to the drug add-on adjustment to the composite payment rate; 2) an update to the wage index adjustments to reflect current wage data, including a revised budget neutrality adjustment; and 3) a reduction in the wage index floor.

There is a zero growth update to the drug add-on adjustment. Therefore, the per treatment drug add-on amount of \$20.33 will remain from CY 2008. It is necessary to adjust the drug add-on adjustment to offset the one percent increase in the composite payment rate to ensure that the per treatment drug add-on amount stays \$20.33. The total drug add-on adjustment for CY 2009 is 15.2 percent.

### Go – what you need to do

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

### Background

Upon implementation of CR 6216, the following changes will be applied to all Medicare-certified ESRD facilities:

- An update to the base composite payment rate with a one percent increase resulting with a base rate of \$133.81 for both hospital-based and independent renal dialysis facilities.
- An update to the drug add-on adjustment to the composite payment rate of 15.2 percent.
- An update to the wage index adjustments to reflect the current wage data.
- A reduction in the wage index floor from 0.7500 to 0.7000, then after applying a budget neutrality factor of 1.056689, the wage index floor is 0.7397.
- The wage index is 100 percent CBSA-based. The wage index tables are located in addendums G and H with in the physician fee schedule's final rule (i.e., CMS-1403-FC) published on November 19, 2008 and which is available on the Centers for Medicare & Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/center/physician.asp>.

**Note:** The ESRD payment changes will be effective January 1, 2009.

In addition to the above rate changes, the *Medicare Benefit Policy Manual* and *Medicare Claims Processing Manual* are amended by CR 6216 to reflect the payment changes for Medicare-certified ESRD facilities.

### Additional Information

The official instruction, CR 6216, issued to your FI or MAC regarding this change was in two transmittals, one that revises the *Medicare Claims Processing Manual* and one that revises the *Medicare Benefit Policy Manual*. These transmittals may be viewed on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R1648CP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R98BP.pdf>, respectively.

If you have any questions, please contact your carrier, FI, or 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6216

Related Change Request (CR) Number: 6216

Related CR Release Date: December 12, 2008

Related CR Transmittal Number: R98BP and R1648CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1648, CR 6216

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## Dialysis Facility Compare Web site: Updated survival and anemia management measures

The Centers for Medicare & Medicaid Services (CMS) has announced important additions to the Dialysis Facility Compare consumer Web site (<http://www.medicare.gov/Dialysis>) that will give consumers even better insight into the quality of care provided by their local dialysis patient facilities.

The improvements include two new quality measures that demonstrate how well dialysis patients are treated for anemia (low red blood cell count) as well as updated information that will help patients better understand survival rates by facility.

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

Source: CMS PERL 200811-37

## Medicare publishes new information on quality of care at dialysis facilities

### Changes to Web site will help consumers compare care and make informed health care choices

The Centers for Medicare & Medicaid Services (CMS) recently announced important additions to the Dialysis Facility Compare consumer Web site (<http://www.medicare.gov/dialysis/>) that will give consumers even better insight into the quality of care provided by their local dialysis patient facilities. The improvements include two new quality measures that demonstrate how well dialysis patients are treated for anemia (low red blood cell count) as well as updated information that will help patients better understand survival rates by facility.

Dialysis Facility Compare links consumers with detailed information about the 4,700 dialysis facilities certified by Medicare and allows users to compare facilities in a geographic region. Users can review information about the size of the facility, the types of dialysis offered, the facilities' ownership, and whether the facility offers evening treatment shifts. Consumers can also compare dialysis facilities based on three key quality measures:

- How well patients at a facility have their anemia under control
- How well patients at a facility have waste removed from their blood during dialysis
- Whether the patients treated at a facility generally live as long as expected.

Dialysis Facility Compare also links users to resources that support family members and specialized groups of kidney patients.

"Dialysis Facility Compare is yet another tool that equips consumers with the tools they need to seek better, value-based health care," said CMS Acting Administrator Kerry Weems. "Adding more information on the Dialysis Facility Compare Web site about anemia – a condition that affects many dialysis patients – and patient survival will help us all learn more about how well the country's dialysis facilities are serving Medicare beneficiaries and the entire healthcare system."

Dialysis Facility Compare has featured information about anemia control since the Web site was launched in 2001. Historically, the Web site has shown the percentage of patients in a facility whose hematocrit levels were at 33 percent or more (or hemoglobin levels of 11 g/dL or more), based on clinical practice guidelines at the time. However, recent evidence about increased risk of certain adverse events associated with the use of erythropoiesis stimulating agents (ESAs), which are used to treat anemia, has raised

concerns about patients whose hemoglobin levels are too high as well as patients whose hemoglobin levels are too low. The Food and Drug Administration has responded by requiring manufacturers to develop a Medication Guide and to ensure that this information is provided to patients. As a result, Dialysis Facility Compare will now feature two anemia measures – one measure will show the percentage of patients whose hemoglobin levels are considered too low (i.e., below 10 g/dL) and a second measure will show the percentage of patients whose hemoglobin levels are considered too high (i.e., above 12 g/dL).

"These two new measures better reflect recent medical evidence about the challenges of managing anemia," said CMS Chief Medical Officer and Director of the agency's Office of Clinical Standards & Quality, Barry Straube, M.D. "Our new measures will help patients and health care providers to better understand how a facility's patients are treated for anemia, a condition for which studies have shown that over and under-treatment may affect patients' health status and quality of life."

In addition to adding new information about anemia treatment, CMS has also updated the way it reports patient survival rates on Dialysis Facility Compare. Since 2001, CMS has reported survival rates by comparing a facility's expected patient survival rate to its actual patient survival rate. (The expected survival rate takes into account the patients' personal characteristics, health, and dialysis history. The actual survival rate is the rate each facility reports to CMS about how many patients have survived in a given timeframe.) Facilities' survival rates were then rated as belonging to one of three categories:

- Better than expected (by 20 percent or more)
- As expected
- Worse than expected (by 20 percent or more).

This method of calculating patient survival resulted in a finding of "as expected" for 94 percent of dialysis facilities nationwide, with only three percent in the "better" or "worse" categories, respectively.

To help consumers make better distinctions among facilities' survival rates, CMS updated the statistical method it used to classify facilities in the three categories. While consumers will continue to see facilities placed into one of these categories, they will find fewer facilities in the "as expected" category and more facilities in the "better" or "worse" categories.



**Medicare publishes new information on quality of care at dialysis facilities (continued)**

These enhancements are only one part of CMS' plans to improve the quality of care in America's dialysis facilities. Earlier this year, CMS revised its conditions for coverage regulations for the first time in over 30 years, which updated the health and safety standards that dialysis facilities must meet to receive Medicare coverage. A key element of this regulation was the development of a new Web-based data entry framework for dialysis facilities nationwide, which will eventually provide substantially more detailed information for consumers as part of Dialysis Facility Compare. CMS is also working to implement a value-based purchasing program to pay for dialysis services, which will reward facilities for providing high-quality, efficient, and effective care.

The Dialysis Facility Compare Web site may be viewed at <http://www.medicare.gov/dialysis>.

Other provider compare Web sites are available through <http://www.medicare.gov/> or directly at <http://www.medicare.gov/HHCompare> for information about home health agencies and nursing homes. For information on hospitals, visit <http://www.hospitalcompare.hhs.gov>.

CMS also provides links to comparative resources about Medicare Advantage and Medicare prescription drug plans at (<http://www.medicare.gov/>). ❖

Source: CMS PERL 200811-34

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

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## SKILLED NURSING FACILITY SERVICES

### Update to the 2009 skilled nursing facility prospective payment system PC PRICER

The Centers for Medicare & Medicaid Services (CMS) has updated the skilled nursing facility (SNF) prospective payment system (PPS) PC PRICER for fiscal year (FY) 2009 with the latest provider specific file data. If you use SNF PC PRICER software, please go to the Web page at [http://www.cms.hhs.gov/PCPricer/04\\_SNF.asp#TopOfPage](http://www.cms.hhs.gov/PCPricer/04_SNF.asp#TopOfPage) and download the latest FY 2009.0 version of the PC PRICER posted on December 1, 2008. ❖

Source: CMS PERL 200812-16

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# ELECTRONIC DATA INTERCHANGE

## Remittance advice remark code and claim adjustment reason code update

*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.

### Provider action needed

This article is based on change request (CR) 6229 which updates remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs). If you use the Medicare Remit Easy Print software, note that Medicare will update that software as a result of implementing CR 6229. Be sure billing staff are aware of these updates.

### Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate RARCs that provide either supplemental explanation for a monetary adjustment or policy information are required in the remittance advice transaction.

### X12N 835 health care remittance advice remark codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, are required to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS, as the X12 recognized maintainer of RARCs, receives requests from Medicare and non-Medicare payers for new codes and modification/deactivation of existing codes. Additions,

deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare.

**Note:** The complete list of remark codes is available at <http://www.wpc-edi.com/codes> on the Internet.

Medicare contractors will use the latest approved and valid codes in the 835, corresponding standard paper remittance (SPR) advice, and coordination of benefits transactions.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of codes. At this site you can find some other information that is also available from the Washington Publishing Company (WPC) Web site. The Web site address is <http://www.cmsremarkcodes.info/> on the Internet.

**Note I:** This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

**Note II:** Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for a monetary adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. These "Informational" codes may be used without any CARC explaining a specific adjustment.

An example of an informational code:

**N369 Alert:** Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation, but does not explain any adjustment.

These informational codes are used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes when a RARC is required with a CARC – 16, 17, 96, 125, and A1.

### Remittance advice remark codes changes

#### New codes

Code	Current narrative
N434	Missing/incomplete/invalid present on admission indicator. Start: 7/1/2008
N435	Exceeds number/frequency approved /allowed within time period without support documentation. Start: 7/1/2008

## Remittance advice remark code and claim adjustment reason code update (continued)

Code	Current narrative
N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made. Start: 7/1/2008
N437	Alert: If the injury claim is accepted, these charges will be reconsidered. Start: 7/1/2008
N438	This jurisdiction only accepts paper claims. Start: 7/1/2008
N439	Missing anesthesia physical status report/indicators. Start: 7/1/2008
N440	Incomplete/invalid anesthesia physical status report/indicators. Start: 7/1/2008
N441	This missed appointment is not covered. Start: 7/1/2008
N442	Payment based on an alternate fee schedule. Start: 7/1/2008
N443	Missing/incomplete/invalid total time or begin/end time. Start: 7/1/2008
N444	Alert: This facility has not filed the election for high cost outlier form with the Division of Workers' Compensation. Start: 7/1/2008
N445	Missing document for actual cost or paid amount. Start: 7/1/2008
N446	Incomplete/invalid document for actual cost or paid amount. Start: 7/1/2008
N447	Payment is based on a generic equivalent as required documentation was not provided. Start: 7/1/2008
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement. Start: 7/1/2008
N449	Payment based on a comparable drug/service/supply. Start: 7/1/2008
N450	Covered only when performed by the primary treating physician or the designee. Start: 7/1/2008
N451	Missing admission summary report. Start: 7/1/2008
N452	Incomplete/invalid admission summary report. Start: 7/1/2008
N453	Missing consultation report. Start: 7/1/2008
N454	Incomplete/invalid consultation report. Start: 7/1/2008
N455	Missing physician order. Start: 7/1/2008
N456	Incomplete/invalid physician order. Start: 7/1/2008
N457	Missing diagnostic report. Start: 7/1/2008
N458	Incomplete/invalid diagnostic report. Start: 7/1/2008
N459	Missing discharge summary. Start: 7/1/2008

## Remittance advice remark code and claim adjustment reason code update (continued)

Code	Current narrative
N460	Incomplete/invalid discharge summary. Start: 7/1/2008
N461	Missing nursing notes. Start: 7/1/2008
N462	Incomplete/invalid nursing notes. Start: 7/1/2008
N463	Missing support data for claim. Start: 7/1/2008
N464	Incomplete/invalid support data for claim. Start: 7/1/2008
N465	Missing physical therapy notes/report. Start: 7/1/2008
N466	Incomplete/invalid physical therapy notes/report. Start: 7/1/2008
N467	Missing report of tests and analysis report. Start: 7/1/2008
N468	Incomplete/invalid report of tests and analysis report. Start: 7/1/2008
N469*	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Start: 7/1/2008
N470	This payment will complete the mandatory medical reimbursement limit. Start: 7/1/2008
N471	Missing/incomplete/invalid HIPPS rate code. Start: 7/1/2008
N472	Payment for this service has been issued to another provider. Start: 7/1/2008
N473	Missing certification. Start: 7/1/2008
N474	Incomplete/invalid certification. Start: 7/1/2008
N475	Missing completed referral form. Start: 7/1/2008
N476	Incomplete/invalid completed referral form. Start: 7/1/2008
N477	Missing dental models. Start: 7/1/2008
N478	Incomplete/invalid dental models. Start: 7/1/2008
N479	Missing explanation of benefits (coordination of benefits or Medicare secondary payer). Start: 7/1/2008
N480	Incomplete/invalid explanation of benefits (coordination of benefits or Medicare secondary payer). Start: 7/1/2008
N481	Missing models. Start: 7/1/2008
N482	Incomplete/invalid models. Start: 7/1/2008

\* Medicare initiated



## Remittance advice remark code and claim adjustment reason code update (continued)

Code	Current narrative
N483	Missing periodontal charts. Start: 7/1/2008
N484	Incomplete/invalid periodontal charts. Start: 7/1/2008
N485	Missing physical therapy certification. Start: 7/1/2008
N486	Incomplete/invalid physical therapy certification. Start: 7/1/2008
N487	Missing prosthetics or orthotics certification. Start: 7/1/2008
N488	Incomplete/invalid prosthetics or orthotics certification. Start: 7/1/2008
N489	Missing referral form. Start: 7/1/2008
N490	Incomplete/invalid referral form. Start: 7/1/2008
N491	Missing/incomplete/invalid exclusionary rider condition. Start: 7/1/2008
N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008
N493	Missing doctor first report of injury. Start: 7/1/2008
N494	Incomplete/invalid doctor first report of injury. Start: 7/1/2008
N495	Missing supplemental medical report. Start: 7/1/2008
N496	Incomplete/invalid supplemental medical report. Start: 7/1/2008
N497	Missing medical permanent impairment or disability report. Start: 7/1/2008
N498	Incomplete/invalid medical permanent impairment or disability report. Start: 7/1/2008
N499	Missing medical legal report. Start: 7/1/2008
N500	Incomplete/invalid medical legal report. Start: 7/1/2008
N501	Missing vocational report Start: 7/1/2008
N502	Incomplete/invalid vocational report. Start: 7/1/2008
N503	Missing work status report. Start: 7/1/2008
N504	Incomplete/invalid work status report. Start: 7/1/2008

\* Medicare initiated

**Remittance advice remark code and claim adjustment reason code update (continued)****Modified codes**

Code	Current modified narrative	Last Modified
M29	Missing operative note/report.	7/1/08
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	7/1/08
N26	Missing itemized bill/statement.	7/1/08
N40	Missing radiology film(s)/image(s).	7/1/08
N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.	7/1/08
N209	Missing/incomplete/invalid taxpayer identification number (TIN).	7/1/08
N232	Incomplete/invalid itemized bill/statement.	7/1/08
N233	Incomplete/invalid operative note/report.	7/1/08
N242	Incomplete/invalid radiology film(s)/image(s).	7/1/08
N350	Missing/incomplete/invalid description of service for a not otherwise classified (NOC) code or for an unlisted/by report procedure.	7/1/08
N367	Alert: The claim information has been forwarded to a consumer spending account processor for review; for example, flexible spending account or health savings account.	7/1/08
N390	This service/report cannot be billed separately	7/1/08
N393	Missing progress notes/report	7/1/08
N394	Incomplete/invalid progress notes/report.	7/1/08

**Deactivated codes**

There are no newly deactivated codes with CR 6229. Lists of all deactivated and scheduled to be deactivated RARCs are available at the WPC Web site on the Internet at <http://www.wpc-edi.com/codes>.

**X12 N 835 health care claim adjustment reason codes**

A national code maintenance committee maintains the health care CARCs. The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early November, March, and July.

The list is available on the Internet at <http://www.wpc-edi.com/codes>.

**New codes**

Code	Current Narrative	Implementation Date
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Start Date: 6/1/2008	1/5/2009
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created. Start Date: 6/1/2008	1/5/2009
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims. Start Date: 6/1/2008	1/5/2009
225	Penalty or interest payment by payer (only used for plan to plan encounter reporting within the 837) Start Date: 6/1/2008	1/5/2009

**Note:** Codes 223 and 224 are Medicare initiated

**Remittance advice remark code and claim adjustment reason code update (continued)****Modified code**

Code	Modified Narrative	Implementation Date
60	Charges for outpatient services with this proximity to inpatient services are not covered. This change to be effective 1/1/2009: Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	1/5/2009

**Deactivated code**

Code	Current Narrative	Implementation Date
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. ( <b>Note:</b> To be used for Workers' Compensation only) – Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code. Start: 01/27/2008 Stop 01/01/2009	1/1/2009

**Note: The code committee also reactivated CARC 207**

**Additional information**

The official instruction, CR 6229, 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/R1634CP.pdf>.

If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, 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 the First Coast Service Options Inc. Medicare Part A customer service center is 1-888-664-4112.

MLN Matters Number: MM6229

Related Change Request (CR) Number: 6229

Related CR Release Date: November 14, 2008

Related CR Transmittal Number: R1634CP

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Source: CMS Pub. 100-04, Transmittal 1634, CR 6229

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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.*

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## EDUCATIONAL EVENTS

### Upcoming provider outreach and educational events

January 2009 – March 2009

#### 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: CORF/ORF

When: Wednesday, February 11, 2009  
 Time: 11:30 a.m. – 1:00 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, March 11, 2009  
 Time: 11:30 a.m. – 12:30 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 [fsohelp@geolearning.com](mailto:fsohelp@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

### Guide for residents, practicing physicians, and other health care professionals

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 available in print and CD-ROM formats 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 200812-33 and 200812-38

### The Adult Immunizations brochure now available for ordering

The October 2008 version of the Adult Immunizations tri-fold brochure, which provides fee-for-service health care professionals with an overview of Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration, is now available for ordering from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network (MLN)*. To place your order, [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 200812-37

### Inpatient Rehabilitation Facility Prospective Payment System fact sheet updated

The revised publication titled Inpatient Rehabilitation Facility Prospective Payment System fact sheet (October 2008), which provides information about the inpatient rehabilitation facility prospective payment system rates and classification criteria, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at <http://www.cms.hhs.gov/MLNProducts/downloads/InpatRehabPaymtfctst09-508.pdf>.

If you are unable to access the hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200812-38

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## 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

### Seminar Registration Hotline 1-904-791-8103

### Seminar Registration Fax Number 1-904-361-0407

### ELECTRONIC CLAIM FILING “DDE Startup”

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

## 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

### 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 ♦**

